FINAL EVALUATION OF THE PERFORMANCE OF THE USAID HIV QUALITY IMPROVEMENT COMPONENTS IN PREVENSIDA AND ASSIST

Managua, Nicaragua
September 2017

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Cover Photo: Graduation event of the Institutional Strengthening Component in NGOs on November 29, 2017. Photographer: Jorge Mejia

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Table of Contents

TABLES OF RESULTS

LIST OF ACRONYMS AND ABBREVIATIONS

ACCCS	Coastal Association for a Campaign Against AIDS
ADESENI	Nicaraguan Association for Sexual Diversity Rights
AIDS	Human Immunodeficiency Syndrome
ALLIANCES	Strategic Alliance for Social Investment in Education and Health
AMODISEC	Association of the Coastal Sexual Diversity Movement
ANICP+VIDA	Nicaraguan Association of Positive Persons for Life
ART	Antiretroviral therapy
ASONVIHSIDA	Nicaraguan Association for HIV/AIDS
ASSIST	Applying Science to Strengthen and Improve Systems Project
BICU	Bluefields Indian and Caribbean University
CAPACITY	USAID Capacity Development Project
CEGODEM	Center for the Study of Governance and Democracy
CEPRESI	Center for AIDS Prevention
CNU	National Council of Universities
CONISIDA	AIDS Nicaraguan Commission
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
DELIVER	Technical Assistance Project on Logistics for Medical Supplies
FAMISALUD	Families United for their Health.
FAREM	Regional Multidisciplinary Faculty
FP	Family Planning
FT	Female Transgender
FY	Fiscal Year
GAM	Mutual Help Group Association
GAO	Western Self-help Group Association
GBV	Gender-Based Violence
GE	Gender Equality
HCI	Health Care Improvement Project
HIV	Human Immunodeficiency Virus
HSH	Men who have sex with men
KAP	Knowledge, Attitudes and Practices
KP	Key Population
LGBTI	Lesbians, Gay, Bisexuals, Transgender and Intersex
M&E	Monitoring and Evaluation
MCH	Maternal and child health
MDS RACCS	Autonomous South Caribbean Region Movement for Sexual Diversity
MOH	Ministry of Health
NGO	Non-Governmental Organization
ODETRANS	Organization of Transgender People of Nicaragua
OVI	Organization for an Integral Life
PAHO	Pan American Health Organization
PAR	Participative Action Research
PASCA	Program for Strengthening the Central American Response to HIV
PASMO	Pan American Social Marketing Organization
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PHIV	People Living with HIV
POLISAL	Health Polytechnic Institute
PREVENSIDA	USAID financed Project for the prevention of HIV/AIDS in high risk populations
QAP	USAID Quality Assurance Project
QMS	Quality Management Program
RACCS	North Caribbean Autonomous Region
S&D	Stigma and discrimination
SCMS	Supply Chain Management System

SPSS	Statistical Package for the Social Science
SRS	Single Registry System
STI	Sexual Transmitted Infections
SW	Sexual Worker
TOR	Terms of Reference
TRANS	Transgender
UCAN	Christian Autonomous University of Nicaragua
UNAN	National Autonomous University of Nicaragua
UNICA	Catholic University
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 Corporation
USAID	United States Agency for International Development
WE	Women Empowerment
WHO	World Health Organization

EXECUTIVE SUMMARY

INTRODUCTION

This report has been prepared in response to a solicitation from the United States Agency for International Development (USAID) Program for an "Evaluation of the Quality Improvement Component for HIV Prevention in Key Populations in PrevenSida and ASSIST" in the period comprised from 2010 to 2020, within the framework of implementation of the strategy of the United States President's Emergency Plan for AIDS Relief (PEPFAR) in Central America.

The purpose of this evaluation was to evaluate the performance of the quality improvement component in PrevenSida and ASSIST, implemented by University Research Co., LLC (URC) in Nicaragua, and to provide recommendations for future activities.

PrevenSida's goal (2010-2017) is to "increase healthy behaviors in order to reduce HIV/AIDS transmission" among high-risk groups through the use of condoms, reducing the number of sexual partners, increasing access to counseling and testing. The project promotes a comprehensive continuous prevention care model based on non-governmental organizations (NGOs) and community-based organizations in key populations (KP): men who have sex with men (MSM), female transgender (FT) and comprehensive care for people living with HIV (PHIV) to strengthen adherence to antiretroviral therapy (ART).

The ASSIST project (2013-2016) had the following goals: a) strengthen the capacity of the universities to provide training in HIV prevention to medical and nursing students (especially new treatment guidelines, reduction of stigma and discrimination, and prevention of human trafficking) and b) promote the quality of pre-service learning, emphasizing the adoption of quality improvement technologies. It successfully promoted the development and implementation of an HIV teaching package in the medical and nursing schools of nine universities in Nicaragua.

METHODOLOGY

The methodology that was developed sought a consistent response based on evidence to five guide questions in the evaluation process:

1. What changes occurred in the quality of the services provided in each activity that can be directly attributed to USAID's direct support?
2. What methods were more effective for transfer of knowledge, attitude improvement and adoption of best practices in each component?
3. How were USAID's principles of gender equality incorporated in quality improvement?
4. To what extent are quality improvement programs sustainable?
5. What lessons can be learned and shared with other counterparts and countries?

Since the nature of the fifth question is conclusive, the first four questions were operationalized in qualitative and quantitative variables that configure the framework guideline established and demarcate a qualitative and quantitative study of a normative nature, which combines information from primary and secondary sources, assuming that each question requires information from existing documentation in the projects and organizations, as well as interviews and focus groups with three types of populations involved in the implementation of the projects:

- Beneficiaries: key population served and university students.
- Direct service providers: promoters who directly provide and offer HIV care services to key populations, people living with HIV and university teachers.
- Institutional boards: directors and technical coordinators in the organizations and deans and academic coordinators in the universities.

During the secondary information source review, numerous documents, databases, educational materials, official reports, information and data collection forms and instruments, banners, etc., were reviewed.

The team conducted field work, gathered extensive documentation and interviewed 50 people in KP, 73 PHIV, 66 promoters, 145 students and 40 teachers. Thirty-four focus groups were conducted with beneficiaries and providers, and 46 directors of organizations, universities and projects were interviewed.

The evaluation was conducted from July to September 2017. The evaluation team consisted of a quality evaluation specialist, an HIV specialist and a gender specialist. None of the team members have conflicts of interests in making this proposal.

Quality was evaluated, bearing in mind the performance of both projects in the implementation of strategies and technical aspects, including process efficiency, user satisfaction, gender equity and potential sustainability. Although there is some evidence of the effectiveness of both projects in reducing risk practices in key populations, this warrants a separate study.

RESULTS

Result 1: What changes occurred in the quality of services provided in each activity that can be directly attributed to USAID's direct support?

PrevenSida

A dynamic process has been developed, aimed at institutional capacity-building in management, administration and service delivery, combined a comprehensive training process structured at the beginning of the project and subsequently underpinned by in-service accompaniment (coaching), evaluative meetings, collaborative improvements and promotion of improvement cycles in the organizations. The results of this process are noticeable in the annual quality standard evaluation system, where a large majority of the organizations surpassed their quality gaps.

This process has focalized more on quality with the formulation of Quality Management Programs (QMPs), which broaden the dimensions of improvement with the inclusion of labor performance measurements, an organizational climate analysis, an external and internal user satisfaction survey and complaint management.

Organization promoters and directors highly value these two phases in terms of the development of their systems and staff capacity. Finally, a majority highlights, as a global outcome, the recognition of the organizations in the institutional scenario of the national or local response to HIV in which they participate.

The existence of clear Continuous Quality Improvement (CQI) processes has promoted a dynamic of change that generates strategic transitions in the forms and level of quality of the services and incorporates new initiatives that configure management and service models, which design and process systematization are highly consolidated.

There is a high level of satisfaction in key populations with respect to the warmth of care received.

ASSIST

A model of transfer was developed by ASSIST, together with the universities, involving sensitization and adjustment of the pedagogical package according to the specificities of each center, training teachers in innovative and updated contents, teaching methodologies and academic evaluation methods. Students, teachers and directors expressed a high degree of motivation and recognition of the contributions made by the pedagogical package and the support received for its implementation. Almost all universities have included HIV contents in the study plans of various subjects, including the curriculum of education.

Quality improvements have been found at the level of the beneficiary population, showing protection behavioral changes in KPs and PHIVs and a significant improvement in medical and nursing students in relation to compliance of standards of knowledge and attitudes with regard to HIV.

A high level of satisfaction was found in relation to the usefulness and contribution of knowledge and the level of student participation.

Concurrently, a high value is perceived at the level of providers (teachers) regarding changes in the development of their own capacity to provide care and education with the best quality standards.

Result 2: What methods were more effective for transferring knowledge, improving attitudes and adopting best practices in each component?

PrevenSida

There is a greater preference in the key population to acquire more knowledge focused on individual or small group activities that enable more and better communication and interaction.

At the key population level, major changes in risk attitudes or protection are counseling linked to diagnostic tests, peer education and counseling linked to Gender-Based Violence (GBV) and stigma and discrimination (S&D). At the level of promoters, attitude changes were found in relation to the population served, mostly mentioning information exchange sessions.

Promoters and directors note that "good practices" are mostly identified in evaluative processes, while relevant positive differences are identified in the results or implementers. Coaching is also mentioned in the identification of good practices. Replication of good practices points to the need to sensitize and promote comprehension of the changes involved to subsequently move to capacity-building in small group sessions and consolidation of in-service accompaniment.

ASSIST

Students indicate that the most effective methods are participative activities and creative and playful modalities (socio-dramas, simulation, etc.), as well as activities that encourage meetings with KPs and PHIVs.

At the level of teachers and promoters, preferences focused on structured training activities and information exchanges or evaluative sessions. A percentage of teachers indicated a bibliographical review (books, articles, regulations).

In terms of skill development, the situation varies as result of the significant increase in the weight of information exchanges and evaluation sessions. A few students mentioned in-service accompaniment (coaching) and performance evaluation.

Result 3: How were USAID's principles of gender equality incorporated in quality improvement?

In terms of gender equality, evidence shows that the two projects have given high relevance to the integration of defense of human rights, the fight against GBV and S&D for reasons of diversity or by the simple fact of being HIV positive. Both projects have developed broad training processes and support for developing actions in this regard. Two work modalities stand out, which are linked to this issue and have

greater effectiveness in changing attitudes (peer dialogue and counseling on GBV and S&D prevention), while exchanges between teachers and students in relation to this issue reflect the level of relevance achieved.

The formulation of global strategic plans for KP and PHIV populations has promoted a greater role and participation in alliances with local institutions and organizations.

Result 4: To what extent are quality improvement programs sustainable?

Sustainability is clearly expressed in the situation faced by the organizations and universities months after USAID funding ended. It was found that although lack of external financing is a very relevant conditionality in the level of maintenance of the processes and CQI, sociocultural elements, materialized in the existence of links between the community base, quality and leadership commitment, exert greater influence for continuing to implement the activities that were initiated with USAID support with their own resources.

NGOs without community links maintain management teams that are highly qualified and stable with the possibility of reactivating processes, but without any real convening power with the population served or with the promoters.

Despite difficulties created by lack of financing, community organizations with active leaderships maintain a low-level dynamic, underpinned by the valuable role of "voluntary activists" who serve as focal points and channels of communication.

Universities do not depend on external financing and their academic vocation feeds systematic updates of scientific and pedagogical systems. The quality of leadership of each university also influences the maintenance of CQI actions.

Result 5: What lessons can be learned and shared with other counterparts and countries?

Without a doubt, numerous elements of the two projects can be highlighted as significant learnings. In a prolific scenario of accomplishments and innovations, the evaluation identifies important lessons learned that can be broadly shared, among which we highlight the most relevant, albeit not exhaustive, as a way of taking an inventory:

Strengthening the health sector: universities and NGOs

- The CQI component is a guarantee of effectiveness in the achievement of results and maintains dynamics that are motivated and committed to change. In the case of PrevenSida and ASSIST, the extensive track record of URC in quality improvement is an added value.
- All processes involved in CQI require a clear commitment from the authorities and leaderships. Deficiencies in this respect multiple obstacles and promote dominance of routine and reduction of all motivation. Sustainability requires this essential factor.
- Adjusting training processes to respond to specific capacities and needs. This lesson is relativized when the preference increases for exchange and evaluation sessions that can be developed by organizations and universities in a more autonomous way unlike training, which requires "external agents".
- Activities that foster meetings between different populations contribute to reduce S&D, highlighting service practices and open events (fairs, forums, marches) in the universities, while this is represented in coverage diversification in organizations serving KP and PHIV, which in fact refers to all PHIV (all genders and sexual identities).
- Systematization and validation of transfer models, as presented by ASSIST, for implementation of the pedagogical package facilitates and makes replication of "good practices" feasible.

Prevention and community care provided by NGOs:

- The intersection of human rights promotion with the fight against GBV and S&D is a fundamental need in the fight against HIV by bringing closer and personalizing the meeting between beneficiaries and providers, optimizing the results.
- The communication and liaison roles developed by NGO facilitators to maintain links between organizations and grassroots communities are crucial for the development and sustainability of the model. This aspect should be highlighted and projected in the systematization of experiences that are replicated.
- Service activities that encourage creative and playful participation of beneficiary populations further strengthen transfer of knowledge, skills improvement and better attitudes.
- The integration of psychological services for Transgenders and PHIV evidences the need to address people in their human and integral dimension. As some PHIV say, "they see us and value us as people".
- It is possible to explore the chances of systematizing themes and communication modalities, such as peer dialogues and group sessions, to incorporate them in the working modalities.

Strategic information for key populations

- The creation of information databases makes it possible to visualize differences and contrasts in reference to standards or between beneficiary populations or implementers, fosters reflection and evidence-based dialogues, triggers dynamics to interpret the gaps found and builds consensus on corrective actions.
- Capacity building for processing and information analysis strengthens the commitments of the people with process of change, to the extent that it always questions the situation based on evidence and prevents routine-based management. The experience of implementing the Participative Action Research (PAR) methodology shows that the application by KPs has great potential.
- Mapping cruising locations: This evidences the need of instruments that provide information about the dynamic of the populations served.

CONCLUSIONS

It was found that PrevenSida and ASSIST have implemented CQI in all the strategies that were implemented with their different partners and beneficiaries, achieving a successful transfer of the proposed model.

In the case of NGOs served by PrevenSida, an unedited action proposal was implemented in the country, which benefitted a group of organizations with managerial weaknesses, some of which had been recently created and had no work experience at the community level or with disperse and "hidden" key populations. Simultaneously, the configuration of the forms of service delivery was addressed, while broad institutional capacity gaps were resolved by training and organizing the managerial and administrative components.

In the case of universities served by ASSIST, CQI was effectively incorporated in the pre-grade training education activity, achieving sustainable changes in the curriculum related to HIV in the careers of medicine and nursing, and valuable teaching and methodological instruments were developed, which have been broadly adopted by the universities. Both projects effectively incorporate USAID's gender equity principles.

Although evidence exists regarding technical and socio-cultural sustainability, lack of funding limits financial sustainability.

1. INTRODUCTION

This report complies with the terms of reference of the external consulting contract agreed with URC (Purchase Order N° US-FY17-P019-6960) and USAID (See Annex 1). The purpose was to evaluate the performance of the quality improvement component of PrevenSida and ASSIST, implemented by URC in Nicaragua, and to provide recommendations for future activities, according to the timeframe established.

The results will be used by USAID Nicaragua to improve the design of future activities and to share "best practices" with other countries of Central America. The audience of the evaluation will be USAID Nicaragua and Regional and, in particular, the general development office and regional HIV program. The results of the study will also be shared with national and local interested institutions, executing partners and beneficiary populations. Finally, the results of the evaluation will be used for final regional reports. The report comprises the following sections: Introduction, Methodology, Results, Conclusions, Lessons Learned and Annexes.

The evaluation, conducted between July and September 2017, covered the period comprised from 2010 to date and was focused on the performance of the quality improvement component implemented in the PrevenSida and ASSIST projects.

2. BACKGROUND

2.1 HIV in Nicaragua: HIV was first detected in Nicaragua in 1987 and currently only 0.2% of the adult population is HIV positive. Nicaragua has one of the lowest HIV prevalence rates in Central America. According to the Ministry of Health of Nicaragua (MOH), 12,164 cases of HIV-positive people accumulated in 2016. Of these, 10,894 are alive and 3,885 under treatment. HIV prevalence between FT and MSM is significantly greater (18.7% and 9.3%, respectively) than among sex workers (SW) (1.1-1.9%). In 2016, the incidence and prevalence rates were estimated at 23 / 100,000 and 24 / 100,000, respectively.

2.2 Cooperation of USAID Nicaragua in HIV: Since 1998, USAID Nicaragua has been implementing HIV activities with bilateral funds directly originating from the Mission's annual budget. Initially, there were only regional projects, but since 2003 some specific activities were included in the health portfolio: PrevenSida, Families United for their Health (FAMISALUD), Strategic Alliance for Social Investment in Education and Health (ALLIANCES 2), Health Care Improvement Project (HCI) / ASSIST and Technical Assistance Project on Logistics for Medical Supplies (DELIVER). Regional projects were implemented (Pan-American Social Marketing Organization (PASMO), Program for Strengthening the Central American Response to HIV (PASCA), Supply Chain Management System (SCMS) and Capacity Building Project (CAPACITY), contributing to the implementation of the cooperation strategy, which includes a strong service quality improvement component.

2.3 PEPFAR Cooperation: A five-year strategy (2010-2014) was formulated with funding from PEPFAR, within the Partnership Framework between the Governments of the United States and Central America, which outlined priority areas in the HIV program, where participating partners, regional organizations, the Government of the United States and other important donors devoted efforts and resources. The overall purpose was to reduce HIV/AIDS incidence and prevalence in KPs in the Central American region by joining resources and coordinating initiatives to enable a robust and more efficient response to the region´s epidemic. As of 2015, projects were adjusted to respond to the new PEPFAR strategy (2015-to date) focused on achieving HIV epidemic control in the region.

2.4. The Nicaragua HIV program: The Nicaragua HIV Program is described in detail in the Terms of Reference (Annex N°1). In summary, the strategy consists of four components:

- **Prevention:** The problem is insufficient coverage and quality of HIV care services in key populations. The strategy is to increase healthy behaviors to reduce HIV transmission.
- **Systems strengthening:** Problems of dependence on external aid and insufficient government funding, institutional weaknesses in providing services and shortage of tests and antiretroviral drugs are addressed. The strategy is to strengthen capacities for the provision of services, human resource development and availability of essential medical supplies.
- **Strategic information:** The problems are insufficient use of information, insufficient knowledge in and by key populations and lack of an effective registration system. The strategy is to strengthen capacities to monitor and use information that increases knowledge of the epidemic and proper decision-making.
- **Policy reform:** The problems are stigma and discrimination toward KPs and PHIV, gender inequities and insufficient participation of other health sectors, universities and NGOs. The strategy is to improve the policy environment to achieve the goals of universal service access.

Development hypothesis:To achieve the above objectives, USAID defined twelve strategic activities. Eleven were implemented by PrevenSida (1-7, 9-12) and three by ASSIST (4, 5 and 6). (See Annex 1, Table 2).

PrevenSida (2010-2020): The PrevenSida project is implemented by URC under Cooperative Agreement AID-524-A-10-00003 and has a total estimated cost of $9,999,540.

On September 20, 2010, USAID Nicaragua signed a cooperation agreement with URC. The objective was to reduce HIV/AIDS transmission in CPs (MSM, FT, SW and other priority populations). This would be achieved by increasing healthy behavior, such as increasing use of condoms, reducing the number of sexual partners of CPs and increasing access to HIV tests for these populations.

From 2010 to 2015, the project focused on four programmatic areas: institutional strengthening, preventive services, reduction of stigma and discrimination, and participation of national HIV/AIDS authorities. In the modification of 2016, the activity was expanded to become a regional program and a fifth component was added: strategic information for CPs. This addition was created to capitalize Nicaragua's experience in strengthening KP NGOs in knowledge management and expanding this approach to a regional level. The project completed the aforementioned four initial programmatic areas in September 2017.

In 2018-2020, a sole objective was established to improve the capacities of CP NGOs in knowledge management related to the HIV epidemic in Central America (Guatemala, El Salvador, Honduras, Nicaragua and Panama). The two intermediate results are:

- Result 1: Apply the lessons learned to strengthen NGOs in the analysis and use of HIV data.
- Result 2: Strengthen the capacity of NGOs to develop new HIV knowledge specifically for CPs.

The project was designed to increase the capacity of NGOs working with CPs on prevention to improve their organizational systems and management processes, in order to achieve an even greater impact in their prevention efforts. The project started with at least 20 NGOs (increased to 50 with the expansion of the project), providing HIV prevention services to CPs in Nicaragua. The expectation was to enable NGOs to continue expanding their prevention efforts focused on CPs with the necessary tools to have a greater impact and to develop and maintain sustainability. Prevention services were offered, including counseling and tests, communication for behavior change, supply of condoms and lubricants, and evaluation and reference to other services: diagnosis and treatment of sexually transmitted diseases, family planning, alcoholism, drug addiction and community support groups. The offer also includes structural activities for reducing stigma and discrimination and GBV. People with positive tests are referred to public health units for confirmation and initial treatment, according to the country's HIV care and treatment guidelines.

Based on the previous experience of the HCI project, also implemented by URC, for achieving the results of the PrevenSida project, modern continuous quality improvement approaches were applied to exceed common barriers in the management of the organizations and provision of preventive services in a complex social context with weak health systems and NGOs facing serious human resource and material constraints. Each improvement collaboration addressed two sets of objectives: improving management capacities and improving access to quality prevention services.

ASSIST project (2013-2016): This project was implemented by URC under Cooperative Agreement AID OAA-A 12-00101. Its component for strengthening universities in undergraduate HIV training received US$650,000 in financing. The transfer of competencies to the universities was identified as the continuation of the process initially carried out by the HCI project with MOH in 2000-2013. The process for transfer of knowledge and skills in the universities took over good practices and lessons learned in technical assistance with health workers providing services. The development of a teaching and management package and methodological tools to improve the competencies of the staff, strengthen institutions and contribute to the sustainability of the processes stand out among MINED´s good practices. ASSIST implemented HIV activities with the objective of: a) strengthening the capacity of universities to offer HIV prevention training to medical and nursing students (especially new treatment guidelines, reduction of stigma and discrimination, gender and prevention of human trafficking) and b) promoting continuous quality improvement in education with an emphasis on the adoption of quality improvement methodologies.

This process was developed with nine universities: Polytechnic Institute of Health (POLISAL), National Autonomous University of Nicaragua (UNAN) in Leon, Bluefields Indian and Caribbean University (BICU), University of the Autonomous Regions of the Caribbean Coast of Nicaragua (URACCAN), Polytechnic University of Nicaragua (UPOLI), Christian Autonomous University of Nicaragua (UCAN), University of Science and Technology (UNICIT), National Autonomous University of Nicaragua (UNAN) in Managua and Regional Multidisciplinary Faculty (FAREM) in Matagalpa. The first stage of technical assistance in the universities involved reviewing teaching methodologies of the contents of the curriculum of the medical and nursing education programs, which involved teacher training (health workers providing services) and student classes (new workers in previous education) until 2013.

ASSIST developed continuous quality improvement processes to adjust the curricula of the universities. The transfer process contemplated three lines of action: transfer of the pedagogical package, selection of contents for integration in the curricula, study plans or syllabus, according to the study plan of each university and profession, and implementation of continuous quality improvement and management of knowledge. Continuous quality improvement has been promoted through visits to the universities and application of rapid improvement teaching/learning cycles. In this capacity building process, teachers have been trained to teach HIV care protocols, reduction of stigma and discrimination, gender approach, trafficking of people, and knowledge management. The participation of ASSIST in capacity building was also relevant for designing and implementing a quality management program in three organizations working with key populations and the LGBTI community.

3. EVALUATION METHODOLOGY

The study responded to five guide questions:

1. What changes occurred in the quality of the services provided in each activity that can be directed attributed to the direct support of USAID?
2. What methods were more effective for transferring knowledge, improving attitudes and adopting best practices in each component?
3. How were USAID's principles of gender equality incorporated in quality improvement?
4. To what extent are quality improvement programs sustainable?
5. What lessons can be learned and shared with other partners and countries?

Given that the first four questions are analytical in nature and the fifth question is conclusive, the four analytical questions were operationalized in variables, which enabled to establish relevant qualitative or quantitative parameters to determine the performance of the quality improvement component in the two projects (Annex 2 – Variable matrix) and were the basis for designing the information collection and analysis instruments.

Type of study: A qualitative/quantitative normative study characterized by incorporating improvement proposals based on the results found. It is an ex-post evaluation, which has the main characteristic of explaining the implementation of the quality improvement component in the PrevenSida and ASSIST programs.

Scope of study: It is made up of a set of civil society organizations (CSO) and universities that have received technical and financial support from USAID through PrevenSida and ASSIST during the period 2010-2017, which were assumed as the basic analysis units, bearing in mind that the quality improvement component evaluated is an institutional attribute rather than people viewed as individuals or collectively, whether as part of the organizations or beneficiary populations.

From the perspective that the CQI component links people in their functionality and effects, the organizational analysis is complemented with an approach of clusters of people linked to each analysis unit (organization/university) in three levels:

- Beneficiaries: Includes population served (KP, PHIV) and medical and nursing students.
- Service providers: Includes promoters of key population and PHIV organizations and university teaching staff.
- Directors: Management and technical staff in organizations and universities.

Sample and area of study: Given the diversity that exists, the closing of the two projects and PEPFAR's current prioritization, five municipalities were prioritized (Managua, Leon, San Carlos, Bluefields and Bilwi) where the largest part of the universe of organizations and universities that have participated in the last years is concentrated. The following was thus established:

- Sample for evaluating PrevenSida: In relation to civil society organizations, those that had been funded in the last year of PrevenSida were selected. A total of eleven organizations participated in the evaluation: Nicaraguan Association for Sexual Diversity Rights (ADESENI), Nicaraguan Association of Positive Persons for Life (ANICP+VIDA), Nicaraguan Association for HIV/AIDS (ASONVIHSIDA), Movement Association for Sexual Diversity in the Caribbean Coast (AMODISEC), Center for AIDS Education and Prevention (CEPRESI), Center of Studies for Governance and Democracy (CEGODEM), Western Self-help Group Association (GAO), Organization of Transgender People of Nicaragua (ODETRANS), Autonomous South Caribbean Region Movement for Sexual Diversity (MDS-RACCS), Coastal Association for a Campaign Against AIDS (ACCCS) and San Lucas Foundation. In the specific case of this last organization, it was incorporated in the evaluative process because it is the first organization that received technical assistance to carry out its quality management plan.

- *Sample for evaluating ASSIST:* Six universities participated: Catholic University (UNICA) (School of Medicine), UNAN-Managua: School of Medicine and POLISAL (Nursing School), UNAN-Leon (School of Medicine and Nursing School), UCAN-Leon (Department of Medicine), URACCAN (Department of Medicine) and BICU (School of Medicine).

The size of the sample of people to be interviewed obeys mainly to diversity inclusion criteria at the level of organizations (type of population served: KP and PLHIC) and universities (Medicine, Nursing) without establishing population representativeness criteria, to the extent that the study is predominantly qualitative in terms of assessments and perceptions (collectivized in the case of beneficiaries and providers).

Counting with qualitative and quantitative support from individual reflections, it was considered when estimating the size of the sample that clusters should have sufficient amplitude to establish consistent frequencies in the qualitative information collected about their perceptions and assessments at this level of disaggregation, having as reference:

- Beneficiaries: universe of people served (KP and PHIV) in the case of PrevenSida; number of students enrolled in the last years in the case of ASSIST.
- Providers: Information on staff trained in the two projects (promoters and teachers) and knowledge accumulated in fieldwork by PrevenSida and ASSIST staff.
- Directors: two to four was estimated per organization or university, to the extent that in-depth interviews are conducted to key informants holding positions of responsibility.

Sources of information: Primary and secondary sources of information were used. Primary information is obtained through surveys, focus groups and interviews. Secondary information consisted in the review of physical and digital documents provided by the two projects, organizations and universities, including periodic reports, communicational and educational material, as well as research conducted within the funding framework and databases of the organizations and universities. The entire process of collecting primary and secondary information counted with the collaboration of the management and technical teams of the PrevenSida and ASSIST projects, who we thank for their excellent readiness and support.

Sources of primary information: Qualitative and quantitative techniques were used, such as surveys, interviews and focus groups. Prior to the fieldwork, the instruments were validated in two sessions: first with KP and PHIV organizations and another with a university of Managua. The process enabled to make important adjustments to the questionnaires and guides.

Survey: Aimed at beneficiary populations of NGOs working with KP and PHIV (See Annex 3. Questionnaire 1) and service provider staff from the same organizations (See Annex 3, Questionnaire 2), medical and nursing students (See Annex 3. Questionnaire 3) and teaching staff of the universities studied (See Annex 3. Questionnaire 4). In the case of students, it was determined that the survey would be self-administered, given their high educational level and limited time available due to tight class schedules, counting with the support and quality control of the field team (field supervisors and interviewers). In the case of KP, PHIV and NGO promoters, their low academic level was considered and the field team conducted individual interviews in the form of a dialogue.

A total of 123 beneficiaries of the PrevenSida Project were interviewed, including 50 members of KP and 73 PHIV, accounting for 19% and 70% of the programmed sample. In the ASSIST Project, 145 university students were interviewed, of which 104 study medicine and 41 study nursing, accounting for 113% and 117% of the programmed sample. In the universe of service providers and teachers, 66 promoters were interviewed, 46 of which are working with KPs AND 20 with PHIV, accounting for 48% and 67% of the sample programmed for the PrevenSida project. Furthermore, 40 university teachers were interviewed, including 25 medical teachers and 15 nursing teachers, accounting for 76% and 107% of the sample programmed for the ASSIST project (See Table 1).

Interview: A semi-structured questionnaire was used to interview senior management personnel in the organizations (See Annex 3. Questionnaire 5). A total of 46 key informants were interviewed, 32 from the organizations and 14 from the universities. In addition, four interviews were made to members of the PrevenSida/ASSIST team and an interview with a director of the Nicaraguan Commission Against AIDS (CONISIDA)/Ministry of Health (MOH).

Focus groups: The focus group technique was developed based on a guide with a maximum of six guiding questions (See Annex 4. Focus group guides), which were centered on identifying consensus around the **Most significant changes in the quality** of the services, establishing a hierarchical order according to the adherence rate. A dialogue was promoted to explain the reason for these changes and their impact on the participants in terms of level of knowledge, change of behaviors or development of competencies, in order to answer the evaluation questions. A reflection on stigma and discrimination towards LGBTI and PLHIC was included as a restriction of the quality, identifying progress and perspectives.

A condensed report of the session (60 minutes) was made, highlighting consensus and dissension, as well as relevant incidences of the session. Focus groups were carried out when more than five participants were present, in order to count with an adequate level of socialization and diverse opinions. In the case of students, more than eight participants were always present. In total, 34 focus groups were carried out, of which 22 were with the beneficiary population, 6 with KPs, 5 with PHIV, 11 with university students, including 7 with medical students and 4 with nursing students. Eight focus groups were conducted with promoters and 4 with university teachers.

Sources of secondary information: A broad documentary review process was developed. The specific sources of information are cited in the bibliography chapter and generally include the review of:

- Annual management reports of the two projects and organizations
- Final reports of consultancies and prior studies.
- Quality management programs of the organizations.
- Measurement tools (checklist, questionnaires for users, complaint management)
- Reports on the application of the instrumental components of the Quality Management Program (QMP) (quality standards, organizational climate and user satisfaction survey).
- Reports on experience systematization, including, among others, the implementation of quality management.
- Presentations regarding relevant experiences.

Information processing and analysis: The surveys were typed in a data capture software developed by the Census and Survey Processing System (CS-Pro) V7 and were processed in a Statistical Package for the Social Sciences (SPSS). The focus groups were transcribed in Word to subsequently develop a category analysis matrix, which is an eminently qualitative technique. The surveys were analyzed at a basic descriptive level with the development of frequency distribution tables. The information triangulation technique was used for the global information analysis, based on the results of the documentary review, surveys, interviews and focus groups. The broad and diverse information compiled was sufficient to cover the variables of the analysis in which the guiding questions of the evaluation were operationalized, enabling to configure a vision of the current situation in terms of functionality and the results of the CQI component in the two projects.

Constraints: The evaluation team considers that the methodological design applied during 54 workdays, which guided data collection, processing and analysis, has provided relevant, sufficient and updated evidence as a basis for ensuring consistency and quality in our response to the guiding questions of the evaluation. In this regard, the results shown correspond to qualitative or quantitative evidence, which verifies a specific characteristic or situation of the CQI component in the two projects evaluated and enables to confirm and support the assessments made in the conclusions.

Like all processes involving a broad diversity of social actors who participate on the basis of their own situation and interests, it was not always possible to fully comply with the time and process parameters initially established in the methodological design and work plan. However, none of the constraints or difficulties presented generate any type of methodological contingency that could be translated to the detriment of the quality or analysis of the information.

In terms of collecting and analyzing secondary information, no contingency or constraint has arisen. On the contrary, we consider that the two projects have highly consolidated monitoring and evaluation systems in their systematization and continuous improvement process, which are complemented with a diversity of relevant experience systematization and documentation initiatives, which, as a whole, enable to have broad information that facilitates verification of parameters and standards that operationalize the main variables of this evaluation.

The main constraints in the evaluative process are related to the collection of primary information, where the participation of organizations and universities was crucial. It can be affirmed in the general appraisal that the survey sample enables the analysis proposed for this evaluation, to the extent that inclusion of all diversity clusters required was achieved at the level of organizations and universities (which are the main analysis unit):

- Sufficient clusters of KP and PHIV for PrevenSida
- Sufficient clusters in the schools of medicine and nursing for ASSIST
- Clusters from the Pacific and Caribbean for the two projects

However, it should be noted that although it was possible to adequately cover previous estimates in the case of student and teacher samples in the universities, as well as population and promoter samples in the organizations that work with PHIV, this was not possible in the case of the participation of key populations, which was notoriously limited in comparison with the programmed samples. This has clearly led to overestimate the necessary sample, which was also influenced by the fact that the subsidy ended a few months before and several organizations no longer had links with its beneficiary population. Therefore, despite reiterated attempts and an extension of the timeframe, the planned calls could not be achieved. However, as previously noted, it was possible to establish sets of sufficient participants to ensure consistency in the analysis at the level of disaggregation of the projects with clusters of beneficiary populations and providers that include all the diversity of organizations/universities linked to PrevenSida and ASSIST.

We also highlight that the main difficulty in relation to the universities was conducting a focus group with teachers in three universities as a result of the time factor and work commitments in the hospitals. In the last week of the fieldwork, the difficulty was a conflict in Puerto Cabezas, which precluded the work team from traveling as scheduled, so the fieldwork phase was extended and compensated by reducing the time available in the work schedule for the processing and analysis phase.

Ethical considerations: The evaluation applied the bioethical principles of informed consent, confidentiality, voluntariness and privacy. The results were shared with the representatives of the beneficiary organizations and will serve to improve the approach of the USAID projects for the benefit of these populations.

4. RESULTS

4.1 What changes occurred in the quality of the services provided in each activity that can be directly attributed to the direct support of USAID?

4.1.1 Quality improvements in the sphere of the PrevenSida project.

The PrevenSida project implemented eleven of the twelve strategies defined by USAID, which are linked to quality improvement: three in prevention, three in strengthening the health sector, two in strategic information and three in policy environment.

Changes in prevention activities:

The strategies assumed by PrevenSida in this component were:

- *Develop and implement innovative and cost-efficient prevention interventions based on evidence.*
- *Improve STI detection, diagnosis and treatment.*
- *Broaden access to counseling services and voluntary tests for key populations.*

The project's previous evaluations and management reports show a high degree of performance in terms of preventive services and support provided to the organizations in each management year. In general, the reports highlight the contributions made by PrevenSida in terms of coverage and strengthening actions. It should be highlighted that the care model proposed by PrevenSida for preventive services is innovation in relation to the services that existed prior to 2010 because it refers to offering services based on interpersonal communication that did not exist before and the proposal is not limited to service provision. It also deals with capacity building in the organizations that do not have experience and a majority that shows clear technical, administrative and managerial weaknesses. In this order, the proposal involves developing services provided by non-professional workers, including some organizations with very low schooling and a clear resistance in professional and institutional scenarios, particularly in relation to HIV tests by non-professional staff.

The reports and interviews show qualitative changes in the services offered and how these services are provided, which are clearly associated to quality improvement processes that have guided strategic adjustments. The first evidence highlighted (Table 2 - Annex 4) are changes in the population targeted for delivery of services, which in the first years is predominantly aimed toward populations with easier access (youth and women at risk, mobile populations, etc.) and which have concentration places that facilitates approaching them. Access difficulties due to stigma and discrimination toward key populations (MSM, FT) and PHIV, determine their exclusion. The evidence and interviews highlight that the "mapping of cruising locations", as a tool incorporated as of 2013, provides information and the basis for a quality leap in the planning and organization of the operational work of the promoters, in such way that access by KP to services and tests progressively increases until it becomes broadly predominant in 2016 (87% and 89%, respectively) (Table 2 - Annex 4). The same happens in the care provided to PWHIV, where the number of persons served is multiplied ten times because the logic of mapping is applied in the places where services are demanded (clinics and hospitals) and the location is based on the knowledge of the PWHIV already contacted. A final boost in this case is associated to the clinical stage survey, initiated by the World Health Organization (WHO) in 2015, which enabled greater approach and knowledge of the life dynamics of PHIV, as well as their more personalized needs and demands.

Recognizing that the service supply should be adjusted to the daily dynamic of the populations helped to identify that services concentrated in establishments created another barrier in terms of access and level of confidence.
Bringing services closer to the places where the population lives was a new strategy, as shown by the predominance of preventive services and tests in establishments in 2011, which passed to be performed in the community (94% and 92%).

The qualitative survey included in this study gives high relevance to the assessments and perceptions of the people interviewed in relation to the quality and usefulness of the services. Fifty-nine percent of the key population served assess as "very good" the way how those actions have been received, 18% assess it as "good", and 24% assess it as "deficient" *(Table 3 - Annex 4)*, mainly linked to the assessment that their partners or relatives are not served and deficient communication.

In exploring the personal usefulness of these services *(Table 4 - Annex 4)*, it was found that 39% of the populations served refer to the expansion of new HIV knowledge, 22% to the possibility of greater socialization (more interaction and exchange of views and clarification of doubts) and 39% to the change of attitudes (new values and behaviors). On the other hand, 55% of the key population associate quality with kind and warm care provided by peers, 22% associate it to learning new knowledge, and 8% refer to interactions at the community level. It is noteworthy to highlight psychological care as a specific mention of quality improvement in the case of PHIV *(Table 5 – Annex 4)*.

The KP and PWHIV focus groups highlighted their perception that organizations have significantly improved their relationship with them as a result of greater levels of confidence and participation. They also indicate that there is a better response to their concerns and demands for information or care. The transgender group also indicates that the situation of this population is difficult, where unemployment persists and the absence of personal life projects reinforce the trend of substance abuse, sexual work and lack of adoption of changes in behavior for protection. In contrast, it was evident among PWHIV groups that the top motivation for participating and socializing with their peers is greater empowerment of their responsibilities with themselves and the aspiration of continuing to improve their quality of life and that of their peers.

From the perspective of the staff that provides services, 86% of the promoters *(Table 6 – Annex 4)* refer to recent significant changes to improve the activities they develop, 47% refer to the change of quality resulting from a more personalized and closer relationship with the key population and PHIV, 34% highlight new learnings and strategies to improve service supply and accessibility, 10% refer to psychological care and another 10% perceive a reduction in stigma and discrimination toward the key population and PWHIV *(Table 6 – Annex 4)*. The focus groups especially mentioned an improvement in the peer dialogue centered on actual life, greater confidence of the KP in the performance of tests, mapping of KP concentration and cruising locations, greater attendance to and permanence of PWHIV in self-help groups and an increase in saving people who abandon ART.

The general assessment of the beneficiaries and providers evidences the preponderance of the continuous quality improvement process in the actions of the projects, which coincides with the evidence resulting from the studies carried out by the PrevenSida team in 2016 *(Study on the Effectiveness of PrevenSida - What works? - 2015)* based on processing available data in the sole register of service and stating that the highest quality of the actions measured by the adequate compliance of combined prevention standards in the key population has clear effects on risk behaviors.

Changes in institutional capacities:

The strategies assumed by PrevenSida were:

- *Strengthen institutional capacity to improve and expand the provision of HIV quality services.*

- *Develop methodologies and implement activities to improve institutional and human resources capacity.*
- *Strengthen supply chain management systems.*

In 2010, an intensive training program began, structured in three essential components: management, administrative-financial management and preventive services, in accordance with the structure of quality standards and performance used to evaluate organizations, in order to establish a baseline. 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. 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.

Hence, the initial turning point represented 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 internal conflicts. 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 2010-2013 *(Table 7 – Annex 4),* only two of a total of ten organizations achieved over 75% compliance. In all five years, no PHIV community-based 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 NGOs, which already had a good performance in the second and third year. Since 2014, they all had achieved an index greater than 75% in all areas and most of them had levels higher than 95%.

The case of community organizations has been quite different. Although most of the organizations show significant improvements in standard compliance each year they participate in the network, few are able to surpass the 75% standard compliance threshold, so their progressivity in managerial, administrative and service quality improvement was clearly slower. Of the 20 NGOs monitored, 18 joined the network with very low performances. By 2014, only eight had achieved higher levels, four had advanced to the intermediate level, and seven maintained low levels of performance (all of them were community-based organizations. From 2015 to September 2016 (last measurement), most of these organizations had entered levels of graduation with over 75% standard compliance, but four of them (ranked as community-based organizations) remain in the classification of "need technical assistance" because standard compliance is below 75%.

Although formal training provided by PrevenSida had no differentiated thematic or methodological elements when the organizations joined as partners with subsidy coverage to meet this heterogeneity, diverse monitoring and evaluation mechanisms were implemented, including supervision and in-service accompaniment (coaching) and evaluative events, which enabled to evidence specific situations and gaps that existed in each organization in order to motivate rapid improvement cycles or improvement collaboration. In fact, significant adjustments or new strategies are evident in the quality indicators, which show that only two of all the organizations included in the last subsidy had limitations in the management area, four in the administrative area, and none in the preventive services area (the lowest service standard compliance is 89%.

The results and capacities developed to optimally carry out the activities according to standards provide evidence in relation to the good performance of the continuous quality mechanisms promoted by PrevenSida, which

progressively lead to standard compliance and maintain it, as shown by the fact that progress is always progressive.

The main reasons alleged by organization promoters and directors to explain the continuity and progressivity of improvements are attributed to the combination of different approach modalities to reduce existing gaps, service accompaniment, improvement cycles, joint working sessions with technical assistance from the project team, all of them targeting specific problems and dealt with according to the specific conditions of each organization.

In particular, improvement cycles that combine several of the assistance modalities mentioned have been especially relevant, to the extent that the involvement of the project team was initially required, but organizations have acquired experience and now develop the necessary capacities to do this on their own, as shown by the fact *(Table 7 – Annex 4)* that all organizations have developed an improvement cycle each year and the current trend is to develop at least two, as observed in 2017 and in the current trend toward annual averages exceeding 1.5 cycles. Improvement cycles or collaborative improvements, which intensified around counseling quality and voluntary tests in the first years, have improved the technique and biosecurity, as well as the attitude and personal presentation of the promoters to gain confidence, and the transfer of tests to community locations has improved KP access and confidence.

Although it does not form part of this evaluation, the strategy of strengthening supply management systems, which as directly assumed by the DELIVER project, the implementation of this strategy required coordination with all strengthening activities undertaken by PrevenSida and, in particular, with CQI processes. In fact, part of the measurement standards in management and administration refer to supply management improvement (inventories, storage, purchases).

In this context, it should be highlighted that some innovative adjustments or the incorporation of new modalities and working strategies are very relevant for the consolidation of the continuous comprehensive care community model, such as:

- Mapping cruising locations through geo-referencing enabled to override accessibility barriers and broaden coverage of key populations, which were difficult to address because they were hidden and dispersed.
- Psychological care, which has ramped up quality care for PHIV and transgender populations, contributing to ownership and empowerment in relation to life options in adverse conditions and better understanding among promoters about their life situation.
- The survey in PHIV clinical stages has not only become the best way for promoters to take ownership of the life situation and health of each PHIV, but it has also enabled to develop a continuous health care cascade, which identifies discontinuity gaps from the link and treatment of PWHIV, making it easier to focus on corrective actions.
- HIV tests performed by promoters not only strengthen their recognition among the key population, but also enables to develop strategies for performing tests in the communities outside of health establishments, improving accessibility, confidence and targeting key populations.

Changes in strategic information

In this component, PrevenSida assumed the following strategies:

- *Strengthen the use of monitoring and evaluation (M&E) data for decision-making.*
- *Strengthen data collection, analysis, interpretation and dissemination.*

Continuous quality improvement is not possible without information that enables to identify gaps of non-compliance or measures indicators linked to results or activities that can be attributed to people, time and space. Having exposed the elements and findings in the previous chapters, it is quite obvious that the two projects contribute a broad collection of approaches, designs, methodologies and instruments suitable for the production and use of information, as a basis for the entire management process, at a strategical, technical and operational

level and, in particular, for ensuring continuous quality improvement, among which the following should be mentioned:

The Unique Register (UR) is one of the valuable contributions of PrevenSida to the national and regional response to the epidemic, as a potential instrument for monitoring people served and as a basis for planning and evaluation that should be replicated, although previous corrections in some of its constituent elements can be and should be improved. The Unique Register is a clear example of the chances of setting up and maintaining it in this type of organizations, which maintenance costs could be assimilated in the funding they are able to obtain and agree on.

Although its greatest usefulness in daily management was centered on productivity and efficiency in the achievement of coverage goals, it also showed the possibility of its adjustment and use for quality analysis and integrality of actions carried out, to the extent that it enables to verify compliance of standards and a combination of different types of preventive actions (structural, biomedical, behavioral) in a single person, as well as the monitoring provided to that person. It also demonstrated the possibility of analyzing the efficiency of the actions provided when the single register of the result indicators is inserted in each service received (with or without risk behavior), providing a very consistent approximation of quality.

The organizations developed an excellent capacity for maintaining it up to date, preserving the quality of the data, and for processing information, in order to monitor their performance, including capacity for preparing basic tabulation tables and graphs for either the banner or for presenting them in a report for dissemination and analysis, as well as capacities for negotiating and consulting with funding agencies.

It also highlights the experience obtained with the inclusion of the community survey to PWHIV for detecting clinical stages and conditions associated to their care and link to the health system in terms of diagnosis and permanence in ART and Self-Help Group (SHG), enabling a first approximation to the cascade of the continuum of care for identifying gaps in quality care.

Staff training in the different subsidized organizations has been outstanding for processing information and obtaining the treatment cascade and clinical stages of the PLHIC population served by each organization. Hence, the learning experience was very enriching in terms of a clearer assimilation of the disease cycles and care process, as well as the entire information production, processing and use cycle.

Another very significant contribution of the two projects has been the insertion of the design of the results standards for applying it in the initial measurements (baselines) and monitoring, with the objective of monitoring and evaluating the progressive quality improvement of the actions or results, such as the quality standards and checklists for institutional strengthening in the case of PrevenSida and competency standards in the Knowledge, Attitude and Practice (KAP) surveys applied by ASSIST to medical and nursing students. In both cases, it is possible to analyze the development of capacities desired by the organizations and health professionals, respectively, in order to evaluate the quality of the improvement actions implemented in the period comprising "before" and "after", as well as the intervention (training programs or improvement cycles). The two measurement methods (checklists and surveys) can be established as systematic and periodic procedures with different options in the design and application modalities so that their costs do not limit their systematization.

The experience obtained with these two innovative systems is not limited to the production and use of strategic information, to the extent that they constituted factors of great motivation for organizations and universities, both for fostering quality improvement of the actions, understood as complex and progressive processes, and for stimulating dialogue and collective reflection. In addition to stimulating capacity-building for the production and analysis of self-referenced information, they can be qualified as excellent examples of communication strategies based on evidence, which constitute methods of great potential for building consensus around the identification of problems and selection of corrective actions.

A special mention should be given to the experience developed with transgender women and PHIV organizations, which was developed by USAID and PrevenSida with theoretical and practical workshops (learning by

doing) about applied scientific research methodologies. In particular, we refer to the development of Participative Action Research (PAR) centered on the analysis of psychological care provided to the population served by these organizations, which results guide care improvements according to depression or anxiety indicators and underpin skills in the production of information, and also constituted a true milestone as an information dissemination initiative as its results were presented at the "HIV Information Management and LGBTI Rights Forum", held in June of this year under the auspices of USAID, which was massively attended by organizations and institutions that form part of the national response.

The PAR experience turns out to be very stimulating, all the more when if we consider that these organizations have staff members with low level of schooling. However, it has been demonstrated that research is a basic human driver that only requires adequate teaching methodologies to stimulate development and systematization of skills that each person has, to the extent that a situation is explored based on a dialogue (survey) and data and information are organized for communication. Hence, all persons can be a subject of research and produce knowledge, which has an immediate application in their scope of action. Monitoring this initiative should be contemplated for the near future. The motivation and learning achieved could be lost.

This study explored beneficiaries and promoters to dimension the degree of access to relevant information, as well as participation in the information analysis processes for planning/evaluation purposes and quality improvement of actions. People were questioned with indicators of approximation, in order to verify the quality conditions of communication actions on prevention, which should involve situational information on the epidemic in the local environment, as well as participation in collective analysis processes: *(Table 8 – Annex 4)* Eighty-six percent of the students and 77% of the key population stated they do not know the number of HIV cases and deaths that occur in the municipality where they live, and 72% of the teachers and 75% of the promoters stated that same condition.

When providers were asked about the usefulness that this information would have, 36% of the teachers and 20% of the promoters stated that it would be useful for sensitizing and reflecting on the need of self-protection, 50% of the teachers and 36% of the promoters would use it to inform students and the population, 14% of the teachers and 44% of the promoters would use it for planning and evaluating prevention work *(Table 9 – Annex 4)*.

This same indicator provides a good approximation about weaknesses in interpersonal communication actions, to the extent that the evidence-based communication approach is not fully assumed, which has greater potential to motivate reflection and peer dialogue for identifying and concretely assessing the level of risk, and facilitates acceptance of responsibility for self-protection and social and sexual relations.

It should be recognized beforehand that this situation has two potential incident factors associated to difficulties in accessing to and availability of official information on epidemiological surveillance that can also be combined with scarce usefulness given to available information in terms of its potential as evidence of concrete situations that promote dialogue and reflection, as occurs with information originating from studies, which greater usefulness is restricted to institutional or academic scenarios or for publication in scientific documents.

4.1.2 Changes in institutional capacities of universities, ASSIST:

The strategies assumed by ASSIST in this component were:

- *Strengthening institutional capacity to improve and expand HIV quality service provision*
- *Developing and implementing methodologies to improve institutional and human resource capacity*

ASSIST had more favorable conditions for its implementation, based on the experience of the HCI project for improving quality of care for maternal, newborn and child health and family planning (FP), which served to design the first pedagogical kits incorporated in the universities, accumulating experience and knowledge, as well as key links and recognition in the university scenario.

The academic environment and specialized training of the participants facilitates and accelerates the development of competency standards in teachers and students.
While recognizing the existence of relevant heterogeneities between the different training centers, mainly derived from the institutional level of the universities, the commitments of the authorities and teaching teams with the results and change processes, the implementation process of the HIV pedagogical package had marked similarities in the sequence:

- Application of KAP research to students as a baseline that identifies gaps in knowledge and attitudes towards HIV.
- Teacher training in the pedagogical package, which joint review enables to more precisely identify gaps in relation to the learning needs of the students.
- Review of the contents and methodologies of the pedagogical package and its relation with the curriculum and study plans of the different subjects.
- The teacher teams select the contents that would be incorporated in the study plans and develop methodological guides for developing different themes with the students.
- Design and application of instruments that stimulate quality improvement of teachers
    - Pre-test and post-test forms to evaluate knowledge.
    - Case studies and socio-drama counseling.
    - Application of checklist to assess the quality of the competences (i.e. counseling).
    - Programming activities and rotations in health units
    - Organization of events to foster interaction and socialization of students with the population
    - LGBTI and PHIV. Fairs, meetings, forums, etc.

At the beginning of the insertion of the "pedagogical package" in 2014, the project developed surveys to measure standards on knowledge and attitudes toward HIV of the students, as a baseline, repeating the same survey with students in eight of the nine universities, after teaching staff was trained and the pedagogical package was applied in educational activities (2015/2016). Six competency standards on HIV knowledge and three competency standards on attitudes towards HIV were analyzed and the results obtained have been classified in four scales: optimal (more than 90% of the students in compliance), satisfactory (76-89% of the students in compliance), deficient (60- 75% of the students in compliance) and critical (less than 60% of the students in compliance).

In general, all disciplines improved KAP standard compliance (Table 10 – Annex 4). Even more remarkable are HIV attitude standards, where only one university surpassed 75% in the baseline. The indicators were completely modified after the implementation process. It is worthwhile to note that the teachers and directors indicated that the KAP survey had sensitized the institution about key training aspects they had not assessed or addressed, creating more motivation for the participation of the teachers in the process.

The results show that all centers and disciplines remarkably improved in the results obtained in relation to the competencies of the students. However, deficient levels still remain in stigma and discrimination towards PHIV in the discipline of medicine, while knowledge about PHIV care is still deficient in nursing.

This process is irregular, depending on the center and discipline. In BICU, for example, medicine had one standard at a critical level in the baseline, four at a deficient level, three at a satisfactory level, and only one at an optimal level. In the second measurement, it had eight standards at an optimal level and one at a satisfactory level, while nursing, which had three standards at a deficient level and six at a satisfactory level, passed to five standards at an optimal level, three at a satisfactory level and one at a deficient level. The cases of POLISAL and URACCAN stand out because these training centers had more standards at a critical level in the baseline (4 and 3, respectively) and in the second KAP survey did not have any standard at this level.

In relation to UNAN-Managua, specifically in the School of Medicine, it is evident that teachers have a greater commitment to incorporate HIV in Physiopathology, Medical Practice, Pharmacy and Internal Medicine, with the application of the tools proposed in the pedagogical package. However, students recognize that this is done with

a vision that is still medicalized, without identifying it as a human rights issue and with a more integral vision. It is necessary to give that qualitative leap, although the issue has already been identified as a basis for reflection. (Focus group with medical students and teachers, UNAN-Managua). A similar finding was found at UPOLI, where teachers, coordinators and deans have a strong commitment to promote HIV as a cross-cutting theme in all subjects taken by nursing students.

In contrast, changes in the coordination of the discipline that recently occurred at URACCAN are identified as a limitation to monitoring the pedagogical package as it has been translated as discontinuity of the improvement processes in the application of the pedagogical package, as well as a lack of monitoring of the teaching processes of subjects linked to HIV identified in the curriculum.

In general, all centers and disciplines noticeably improved in the results obtained in relation to the competencies of the students. However, the need to strengthen work to reduce stigma and discrimination towards PHIV is evident in medical students.

The qualitative survey included in this study gives high relevance to the assessments and perceptions of the people interviewed, in relation to the greater quality and usefulness of the teaching activities received. Sixty-five percent of the students assess the way how they have received these actions as "very good", 31% rank it as "good" and 4% assess it as "deficient" *(Table 11 – Annex 4).* Exploring the personal usefulness these services have had, it was found that 38% of the students mention the expansion of new knowledge on HIV, 37% point to the possibility of greater socialization (more interaction and exchange of views and clarification of doubts) and 25% of the students express change of attitudes (new values and behaviors) *(Table 12 – Annex 4).*

Fifty-one percent of the students associate teaching quality with good HIV knowledge management and teaching methodologies, 7% link quality to participative methodologies and interaction and 6% to approaches (rights, taboos). Other associations are linked to teaching constraints inasmuch as 25% point to insufficient time for addressing issues and in-service practice. Another 5% indicates non-compliance of study plans and methodological deficiencies of teachers *(Table 13 – Annex 4)*. In this regard, many of the focus groups highlighted open HIV events as a contribution to quality (fairs, marches, forums) and meetings with PHIV, either in the services or in the events, which has enabled greater sensitization and knowledge of real situations. In the focus groups with students, the need to continue improving teaching methodologies in a demonstrative way and oriented toward significant learning, highlighting the modalities that stimulate student participation and those that take place in settings other than the classroom (fairs, forums).

From the perspective of the staff providing services, 95% of the teachers indicated recent significant changes in the improvement of the activities they develop, 50% refer to the expansion of HIV topics in the programs and scientific knowledge updates, 26% highlight the insertion of HIV in the curriculum and as a cross-cutting content in several subjects, 13% point to a notable sensitization of teachers and students about people at risk or HIV patients, and 11% highlight the incorporation of new pedagogical technologies that foster greater participation of students *(Table 14 – Annex 4).*

In the quality improvement collaborative work carried out between universities in the application of the pedagogical packages on maternal and child health and HIV, no systematic mechanism was established for exchanging experiences and sharing "good practices". Teaching motivations were mentioned in relation to the application of approaches, methodologies and instruments in other themes and subjects, indicating it would be relevant to share them as elements contributed by the project beyond the scope of HIV.

In the sphere of the universities, the need of ongoing updates for the development of universal scientific knowledge or changes in world, regional or national policies and strategies is recognized. In fact, a new phase begins with new paradigms centered in the care continuum and 90-90-90 strategy, which will demand the development of new contents and new methodologies. In this regard, the importance of maintaining interinstitutional relations with MOH, the universities, the university community and international organizations is highlighted as a challenge.

In the focus groups with nursing teachers from POLISAL, it was highlighted that they have inserted HIV in the curriculum, adding that they felt the need to integrate no discrimination, respect for gender identity and sexual orientation in the subject of integral seminars, and that respect for sexual diversity is included as a principle.

In the North Caribbean, the need to strengthen this theme is perceived, taking into account the cosmovision of the indigenous communities, where deeply ingrained myths prevail, which maintain stigma towards PHIV and the LGBTI population. The theme has been addressed at the university, however, it is necessary to further deepen, taking into account that the region ranks in third place in HIV incidence at national level and has one of the highest AIDS mortality rates.

In this same line of action, virtual courses developed by ASSIST for organization members (11) and universities (27) about the research methodology, HIV care continuum and continuous quality improvement (CQI) stand out. The association and use of existing capacities, in the case of the universities, and the use of distance education technologies are a clear example of local potentials to multiply these capacities in people who are unable to have access to professional development opportunities for economic reasons, distance or time, while products are obtained, such as studies and improvement plans linked to their direct application in improvement processes for prevention and care of HIV.

4.1.3 Quality Management Programs in both projects

As of the initial design of the two projects, it is evident that both proposals represented very significant changes in the way that previous actions of the same nature were developed and aimed at the same populations. In this regard, the two projects constitute interventions aimed at creating opportunities and capacities to enable quality changes, given the great heterogeneity and situation of weakness and previous practices in the NGOs incorporated by PrevenSida and given the pedagogical culture and limited HIV management prevailing in health staff training centers.

Getting to the results previously shown is the result of a broad and intensive effort that has materialized in the sequential and combined implementation of diverse assistance processes, standing out a similar start-up strategy in the two projects, PrevenSida and ASSIST, which started in 2010 and 2014, respectively, with training programs that responded to general diagnoses of the main gaps existing in the face of the parameters initially defined by the organizations in the case of PrevenSida and by the teachers and students in the case of ASSIST, on the basis of which differentiated conditions were established in the development.

Since 2015, ASSIST and PrevenSida are jointly implementing a process for the formulation of a QMP with nine organizations, which constitute the continuity of the renewed institutional strengthening process to be executed and maintained by the organizations, systematizing the previous experience and including new dimensions focusing on quality management, including measurement of external and internal user satisfaction, design of service strategies, complaint and claim management, organizational climate analysis, performance evaluation and improvement cycle implementation.

All organizations already have their own QMP. Its formulation has implied intensive accompaniment from the PrevenSida/ASSIST team. The configuration of these programs in each organization has been a vigorous accompaniment and technical assistance process with the quality assurance teams, in order to ensure full understanding, valuation and management of the methodologies. The process poses enormous challenges insofar as it has to do with placing diverse methodologies in a single instrument, the implementation of which represents carrying forward complex processes in a dynamic that finally merges the M&E system with the quality improvement component.

Unquestionably, the qualitative leap that the QMPs represent should be highlighted in terms of:

- Including the VOICE of the beneficiary population as an evaluation and quality improvement parameter.
- Establishing performance evaluation standards, which provide crucial elements to qualify the quality with which the personnel of the organizations carries out the different activities.

- The extensive list of organizational climate evaluation indicators contributes crucial parameters, including, inter alia, leadership, participation and motivation, which have played a crucial role in the continuous quality improvement dynamic and their impact on the effectiveness of the actions for controlling the HIV epidemic.
- Many of the quality standards included in the QMPs give continuity to the standards and indicators used in the six previous annual measurements, preserving an experience that has shown results.

In the same context of leadership and participation standards proposed in the organizational climate, this study explored the opinion of the beneficiary population and providers about their participation in quality action evaluation events and their perception on whether leaders or directors validate their influence on the decisions *(Table 15 – Annex 4)*. Sixty-nine percent of the students and seventy-five percent of the teachers indicated that they have participated in teaching activity evaluation events, and sixty percent of the key population and seventy-four percent of the promoters have participated in care service evaluations. Sixty-three percent of the students and ninety percent of the teachers believe their opinion is taken into account to improve teaching activities, while sixty-five percent of the key population and eighty-eight percent of the promoters perceive they are taken into account.

The almost general assessment of the promoters and organizations partnered with PrevenSida is that the QMPs have been an important contribution. Firstly, the learning provided by the technical assistance process for its formulation, and secondly, the perception of its great usefulness to ensure overall strengthening of the organizations, in addition to providing more transparent evidence that strengthens the image of the organizations in front of other institutions.

4.2 What methods were more effective for transfer of knowledge, attitude improvement and adoption of best practices in each component?

With the perspective of validating the actions developed by the two projects in terms of achieving results in the beneficiary populations and service providers, the evaluative question asks about the most efficient methods for the transmission of knowledge for attitude changes and adoption of "good practices". The evaluation explored existing documentation and included relevant questions in the interviews with the participants. The main findings were:

4.2.1 In the universe of PrevenSida: In the survey to the beneficiaries *(Table 16 – Annex 4),* 41% of the key population pointed to group "talks" and 24% to small group sessions as the modality that contributes more knowledge, 16% stated forum participation and 12% counseling.

An ample majority of the promoters (53%) *(Table 17 – Annex 4)* believes that training is the modality that has contributed more to increase knowledge, 35% of the promoters mention exchange and/or evaluation sessions and 4% mention forums and videos as the best method for increasing knowledge. Three percent of the promoters mentioned in-service accompaniment (coaching).

Forty-seven percent of the promoters *(Table 18 – Annex 4)* indicate that training if the method that contributes more to capacity building for performing their work and 38% mentioned exchange and/or evaluation sessions. Thirteen percent of the promoters mentioned in-service accompaniment (coaching). In the focus groups with these populations, the methodologies that promote participation and interaction were ratified as the methodologies that contribute more to focus on the knowledge that interests them more and are considered for useful to clarify doubts.

It is important to highlight that the promoters and directors indicated that although the validity and effectiveness of training is recognized as a method for transfer of knowledge and capacity building, they also stated that it should be adapted to the conditions and capacities of the participants and the same topics should not be provided to all persons because the work experience and competencies of the participants are different and because each organization has its own particular characteristics.

In terms of the methods aimed at attitude changes, their greater complexity is recognized at the outset. Albeit recognizing cultural and social circumstances of a collective dimension, these methods propose to achieve a change of behavior, which ultimately can only be achieved with the voluntary decision and consent of each person,

making it necessary to traverse a complex and progressive process of self-recognition and empowerment. In the case of the key population *(Table 19 – Annex 4),* 39% indicate small group sessions, including Mutual Help Groups for PHIV, to the extent that they can socialize life experiences, 25% identify talks and workshops, 21% highlight counseling and 12% mention collective activities, such as videos, forums and fairs.

Forty-nine percent of the promoters view training as the modality that contributes more to improve their attitudes in their relationships with the beneficiary population *(Table 20 – Annex 4)*. The increasing valuation of the exchange and/or evaluation sessions mentioned by 43% of the promoters stands out. Two percent of the promoters mentioned in-service accompaniment (coaching) and 2% of the promoters mentioned performance evaluation. Finally, 3% of the promoters mention forums and videos as the best method for improving attitudes.

4.2.2 In the universe of ASSIST: In the survey (Table 21 – Annex 4), 48% of the students indicated teaching activities conducted with participative dynamics and seminars as the most useful for acquiring new knowledge (among them, 17% mention participative classes and 21% mention seminars and workshops), 24% indicated lectures and 15% indicated scientific update sessions. Sixty-two percent of the teachers (Table 22 – Annex 4) think training is the modality that contributes more to increase knowledge. Twenty-one percent mention exchange and/or evaluation sessions. Fifteen percent of the teachers indicate the use of bibliographies (books, articles, regulations) and, finally, 3% of the teachers mention forums and videos as the best method for increasing knowledge.

In terms of changes of attitude about HIV, 34% of the students indicated open activities and meetings about HIV with other populations (fairs, forums, marches) have contributed to see the HIV situation differently and reconsider values and attitudes (including 20% who mention in-service practices and 14% who mention community activities). In this same order, 31% point to teaching activities to promote interaction, such as seminars and workshops, while 13% mention "participative classes", 13% indicate lectures and 7% indicate audiovisual activities *(Table 23 – Annex 4)*.

For 46% of the teachers, training is the modality that has contributed more to improve attitudes in their relationships with the beneficiary populations. Forty-three percent of the teachers mention exchange and/or evaluation sessions and three percent mentioned performance evaluation. Six percent of the teachers point to the use of bibliographies (books, articles, regulations) and, finally, three percent of the teachers view forums and videos as the best method for improving attitudes *(Table 24 – Annex 4).*

In the case of ASSIST, the situation has been less complex given that conditions have greater homogeneity and most of the contents refer to transfer of scientific knowledge of universal value. Even so, the training processes have been adapted to diverse situations and priorities and, in fact, training events confined to each center were predominant.

We highlight the growing weight of the exchange or evaluation sessions to improve skills and attitudes, as well as the fact that in these two dimensions in-service accompaniment (coaching) and performance evaluation also emerge, which was more spontaneously assessed when we asked about the most useful support and was also assessed in the focus groups. In the case of the performance evaluation, it can be attributed to its relatively recent inclusion as a QMP instrument.

Based on the evidence presented, it is clear that it is possible to differentiate the work methods or modalities that contribute more to improve the active transfer of knowledge and facilitate change of attitudes and unfavorable behaviors towards HIV and that, as a common factor, it must be based on interaction and "horizontal" socialization between those who provide services and those who receive them in an assertive and proactive way, recognizing people as active subjects of change.

4.2.3 Best practices: In the case of "best practices", a majority of the organization directors and team members of the two projects indicated evaluative sessions and in-service accompaniment (coaching) as the events where differences linked to results or performance are more easily and clearly identified. These implementation modalities are innovations and warrant an in-depth evaluation, in order to propose them as models to replicate.

Obviously, work performance evaluation will surely grow in the near future as a way to detect not only gaps to correct, but also "good practices" to replicate.

In terms of replication and adoption of "good practices", the people interviewed indicated the need to sensitize and value a proposal of change as a necessary step to motivate and make feasible the adoption of good practices, mentioning improvement collaborative projects as ideal spaces for this purpose. They also mention in-service accompaniment, including group sessions and individual counseling, as the most mechanism that fosters rapid assimilation of concepts and capacity-building among people who apply a new "good practice", which requires monitoring and evaluation to promote its consolidation.

As an excellent example of the "good practices" adoption method, we highlight the systematized process shown by ASSIST with the implementation of the pedagogical packages, to the extent that it evidences a model of sensitization, transfer of knowledge, counseling for the design of the application of the particular elements and generation of information to monitor results and performances that has already been validated.

4.3 How were the USAID's principles of gender equality incorporated in quality improvement?

Given that the nature of the two projects focused on national capacity-building to improve the response to the HIV epidemic, the gender approach and the fight against all forms of stigma and discrimination, have been an integral part of the entire initial design and implementation process, increasingly highlighting that gender equality and the fight against S&D has been weighing more in the content and work methodologies in the different scenarios where actions are carried out.

4.3.1 In the sphere of PrevenSida: Although gender equality was a crucial part of the work from the beginning of the project, learning with the LGBTI populations and their organizations during the first years enabled to dimension the reality of the impact of inequalities, roles and power relations between genders on the risk conditions of HIV transmission. The broad support to organizational, managerial and technical strengthening, enabling institutional maturity in the organizations, made it possible to support in 2014 the formulation of National Strategic Plans by population group, mainly FT and PHIV populations, which were based on the approach of social determinants of the World Health Organization (WHO) and Pan American Health Organization (PAHO), which constituted a process of information collection and analysis, which concludes with action plans where gender equality, the fight against S&D and all forms of gender-based violence acquire value as a transversal axis of all actions. The formulation of global strategic plans for FT and PHIV has fostered a greater role and participation in alliances with local organizations and institutions.

The support of the project was committed with the understanding that the principles of gender equality of USAID are an integral part of all strategies and actions planned. To the extent that the strategic plans are at national level and not just for one organization, and are the expression of alliances between existing organizations in each population group and have been an instrument of great value for directing and supporting the participation and impact of these populations in national and local institutions, mainly in the institutions coordinating the national response to HIV (CONISIDA at national, departmental and municipal levels).

In 2014-2015, an intensive training program focusing on gender equality, S&D and GBV was developed and inserted in the set of counseling services aimed at key populations and PHIV, who showed conditions of greater vulnerability and therefore translated to higher HIV infection risks or abandonment of ARVT. Counseling includes reference to social, legal or health support institutions when it is deemed relevant.

It stands out that two care modalities, which design and methodology are focused on gender equality, show the highest potential in bringing about changes in risk behaviors, as previously mentioned in relation to S&D and GBV counseling and peer education, which begins by considering the annulment of all inequalities between providers and beneficiaries. The results seem to be translating achievements in the empowerment of key populations served with these modalities.

Upon exploring the perception of S&D in the organizations *(Table 25 – Annex 4)*, only 6% of the key population and 4% of the promoters perceive discrimination toward women in their immediate environment (institutional), 7% of the KP and 12% of the promoters perceive discrimination towards the LGBTI population, and 7% of the KP and 7% of the promoters perceive discrimination towards PHIV. In most cases, participants indicate that this situation is decreasing and that campaigns in favor of GE and against S&D and GBV are maintained.

4.3.2 In the sphere of ASSIST: In the universities, a lot of emphasis was given to GE and S&D related to sexual diversity or HIV as of the high indexes of stigma and discrimination detected in students in the first KAP survey. Hence, the relevant gender contents were incorporated in the "pedagogical package". In teacher training, reflection and search for alternatives to improve this situation was stressed. In addition, ASSIST developed in 2016 a training course on GBV and human trafficking, incorporating 96 teachers from seven universities, achieving an increase of 20 percentage points (from 70% to 92%) in knowledge and attitude standard compliance at the end of the course. Another highlight is that BICU, after having the lowest score prior to the course (58%), had the highest score after the course (98%).

Diverse actions have been derived from this initiative at the university level, such as campaigns against GBV and S&D against LGBTI populations. In the survey conducted as part of this study *(Table 25 – Annex 4),* the situation was explored, finding that 8% of the students and 18% of the teachers perceive discrimination towards women in their study center, 29% of the students and 35% of the teachers perceive discrimination towards the LGBTI population, and 15% of the students and 18% of the teachers perceive discrimination towards PHIV.

For the best assessment of this topic, it is necessary to assess that gender equality was not broadly addressed in the universities and it is currently recognized that there has been an openness for the inclusion of the LGBTI population in the universities. However, differentiated care for this population group has not yet been established in health services. Medical and nursing students are not aware of Ministerial Resolution 671-2014. In the focus groups with students, it was recommended to integrate demonstrative methodologies that imply contact with PHIV.

In a large majority of cases, it was stated that this situation is decreasing and that campaigns in favor of GE and against S&D and GBV are maintained in the universities. As a clear sign of the relevance achieved by this topic in the universities, two focus groups with students highlighted that S&D persisted at a higher level among teachers rather than students, evidencing a clear commitment with the need to expand the intra-university dialogue in the face of a problem that is assessed as relevant.

> It is clear that the scenario of the health staff training centers, especially in medicine, shows very particular situations, which could be perceived as discrimination. Although the efforts made have obtained results, there is still much more to do. However, one cannot ignore that as of the support provided by ASSIST stigma and discrimination have been identified as an issue for reflection and debate, both by teachers and students, and how it can be mainstreamed in all the training activities of human health resources and addressed from a rights, gender and intercultural perspective.

4.4 To what extent were the quality improvement programs sustainable?

It is evident that the closing of the two projects in previous months places the sustainability analysis in a very unique dimension, as the concern is no longer to ensure future sustainability, but rather to see the current situation and to profile, to the extent possible, the immediate future of what exists.

4.4.1 PrevenSida: From a sustainability perspective, it is clear that the organizations have had three or more years of experience assisted by the supports of USAID. Teams and people with greatly developed capacities and skills have been profiled, both in the services and managerial and administrative dimension. It is expected that such accumulated capital will be maintained and developed even further, as long as it is applied as part of the institutional culture generated and independently from the projects or funding they have. It is expected that the strategic plans and quality management

programs, (QMP), as well as the information systems and knowledge management methodologies will endure. In the worst case scenario, as already occurs in some organizations where the team of promoters was displaced, the processes will be weakened. However, depending on the experience and leadership of the senior officials, these could be reactivated with new projects.

From a socio-cultural perspective, the situation is quite different, as shown by the NGOs whose predominant logic is to manage projects without any stable and organic links with any community base, as happened two months after the closing of the subsidy, when only the technical and managerial experience accumulated by the senior management remains. The almost total absence of the team of promoters and the impossibility of convening the beneficiary population indicates very clearly the conditions that exist. However, it is necessary to recognize the existence of consolidated leaderships and well-structured technical teams in some NGOs, which could enable the reactivation of the processes in the future. If this situation should appear, it would be an opportunity to incorporate the creation of links with community leaderships in the work model, which could provide greater sustainability.

The situation is also differential in the case of organizations that have a community base, with which we verified their permanence and strengthen, beyond the absence of funding and convening capacity, although economic difficulties for the sustainability of the process are clearly evident. Such is the case of PWHIV organizations and some FT organizations, where the maintenance of actions and some institutional dynamics perceived have depended on the commitment and link with the base populations, the leaderships committed with them and a communication dynamic between them ensured by people who are calling themselves "activists", whose role in the operation of the model developed by PrevenSida has not been sufficiently made visible. The experience obtained showed differentiated situations between organizations positioned in this group, resulting from the particular combination that exists in each of them, i.e. community link, quality and commitment of the leadership and the role of intermediation maintained by the "activists".

4.4.2 ASSIST: The technical dimension is the scenario for the development of the universities, so all developments achieved by ASSIST have been incorporated to the dynamics of the academia. It is expected that the motivation and enthusiasm stemming from the set of pedagogical innovations will be concreted in the application of the continuous quality improvement mechanisms and that the maintenance of the pedagogical packages and their update and effectiveness will be ensured.

We were able to verify that the universities do not depend on external funding and that their academic vocation feeds systematic scientific and pedagogical update processes. The quality of the leadership also has a bearing on the maintenance of CQM actions. Institutionality factors exists, as well as the absence of funding threats, counting with the best labor stability conditions of the country, such as the case of university teachers. So the sustainability of the quality improvement component in teaching about HIV has a very good outlook, moreover if one considers that many universities have advanced to structural changes, such as the incorporation of HIV in the curriculum and study plans. In such a way that sustainability in this institutional scenario will depend on the level of commitment and quality of the leadership, in order to maintain the enthusiasm that was perceived by us in a majority of the cases and which is even more evident in nursing disciplines. Two private universities whose structure and teaching discipline seem to have collapsed are excluded from this condition.

It is anticipated that the dynamic of the continuous quality improvement processes incorporated by ASSIST in the academic scenario will be maintained not only because they coincide with the scientific spirit that forms an integral part of the academic sphere, but also because they do not generate greater additional costs. However, if the need to involve faculty and discipline authorities, whose leadership is determinant for ensuring updates and improvements in the methodologies and specific tools contributed by ASSIST, including rapid improvement cycles and collaborative projects, even though their basic logic coincide with the dynamics that are traditional for an institution truly committed to scientific development, it will require leaderships that always maintain them in response to the demands for change.

4.4.3 In a more general institutional sphere: From a more general political and institutional perspective, the sustainability of the achievements to improve the quality of HIV actions by PrevenSida and ASSIST is linked to the chances of systematizing the consolidated model for its replication in new scenarios, either targeted at the integral continuous care model already validated or adaptations in a scenario of drastic changes in paradigms and strategies, as seems to be the case of the Central America region. Special attention should be given to the dissemination of the achievements and virtues of the model that has been configured in the sphere of care provided to key populations, such as health personnel training centers, which is not only profiled at institutional levels, but also at the level of stewardship and coordination of the national response to HIV. It should be noted that the universities also recognize, for the continuity of HIV actions, the need of constant updates and links with State institutions and national and international NGOs, as well as the possibility of alliances with other universities within or outside of the country, which enable to have common proposals and guarantee integral and updated training, taking up good practices that arise when working as a network.

5. CONCLUSIONS

It was verified that PrevenSida and ASSIST have maintained from the outset a clear dynamic of continuous change that identifies development phases, where the sequence of the evaluation and adaptation, which can only be sustained by a consistent continuous quality improvement component that efficiently identifies the need to adjust to the programmatic guidelines of PEPFAR, changes in the national scenario or strengthening of the organizations and universities in their particular contexts.

An unedited action proposal was implemented in the country, associated to a group of organizations with managerial weaknesses, some of which had been recently created and had no work experience with dispersed and "hidden" key populations at the community level. Simultaneously, the configuration of the service delivery forms was addressed, while far-reaching institutional capacity gaps were resolved by training and organizing the managerial and administrative components.

Three years of experimentation and learning underpinned the monitoring and evaluation mechanisms, which stimulated constant monitoring and analysis for channeling the processes, in order to consolidate the network of organizations, while they overcame access barriers created by stigma. Paradoxically, the phase culminated with a rapid expansion of populations, territories and subsidized organizations, a supply model that increases accessibility and a group of organizations with an increasing consolidation of their managerial structures.

In the last two years, the projects were centered on quality targeting key populations. Tools were developed and improved along the way. Mapping of sites, improvement cycles and the increasing approach of stigma and gender-based violence configure a set of dynamics that enable to address the consolidation phase of a continuous care model that reinforces care provided to PHIV and introduces new instruments in the quality improvement component, culminating with an articulated visualization of the components. The closing came in the middle of the unconcluded consolidation process, but equipped with the tools provided by QMPs.

5.1 Quality changes attributable to USAID support

It is in the interest of this study to note that a process underlying the three phases, as a revitalizing axis, clearly showing production of information, contrasting with the standards that are defined, and showing mechanisms for the incorporation of adjustments or new initiatives. As a result, clear transits and incorporations are made, which are attributable to USAID support.

5.1.1 Prevention and care: Site mapping is a quality leap for overcoming access barriers and key population focalization. It enables to move from the expansion of disperse care to a territorial and population focalization and from coverage of other populations (youth and women at risk, mobile population, etc.) to a predominant KP and PHIV coverage. It reflects increasing confidence in KP stemming from the quality of the tests taken to the communities and focalized in KP. Implicit counseling shows ostensive quality improvements in changing behaviors. Promotional contacts centered on condoms are transiting to the consolidation of an interpersonal communication model based on peer dialogue and small groups for changes toward protection behaviors, which according to studies have demonstrated efficiency. The process for reinforcing actions against S&D and GBV has not only been a qualitative leap in terms of addressing a serious problem affecting KP and PHIV populations, but also an opportunity for learning and building the capacities of the promoters for dialogue and accompaniment. The population served expresses a high degree of satisfaction derived from the perception of a more personalized and warm care, which creates more confidence and is perceived as more comprehensive for KP and PHIV.

Initiatives like the survey on the clinical stages of the disease and linkage to MHPs and ART, which in addition to providing greater rapprochement with PHIV facilitated overcoming the fragmentation of combined prevention care, counseling and voluntary tests and care to PHIV, profiling its articulation in a comprehensive and continued care model. The care continuum already seems to be a consistent axis that intertwines prevention and care with tests as a strategic focal point and monitoring of adhesion gaps as an invigorating element of the actions.

The incorporation of psychological care to PHIV and FT has been a quality improvement milestone, consistently addressing a huge void in care that subsequent service supply modalities could not absorb. Its reiterated mention by the beneficiary population has demonstrated the appropriateness of the initiative and the need to further evaluate the experience to identify ways to incorporate some of its elements in the care modalities, such as peer dialogue and group sessions.

5.1.2 Strengthening the health sector: The clear achievements by the institutional strengthening process assumed by PrevenSida, aimed at management, administration and service delivery, have resulted in self-satisfaction in the organizations, which recognize themselves as competent organizations capable of providing efficient and better care to the beneficiary population, in addition to achieving recognition from other institutional bodies with which they participate in the coordination of the national or local response to the epidemic, as well as cooperation organizations that identify their strengths. The formulation and start-up of the implementation of the quality management program (QMP) envisage in-depth strengthening.

ASSIST represents the holistic and prospective vision of the integral continuous care model, not only in terms of its integration at the end of the graduation of the professionals. The dynamic of incorporating the pedagogical package and the attention given to stigma and discrimination have led to service and activity meetings that facilitate interaction. The approaches and instruments of the process have similarities with PrevenSida, albeit clear differences in the scenarios and incident factors, as well as clear transitions and incorporations.

- In the goals centered on knowledge, the adoption of a competency development approach linked to the demands of the epidemic in the country has been encouraged.
- After finding that the HIV issue is fragmented in subjects, progress has been made toward the configuration of a pedagogical unit that articulates different subjects and is incorporated in the curriculum.
- Starting from a high prevalence of rejection and stigma towards LGBTI and PHIV populations, evidence shows that this issue has achieved high relevance, which is stated as a commitment to change towards respect of rights and equality.
- The preferences stated by the students and the demands for support of the teachers have evidenced an increasing valuation of teaching activities, which in addition to being participative foster creative teaching modalities and facilitate meetings between students and KP and PHIV, restricting the weight of the masterful and vertical teaching that previously predominated.

5.1.3 Strategic information: The two projects show the incorporation of quality improvement initiatives in the production, processing and use of strategic information, underpinned by the process of consolidation of care and teaching models that have been implemented, among which the following stand out:

- Combining training, supervision and flow of reports, the SRS has managed to develop an evidence-based management culture, so that organizations assume that they count with data on advances or deviation according to expectations, as an element of daily necessity, in order to timely analyze and take action. The SRS included modifications on the go that constituted relevant qualitative leaps due to the chances of analysis generated, such as integration of prevention and testing modules, the inclusion of a results indicators registry (behaviors) and a survey on clinical stages in PHIV, which have enabled to conduct effectiveness studies and achieve a more integral visualization of results and gaps in MAG and ART.

- The incorporation of standard compliance measurements, as the case of institutional strengthening and KAP surveys with students, have enabled to establish baselines for comparison monitoring, which shows advances or deadlocks as a result of the implementation.
- The capacity-building initiatives of the organizations to produce information and use it, based on a scientific method, such as case studies on psychological care with a PAR approach, show chances of development in scenarios with marked limitations due to the level of schooling of the participants.
- The integration of several situation measurement instruments of high relevance for the organizations, such as performance evaluation, organizational climate, institutional quality parameters and user satisfaction, has initiated an extensive information production process, which systematization will represent a change of strategic magnitude in the institutionalization of the organizations.

A notable level of lack of knowledge exists about the behavior of the HIV epidemic in the territories where the populations live and the organizations and universities operate. This curbs creation of communication processes based on evidence and can be evaluated and planned based on situational knowledge.

5.2 More efficient methods

As already pointed out, the different care modalities have been adjusted and their quality has been improved to the extent that experiences accumulate and, fundamentally, to the extent that continuous quality improvement mechanisms identify and correct deficiencies in the achievements or incorporate new elements or progressively profiled actions, such as the components of the integral continuous care model for HIV prevention and treatment.

The beneficiary population identifies individual or small group care activities as methods that facilitate transfer of knowledge and development of new attitudes and skills in light of more chances of interpersonal communication and interaction. Previous studies corroborate this appreciation, highlighting peer education, counseling linked to testing and the fight against GBV and S&D as more effective for developing new attitudes and protection behaviors.

Direct providers of training services or activities consider training as the most valuable method for transfer of knowledge, capacity-building and attitude improvement. However, exchanges and evaluation sessions are increasingly mentioned in relation to development of skills and improvement of attitudes. In-service accompaniment and performance evaluation were also mentioned.

Promoters and senior managers identify exchanges, evaluation events and in-service accompaniment as instances where differences are identified, evidencing "good practices" in care or activity processes in the organizations. It is pointed out that the replication of "good practices" requires sensitization processes and proposals for promoting change, finding that improvement collaborative projects are a favorable scenario for this, however, their implementation requires group session mechanisms that develop the necessary concepts and skills for assimilation. Coaching mechanisms are most suitable for direct counseling to people who begin to apply a new work modality.

5.3 Application of gender equality principles

In the context of the fight against HIV and in the scenario of work with key populations and PHIV, the promotion of gender equality and women empowerment finds its greatest expression in the fight for respect toward sexual diversity rights, the fight against gender-based violence, and the fight against stigma and discrimination toward the LBGTI and PHIV populations.

PrevenSida incorporated these components from the outset of its implementation, but it was in the middle stage that it intensified training for the promoters of the organizations, in order to address and respond to a life situation that not only represented obstacles in accessibility, but also the possibility of developing protection capacities in the population served,

a good part of them immersed in high vulnerability conditions due to GBV or power relations of commercial sexual conditions. Hence, the gender approach permeates all care activities promoted. The expansion of coverage was encouraged with specific counseling on human rights contents and GBV or discrimination management to the point of finding two care modalities that reflect equality and the fight against inequalities with greater effectiveness, as shown in the achievement of protection behaviors, such as peer dialogue and GBV and S&D counseling, which reflect a lot of attention to the quality of these actions and their results in KP empowerment.

The promotion of gender equality alliances has been materialized in diverse moments and events periodically promoted. A first element highlighted is the support provided by PrevenSida to the formulation of strategic plans for each of the key populations (MSM, FT, PHIV), which transcended the subsidized organizations and positioned itself in the global national scenario of that population, and it also transcended HIV and positioned itself in the dimension of more general life perspectives, developing a crucial instrument for orientating a more social management in all of the institutions. Other examples of the alliances are the ephemerides and commemorations (Gay Pride Day, International HIV Day, etc.), where all organizations involved jointly develop marches, meetings, forums, etc. Eventually, participation is promoted as a whole in advocacy processes and policies and laws that materialize GE/Women Empowerment.

Gender equality was the main axis underpinning the ASSIST project, taking into account the conditions of sensitization and openness derived from the results of the first KAP survey with students. It also incorporates a GE, GBV and S&D module in the pedagogical package. That component was intensified in teacher training, facilitating the configuration of a new vision of health issues that breaks away from the limited biomedical concept to reassess human, social and cultural dimensions that the HIV issue inevitably makes relevant. In fact, the recognition of high levels of discrimination toward sexual diversity and HIV in the training centers is projected as a "pending issue" that gives continuity to the processes beyond the closing of the project.

5.4 Sustainability of Continuous Quality Improvement

The scenario in which this evaluation was developed unveiled the real chances that the achievements reached will be sustained and continued to their consolidation over time. The university scenario shows the greatest guarantees of that, to the extent that it does not depend on eventual financing and has high degrees of consolidation in its managerial processes and pedagogical culture. However, it was found that the socio-cultural elements expressed in the quality and commitment of leadership are a conditionality for sustainability, to the extent that they can reduce the relevance of the HIV issue or pedagogical innovations incorporated, and can even become clear obstacles, as evidenced in two training centers. In contrast, when authorities commit and are able to maintain the academic spirit of continuous improvement, its permanence is clearly assured. In the scenario of the organizations, it was found that although the economic dimension is a very relevant conditionality, the nature and vocation of the organizations are the driving factors of the following findings:

- The predominant rationale of NGOs is the execution of projects, but they lack or do not generate permanent links with the populations served. When the subsidy ends, all achievements are undercapitalized and there are no promoters or opportunities to convene the populations.
- In contrast, organizations that by their community nature are KP or PWHIV associations, remain active and connected to their populations in spite of the difficulties resulting from lack of financing, management and promoters. We highlight the role developed by the so-called "activists" in these organizations, who even in times of funding have worked as liaisons in a voluntary way and constitute communication and convening "nodes" between the organization teams and the base population.
- Unlike the above, communication and care is weak in some organizations that have links with their populations, but whose leadership does not clearly express or show a permanent commitment toward them, and there is an absence of convening capacity, as was the case in the field work of this evaluation.

5.5 Lessons learned:

Unquestionably, the elements that can be mentioned as lessons learned in the two projects are countless in a prolific scenario of achievements and innovations. In the form of an inventory that highlights what we consider more relevant, but certainly not exhaustive, we mention the following:

Strengthening of the health sector: universities and NGOs

- The CQI component is a guarantee of effectiveness in achieving results and maintaining dynamics that are motivated by and committed to change. In the case of PrevenSida and ASSIST, URC's broad trajectory in quality improvement is an added value.
- All processes involved in CQI require a clear commitment from the authorities and leaderships. Deficiencies in this regard multiply obstacles and promote routine dominance and reduction of all motivation. Sustainability requires this essential factor.
- Adjusting training processes so they respond to specific capacities and needs. This lesson is downplayed when the growing preference is exchanges and evaluation sessions, which can be developed in a more autonomous way by organizations and universities, unlike training that requires "external agents".
- Activities that foster meetings between different populations contribute to reduce S&D, highlighting in-service practices and open events (fairs, forums, marches) in universities, while in organizations that work with KP and PHIV populations this is represented in the diversification of coverage, which in fact is inherent to PHIV (all genders and sexual identities).
- The systematization and validation of the transfer models, like the one presented by ASSIST for the implementation of the pedagogical package, facilitates and enables replication of "good practices."

Prevention and community care provided by NGOs:

- Mainstreaming the promotion of rights and the fight against GBV and S&D constitutes a need in the fight against HIV by bringing closer and personalizing meetings between beneficiaries and providers and optimizing results.
- The liaison and communication roles developed by NGO facilitators to maintain links between the organizations and community bases should be highlighted and projected in the systematization of the experiences that are replicated.
- Service activities that foster creative and playful participation of the beneficiary populations stimulate transfer of knowledge, capacity-building and attitude improvement.
- The integration of psychological care services to key populations and PHIV evidences the need to address people in their human and integral dimension. As some PHIV say, "they see us and value us as persons".
- It is possible to explore the chances of systematizing themes and communication modalities to incorporate them in work modalities, such as peer dialogues and group sessions.

Strategic information for key populations

- The creation of databases makes it possible to visualize differences and contrasts, either in reference to standards or between beneficiary populations or implementers, fostering reflection and dialogue based on evidence, triggering dynamics of interpretation of the gaps found and the construction of consensus on corrective actions.
- Capacity-building in information analysis and processing strengthens people's commitments to change processes, to the extent that the evidence-based situation is always questioned and precludes routine-based management.
- Mapping of meeting places: Evidences the need for instruments that provide information about the dynamic of the populations served.

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7. ANNEXES

Anexo N° 1. Términos de Referencia

STATEMENT OF WORK

FINAL PERFORMANCE EVALUATION OF THE USAID NICARAGUA HIV QUALITY IMPROVEMENT COMPONENTS IN PREVENSIDA AND ASSIST ACTIVITIES

I. Background

HIV epidemic in Nicaragua[1]

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. According to Nicaragua's Ministry of Health (MOH), by 2016, there were 12,164 reported cumulative cases of HIV positive individuals; of them, 10,894 are alive and 3885 under treatment. HIV prevalence among transgender women and men who have sex with men (MSM) are significantly higher (18.7% and 9.3 percent) than among sex workers (1.1 to 1.9 percent) or the general population (0.2 percent). In 2016, incidence and prevalence rate were estimated at 23/100,000 and 24/100,000 respectively.

USAID's HIV/AIDS program[2]

Since 1998, USAID/Nicaragua has been implementing HIV activities with bilateral funding, which came directly from the Mission's annual budget. Initially there were only regional projects, but since 2003, some specific activities were included in the health portfolio (PrevenSida, Famisalud, Alliances 2, HCI/ASSIST and Deliver). In addition to those bilaterally-funded projects, the USAID HIV Regional Program has also been implementing several projects (PASMO, PASCA, SCMS and Capacity), contributing to the implementation of the USAID Nicaragua HIV cooperation strategy, including a strong component of health services quality improvement (QI). The program is transitioning to a regional platform and all the bilateral projects are ending (Deliver in July 2016, ASSIST in December 2016 and PrevenSida close-out is planned for December 2017).

Partnership Framework between USG and Central America[3]

With PEPFAR-2 funding, the Partnership Framework (PF) between the USG and Central America Governments was a five-year plan (2010-2014) that outlined the priority areas for HIV programming in which the participating partners, including host governments, national and regional organizations, the USG, and other major donors dedicated their efforts and resources. The overall purpose of the PF was to reduce HIV/AIDS incidence and prevalence in key population (KP) in the Central American region by

joining resources and coordinating initiatives that enabled a robust and more effective response to the region's epidemic. The PF addressed four major gaps in HIV programming in the areas of prevention, health system strengthening, strategic information and policy environment. Table 2 shows the HIV strategic approach implemented in Nicaragua, and how the quality component is a cross cutting issue.

1 Ministry of Health, Nicaragua, 2016
2 http://transition.usaid.gov/our_work/global_health/aids/News/hiv_fastfacts.pdf
3 Partnership Framework in Central America 2010-2015: http://www.pepfar.gov/countries/frameworks/central_america/index.

Table 2 HIV program in Nicaragua under the Central America Partnership Framework (2010-2016)[4]

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** **URC: Health Care Improvement and ASSIST** JSI: Deliver (closed) SCMS Regional (closed)
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 (closed)
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**

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

Currently, to reach the overall goal of sustainable epidemic control in the region, the PEPFAR 3 Central America Regional (CAR) program focus on achieving three strategic outcomes: 1) Improve sustainability and financing of the national HIV responses across Central America; 2) Improve availability, accessibility and quality of HIV services for key populations (KP) including the reduction of stigma and discrimination; and 3) Expand the availability of HIV services by supporting systems and policies for Test and Start and Viral Load (VL) testing. PEPFAR CAR will optimize impact by drawing upon areas of synergy between regional, national and site level programs and activities.

PrevenSida project' capacity building component with local NGOs (2010-2017)

The PrevenSida project (HIV prevention among KP in Nicaragua) is implemented by University Research Co., LLC (URC). It is supported by the United States Agency for International Development (USAID) with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funds. It has four expected results: strengthening KP's Non-Governmental Organizations (NGO), providing prevention and care services, reducing stigma and discrimination, and increasing the NGO's participation in the national response. The NGOs, after a period of two years of formal training and in-site support in managerial, administrative, and technical aspects for the service provision, are ready to provide HIV services. They offer prevention services including: HTC, BCC, condoms and lubricants provision, and assessment and referral for other services: diagnosis and treatment of sexually transmitted infections (STI), family planning (FP), alcoholism and drug addiction, and community support groups. The offer also includes structural activities to reduce stigma and discrimination, and gender-based violence (GBV). People with positive tests are referred to public health units for confirmation and to link up with care and treatment according to the country's HIV care and treatment guidelines.

The project was design to increase the ability of NGOs working in prevention with KP to improve their organizational systems and management processes in order to have an even greater impact in their prevention efforts. By working initially with at least 20 NGOs (increased to 50 with the project extension) providing HIV prevention services to MARPS in Nicaragua, they were expected to enable the NGOs to continue and expand their prevention efforts focused on KP, enhancing their institutional capacity and providing them with the tools needed to have stronger impact, and to further develop and maintain internal sustainability.

Based on the USAID Health Care Improvement Project (HCI)'s previous experience, in order to achieve the outcomes in the PrevenSida project, modern continuous quality improvement approaches were applied to overcome the common barriers in organizations' management and preventive services provision even in a difficult social context, in weak health systems and in NGOs facing severe limitations of human and material resources. Each improvement collaborative addressed two sets of aims: Improving managerial capabilities and improving access to quality preventive services.

ASSIST project' capacity building component at Universities (2013-2016)

The Health Care Improvement (HCI) route (2006-2012): The transfer of skills to universities was 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 health

workers in the mother-child health, family planning and HIV/AIDS components. 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. This process was 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 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) until 2013.

ASSIST implemented HIV activities aiming to a) strengthen universities' capacities to provide HIV pre-service training for medical and nursing students (especially new treatment guidelines, reducing stigma and discrimination, gender and prevention of trafficking in people) and b) Promoting the continuous of quality improvement (QI) of teaching with emphasis on the adoption of QI methodologies.

ASSIST developed continuous quality improvement processes to adjust 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 was also relevant for designing and implementing a quality management program in three organizations that work with key populations and the LGBTI community.

II. Scope

USAID/Nicaragua is seeking quotations to provide a consultancy for a final performance evaluation of the HIV Quality Improvement components of the PREVENSIDA and ASSIST activities, both implemented by URC. The contractor will be required to answer all evaluation questions listed under Section III below.

The contractor must provide the following deliverables within the terms defined by the contract:

- Detailed evaluation design to be submitted with the proposal
- In-brief and out-brief preliminary findings with the USAID Nicaragua management and staff
- Draft report to be submitted within seven (7) working days of completing the out brief with USAID
- Final evaluation report in accordance with the USAID Reporting Guidelines

The time frame to be covered by the evaluation is from the start of each activity through the initiation of this evaluation.

	PrevenSida	**ASSIST**
Activity numbers	Cooperative Agreement No. AID-524-A-10-00003	
Activity dates:	Sept 20 2010 to Dec 30 2017	2013-2016
Activity funding	$8,565,540	$650,000
Implementing organization	URC	
AOR's Representative	Marianela Corriols, USAID N	Jim Heiby, USAID W
M&E Specialist	Marcela Villagra	
Office Chief	Angela Cardenas	

III. Purpose

The purpose of the study is to evaluate the performance of PREVENSIDA and ASSIST's quality improvement component, implemented by URC in Nicaragua, and to provide recommendations for future activities.

The results of the evaluation will be used by USAID/Nicaragua to improve future activities design and to share best practices with other countries in Central America. The audience of the evaluation will be USAID/Nicaragua and Regional and in particular the Office of General Development and the HIV Regional Program. The results of the study will also be shared with local stakeholders, counterparts and beneficiaries. Finally, the evaluation results will be used for reporting purposes to regional stakeholders.

IV. Evaluation questions

The evaluation findings must be supported by evidence. The contractor must answer the following questions in the evaluation related to the implementation of the quality improvement component in the PrevenSida and ASSIST activities.

General:

1. What were the changes that occurred in the quality of HIV services provided in each activity directly attributable to USAID support?
2. What were the most effective methods of knowledge transfer, improvement of attitudes and adoption of best practices in each component?
3. How the USAID's gender equality guiding principles were incorporated in the QI component?[5]

[5] USAID Gender Equality and Female Empowerment Policy
https://www.usaid.gov/sites/default/files/documents/1865/GenderEqualityPolicy_0.pdf

4. How sustainable the quality improvement programs are?
5. What lessons can be learned and shared with other counterparts and countries?

V. Evaluation Methods

The evaluation design will be submitted by the contractor in response to the solicitation and reviewed by USAID. The finalized evaluation design must be submitted five days after the signing of the contract. The evaluation design must outline in detail what methods the contractor will use to prepare answers for each evaluation question. It must include a detailed evaluation matrix (including the key questions, methods, data sources and analysis plan used to address each question), draft questionnaires, validation and dissemination plan. The methodology section should address strengths and weakness –if any- of the proposal, and how the later will be mitigated. This information will be discussed during the in-brief meeting with USAID. The design will be shared with the implementing mechanisms and local counterparts (civil society organizations and universities). The work plan must include the anticipated schedule and logistical arrangements and delineate the roles and responsibilities of the evaluation team' members.

VI. Evaluation team

The evaluation must be conducted by a team composed by one international and two local experts. The contractor has to demonstrate that the proposed team members have sufficient expertise to carry out the task to a high standard. The contractor must justify and explain the proposed team configuration and distribution of roles among team members. The Team Leader must have justifiable experience of at least seven years conducting evaluations and assessments in the HIV and quality improvement technical area, including improvement cycles, quality assessments, and quality improvement programs. Experience with CSO's and universities will be an advantage. The expert should have a master's level education or higher in the field of health, quality improvement or other relevant field. Experience in Nicaragua and the Central America Region is required. The team leader will be responsible for the day to day management of the team, data collection and synthesis, presentations, and draft and interim/final report preparation.

The Evaluation Expert must have a demonstrated experience in planning and conducting evaluations using qualitative and quantitative data collection and analysis methodologies, preferable (not required) in the health sector. The Evaluation Expert could be based in a third country and help the team with the evaluation design (methodologies and limitations in particular), at least one week of in country site visits and report writing.

A second locally-hired expert must have demonstrated experience (of at least three evaluations) in HIV projects in Nicaragua, particularly among key populations. Experience of participating as a team member in conducting USAID or other donor-funded activity assessments/evaluations will be an advantage.

Fluency in Spanish language is a requirement for all team members. One of the experts should have demonstrated expertise in gender-related issues.

The contractor must provide information about the selected evaluation team members including their CVs and explain how they meet the requirements set forth in the evaluation SOW. All evaluation team members must be familiar with USAID's Evaluation Policy and Automated Directive System Chapter 201 (ADS updated in 2016).

All team members are required to provide to USAID a signed statement attesting to a lack of conflict of interest in relation to the activities being evaluated. USAID may request an interview with any of the proposed evaluation team member/s via conference call/Skype or any other means available.

VII. Activity Documents for Review and Logistics

The AOR, through the General Development Office, will put the contractor in contact with its implementing partner and may provide help with organizing a small number of internal USAID meetings, if needed. Relevant reports and other activity documentation will be provided by the Mission to the contractor. These documents include:

- Activity Description as is stated in the award;
- Implementing partners Quarterly Reports;
- Initial list of in-country contacts;
- Activity results framework;
- Performance Management Plan indicator tables;
- M&E plans submitted and approved by USAID;
- Other deliverables (expert reports, publications) produced by partner.

The contractor will conduct most of the meetings in Managua. Some meetings will require traveling to regions outside Managua, such as Leon, Mateare, Matagalpa, RACCN and RACCS.

VIII. Deliverables

I. Detailed performance evaluation design and the work plan. Within five (5) days after signing, the contractor must present a design plan and a work plan. The research design must be an integral part of the proposal, and must explain in details methods and methodologies that will be used to collect required information to get answers for each evaluation question. The work plan must include the anticipated schedule and logistical arrangements and delineate the roles and responsibilities of members of the evaluation team.

2. In brief with the mission: This will be a presentation of how the questions asked in SOW will be answered. Prior to in brief research teams may have working meetings with USAID to agree at the details of the design.

3. Outline of the report and Out brief: After the field visits are completed, the contractor must present an outline of the evaluation report with general findings, analysis, conclusions, and anticipated recommendations. Prior to out brief research team may have working meetings with USAID to agree all the details of the report.

4.Draft Report: The contractor must submit a draft report within seven (7) working days of completing the out brief with USAID. This document should explicitly respond to the requirements of the SOW, should answer the evaluation questions, be logically structured, and adhere to the standards of the USAID Evaluation Policy and the criteria to ensure the quality of the evaluation report.

5.Final Report: The contractor must incorporate USAID's comments and submit the final report to USAID Nicaragua within five (5) working days following receipt of comments on the draft report. Final evaluation report should follow USAID's template, and should not exceed 25 pages, excluding executive summary and annexes. The contractor will make the final evaluation reports publicly available through the Development Experience Clearinghouse at http://dec.usaid.gov within 30 calendar days of final approval of the formatted report with USAID consent. In case it is determined that the full report includes sensitive information, the contractor will produce a revised/sanitized version and will submit it to the DEC.

The evaluation final report should include an executive summary, introduction, background of the local context and the activities being evaluated, the main evaluation questions, the methodology, the limitations to the evaluation, findings, conclusions, and recommendations and lessons learned. The executive summary should be 3-5 pages in length and summarize the purpose, background of the activity being evaluated, main evaluation questions, methods, findings, conclusions, and recommendations and lessons learned.

The evaluation methodology shall be explained in the report in detail. Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (e.g., selection bias, recall bias, unobservable differences between comparator groups, etc.) In the background section, it is expected to include the following aspects: management approach to improve and maintain quality that emphasized internally driven and continuous assessment of potential causes of quality defects; activities that contributed to the design, assessment, and monitoring of standards and that improve quality of service delivery, client satisfaction and effective utilization and actions aimed to avoid quality reduction and course correction.

The annexes to the report shall include:
- The Evaluation Scope of Work
- Any "statements of differences" regarding significant unresolved difference of opinion by funders, implementers, and/or members of the evaluation team
- All tools used in conducting the evaluation, such as questionnaires, checklists, and discussion guides
- Sources of information, properly identified and listed
- Disclosure of conflicts of interest forms for all evaluation team members, either attesting to a lack of conflict of interest or describing existing conflict of interest.

6.All records from the evaluation. All quantitative data collected by the evaluation team must be provided in an electronic file in easily readable format agreed upon with USAID. The data should be organized and fully documented for use by those not fully familiar with the activity or the evaluation. USAID will retain ownership of the survey and all datasets developed.

IX Duration

The consultancy will have a chronological period of three months from the first of June of 2017.

X Estimated level of effort

Activities	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12
1. Fase de organización												
Reuniones de coordinación	0.5		0.5			0.5		0.5				
Revision documental y bibliográfica	2											
Elaboración de plan de trabajo	1											
Elaboración de propuesta metodológica detallada,	1.5											
Presentación de PT /PM (1er producto)												
Diseño de herramientas y guías		3										
Validación de herramientas local en Managua		1										
Ajuste a herramientas			1									
2. Fase de Campo												
Visitas a universidades			2	5	2							
Visitas a ONGs			2	5	2							
3. Fase de análisis y redacción												
Análisis de los datos					1	2						
Elaboración del resumen de hallazgos y presentación a USAID						2.5						
Elaboración del primer borrador de informe final							5					
4.Validacion												
Ajustes al primer borrador								1				
Taller de validacién externa								1				
Elaboración de informe final en español								3				
Traducción de informe final al ingles												

X1 Application Submission Process

If you decide to submit an application, it should be received by the closing date and time indicated via e-mail attachment at cwong@urc-chs.com to the attention of Dr. Yudy Wong. Electronic technical and cost applications must be submitted on separate documents by the established date and time. The language for this Request for Application (RA) can be: Language: English or Spanish

Any questions concerning this RFA must be submitted in writing to onunez@urc-chs.com to the attention: Oscar Nuñez

DEADLINE FOR APPLICATIONS

All applications must be submitted by 04:00pm, May 18, 2017. Via email at cwong@urc-chs.com to the attention of Dr. Yudy Wong.

Documents to submit.

- Letter of interest, confirming immediate availability
- Curriculum vitae of each member of the evaluation team
- Technical and financial offer in US dollars separately.

XII List of acronyms

ACRONYMS

AIDS	Acquired Inmuno- Deficiency Syndrome
ALLIANCES 2	USAID project on public-private alliances for health and education
ADRA	Adventist Development and Relief Agency
ARV	Antiretroviral
BCC	Behavior Change Communication
CONISIDA	Comisión Nacional de Lucha contra el SIDA [*National HIV Commision*]
DELIVER	USAID Project on logistics implemented by JSI
ENDESA	Encuesta Nicaragüense de Demografía y Salud [*Nicaraguan Demographic and Health Survey*]
FAMISALUD	Familias Unidas por Su Salud [*Families United for Health*]
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

Anexo N° 2. Matriz de operacionalización de preguntas directivas de la Evaluación

Variables derivadas de preguntas evaluativas	Variable Operacional	Valores / Escala	Indicador	Definición operacional	Fuente y metodo de información
P1. Que cambios ocurridos en la calidad de los servicios pueden ser atribuidos al apoyo directo de USAID?					
Hay cambios significativos en los indicadores de resultado que puedan ser atribuibles a las actividades de de los proyectos PrevenSida o ASSIST?	Hay cambios de comportamientos de riesgo protección que otros proveedores	Cuantitativa/continua	Tasa de prevalencia de personas con comportamientos de protección	Diferencia en tasas es estadisticamente significativa	Estudio Place/PrevenSida,
	Mayor adherencia a TAR y tasa de PVIH en supresion vírica	Cuantitativa/Discontinua	Tasa de prevalencia de PVIH en adherencia TAR y en "supresión vírica"	Diferencia estadisticamente significativa	Encuesta PVIH/RU/PrevenSida
	Mayor desarrollo de competencias en estudiantes Vs otras asignaturas/temas	Cualitativa / discontinua	Estudiantes que cumplen parametros de competencias de su perfil profesional	Diferencias en prevalencia de estudiantes aprobados y cumplen mas del XX% de competencias	Evaluacion de estudiantes Listas de chequeo universidades
Se han dado cambios en los servicios de atencion en la red de PrevenSida o en las actividades docentes sobre VIH que ha apoyado ASSIST?	Cambios en marco normativo taes como: protocolos vigentes; normas de atención, Curriculums, planes de estudio, organización de clases	Cualitativa / discontinua	Existencia y explicación de cambios .Resultados de ajustes realizados en el período	Ha habido cambios (Si/No), en qué? por qué? Ha habido cambio en resultados (comportamientos)?	Entrevista a equipo URC y de OSC, entrevistas y GF con promotores de ONG
	En la forma de realizar las actividades (relaciones interpersonales proveedor/beneficiario, Docente/estudiantes, participación, uso de tecnologias, modalidades)	Cualitativa / discontinua	Existencia y explicación de cambios .Resultados de ajustes realizados en el período	Ha habido cambios (Si/No), en qué? por qué? Se vinculan con cambios en los resultados (comportamientos / competencias)?	Entrevista a Directivas OSC/UNI; entrevistas y GF con promotores/Docentes; encuesta/GF con beneficiarios (PC, PVIH, Est)
	Cambio en los sitios y ambientes de realizacion (mapeo, planes, utilizacion de información producida,				
	Ajustes del Curriculum y plan de estudios; razones y resultados de ajustes realizados en el período (vinculacion de politicas y programas nacionales de salud en VIH; mecanismos de actualizacion cientifica y tecnológica en temas de VIH,	Cualitativa / discontinua	Existencia y explicación de cambios en Curriculum, plan de estudios o enfoques pedagógicos	Ha habido cambios (Si/No), en qué? por qué? Ha habido cambio en resultados (competencias)?	Entrevista a equipo URC, directivas de Univ/OSC y Docentes universitarios
Se verifican cambios en las capacidades gerenciales de las organizaciones de las organizaciones y de las carreras vinculadas a los apoyos de los proyectos USAID?	Comunicación interpersonal, (dialogo/participacion), Nivel de confianza/satisfacción de beneficiarios; razones de cambio/no cambio en beneficiarios de poblaciones clave	Cualitativa / discontinua	Existencia y explicación de cambios en modalidades de atención.	Ha habido cambios (Si/No), en qué? por qué? Ha habido cambio en resultados (comportamientos)? O en el nivel de satisfaccion de beneficiarios/as	Entrevista a equipo PrevenSida, directivas y promotores de OSC, población clave atendida
	Innovacion y ajustes en metodologias e instrumentos pedagógicos, evaluacion de docentes, Comunicación interpersonal, (dialogo/participacion), Nivel de confianza/satisfacción de beneficiarios; razones de cambio/no cambio en	Cualitativa / discontinua	Existencia y explicación de cambios en metodologias pedagógicas o en instrumentos didacticos.	Ha habido cambios (Si/No), en qué? por qué? Ha habido cambio en resultados (competencias)? O en el nivel de satisfacción de estudiantes	Entrevista a equipo ASSIST y directivas universitarios. Entrevistas y GF con docentes y estudiantes

Matriz de operacionalización de preguntas directivas de la Evaluación

Variables derivadas de preguntas evaluativas	Variable Operacional	Valores / Escala	Indicador	Definición operacional	Fuente de información
P1. Que cambios ocurridos en la calidad de los servicios pueden ser atribuidos al apoyo directo de USAID?					
Se han creado, mejorado o consolidado capacidades de producción de información y gestión del conocimiento vinculadas a los apoyos de los proyectos USAID?	Lugares (acceso, privacidad, comodidad, etc), vinculacion familiar, de grupo, de comunidad; articulacion con servicios complementarios	Cualitativa / discontinua	Existencia y explicación de cambios en sitios, ambientes y condiciones en que se brinda la atención.	Ha habido cambios (Si/No), en qué? por qué? Ha habido cambio en resultados (comportamientos)? O en nivel de satisfaccion de PC	Entrevista a equipo PrevenSida y directivas OSC. Entrevistas y GF con promotores y población clave atendida
	Diseño y desarrollo de practicas en servicio, integracion de estudiantes en provision de servicios, desarrollo de docencia practica en servicios	Cualitativa / discontinua	Existencia y explicación de cambios en metodologias aprendizaje práctico en servicio. Nivel de satisfaccion de estudiantes	Ha habido cambios (Si/No), en qué? por qué? Ha habido cambio en resultados (competencias)? O en el nivel de satisfaccion de estudiantes	Entrevista a equipo ASSIST y directivas universitarios. Entrevistas y GF con docentes y estudiantes
Existen innovaciones en el sistema de monitoreo y evaluación del desempeño y aceptabilidad de la atención?	Se han establecido parámetros, responsabilidades y procedimientos de evaluación de la atención	Cualitativa / discontinua	Existencia/cambios de sistema de evaluacion de la atención	Existencia y funcionamiento de procedimientos sistemáticos de evaluación	Entrevistas a directivas (OSC, UNI), Entrevistas y GF a Proveedores (Pom, Doc)
	Se ha creado algun sistema de registro continuo de las personas, actividades y resultados de la atención/Docencia	Cualitativa / discontinua	Existencia/cambios de sistema de información para la evaluacion de la atención	Ha habido cambios (Si/No), en qué? por qué?	Entrevistas a directivas (OSC, UNI), Entrevistas y GF a Proveedores (Pom, Doc)
	Se analiza colectivamente la información de manera periodica y sistematica	Cualitativa / discontinua	Periodicidad y productos de sesiones colectivas para la evaluacion de la atención	Frecuencia, participación, problemas analizados, decisiones adoptadas	Revision documental, Entrevistas a personal de Univ y de OSC
	Las personas beneficiarias (población clave y estudiantes) participan regularmente en eventos de evaluacion	Cualitativa / discontinua	Participación e incidencia de PC y estudiantes en evaluacion de la atención	Frecuencia de la participación, satisfacción con incidencia (son tenidos/as en cuenta)	Entrevistas a población clave y estudiantes
	Se mantiene un mecanismo de seguimiento de las recomendaciones y compromisos adoptados como producto de la evaluacion	Cualitativa / discontinua	Grado de implementación de decisiones sobre ajustes en la atencion que han sido adoptadas	Proporción de decisiones según grado de implementación (Total, parcial, en proceso, nula)	Revision documengal y Entrevistas a personal de Univ y de OSC
Existen innovaciones en apoyo a fortalecer la incidencia y participación de las poblaciones beneficiarias y de Docentes/estudiantes en decisiones de política pública que inciden en la respuesta nacional o local al VIH?	Realizacion de estudios especiales que aportan conocimiento de situacion de la atención preventiva a PC, a PVIH o de la docencia universitaria en VIH	Cualitativa / discontinua	Numero y relevancia de estudios realizados sobre calidad de servicios o docencia	Verificacion y valoración de divulgación y utilización de estudios realizado	Entrevistas a equipo USAID/URC, Entrevistas a directivas de universidades y OSC, Entrevistas a instancias de la coordinacion de la respuesta nacional
	Desarrollo de ´procesos especiales de formulación de politicas, planes que facilitan la incidencia en los entornos sociales o institucionales	Cualitativa / discontinua	N° y relevancia de productos y eventos de incidencia en calidad de servicios o docencia	Verificacion y valoración de productos o eventos de incidencia	
	Desarrollo de procesos de asistencia para mejorar la particiación de las OSC o universidades en ámbitos de decisión nacional o local de la respuesta al VIH.	Cualitativa / discontinua	OSC y universidades que participan e inciden en decisiones locales o nacionales frente al VIH	Valoracion de la participación (eventual, sistematica) y de la incidencia (Limitada/ notoria/ muy relevante)	

Matriz de operacionalización de preguntas directivas de la Evaluación

Variables derivadas de preguntas evaluativas	Variable Operacional	Valores / Escala	Indicador	Definición operacional	Fuente de información
P2. Que metodos son mas efectivos para: Trasnferir conocimiento, Mejorar actitudes, Adopcion de "mejores prácticas"					
Valoración e innovaciones en metodologias y desarrollo de eventos de capacitación en servicio y pre-servicio	Diseño e implementación de programas y eventos de capacitación en y pre servicio, con temática relevante y pertinente a la situación y con metodologías que promueven asimilación de nuevo conocimiento y desarrollo de nuevas competencias para la mejora de la atención/docencia	Cualitativa / discontinua	Reconocimiento y valoración de programas y eventos d capacitación, como metodo mas relevante en asimilación de nuevo conocimiento y desarrollo de nuevas competencias.	Valoración de dinámicas magistrales o participativas; preferencias y satisfacción del personal capacitado; principales aprendizajes, percepcion de utilidad de evetos o temáticas (alta, media, nula)	Entrevista a proveedores y beneficiarios de la capacitación (Docentes universitarios y promotores de ONG)
Valoración de metodologias y desarrollo de procesos de supervisión/acompañamiento en servicio (coachig)	Diseño e implementación de sistema de supervisión y acompañamiento en servicio (coaching) como reforzamiento de la capacitación y enfocada a promover el mejoramiento	Cualitativa / discontinua	Reconocimiento y valoración de visitas de supervición, como metodo mas relevante en asimilación de nuevo conocimiento y desarrollo de nuevas competencias.	Valoración del procedimiento y la frecuencia de visitas, preferencias y satisfacción del personal superviado; principales aprendizajes y cambios relizados en los servicios, seguimiento de recomendaciones	Entrevista a Docentes universitarios y promotores de ONG
Valoración de metodologias y desarrollo de eventos de evaluacion e intercambio colectivo (Funcionalidad de equipos, colaborativos de mejoramiento, encuentros interorganizacionales)	Frecuencia y valoracion general de los eventos,e intercambios, principales aprendizajes y cambios relizados en los servicios,	Cualitativa / discontinua	Reconocimiento y valoración de procesos de evaluación e intercambio, como metodo mas relevante en asimilación de nuevo conocimiento y desarrollo de nuevas competencias.	Valoración de la frecuencia y utilidad de procesos de MyE en el mejoramiento de la atención. Frecuencia y valoración de colaborativos de mejora. seguimiento de recomendaciones. Percepcion de que opinión de Docentes/Promotores es tenida en cuenta en ciclos de evaluacion y mejora.	Entrevista a Docentes universitarios y promotores de ONG
Identificacion de aportes de conocimiento y "mejores prácticas" de PrevenSida y ASSIST asumidos en politicas y programas nacionales o por otras instituciones	Modalidades de divulgación y socializacion de resultados y evaluaciones en el entorno institucional, procesos de sistematizacion de "mejores prácticas", procesos de asistencia técnica a otras instituciones para implementar innovaciones	Cualitativa / discontinua	Reconocimiento y valoración de experiencias e innovaciones que se han replicado en otras instituciones/carreras	Valoración de las modalidades de divulgación y socializacion de resultados y evaluaciones en el entorno institucional. Existencia y valoración de sistematizacion de "mejores prácticas", procesos de asistencia a otras instituciones para implementar innovaciones	Entrevistas a equipo USAID/PrevenSida/ASSIST; entrevistas a directivos de universidades y ONG´s

Matriz de operacionalización de preguntas directivas de la Evaluación

Variables derivadas de preguntas evaluativas	Variable Operacional	Valores / Escala	Indicador	Definición operacional	Fuente de información
P3. Como fueron incorporados los principios de igualdad de género de USAID en el mejoramiento de la calidad?					
Integrar la igualdad de género y el empoderamiento de la mujer en el trabajo de USAID	Visibiliazacion de la IG/EM en evaluación, innovaciones y ajustes a las actividades de PrevenSida y ASSIT	Cualitativa / discontinua	La IG/EM se encuentra como componente transversal de las decisiones y acciones de PrevenSida y ASSIST	Se identifica la IG/EM en documentos directrices y en funcionamiento del componente de MCC.	Revisión documental. Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC, promotores de OSC, docentes, estudiantes
Perseguir un enfoque inclusivo para promover la IG/EM abordando todas las desigualdades injustas	Integración de enfoque de equidad (Género, intergeneracional, etnica, territorial) en las politicas/Planes y en el diseño e implementacion de actividades de los dos proyectos.	Cualitativa / discontinua	Valoración de las dimensiones de la equidad en el diseño y funcionamiento del componente de MCC	Se oidentifican estrategias inclusivas Ej: integración de parejas femeninas de bisexuales, enfoque diferencial a jóvenes de las poblaciones clave	Revisión documental. Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC, promotores de OSC, docentes, estudiantes
Construir alianzas a través de una amplia gama de partes interesadas en la IG/EM:	Visibilización de factores derivados de oposiciones u alianzas como facilitadores o restrictivos de la calidad de las acciones y de la equidad de género	Cualitativa / discontinua	Valoración de estrategias de concertación y alianza con actores locales y nacionales relevantes y con interes en IG/EM frente al VIH	Se identifican alianzas locales y nacionales enfocadas en IG/EM frente al VIH. Valoración de sus resultados en MCC	Revisión documental. Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC
Apalancamiento de la IG/EM con la innovación, la tecnología y la ciencia	Identificación de innovaciones de produccion de conocimiento y en uso de tecnologías para mejorar calidad y equidad de género en las acciones de los dos proyectos	Cualitativa / discontinua	Relevancia de la valoración del desrrollo de capacidades de producción de conocimiento y habilidades tecnológicas	Reconocimiento de empoderamiento y mayores capacidades de concertacion basadas en nuevo conocimiento y manejo tecnológico	Revisión documental. Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC
IG/EM como desafío en entornos afectados por crisis y conflictos	Abordaje de relaciones de EyD/VBG (intrafamiliares, comunitarias e institucionales) que facilitan o restringen la calidad de las acciones de los dos proyectos	Cualitativa / discontinua	Valoración de esfuerzos por reducir estigma y discriminación. Mejoras de la atención por reduccion de EyD/VBG	Percepcion de incremento ó reduccion de EyD/VBG y su incidencia en mejoras de la atención y sus resultados en la prevención	Revisión documental. Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC, promotores de OSC, docentes, estudiantes
Servir como un líder de pensamiento y una comunidad de aprendizaje	Integración de enfoque de equidad de Género en el sistema de monitoreo y evaluacion, asi como en estudios y evaluaciones externas de los dos proyectos. Socializacion de nuevos conocimientos producidos	Cualitativa / discontinua	Produccion e incidencia de nuevo conocimiento y nuevas prácticas que mejoran atencion/docencia en VIH por integración de IG/EM	Reconocimiento de PrevenSida y ASSIST en la integración de la IG/EM en la lucha contra el VIH.	Revisión documental. Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC

Matriz de operacionalización de preguntas directivas de la Evaluación

Contenidos derivados de preguntas evaluativas	Opracionalizacion general				Fuente de información
P4. Hasta que punto son sostenibles los programas de mejoramiento de la calidad?					
Son tecnicamete sostenibles?	Nivel de consolidación lograda en los mecanismos de actualización cientifica permanente, incluyendo nuevos conocimientos de la situación nacional y local de la epidemia de VIH	Cualitativa / discuntinua	Valoración e implementacion de procesos sistemáticos de actualizacion cientifica y roducción de nuevo conocimiento en VIH	Verificacion de existencia y sistematicidad de procesos de actualización y produccion de conocimiento	Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC, promotores de OSC, docentes,
Son culturalmente sostenibles?	Nivel de consolidación y autonomía lograda en los mecanismos de aseguramiento continuo de la calidad en las universidades y OSC.	Cualitativa / discuntinua	Apropiación de la MCC como procedimiento habitual en proveedores de servicios o docencia	Verificación de actividades sitemáticas de evaluación , intercambios y colaborativos periodicos,	Entrevistas a: promotores de OSC, docentes,
Son políticamente sostenibles?	Posibilidades de expansión o replicacion de los mecanismos de mejoramiento continuo de la calidad en otros ambitos de la respuesta nacional al VIH	Cualitativa / discuntinua	Apropiación de la MCC como procedimiento habitual de gerencia en OSC y Universidades	Verificación de vigencia de Planes de MCC, cumplimiento de responsabilidades, presencia de facilitadores/s, actividades sitemáticas, colaborativos periodicos,	Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC
Son economicamente sostenibles?	Visibilizacion de progresividad de ajustes a la calidad acordes a capacidades existentes y acumulables.	Cualitativa / discuntinua	Capacidad presente y futura de asimilación de costos de actividades de mejoramiento continuo de la calidad de las acciones en universidades y OSC	Percepción de incremento o nó de costos de la integración del MCC en el proceso gerencial	Entrevistas a: Equipo USAID/URC, directivas de universidades y OSC
P5. Que lecciones pueden ser aprendidas y compartidas con otras contrapartes y paises?					
Valoración de hallazgos que por su relevancia como innovación y frente a resultados se consideren como "mejores prácticas" para su socialización o replicación.	Inclusion en informe de evaluacion de valoracion de hallazgos como "mejores prácticas" para su socializacion o replicación		En cada hallazgo de experiencias exitosas o de restricciones en los procesos de mejoramiento continuo de la calidad de las acciones de los dos proyectos , se determinara y valorará su relevancia y pertinencia de su socialización y oferta a otras contrapartes y paises que puedan estar interesados		Analisis del equipo de evaluación y proceso de validación del informe con equipos USAID/URC, con OSC y universidades.

Anexo 3. Cuestionarios

Cuestionario Nº 1. Encuesta a población atendida por OSC PrevenSida

Buenos dias/tardes, de parte del Equipo de Estudios Evaluativos agradecemos su presencia, estamos realizando un análisis acerca de la forma en que las organizaciones que trabajan contra el VIH/SIDA han mejorado la calidad de la atención integral y continuada al VIH; su opinion es muy importante para lograrlo, por eso, solicitamos su valiosa y sincera colaboración.
Recuerde que no es un exámen, solo se pregunta lo que USTED piensa, por lo tanto, no hay respuestas correctas o incorrectas
Esta encuesta es anónima y totalmente confidencial, ninguna persona diferente al equipo investigador tendrá acceso a la entrevista que usted nos brinde y solo será utilizada para el propósito declarado.

Municipio:___Organización__Fecha_____
Edad:_____años Sexo: Masculino_____Femenino:____Transgénero: _
Edad (años cumplidos) _____ **Trabaja: Sí___No_____**

Nivel de escolaridad aprobado: Primaria: __ Secundaria: __ Universitaria: _ Postgrado: ___

1. ¿En qué actividades de esta organización ha participado en el último año? .. *ultimos*

De las actividades que ha participado ¿Cuálha sido para usted la mas útil?
_____Por qué?:
¿Cuál otra actividad que mencionó considera qué es muy útil y por qué?
_____Por qué?:
¿Cómo valora la forma en qué ha sido atendida/o en los servicios/actividades? Excelente_____Buena _____Deficiente__
¿Por qué? _____

5. ¿Cuáles de los servicios o actividades recibidos por usted ha sido más útil para:
Considere: sesion de grupo pequeño, Contacto ocasional, Educacion con un par, video foros, Grupos de ayuda mutua, consejeria, otra (cual??

Actividad o servicio

Adquirir más o nuevos conocimientos? Desarrollar su capacidad para prevenir _____
Mejorar actitudes frente a estigma y discriminación _____
¿Ha participado usted en la evaluación de las actividades o servicios? Sí No _____
¿Considera que su opinión es tomada en cuenta para mejorarlas? Si No _____
¿En alguna ocasión ha sentido algun tipo de discriminación en estas actividades?
Sí/No _____ ¿De qué manera? _____

¿Considera que en esta organización hay discriminación hacia:
Hacia Las mujeres? Si_____No _____ ha aumentado o disminuido? ha aumentado o disminuido? ha
Hacia la población LGBTI? Si_____No _____ aumentado o disminuido? _____
Hacia las personas VIH positivas? Si_____No _____
_____
_____

¿En su opinión cual ha sido la actividad mas importante que ha desarrollado esta organización para:
Reducir la desigualdad de género _____
Reducción del estigma y discriminación a población LGBTI o VIH+?
¿Conoce usted el número de casos y muertes por VIH que ha ocurrido en su municipio en el último año? SI NO

¿Usted considera que la población LGBTTI y las Personas VIH+ son bien atendidas en los servicios de salud
SI NO ___
por qué? _____
¿Usted considera que la opinión de las comunidades LGBTTI y las Personas VIH+ son tomadas en cuenta por las personas de esta organización? SI NO ___

¿Qué recomendaciones daría para
Mejorar los servicios de prevención brindades a las poblaciones de mayor riesgo? Mejorar los servicios de atención brindada a las personas VIH +?

14. Para finalizar permitanos hacer algunas preguntas mas personales *que bien puede decidir no responder:*
Su orientación sexual es: Heterosexual ____ Gay_____Bisexual_____Lesbiana _____

En el último mes usó condón en todas sus relaciones sexuales?. Si No _ En el último mes tuvo relaciones sexuales con más de una pareja?. Si No _____ En el último año, se ha realizado usted la prueba de VIH?. Si No _____

Muchas gracias por su valiosa colaboración!!!

Cuestionario Nº 2. Encuesta a promotores y voluntarios de las ONG

Organización: _____ **Municipio:** _____

Edad:_____**años** **Género: Masculino**_____**Femenino:**_____**Transgénero:** _____

Trabaja en la organización o es voluntario/a _____ **Tiempo de trabajar o colaborar:**_____**años**

Nivel de escolaridad aprobado: Primaria: ____ **Secundaria:** ____ **Universitaria:** ____ **Postgrado:** _____

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1. ¿Ha habido algún cambio importante en la forma de atender a la población clave? o VIH+? Sí No_____

Si respuesta es No…. Ir a pregunta N° 3 *En caso Si..* **Cual cambio?** _____

¿Cual considera usted que es la razón principal de ese cambio?, _____

¿En su opinión ese cambio ha tenido algún efecto en la población atendida? Si No ___

Si respuesta es Sí **Cual efecto?** _____

2. ¿Ha habido otro cambio en la atención que usted considera importante de mencionar? Si No ___

Si respuesta es Sí **Cual?** _____

3. ¿En los últimos años, han mejorado los indicadores de riesgo *(uso de condón, numero de parejas, prueba anual)* **en la población atendida por su organización? Si No No sé**___ *Si responde No sé .. Pasar a N°4*

Si responde Si o No **De que manera han verificado o medido esos indicadores?** _

En su opinión ¿cuál es la razón principal para lograr o no lograr cambios? _____

---

4. ¿En su opinión cómo calificaría la forma en que usted realiza sus actividades?

Por favor enumere y califique:

N°	Actividad /servicio	Califique como: Buena / Regular / Deficiente

5. ¿De las actividades o servicios que enumeró, cuál considera que realiza mejor y por qué?

6. ¿Conoce usted la situacion actual del VIH en su municipio *(datos de últimos años)* **? Si No**____

Si respuesta es S i .. **¿Ha sido útil esa información? Si NO** ___ **para qué?**_____

7. ¿En el desarrollo de sus capacidades como promotor/a, qué apoyos recibidos por usted ha sido más útil para:

	Que apoyo (*)	Qué organización lo brindó?
a) Adquirir más o nuevos conocimientos?		
b) Desarrollar habilidades de comunicación?		
c) Reducir estigma y discriminación?		
d) Identificar o reproducir "mejores prácticas"		
e) Procesar y analizar información		
f) Mejorar su aporte al fortalecimiento institucio		
g) Otra *(Cual?)* _____		

(*)Por ej: capacitación, supervisión/coaching, intercambios de mejoramiento, sesiones evaluativas, evaluación del desempeño, otros(anotar cual)

8. ¿En su opinión cual de esos apoyos ha sido más útil para el fortalecimiento general de la organización?

Por qué? _____

9. En su opinión la población atendida por su organización ...

a) Comprende bien los mensajes que se les brinda? Si No Por qué: _____

b) Asimila y asume nuevas actitudes: Si No ___ Por qué? _____

c) Está satisfecha con la atención recibida? Si No Por qué? _____

10. ¿Considera que en su organización hay discriminación hacia:

a) Hacia Las mujeres? Si____No ____ ha aumentado o disminuido? _____

b) Hacia la población LGBTI? Si____No ____ ha aumentado o disminuido?

c) Hacia las personas VIH positivas? Si____No ____ ha aumentado o disminuido? _____

11. ¿En su opinión cual ha sido la actividad más importante que ha desarrollado su organización para:

Reducir la desigualdad de género _____

Reducir el estigma y discriminación a población LGBTI o VIH+? _____

¿Han recibido apoyo de otras organizaciones en estas actividades? Si No____No sé ___

Si respuesta es Si . . Cual organización cree que ha brindado el apoyo más útil? _____

12. ¿Su organización participa con otras organizaciones en actividades que promuevan la igualdad de género y la reducción del estigma y discriminación hacia la población GBTI y PVIH? Si No____. No sé __

Si respuesta es Si **mencione una actividad destacada:** _____

13. ¿En su opinión, considera que se registran adecuadamente los datos acerca de los comportamientos de riesgo en la población clave o VIH+? Si No ,

y de las actividades/servicios que ustedes ofrecen? Si____No ____

14. ¿Se realiza análisis colectivo de éstos datos? Si____No ____ participa usted? Si____No ____

Recientemente se ha hecho algún cambio para mejorar la utilización de ésta información? Si No ___

Si respuesta es Si . **Cual cambio?** _____

15. Considera que su opinión es tomada en cuenta para mejorar el trabajo de la organización? Si No ___

16. Se reunen las instituciones locales para analizar la situación del VIH en el municipio? Sí No No sé ___

17. Considera que su organización es tomada en cuenta por las instituciones del municipio? Sí No___

18. Considera que su organización puede seguir mejorando la calidad de los servicios por si sola? Sí No ___

¿De qué depende que la calidad pueda mantenerse a lo largo del tiempo? _____

19. ¿Qué recomendaría usted para:

a) Mejorar la calidad de los servicios o de las acciones, _____

b) Mejorar su propio desempeño como promotor/a _____

c) Para reducir el estigma y discriminación: _____

d) Otra,*(cual?)* _____ _____

20. Para finalizar permítanos hacer algunas preguntas mas personales *que bien puede decidir no responder:*

Su orientación sexual es: Heterosexual ____ Gay_____Bisexual_____Lesbiana ____

En el último mes usó condón en todas sus relaciones sexuales?. Si No ____

En el último mes tuvo relaciones sexuales con más de una pareja?. Si No ___

En el último año, se ha realizado usted la prueba de VIH?. Si No ___

Muchas gracias por su valiosa colaboración!!!

Cuestionario Nº 3. Encuesta a estudiantes de Medicina y Enfermería

Buenos dias/tardes, de parte del Equipo de Estudios Evaluativos agradecemos su presencia, estamos realizando un análisis acerca de la forma en que las universidades que forman personal de salud han asumido y mejorado la docencia acerca de la atención integral y continuada al VIH; su opinion es muy importante para lograrlo, por eso, solicitamos su valiosa y sincera colaboración. Recuerde que no es un exámen, solo se pregunta lo que USTED piensa, por lo tanto, no hay respuestas correctas o incorrectas. Esta encuesta es anónima y totalmente confidencial, ninguna persona diferente al equipo investigador tendrá acceso a la entrevista que usted nos brinde y solo será utilizada para el propósito declarado.

Municipio: Universidad/carrera Año

Edad: años Sexo: Masculino Femenino: Transgénero:

Edad (años cumplidos)

2. **De las actividades que ha participado ¿Cuálha sido para usted la mas útil?**

_____ **Por qué?:**

3. **¿Cuál otra actividad que mencionó considera qué es muy útil y por qué?**

_____ **Por qué?:**

4. **¿Cómo valora la forma en qué se ha desarrollado la docencia sobre VIH?**
   Buena Regular Deficiente
   ¿Por qué?

5. ¿En su valoración cómo calificaría la aplicación de las diferentes metodologías docentes?
   Por ej:Clase magistral, clase participativa, seminarios, audiovisuales, prácticas en servicios, otras (especificar)

5. ¿Cuáles de las actividades docentes sobre VIH que ha recibido usted ha sido más útil para:
   Considere: clases magistrales, clases participativas, prácticas en servicio, seminarios, videos, actualizacion científica, otra (cual)

   Adquirir más o nuevos conocimientos?

   Desarrollar sus habilidades para promover la prevención

   Desarrollar sus habilidades para promover el tratamiento

   Mejorar manejo y análisis de información?

   Mejorar actitud ante población LGBTI o VIH+

6. **¿Ha participado usted en la evaluación de las actividades docentes? Sí No**
   ¿Considera que su opinión es tomada en cuenta para mejorarlas? Si No

7. **¿En alguna ocasión has sentido algun tipo de discriminación dentro de la universidad?**

Sí No

¿De qué manera?

8. ¿Considera que en esta carrera hay discriminación hacia:

a) **Hacia Las mujeres?** **Si** **No**

b) **Hacia la población LGBTI?** **Si** **No**

c) **Hacia las personas VIH positivas?** **Si** **No**

ha aumentado o disminuido? ha aumentado o disminuido? ha aumentado o disminuido?

9. ¿En su opinión cual ha sido la actividad mas importante que ha desarrollado esta facultad para:

Reducir la desigualdad de género

Reducción del estigma y discriminación a población LGBTI o VIH+?

por qué?

10. ¿Conoce usted el número de casos y muertes por VIH que ha ocurrido en su municipio en el último año? SI __ NO __

11. ¿Usted considera que la población LGBTI y las Personas VIH+ son bien atendidas en los servicios de salud Si __ No __

por qué?

12. ¿Usted considera que la opinión de las comunidades LGBTTI y las Personas VIH+ son tomadas en cuenta por las autoridades de salud ? Si __ No __

13. ¿Qué recomendaciones daría para
Mejorar los servicios de prevención brindadas a las poblaciones de mayor riesgo?
Mejorar los servicios de atención brindada a las personas VIH +? Mejorar las

actividades docentes sobre VIH en su facultad?

14. Para finalizar permítanos hacer algunas preguntas mas personales ***que bien puede decidir no responder:***

Su orientación sexual es: Heterosexual

Gay **Bisexual** **Lesbiana**

En el último mes usó condón en todas sus relaciones sexuales?. Si No

En el último mes tuvo relaciones sexuales con más de una pareja?. Si No __ En el último

año, se ha realizado usted la prueba de VIH?. Si No

Muchas gracias por su valiosa colaboración!!!

Cuestionario N° 4. Encuesta a personal docente

Buenos dias/tardes, de parte del Equipo de Estudios Evaluativos agradecemos su presencia, estamos realizando un análisis acerca de la forma en que las universidades que forman personal de salud han asumido y mejorado la docencia acerca de la atención integral y continuada al VIH; su opinion es muy importante para lograrlo, por eso, solicitamos su valiosa y sincera colaboración.

Recuerde que no es un exámen, solo se pregunta lo que USTED piensa, no hay respuestas correctas o incorrectas

Esta encuesta es anónima y totalmente confidencial, ninguna persona diferente al equipo investigador tendrá acceso a la entrevista que usted nos brinde y solo será utilizada para el propósito declarado.

Universidad y carrera: _____ **Municipio:**__

Edad:_____**años** **Género: Masculino** _____ **Femenino:** __ **Transgénero:** _____

Tiempo de trabajar como docente _____ **Tiempo en esta universidad:**_____**años**

Titulo Universitario:_____**Postgrado:** __

1. ¿En los últimos años, ha habido algún cambio importante en la docencia sobre el VIH? Sí No_____

Si respuesta es No…Ir a pregunta N° 3 *En caso Si..* **Cual cambio?**

¿Cual considera usted que es la razón principal de ese cambio?,___

¿En su opinión ese cambio ha tenido algún efecto importante en los/as estudiantes? Si No _____

Si respuesta es Sí **Cual efecto?**

2. ¿Hay alguna diferencia notable entre la docencia sobre VIH y la docencia sobre otros temas? Si No __

Si respuesta es Sí **Cual?**

3. ¿En los últimos años, han verificado logros en los resultados de la enseñanza sobre VIH? Si No _____

De que manera han verificado o medido esos indicadores?_____

En su opinión ¿cuál es la razón principal para lograr o no lograr cambios en los resultados?

_____

4. ¿En su autovaloración cómo calificaría la forma en que usted aplica las diferentes metodologías docentes?

Por favor enumere y califique:

N°	**Metodologías docentes**	**Con temas de VIH: Buena / Regular / Deficiente**	**Con temas diferentes a VIH: Buena / Regular / Deficiente**

_____

Por ej:Clase magistral, clase participativa, seminarios, audiovisuales, prácticas en servicios, otras (especificar)

~~5. ¿De las metodologías docentes que enumeró, cuál considera que realiza mejor y por qué?~~

6. ¿Conoce usted la situacion actual del VIH en su municipio *(datos de últimos años)* **? Si No**_____

Si respuesta es Si .. **¿Ha sido útil esa información? Si NO para qué?**___

7. ¿En el desarrollo de sus capacidades como docente, qué apoyo recibido por usted ha sido más útil para:

	Qué apoyo (*)	**En VIH? Si/No**	**Qué organización lo brindó?**
a) Adquirir más o nuevos conocimientos?			
b) Desarrollar habilidades de comunicación?			
c) Reducir estigma y discriminación?			
d) Identificar o reproducir "mejores prácticas"			
e) Procesar y analizar información			
f) Mejorar su aporte al fortalecimiento institucio			
g) Otra *(Cual?)* _____			

(*)capacitación, supervisión, intercambio de mejoramiento, sesión evaluativa, evaluación del desempeño, actualización bibliográfica,

8. ¿En su opinión cual de esos apoyos ha sido más útil para el fortalecimiento general de la carrera?
Por qué?
En su opinión la población estudiantil de la carrera ...
Comprende bien el conocimiento revisado sobre VIH? Si No Por qué: _____
Asimila y asume nuevas actitudes ante el VIH: Si No Por qué? ___

Está satisfecha con la docencia recibida sobre VIH? Si No Por qué? _____
¿Considera que en su facultad/carrera hay discriminación:
Hacia Las mujeres? Si_____No _____ ha aumentado o disminuido? ha aumentado o disminuido?
Hacia la población LGBTI? Si_____No _____ ha aumentado o disminuido? _____
Hacia las personas VIH positivas? Si_____No _____
_____

¿En su opinión cual ha sido la actividad más importante que ha realizado la facultad para:
Reducir la desigualdad de género
Reducir el estigma y discriminación a población LGBTI o VIH+?
¿Han recibido apoyo de otras organizaciones en estas actividades? Si No____No sé _____
Si respuesta es Si . . Cual organización cree que ha brindado el apoyo más útil?
¿La facultad participa con otras organizaciones en actividades que promuevan la igualdad de género y la reducción del estigma y discriminación hacia la población GBTI y PVIH? **Si No. No sé** _____
Si respuesta es Si **mencione una actividad destacada:**
¿En su opinión, considera que se evaluan adecuadamente el desarrollo de nuevas competencias en los/as estudiantes? **Si No ,**
y de las actividades docentes que ustedes ofrecen? **Si**_____**No** _____
¿Se realiza análisis colectivo de éstos datos? **Si**_____**No** _____ **participa usted?** Si_____No _____

Recientemente se ha hecho algún cambio para mejorar la utilización de ésta información? **Si No** _____
Si respuesta es Si . **Cual cambio?**
Considera que su opinión es tomada en cuenta para mejorar el trabajo en la facultad? **Si No** _____
Se reunen las instituciones locales para analizar la situación del VIH en el municipio? **Sí No No sé** _____
Las instituciones del municipio toman en cuenta la opinión universitaria sobre VIH? **Sí No**_____
Considera que su Facultad puede seguir mejorando la calidad de la docencia por si sola? **Sí No** _____
¿De qué depende que la calidad pueda mantenerse a lo largo del tiempo?___
¿Qué recomendaría usted para:
Mejorar la calidad de la docencia,
Mejorar su propio desempeño como docente
Para reducir el estigma y discriminación:
Otra,*(cual?)* _
Para finalizar permítanos hacer algunas preguntas mas personales *que bien puede decidir no responder:*
Su orientación sexual es: Heterosexual _____ Gay_____Bisexual____Lesbiana ___

En el último mes usó condón en todas sus relaciones sexuales?. Si No _____ En el último mes tuvo relaciones sexuales con más de una pareja?. Si No _____ En el último año, se ha realizado usted la prueba de VIH?. Si No
_____
Muchas gracias por su valiosa colaboración!!!

Cuestionario Nº 5. Entrevista a Directores de organizaciones que atienden PC y PVIH+

Encuestador: _____ Fecha de entrevista_____

ONG: _____ Cargo de entrevistado/a: __ Años en el cargo:_____

Edad:_____años cumplidos Escolaridad, Ultimo grado aprobado: _____

¿Cuál considera que es el mayor logro que ha alcanzado èsta organización en los ùltimos años?

_____

y cual considera que es la principal razòn que explica ese logro?

_____

Enfocandonos en los indicadores de comportamientos de riesgo que se quieren modificar en la población atendida por su organización *(PC: uso de condón, nùmero de parejas, prueba anual./ PVIH+: inicio y adherencia a TAR, participaciòn en GAM);* **han verificado algùn cambio en esos indicadores en los ùltimos años? Si No ___**

No sé *Si responde No sé.. Pasar a N°4 ..... Si responde Si* **Han mejorado? Si No _____**

_____

3. De que manera han medido esos indicadores? _____ En su opinión ¿cuál es la razón principal que explica ese cambio ***(o que no haya cambio)*** ?

_____

¿Ha habido algún cambio importante en la calidad de la atenciòn a población clave ***(VIH+)*** ? Sí No____

Si respuesta es No…. Ir a pregunta N° 5 En caso Si.. **Cual cambio?_____**

Que acciones especìficas han implementado para lograr ese cambio de calidad?

En qué mes y año iniciaron la implementaciòn de estas acciones? Mes ___ Como surgiò la motivaciòn Año _____
para emprender este cambio?

_____

¿Han recibido apoyo de otras organizaciones en estas actividades? Si No_____No sé _____

Si respuesta es Si . . **Cual organización cree que ha brindado el apoyo más útil?**

¿En su opinión, considera que se registran adecuadamente los datos acerca de los comportamientos de riesgo en la población clave o VIH+? Si No ,

y de las actividades/servicios que ustedes ofrecen? Si_____No _____

Si respuesta es NO… **Por que nò? _____**

¿Se realiza análisis colectivo de éstos datos? Si_____No _____ Con que frecuencia?

_____

Recientemente se ha hecho algún cambio para mejorar la utilización de ésta información? Si No _____

Si respuesta es Si . . **Cual cambio?**

Con el análisis de èsta informaciòn, han mejorado las decisiones que toman? Si No ___

Si respuesta es Si . . **En que han mejorado?**

El aporte de los/as Promotores/as en éstos análisis y decisiones es bueno o limitado?

8. ¿Conoce usted la situacion actual del VIH en su municipio *(datos de últimos años)* **? Si No_____**

Si respuesta es S i .. **¿Ha sido útil esa información? Si NO _____**

_____

Se reunen las instituciones locales para analizar la situación del VIH en el municipio? Sí No _____

Considera que su organización es tomada en cuenta por las instituciones del municipio? Sí No_____

Cual es la principal instancia de coordinaciòn con otras instituciones en la que su organizaciòn participa regularmente?

_____

Cual es el principal logro de esta coordinación? _____

En su opinión, cual es el principal logro del fortalecimiento institucional en los últimos años?

_____

¿cuál es la razón principal que explica ese logro?

¿Han recibido apoyo de otras organizaciones en este fortalecimiento? Si No _____

Si respuesta es Si . . **Cual organización cree que ha brindado el apoyo más útil?**

13, La organizaciòn cuenta con algùn Plan de Gestion o mejoramiento de la calidad? Si No_____ Cual considera usted que es el principal aprendizaje del proceso de su elaboración?

y cual considera el principal logro que hasta el momento han tenido con su implementaciòn? Que acciones implementadas son las que explican ese logro?

¿En el desarrollo del personal de la organizaciòn, qué apoyos recibidos ha sido más útil para:

	Que apoyo (*)	Qué organización apoyó?
Adquirir más o nuevos conocimientos?		
Desarrollar habilidades de comunicación?		
Reducir estigma y discriminación?		
Identificar o reproducir "mejores prácticas"		
Procesar y analizar información		
Mejorar su aporte al fortalecimiento institucional		
Otra *(Cual?)*		

(*)Por ej: capacitación, supervisión/coaching, intercambios de mejoramiento, sesiones evaluativas, evaluación del desempeño, otros(anotar cual)

¿Cual de esos apoyos ha sido más útil para el fortalecimiento general de la organización? Por qué?

16. En su opinión la población atendida por su organización ...

Comprende bien los mensajes que se les brinda? Si No Por qué: _____

Asimila y asume nuevas actitudes: Si No Por qué? ___

_____

Está satisfecha con la atención recibida? Si No Por qué? ____

¿Considera que en su organización hay discriminación hacia:

Hacia Las mujeres? Si_____No _____ ha aumentado o disminuido? ha aumentado o disminuido?

Hacia la población LGBTI? Si_____No _____ ha aumentado o disminuido? _____

Hacia las personas VIH positivas? Si_____No

_____

_____

_____

¿En su opinión cual ha sido la actividad más importante que ha desarrollado su organización para:

Reducir la desigualdad de género

Reducir el estigma y discriminación a población LGBTI o VIH+?

Han recibido apoyo de otras organizaciones en estas actividades? Si No ____ Cual? _____

Considera la organización puede seguir mejorando la calidad por si sola? Sí No _____

¿De qué depende que la calidad pueda mantenerse a lo largo del tiempo?

Hay alguna experiencia de trabajo de la organización que destaque como "mejor pràctica"? Si No____ Cual experiencia?

Recomendarìa su aplicaciòn a otras organizaciones? Si No _____

¿Qué recomendaría usted para:

Mejorar la calidad de los servicios o de las acciones,

Mejorar su propio desempeño como directivo/a

Para reducir el estigma y discriminación:

Otra,*(cual?)* _

Para finalizar permítanos hacer algunas preguntas mas personales que bien puede decidir no responder*:*

Su orientación sexual es: Heterosexual _____ Gay_____Bisexual____Lesbiana ___

En el último mes usó condón en todas sus relaciones sexuales?. Si No _____ En el último mes tuvo relaciones sexuales con más de una pareja?. Si No _____ En el último año, se ha realizado usted la prueba de VIH?. Si No _____

Muchas gracias por su valiosa colaboración!!!

para qué?

Anexo 4. Guías de grupo focales

Guía de grupo focal con promotores/voluntarios de ONG

1. ¿Cuál es el cambio más significativo que se ha dado en los servicios que ustedes prestan?

2. ¿Cuál ha sido el principal medio para el mejor desempeño de sus funciones? ¿Por qué?

3. ¿Conocen ustedes la situación actual de la epidemia en su municipio? Sí/No, ¿Cuál es la principal razón que explica ese nivel de conocimiento?

4. ¿Con qué frecuencia participan ustedes en la evaluación de resultados y servicios de la organización? ¿Consideran ustedes que en la organización se evalúan adecuadamente los resultados y las acciones realizadas?

5. En la opinión de ustedes, han desarrollado las capacidades para producir, analizar y utilizar información sobre VIH? Sí/No, Den un ejemplo de ello.

6. ¿Considera que ha aumentado o disminuido la igualdad de género o la discriminación hacia la población LGBTI y PVIH, en la organización?. Por que?

7. ¿En la opinión de ustedes, el mejoramiento de la calidad de las actividades la pueden mantener las organizaciones por sí solas? ¿Qué hace falta para asegurar la sostenibilidad de la mejora de la calidad?

8. ¿Cuál es la principal recomendación que ustedes harían para mejorar aún más la calidad de las actividades de las organzaciones?

Guía de grupo focal con Docentes

1. ¿Cuál es el cambio más significativo que se ha dado en la docencia sobre VIH?

2. ¿Cuál ha sido el principal medio para el mejor desempeño de sus funciones docentes? ¿Por qué?

3. ¿Conocen ustedes la situación actual de la epidemia en su municipio? Sí/No, ¿Cuál es la principal razón que explica ese nivel de conocimiento?

4. ¿Con qué frecuencia participan ustedes en la evaluación de la docencia en la universidad? ¿Consideran ustedes que en la facultad se evalúan adecuadamente los resultados y las acciones docentes realizadas?

5. En la opinión de ustedes han desarrollado las capacidades para producir, analizar y utilizar información sobre VIH? Sí/No, Den un ejemplo de ello.

6. ¿Considera que ha aumentado la igualdad de género o la discriminación hacia la población LGBTI y PVIH, en la facultad/carrera?

7. ¿En la opinión de ustedes, el mejoramiento de la calidad de las actividades docentes puede ser sostenida en el futuro por la facultad por sí sola?. ¿Qué hace falta para asegurar la sostenibilidad del mejoramiento de la calidad?

8. ¿Cuál es la principal recomendación que ustedes harían para mejorar aún más la calidad docente?

Guía de grupo focal con Poblaciones claves, PVIH

1. ¿Consideran ustedes que se han logrado cambios en los comportamientos de riesgo? *(PC= uso Condón, Nº parejas, Prueba anual. PVIH=Inicio de TAR, adherencia a TAR, mantenimiento en GAM, CV indetectable*) Mucho Poco_____casi nada ¿Cuáles son las razones principales de esos cambios?

2. ¿Cuál es el cambio más significativo que se ha dado en los servicios que ofrecen estas organizaciones?

3. ¿Conocen ustedes la situación actual de la epidemia de VIH en su municipio? Sí/No ¿De qué manera podemos mejorar ese conocimiento?

4. ¿Han participado ustedes en procesos de evaluación de los servicios de estas organizaciones? Sí/No ¿Consideran que su opinión es tomada en cuenta para mejorar los servicios?

5. ¿Considera que ha aumentado o disminuido la igualdad de género o la discriminación hacia la población LGBTI y PVIH, en la organización?. Por qué?

6. ¿Cuál es la principal recomendación que ustedes harían para mejorar la calidad de los servicios que estas organizaciones les ofrecen?

Guía de grupo focal con estudiantes

1. ¿Consideran ustedes que ha habido cambios significativos en el nivel de conocimientos y competencias de ustedes para la prevención y atención del VIH? Mucho_____Poco_____casi nada ¿Cuáles son las razones principales de esos cambios?
2. Hay alguna diferencia con otros temas o asignaturas? Si/NO, cuáles diferencias?
3. ¿Cuál es el cambio más significativo que se ha dado en la docencia que se brinda en esta facultad?
4. ¿Conocen ustedes la situación actual de la epidemia de VIH en su municipio? Sí/No ¿De qué manera podemos mejorar ese conocimiento?
5. ¿Han participado ustedes en procesos de evaluación de la docencia en esta carrera? Sí/No ¿Consideran que su opinión es tomada en cuenta para mejorar la docencia?
6. ¿Considera que ha aumentado la igualdad de género o la discriminación hacia la población LGBTI y PVIH, en la universidad?
7. ¿Cuál es la principal recomendación que ustedes harían para mejorar la calidad de la docencia?

Table 1. Sample of coverage. Survey of beneficiary population and providers

Universos de personas	Encuestas			Grupos focales		
	Muestra	Realizado	%	Muestra	Realizado	%
Proyecto PrevenSida						
PC	265	50	19	8	7	88
PVIH	105	73	70	3	4	133
Promotores en PC	95	46	48	8	5	63
Promotores en PVIH	30	20	67	3	3	100
Proyecto ASSIST						
Estudiantes de medicina	92	104	113	6	8	133
Estudiantes de enfermería	35	41	117	3	3	100
Docentes de medicina	33	25	76	6	3	50
Docentes de enfermería	14	15	107	3	1	33

Fuente: Informe final de trabajo de campo. Sep/2017. Evaluación del componente de MCC en PrevenSida y ASSIST

Table 2. Quality changes in PrevenSida services

Indicadores relevantes de servicios de PrevenSida	2011	2016
Población clave como % del total de personas atendidas	36	87
% de atenciones orientadas a PC del total de atenciones	35	89
% de atenciones realizadas en lugares de la Comunidad	65	94
% de población clave atendida con educación de pares	25	36
Promedio de atenciones a cada PC atendida	1,6	2,0
% de población clave con CPV del total de PC atendida	16	27
% CPV en PC del total de pruebas realizadas	37	89
% pruebas realizadas en establecimiento	82	5
% pruebas realizadas en lugares adecuados por la comunidad	7	92
N° de PVIH atendidos	404	3.879
% PVIH en GAM		36
% PVIH en TAR		87
% PVIH en TAR en condición de "supresión vírica"		69
% de PVIH con consejería y prueba a pareja serodiscordante (2017)		67

Fuente: Evaluación de la eficacia del modelo de PrevenSida. 2011-2016.

Table 3. Assessing the quality of the services received

Valoración	Población atendida	
	N	%
Muy Buena	72	59
Buena	22	18
Deficiente	29	24
Totales	**123**	**100**

Table 4 - Why do you consider more useful the services received

Población atendida		
Utilidad	**N**	**%**
Nuevos conocimientos	48	39
Aclarar dudas/mitos	27	22
Mejor actitud a la salud	47	39
Totales	122	100

Table 5 – Reasons for assessing the quality of the services received

Población atendida - PrevenSida		
Servicio más util	**N**	**%**
Aprendizaje muy útil	27	22
Interacción comunitaria	10	8
Buen trato, respeto	67	54
Atención psicológica	2	2
No se tiende a todos (pareja)	8	7
Mala comunicación	9	7
	123	100

Table 6 – Perception of change in services / What change?

Promotores/as - PrevenSida		
Perciben cambio en servicios/ Cual cambio	**N**	**%**
Perciben cambios significativos	62/70	86
Atención más personalizada	29	47
Mas aprendizajes	11	18
Estrategias de trabajo	10	16
Atención Psicológica	6	10
Reducción de E&D	6	10
	62	**100**

Table 7 - Institutional quality standard strengthening 2011- 2016. PrevenSida

Seguimiento de línea de base - 20 Organizaciones	**2011-2013**	**2015-2016**
Organizaciones con más de 75% en estándares de gerencia	3	15
Organizaciones con más de 75% en estándares de administración	5	13
Organizaciones con más de 75% en estándares de servicios preventivos	2	18
Organizaciones con más de 75% en estándar global	2	15
Realización de ciclos de mejora	**2011**	**2017**
Número de organizaciones	7	9
Organizaciones que realizaron 2 ciclos de mejora es ese año	2	6
Organizaciones que realizaron 1 ciclo de mejora es ese año	5	3
Promedio de ciclos de mejora en OSC con mas de 3 años de subvención N=17		
Organizaciones con 1 ciclo de mejora x año		6
Organizaciones con 2 ciclos de mejora x año		1
Organizaciones con 1.5 a 1.9 ciclos de mejora x año		6
Organizaciones con 1.1 a 1.4 ciclos de mejora x año		4

Fuente: Informes de seguimiento anual de estándares de desarrollo institucional PrevenSida

Table 8 – Knowledge of information on the HIV epidemic in your municipality

Universo entrevistado	No conocen epidemia local		
	N	No conocen	%
Estudiantes	145	124	86%
Población atendida	123	95	77%
Total Beneficiarios/as	268	219	82%
Docentes	39	28	72%
Promotores OSC	69	52	75%
Total proveedores	108	80	74%

Table 9 - Usefulness linked to local knowledge of the epidemic

Utilidad de la información	Docentes		Promotores/as	
	N	%	N	%
Mejorar conocimiento de todos	10	36	10	20
Sensibilizar/reducir tabús	13	46	12	24
Planificar/evaluar trabajo	4	14	22	44
Educar a la población	1	4	6	12
Total	**28**	**100**	**50**	**100**

Table 10 - Institutional quality standard strengthening 2011-2016. ASSIST

Cambios en estándares de calidad - ASSIST	2014- 2015	2016
Universidades con medición de estándares CAP de VIH en estudiantes	0	9
Universidades con más de 75% de estándares de conocimiento	8	8
Universidades que mejoran más del 5% en los estándares de conocimientos		6
Universidades con más de 75% de estándares de actitud ante VIH	1	8
Universidades que mejoran más del 5% en los estándares de actitud		8
Calificación global de estándares CAP en estudiantes. (%)	70	92
Universidades con docentes capacitados en metodologías educativas en VIH	0	9
Universidades con docentes capacitados en EyD y VBG	0	7

Fuente: Informes anuales de gestión- Proyecto USAID/ASSIST.
Informe de sistematización de proceso de implementación del Paquete pedagógico en Universidades

Table 11 - Assessing the quality of the teaching activities

Valoración	Estudiantes	
	N	%
Muy Buena	94	65
Buena	45	31
Deficiente	6	4
Totales	**145**	**100**

Table 12 - Assessing the main usefulness of the teaching activities

Estudiantes		
Principal utilidad	**N**	**%**
Nuevos conocimientos	54	38
Aclarar dudas/mitos	53	37
Mejor actitud/Habilidades	36	25
Totales	143	100

Table 13 - Reasons for assessing teaching quality

Estudiantes		
Parámetros de calidad	**N**	**%**
Conocimiento actual y completo	74	51
Aclara dudas y tabús	3	2
Se enfoca en la persona	6	4
Muy participativo	10	7
No se cumple plan	7	5
Insuficiente tiempo	36	25
Deficiente metodología	7	5
Otras	2	1
Totales	145	100

Table 14 - Identification of main teaching change

Docentes		
Cambio en calidad docente	**N**	**%**
Perciben mejoras docentes	38/40	95
Cual cambio?		
Nuevos temas en VIH	19	50
Mejor metodología	2	5
Inclusión curricular	10	26
Más participación de estudiantes	2	5
Aclaran tabús, mayor sensibilización	5	13
Total	**38**	**100**

Table 15 - Capacity for participation and incidence in quality evaluation

Universo entrevistado	Participación en evaluación			Su opinión es tenida en cuenta		
	N	Participan	%	N	Inciden	%
Estudiantes	145	100	69%	136	86	63%
Población atendida	123	74	60%	97	63	65%
Total Beneficiarios/as	268	174	65%	233	149	64%
Docentes	40	30	75%	40	36	90%
Promotores OSC	69	51	74%	69	61	88%
Total proveedores	109	81	74%	109	97	89%

Table 16 - Activities that contribute more to transfer of knowledge. Population served

Población atendida (PC, PVIH) en PrevenSida		
Actividad para transferir conocimientos	**N**	**%**
Charlas	46	41
Grupo pequeño-GAM	27	24
Consejería	13	12
Educación de pares	4	4
Foro video	18	16
Otras	3	3
	111	100

Table 17 - Activities that contribute more to transfer of knowledge. PrevenSida providers

Promotores/as de OSC en PrevenSida		
Actividad para transferir conocimientos	**N**	**%**
Capacitación	37	53
Supervisión/coaching	2	3
Sesiones de intercambio/evaluación	25	35
Actividades abiertas (foros, videos)	3	4
Otras	4	5
Total	**70**	**100**

Table 18- Activities that contribute more to development of skills. PrevenSida providers

Promotores/as de OSC en PrevenSida		
Actividad para desarrollo de habilidades	**N**	**%**
Capacitación	28	47%
Coaching	8	13%
Sesiones evaluativas e Intercambio	23	38%
Eventos abiertos	1	2%
Total	**60**	**100%**

Table 19 - Activities that contribute more to change of attitudes. Population served

Población atendida (PC, PVIH) en PrevenSida		
Actividad para el cambio de actitudes	**N**	**%**
Charlas y talleres	25	25
Sesiones de grupo pequeño-GAM	40	39
Consejería	21	21
Educación de pares	3	3
Foro video	12	12
Otras	1	1
	102	**100**

Table 20 - Activities that contribute more to change of attitudes. Promoters

Promotores/as de OSC en PrevenSida		
Aportan al cambio de actitudes	**N**	**%**
Capacitación	31	49%
Coaching	2	3%
Sesiones evaluativas e Intercambio	27	43%
Evaluación del desempeño	1	2%
Eventos abiertos	2	3%
Total	**63**	**100%**

Table 21 - Activities that contribute more to transfer of knowledge.. ASSIST students

Estudiantes de medicina y enfermería. ASSIST		
Actividad para transferir conocimientos	**N**	**%**
Clases magistrales	35	24
Clases participativas	25	17
Prácticas de servicio	11	8
Seminario/Taller	45	31
Audio visuales	7	5
Actualización científica	18	13
Otras	2	1
Totales	143	100

Table 22 - Activities that contribute more to transfer of knowledge. ASSIST teachers

Docentes de medicina y enfermería. ASSIST		
Actividad para transferir conocimientos	**N**	**%**
Capacitación	24	62%
Sesiones evaluativas e Intercambio	8	21%
Revisión Bibliográfica	6	15%
Eventos abiertos	1	3%
	39	**100%**

Table 23 - Activities for changing attitudes toward LGBTI and PHIV populations. ASSIST students

Estudiantes de medicina y enfermería. ASSIST		
Actividad para el cambio de actitudes	**N**	**%**
Clases magistrales	16	13
Clases participativas	16	13
Prácticas de servicio	25	20
Seminario/Taller	38	31
Audio visuales	8	7
Actualización cientifica	1	1
Eventos con la comunidad	17	14
Otras	2	2
Totales	**123**	**100**

Table 24 - Activities for changing attitudes toward LGBTI and LHIV populations. ASSIST teachers

Docentes de medicina y enfermería. ASSIST		
Actividad para cabio de actitud	**N**	**%**
Capacitación	16	46%
Sesiones evaluativas e Intercambio	15	43%
Evaluación del desempeño	1	3%
Revisión Bibliográfica	2	6%
Eventos abiertos	1	3%
Total	**35**	**100%**

Table 25 - Perc Perception of discrimination in the organizations/universities

Universo entrevistado	N	Hacia las mujeres		Ante población LGBTI		Hacia PVIH	
		Perciben E&D	%	Perciben E&D	%	Perciben E&D	%
En el ámbito de PrevenSida							
Población atendida	123	7	6%	8	7%	8	7%
Promotores de OSC	69	3	4%	8	12%	5	7%
En el ámbito de ASSIST							
Estudiantes	145	11	8%	42	29%	22	15%
Docentes	40	7	18%	14	35%	7	18%

Anexo 5. Tablas de informantes clave entrevistados

Listado de directores de ONG

No	Nombres y apellidos	Cargo	Organización
1	Fidel Moreira	Director Ejecutivo	CEGODEM
2	Norman Gutiérrez	Director Ejecutivo	CEPRESI
3	Leticia Romero	Presidenta	ASONVIHSIDA
4	Norma Rubí	Directora	GAO
5	Marlene Vivas	Directora	ADESENI
6	Naty Gutiérrez	Directora	AMODISEC

Lista de directivos de las universidades

No	Nombres y apellidos	Cargo	Universidad
1	Gregorio Matus	Jefe de Departamento de Salud Pública	UNAN-León
2	Mauricio Gutiérrez	Coordinador de Prácticas Médicas	UNAN-Managua
3	Olma Zelaya Reyes	Decana Escuela Enfermería	UPOLI
4	Juana María Salmerón	Directora de la Escuela Enfermería	UNAN-León
5	Guisell Cerda	Directora de Departamento de Enfermería	POLISAL

Lista de informantes claves USAID y MINSA

No	Nombres y apellidos	Cargo	Lugar
1	Oscar Núñez	Director	USAID PrevenSida
2	Ivonne Gómez	Directora	USAID|ASSIST
3	Yudy Carla Wong	Oficial	USAID PrevenSida
4	Rafael Arana	Responsable MyE	USAID PrevenSida
5	Danilo Núñez	Oficial	USAID|ASSIST
6	Carlos Sáenz	Secretario General	MINSA

Anexo 6. Curriculum Vitae

Carlos Hernández

Áreas de mayor experiencia:

- Investigación social vinculada a procesos de planificación, participación, auditoria social y comunitaria.

  Diseño metodológico e instrumental (cuestionarios, muestreo, mesovariables, programas de digitación, procesamiento y mantenimiento de bases de datos), análisis cualitativo y cuantitativo avanzado, estrategias de comunicación de resultados para el dialogo, la concertación y el empoderamiento. Los estudios realizados se enmarcan en procesos de :

  - ∞ Formulación y Evaluación de políticas públicas, programas y proyectos. Evaluación participativa.
  - ∞ Auditoria social/Control ciudadano. Evaluación de la gestión pública y privada del desarrollo.
  - ∞ Evaluación de servicios de atención ciudadana. Transparencia y rendición de cuentas.
  - ∞ Análisis de vulnerabilidad y equidad social (desigualdades económicas, de género, generacional, territorial, étnico, laboral)

- Desarrollo de sistemas de protección social enfocados a la inclusión, reducción de vulnerabilidad y ejercicio de derechos (Seguridad alimentaria, salud, educación, microeconomía familiar, vivienda, violencia, desastres). Modelos de convivencia y participación ciudadana. Programas de desarrollo de la cultura ciudadana.
- Diseño de sistemas de monitoreo y evaluación vinculados a Gerencia estratégica por resultados.
- Docencia de postgrado y desarrollo de equipos humanos en instituciones públicas y no gubernamentales.

  Enfoques pedagógicos basados en la evidencia para la acción a nivel comunitario

Maricela Larios

2015: Maestría de Salud Pública (CIES-UNAN).
1999: Licenciatura en Psicología. (UNAN-Managua).

EXPERIENCIA LABORAL
Experiencia en investigaciones:
2017: Consultora asociada Diagnóstico sobre la situación de la niñez y Adolescencia en Managua y Juigalpa. Estudio de Aldea SOS. Oficina Nacional. MSc. Marvin García Urbina. Telf. 88032042.

2014: Consultora asociada Diagnóstico de inclusión de la perspectiva de género en la respuesta al VIH. MSc. Rebeca
Centeno. PNUD.

2013: Diagnóstico de Oportunidades de Acceso a Servicios de Salud Sexual y Reproductiva para Adolescentes y
Jóvenes en el marco del MOSACF. Markus Behrend. Representante de UNFPA

2013: Apoyo en recolección de información del estudio Índice de Esfuerzo del Programa contra el VIH y sida.

2013. MSc. Anne Christian Largaespada. Representante de país de USAID/PASCA- Nicaragua. Telf. 88854699.

2012: Miembro del equipo de investigación: Estudio de Monitoreo de la Respuesta Política al VIH en Nicaragua
USAID/PASCA. MSc. Anne Christian Largaespada.

2011: Consultora asociada en elaboración de Mapeo diagnóstico de Redes Regionales y Nacionales, organizaciones y grupos formados o en formación que realizan proyectos y actividades dirigidas a la prevención y/o atención del VIH con población PEMAR. Informe Nicaragua.

Gioconda Vásquez

Medica con maestría en Salud Pública, con amplio conocimiento y experiencia en temas de VIH, ha desarrollado diversos trabajos en desarrollo y evaluación de sistemas y proyectos de salud. Cuenta con amplio reconocimiento en los entornos institucionales de capacitación y formación de personal de salud, ejerciendo funciones de docente en temas de salud pública y como consultora en revisión curricular y elaboración de protocolos e instrumentos pedagógicos.

Profesión: Consultora
Títulos: Médico General
Maestra en Salud Pública
Diplomado en Salud Sexual Reproductiva
Diplomado en Monitoreo y Evaluación para la gestión de políticas y programas de VIH
Celular: (505) 89480183. Claro
E-mail: vasquezgio62@hotmail.com

HABILIDAD Y COMPETENCIAS

- Para identificar objetivos comunes en equipos conflictivos y favorecer el desarrollo de procesos
- Habilidad interpersonales de respeto, apoyo y comunicación con los demás miembros del grupo
- Para la organización, planificación , monitoreo y evaluación de procesos
- Para trabajar con efectividad, tomar decisiones informadas con una supervisión directa.
- Para trabajar bajo presión en favor de metas

- Para adaptarse a los cambios que surgen en el proceso de implementación de las actividades de un proyecto
- Excelente redacción de informes , edición de documentos
- Dominio de Windows avanzado, MS Office y bases de datos.

EXPERIENCIA LABORAL 2014-2017

Investigadora principal en la Elaboración Mapeo de Instituciones públicas y seguridad social que ampliaran la cobertura de oferta de pruebas para detección de VIH en el marco del plan de expansión de la prueba**"** La muestra abarco 50 instituciones de todo el país, siendo el objetivo mapear las capacidades en términos de recursos, organización, capacidades científicas y financieras para ampliar la oferte de pruebas de VIH y proponer planes de mejora. Se utilizaron herramientas de mapeo de actores modificados