# Appendix 1: Participants Handout - Day 1

ACRONYMS

|  |  |
| --- | --- |
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Therapy |
| CSO | Civil Society Organisations |
| DIC | Drop In Centre |
| DQA | Data quality assessment |
| FGD | Focus Group Discussions |
| FSW | Female Sex Workers |
| GFATM | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HBV | Hepatitis B Virus |
| HCT | HIV Counseling and Testing |
| HCV | Hepatitis C Virus |
| HIV | Human Immunodeficiency Virus |
| IBBS | Integrated Bio-Behavioral Surveillance |
| IEC | Information, Education and Communication |
| KII | Key Informant Interviews |
| KP | Key Populations |
| M&E | Monitoring and Evaluation |
| MSM | Men having sex with men |
| MST | Methadone Substitution Therapy |
| MSW | Male Sex Workers |
| NGO | Non-Governmental Organization |
| ORW | Outreach Worker |
| OST | Opioid Substitution Therapy |
| PE | Peer Educators |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PSM | Procurement and Supply Management |
| PWID | People Who Inject Drugs |
| QI | Quality Improvement |
| SRH | Sexual Reproductive Health |
| STI | Sexually Transmitted Infections |
| TB | Tuberculosis |
| UIC | Unique Identifying Code |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNODC | United Nations Office on Drugs and Crime |
| WHO | World Health Organisation |
| WID | Women Who Inject Drugs |

**INTRODUCTION TO THE CONCEPTS OF MONITORING AND EVALUATION**

**PROGRAM COMPONENTS.**

Monitoring and Evaluation of programs entails tracking and assessing basic program elements including inputs, activities, outputs, outcomes, and impact.

**Inputs**: These are resources used in a project/program such as money, staff, curricula, and materials. Examples of donors include the Global Fund for AIDS, TB and Malaria, United States Government, World Bank, PEPFAR and other donors.

**Activities:** Refer to the services that the program/project provides to accomplish its objectives such as outreach, materials distribution, counselling sessions, workshops and training or specified technical assistance. Examples services include provision of pre-test counselling, HIV tests, post-tests counselling, training of C&T personnel and site managers.

**Outputs:** These are direct products or deliverables of the program such as number of counselling sessions completed, number of people reached, number of materials distributed, number of clients receiving pre-test counselling, HIV tests or post-test counselling

**Outcomes**: These are program results that occur both immediately and sometime after the activities are completed such as changes in knowledge, attitudes, beliefs, skills, behaviours, access, policies, and environmental conditions.

**Impacts:** Refer to the long-term results of one or more programs over time such as changes in HIV infection, morbidity, and mortality. Impacts are rarely, if ever attributable to a single program; yet a program may with other programs contribute to impacts on a population. Examples impacts include decrease in HIV transmission rates, decrease in HIV incidence, decrease in HIV morbidity and mortality.

**WHAT’S MONITORING?**

Monitoring is the routine tracking of information about a program/project and its intended outputs, outcomes, and impacts. It is aimed at measurement of progress towards achieving program/project objectives. Most often monitoring involves counting what we are doing. It also tracks cost and how the program/project is functioning. Monitoring is an internal activity and is usually done by those responsible for project implementation. It should be carried out regularly such as monthly, quarterly, half-yearly or annually.

Efficiency monitoring on the other hand aims at determining whether optimal use of resources is being made to achieve program objectives. Programs can be efficient yet inefficient, for example, a project may have reached the target number of expectant mothers, but used an excessive number of field workers. Monitoring should also be distinguished from supervision. A supervisor carries out daily supervision of project inputs and operational processes and reports to the operational manager. Monitoring, on the other hand, is to assess the overall implementation of the project at different levels and focuses not only on inputs and processes, but also on project outputs.

**WHAT IS EVALUATION?**

Comprehensive evaluation is based on research and analysis covering the conceptualisation and design of programs, the monitoring of program interventions and the assessment of program utility. It focuses on why results are or are not being achieved and on intended and unintended consequences and issues of interpretation, relevance, effectiveness, efficiency, impact, and sustainability. It is usually rigorous and based on scientific analysis of information about program activities, characteristics, and outcomes to determine the merit or worth of a specific program.

**TYPES OF MONITORING AND EVALUATION**

**ASSESSMENT & PLANNING**

This involves the collection of information and data needed to plan programs/projects and initiatives. These data may describe the needs of the population and factors that put people at risk, as well as the context, program response and resources available (both financial and human). It answers questions such as: what are the needs of the population to be reached by the program/project or initiative? How should the program/project or initiative be designed or modified to address population needs and what would be the best way to deliver this program/project or initiative?

**INPUT/OUTPUT MONITORING (PROCESS MONITORING)**

It involves the basic tracking and reporting of information about program inputs or resources that go into a program such as funding, number of prevention and education materials required for distribution. Process monitoring collects data describing the individuals served, the services provided, and resources used to deliver those services. It answers questions such as: What services were delivered? What population was served? How many people were reached with the services? What staffing/resources were used?

**PROCESS EVALUATION**

Here the focus is on program implementation. Data is collected, and detailed analysis is conducted about how intervention was delivered, what were the differences between the intended population and population served, and what was their access to the intervention. It answers questions such as: was the intervention implemented as intended? Did the intervention reach the intended audience? What barriers did clients experience in accessing the intervention?

**OUTCOME MONITORING**

This is necessary in knowing whether outcomes were attained. It is the basic tracking of variables that have been as measures or “indicators” of desired program outcomes. With national AIDS programs, outcome monitoring is typically conducted through population-based surveys to track whether desired outcomes have been reached. For NGOs, CBOs and interventions, monitoring outcomes usually means tracking information directly related to program clients, such as change in knowledge, attitudes, behaviour, beliefs, skills, and access to services. It answers questions such as: Did the expected outcomes occur e.g. expected knowledge gained; expected change in behaviour occurred; expected client use of services occurred?

**OUTCOME EVALUATION**

This involves collection and analysis of data to determine if and by how much an intervention achieved its intended outcomes. It attributes observed change to the intervention tested and describes the extent of program outcomes that can be attributed to the intervention. This type of evaluation indicates what might happen in the absence of the program. It requires a rigorous design methodology with a control and comparison group. It answers questions such as: Did the intervention cause the expected outcomes?

**IMPACT MONITORING**

This type of monitoring is also known as disease surveillance. Disease surveillance is the ongoing systematic collection, analysis, and interpretation of data to describe diseases and their transmission in populations. It is concerned with monitoring of disease incidence and prevalence . Impact monitoring collects data at the jurisdictional, regional, and national levels.

**IMPACT EVALUATION**

Impact evaluation deals with the rise and fall of disease incidence and prevalence as a function of HIV/AIDS programs. It answers the question, “what long term effects does a program have on HIV infection?” Impacts on entire populations are rarely attributable to a single program or even several programs. Therefore, impact evaluations on populations require a rigorous evaluation design that includes the combined effects of many programs on at-risk populations. Impact evaluations are resource-intensive and technically complex.

**DISTINCTION BETWEEN MONITORING AND EVALUATION**

|  |  |
| --- | --- |
| MONITORING | EVALUATION |
| 1. Indicates whether program is being implemented as planned | 1. Identifies changes over time in overall outcomes |
| 2. Identify changes over time in inputs, use of services and some inputs | 2. Indicate the extent to which observed changes are the result of the program intervention |
| 3. Suggest problem areas and possible solutions |  |

**COMPREHENSIVE PACKAGE OF INTERVENTIONS FOR PREVENTION, TREATMENT, AND CARE OF HIV AMONG PWID (WHO/UNODC/UNAIDS, 2012)**

**A. Harm Reduction Components**

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education, and communication (IEC) for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis, and treatment for viral hepatitis
9. Prevention, diagnosis, and treatment of tuberculosis (TB)

**B. Interventions Responding to the Needs of Women who use drugs**

1. Sexual and reproductive health, including services for STIs and prevention of mother-to-child transmission (PMTCT)
2. Maternal and child health
3. Gender-specific peer education and support
4. Gender-based violence-related services
5. Services tailored for women who use drugs who are also engaged in sex work
6. Provision of female condoms
7. Parenting support
8. Child care
9. Couples counselling (aimed at ensuring that the responsibility for reducing HIV and health risks is equally shared between both partners)
10. IEC that is specifically relevant to women who use drugs (including safer injecting and safer sex techniques)
11. Legal aid (attuned to be accessible and relevant to the needs of women who use drugs)
12. Provision of psychosocial and ancillary services and commodities
13. Income-generation interventions for women who use drugs

**C. Key Implementation Considerations**

1. Service delivery and integration
2. Discreet and accessible service locations
3. Women-only spaces and/or times at drop-in centres or separate venues
4. Specific outreach for women who use drugs
5. Collaboration and cross-referral with programmes addressing sex work and HIV
6. Secondary needle and syringe distribution
7. Addressing stigma and discrimination
8. Advocacy for improved services and the elimination of policy, legal and social obstacles
9. Resourcing
10. Data
11. Participatory planning, implementation, and evaluation

NOTE: Where interventions listed in A and B (above) cannot be included on-site, strong referral linkages should be developed with relevant service providers as available.

References

1. Adamchak, S. et al.2003. A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs. Focus on Young Adults.
2. Global AIDS Program.2003. Monitoring and Evaluation Capacity Building Program Improvement. Field Guide.
3. UNODC Policy Brief: Women who inject drugs and HIV: Addressing specific needs

# Appendix 2: Participants Handout - Day 2

Case Study: Dunialand

Fact Sheet

Dunialand became a Federal Democratic Republic in 1936 and achieved independence in 1945. It is rebuilding its country after the end of a 5-year civil war. President Arkei held legislative elections in September 2012 and, despite promising to hold presidential elections in 2017, has since pushed through a new constitution that calls for elections in 2018. Continuing concerns include: the trajectory of democratization, endemic corruption, poor inter-ethnic relations, and terrorism.

* Location: Asia
* Border countries: Baruland, Aparadesh and Tyskistan.
* Natural resources: petroleum and gas, iron ore, gold, bauxite, uranium
* Languages: Dunia (official) and English
* Religions: Hinduism, Buddhism, Islam, Catholic and Christianity
* Population: 11,056,072 (July 2015 est.)
* Age structure:
  + 0-14 years: 43.2% (male 2,910,981/female 2,856,527)
  + 15-64 years: 54.1% (male 3,663,400/female 3,549,896)
  + 65 years and over: 2.7% (male 157,778/female 199,959) (2011 est.)
  + Median age: 18.1 years
* Maternal mortality rate: 40.4 deaths/100,000 live births (2008) 40.4
* Infant mortality rate: 10.3 deaths/1,000 live births
* Life expectancy at birth: 60.5 years
* Health expenditures: 4.6% of GDP (2015)

**Literature Review of Available Data**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Countries | IDU % | FSW % | Prisoners % | MSM % | STI % |
| Baruland | **3.4%** | **2.1%** | **0.9%** | **0.3%** | **0.2%** |
| Aparadesh | **8%** | **1.1%** | **0.4%** | **0%** | **0.2%** |
| Tyrkistan | **15.8%** | **0.7%** | **6.2%** | - | - |
| Dunialand | **26.3%** | **9.7%** | - | **11.5%** | **2.5%** |

**Figure 1: HIV Prevalence Among Targeted Group**

|  |  |  |
| --- | --- | --- |
| Provinces in Dunialand | 2015 | 2016 |
| Province 1 | 27 | 6 |
| Province 2 | 150 | 324 |
| Province 3 | 186 | 72 |
| Province 4 | 88 | 61 |
| Province 5 | 260 | 347 |
| Province 6 | 13 | 35 |

**Figure 2: Number of Women who use drugs Accessing HCT (2015 - 2016)**

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**Figure 4: Percentage (%) of WID who experienced Human Rights Violations (2016)**

Structural Factors of Risk and Vulnerability

* Poverty (60% of population)
* Unemployment
* Increase numbers of people who use drugs on an annual basis of approximately 15% growth rate (45-55 thousands, 60% are injecting)
* Increase in numbers of female sex workers
* Very large numbers of internal and external migration
* Lack of access to information on HIV&AIDS
* Lack of anonymous HIV testing services
* Other vulnerable groups such as military, militia, prisoners, clients of sex workers and others are not covered in existing prevention programs

Laws and Regulations

SELECTED ARTICLES FROM DUNIALAND’S CONSTITUTION

Article 22 all citizens shall be equal before the law, regardless of race, religion, status, or sex, enjoy equal opportunities, enjoy the benefits derived from his labour in proportion to his contribution in manual or mental labour and have the right to inherit according to law.

Article 32A the Democratic Republic shall care for mothers and children.

Article 367 every citizen shall, in accord with the health policy laid down by the Democratic Republic, have the right to health care.

THE PENAL CODE

Sections 354 and 509 addresses violence with criminal intent, and threatening a woman’s dignity either by verbal or physical gestures or physical action – protecting women against abuse, and seduction and sex with under-age women.

PRISONS ACT

The *Prisons Act 1894-1909* Chapter VI establishes rights of prisoners to request to see a medical officer and the obligation of the prison authorities to provide a hospital or proper place for the reception of sick prisoners.

DANGEROUS DRUG ACT, 2001

* (1)  Any person who unlawfully –
  1. (a)  smokes, inhales, sniffs, consumes, or administers to himself or any other person, in any way whatsoever, any dangerous drug;
  2. (b)  possesses, purchases, offer to purchase or transports any dangerous drug;
  3. (c)  has in his possession any pipe, syringe, utensil, apparatus, or other article for use in connection with smoking, inhaling sniffing, consuming or the administration of any dangerous drug,

shall commit an offence and shall, on conviction, and be liable to a fine not exceeding 50,000 rupees, to imprisonment for a term not exceeding 2 years.

Additional Information

* Opiate substitution therapy is only available at public hospitals in Region 2, 3 and 5. These hospitals also offer HCT and ARV treatment.
* Government policy states that ART can only be provided to drug users who are registered with the Ministry of Home affairs and undergone MMT initiation and taking methadone regularly.
* Only 20% of all those in need of ARVs are receiving them; no reliable data is available on adherence rates, but it is generally assumed that adherence is low.
* Incidence of tuberculosis is increasing rapidly
* Hepatitis C prevalence amongst injecting drug users is at 55% (2016). Treatment for Hepatitis C costs USD10,000 per patient and only available in the capital city.
* There is a growing number of young people using cannabinoids and amphetamine-type stimulants (ATS) such as "ecstasy" and methamphetamine. Not much information is available regarding this new phenomenon.
* Poor laboratory control – confidentiality of patient information compromised
* Poor monitoring & evaluation – unable to evaluate performance of existing programs
* Very few non-government organizations working on HIV prevention, treatment, and care

GUIDELINES FOR GROUP WORK

1. Group 1 – Propose a package of intervention based on available data.
2. Group 2 - Identify Strategic Information Gaps and Needs and where possible, identify technical assistance and capacity building required.
3. Group 3 – Develop key advocacy message to present to policy makers.

# Appendix 3: Participants Handout - Day 3

**Group Work 1: Framework for Linking Data with Action**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Decision/ Action | Program/ Policy Question | Decision Maker (DM), Other Stakeholders (OS) | Indicator/  Data | Data Source | Timeline  (Analysis) (Decision) | Communication Channel |
|  |  |  |  |  |  |  |

**Group Work 2: What Sort of Systems and Tools Do You Need to Monitor Your Programmes?**

Instructions

1. Select a note taker
2. Refer to mapping done from previous days
3. Select 2 priority programmatic areas which require strategic information strengthening
4. Discuss types of data source, tools needed to collect the data and at what level of M&E system the data will contribute to planning and decision making

Time: 30 minutes

**Group Work 3: Identify Capacity Building Needs**

Instructions:

1. Refer to previous group work (2 areas of strategic information strengthening)
2. When thinking of capacity building needs, consider applying a combination of:
   1. Assessment of current data use/utility
   2. barriers to data use
   3. barriers to communicating data
   4. Identify capacity building initiatives around data use concepts, use of tools, data analysis
   5. Tool application
   6. Organization development (e.g., leadership, systems improvement)
   7. Collaborative efforts between data users and producers

Time: 30 minutes

**Group Work 4: Action Planning Matrix (example)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ACTIVITY | PRIORITY   * High * Medium * Low | FEASIBILITY/ SUPPORT   * High * Medium * Low | CHANGE IN COSTS   * High * Medium * Low * Nil | OTHER RESOURCES NEEDED   * Significant * Few * None | CAPACITY   * Excellent * Good * Fair * Little/ None |
| Gender-based violence-related services | High  Timeline: Jan 2018 | Medium  TA Partner: UNFPA?  Funding: GF CRG? | High  (no intervention in place at present) | Significant  (technical assistance required) | Little |
|  |  |  |  |  |  |

# Appendix 4: Pre-and-Post workshop Knowledge Test

**PARTICIPANT PROFILE:**

1. Participant Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Which sector do you represent?
   * Government
   * Non-Government
   * International NGO
   * Other International Agency
3. Area of Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you attended a training on Monitoring and Evaluation before?
   * YES
   * NO
5. If YES, where and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre and Post Workshop Knowledge Test (For Participants)**

1. Monitoring is sometimes referred to as:
2. Evaluation
3. Impact Evaluation
4. Process Evaluation
5. Performance Evaluation
6. At what stage of a program should monitoring take place?
7. At the beginning of the program
8. At the mid-point of the program
9. At the end of the program
10. Throughout the life of the program
11. Which of the following is NOT considered “monitoring”?
12. Counting the number of people trained
13. Tracking the number of brochures disseminated
14. Attributing changes in health outcomes to an intervention
15. Collecting monthly data on clients served in a clinic
16. The success of a program should be measured by a single indicator.

a. True

b. False

5. Which of the following is not true? M&E indicators are important because they:

1. signal the need for corrective action and management
2. evaluate the effectiveness of various management actions
3. provide evidence as to whether objectives are being achieved
4. audit the financial performance of a project
5. Which category of definition do these indicators fall under? Tick (√) your answer:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | INPUTS | ACTIVITIES | OUTPUTS | OUTCOME | IMPACT |
| Health commodities – needles, syringes, condoms |  |  |  |  |  |
| Increased skills and knowledge of service providers |  |  |  |  |  |
| Number of women who use drugs receiving HIV testing & referred to ART |  |  |  |  |  |
| HIV counselling and testing |  |  |  |  |  |
| Reduced incidence of HIV |  |  |  |  |  |
| Reduced HIV related morbidity |  |  |  |  |  |

1. Which of the following is NOT an appropriate measure to mainstream gender in HIV programmes for women who use drugs?
   1. Develop specific guidelines, indicators and targets that address the needs of women who use drugs about harm reduction services, sexual and reproductive health, pre-and post-natal care, and other key interventions.
   2. Integrate gender analysis into policy and programme planning and monitoring and evaluation frameworks, and build capacity to address gender inequalities faced by WID.
   3. Ensure that law enforcement training and health-care staff training curricula include materials on the needs and rights of WID, stigma reduction and appropriate referrals to harm reduction services.
   4. Re-allocate harm reduction programmatic funds to compulsory rehabilitation of women who use drugs and are engaged in sex work.
2. Which of the following is NOT an example of a gender responsive monitoring and evaluation indicator?
   1. % of WID who received gender-responsive harm reduction services (including SRH, OST, HCT, ART, response to violence)
   2. % of men who inject drugs whose partners have been accessed with gender-specific services.
   3. % of people who inject drugs tested for HIV
   4. % of HIV-positive pregnant women who are partners of men who inject drugs who received PMTCT during pregnancy.
3. Identify which category the following data types belong to. Tick (√) your answer:

|  |  |  |
| --- | --- | --- |
|  | QUALITATIVE | QUANTITATIVE |
| Observations |  |  |
| Census |  |  |
| Focus Groups |  |  |
| Integrated Bio-Behavioural-Surveillance (IBBS) |  |  |
| KAP (Knowledge, Attitude, Practice) |  |  |
| Key Informant Interviews |  |  |
| Social research |  |  |