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Final Report

FIRST INTERIM EVALUATION

Public Health Communications (AIDSCOM)

and

Technical Support (AIDSTECH)

Components of

A.I.D. AIDS Technical Support Project

Conducted September 5 - October 18, 1989

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Prepared for the

Agency for International Development

**S&T/Office of Health
S&T/Office of Education**

**Office of International Health
Public Health Service
Department of Health and Human Services
Rockville, MD 20857**

LIST OF ACRONYMS AND ABBREVIATIONS

AED Academy for Educational Development
 AIDS Acquired Immune Deficiency Syndrome
 AIDS T/S AIDSCOM and AIDSTECH, Components of Technical Support Project
 AID/W Agency for International Development/Washington
 AMREF African Medical Research Institute
 BRL Bureau of Research Labs

CBD Community Based Distributors
 CDC Centers for Disease Control
 CDCS Center for Communicable Disease Control Services (Philippines)
 CMA Crescent Medical Aid
 COIN Non Profit Information Center (Dominican Republic)

DOH Department of Health
 EIL Experiment in International Living
 FHI Family Health International
 FUE Federation of Uganda Employers
 GOP Government of the Philippines

HIV Human Immunodeficiency Virus
 IEC Information, Education and Communication
 KAP Knowledge, Attitudes and Practices
 KEMRI Kenya Medical Research Institute
 KNAC Kenya National AIDS Committee

KNACP Kenya National AIDS Control Programs
 LOP Life of Project
 MOH Ministry of Health
 NACP National AIDS Control Program
 NCCK National Council of Churches in Kenya

NCPA National Committee for the Prevention of AIDS
 NGO Non-Governmental Organization
 NIH National Institutes of Health
 NRA National Resistance Army
 OYB Operational Year Budget

PAHO Pan American Health Organization
 PCF Population Center Foundation
 PIO/T Project Implementation Order/Technical
 PROCETS Program for Control of Sexually Transmitted Diseases (Dom. Rep.)
 PVO Private Voluntary Organization

LIST OF ACRONYMS AND ABBREVIATIONS (Cont.)

RITM	Research Institute of Tropical Medicine (Philippines)
STD	Sexually Transmitted Disease
TAG	Technical Advisory Group
TASO	The AIDS Support Organization
TOT	Trainers of Trainers
USAID	United States Agency for International Development
USAID/U	USAID/Uganda
WHO/GPA	World Health Organization Global Programme on AIDS

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EXECUTIVE SUMMARY

Four consultants and two USAID field participants conducted the first interim evaluation of two major components (AIDSCOM and AIDSTECH) of the USAID AIDS Technical Support Project, between September 5 and October 18, 1989. Three-person teams travelled to the Philippines, Uganda, and Kenya, and two consultants to the Dominican Republic, after four days of orientation in Washington, D.C. and Raleigh, North Carolina.

AIDS presents a unique challenge to the world's public health community. Since the transmission of the HIV causative agent is primarily sexual, programs in the field must confront a topic that is highly intimate in nature, little understood, frequently polarizing in public discussion, and sensitive politically, culturally and religiously. Given the considerable barriers encountered in the field, USAID and the two contracting institutions for AIDS T/S must be commended for putting in place within twenty-four months a worldwide program of resources and activities that significantly contribute to a firm foundation for reducing and controlling the spread of AIDS. Many program activities are just now beginning to generate critical information about the effectiveness of interventions for behavioral change, and other activities are advancing host country infrastructures for surveillance, blood screening, management of public communications efforts, personnel training, and service delivery.

The parameters of the evaluation report are fixed by the constraints on the evaluation team. The evaluation schedule and total amount of time available precluded examination of certain items listed in the written scope of work, and limited the basis on which some observations and recommendations are made. These limitations are explicitly noted where appropriate. Nevertheless, the team believes the overall design of the project is sound. There is an appropriate and growing emphasis on behavioral research, and interventions to reduce sexual transmission. There is a need for clarification, however, of the vast scope of non-behavioral activities originally envisioned. The scope of these activities need to be narrowed and prioritized.

AIDSTECH behavioral research activities are contributing valuable information in the Philippines and the Dominican Republic. However, critical questions need to be answered: should AIDSTECH be developing the kind of expertise in behavioral change as is present in AIDSCOM? Should AIDSTECH and AIDSCOM pursue a cohesive strategy for research and demonstration? Which areas of technical support will be diminished to accommodate what appears to be an expansion by AIDSTECH in behavioral activities?

While the overall project design is sound, some strategies are conceptually inconsistent, or may be presenting difficulties, or are not being pursued to their fullest potential. For example, the considerable contribution of USAID to WHO/GPA could be more directly related to the AIDS operations in-country. Management of the two contracts for AIDSCOM and AIDSTECH needs close coordination to ensure a cohesive AIDS strategy, especially where they operate in the same country and where both are engaged in projects of behavioral research and interventions to reduce sexual transmission of HIV. The strategies of institution-building, sustainability, buy-ins, and use of sub-agreements need to be reconciled with the need of AIDS T/S staff and consultants to methodically direct and shape research and demonstration projects in pursuit of systematic development of behavioral change methodology.

Both projects have heavy coordination and administrative demands inherent in large, global programs, but both appear to comply well with meetings, approval procedures, reporting requirements, document requests, and other demands. Senior management of both institutions are closely involved with project directors in overall direction and management. Their management tasks should be made easier when the AIDS T/S agenda is clarified and prioritized, particularly the research agenda, and decisions can more accurately be made to match staff expertise with scope of work. Deputy directors are essential because project management requires a wide range of skills and job organization far beyond the capability of any single person. Management of the vast amount of information generated by a global program is fairly efficient, reflected in the voluminous documents and readily available data. Plans for information-sharing and application of lessons learned have not yet been detailed and are not necessarily furthered by the kinds of documentation and communications currently in place. Indeed, the resources consumed by generating the latter kinds of information might distract from the systematic extraction and application of lessons learned.

AIDSTECH has a far greater challenge in field management than AIDSCOM, due in large part to the multiplicity of areas of technical support which is not conducive to a single resident advisor; the approval procedures required for sub-agreements both at home and in the field; and the coordination of separately managed sub-agreements, even with strong host country infrastructures. The use of local coordinators and efforts to reduce the formality of sub-agreements or to build in a greater monitoring role for AIDSTECH advisors may alleviate difficulties inherent in such a complex program.

The quality of program performance in on-going activities is high in all four countries visited. The level of professional skills of staff, consultants, and contractors was found to be high. Weaknesses identified were more related to organizational and management issues, such as the appropriateness of using a particular staff or consultant in a chosen situation. The field visits provided an opportunity to understand the practical conditions that influence AIDS T/S strategies.

In the Philippines, a public information campaign will be launched in January based on KAP surveys among selected targets including commercial sex workers, but the objectives have been narrowed by funding and time constraints. An AIDSTECH STD project has produced very interesting information about female sex workers, and STD services are being improved; but the project operates in isolation from any country operational plan. Some AIDSTECH project activities are progressing very well; one was receiving little leadership from the host country project manager; and some have been delayed and may be revised or not pursued. Because further sub-agreements for research and STD interventions are being initiated by AIDSTECH in other geographic areas, the team recommended that AIDSTECH insist on far more integration with the research methodology of the existing project than the sub-agreements seemed to require.

In Uganda, AIDSCOM provides training and other technical assistance to two projects which work closely with the USAID mission. The team recommended a more on-going AIDSCOM presence to oversee and help activities. In Kenya, some AIDSTECH activities had been delayed, and proposed research was slowed in the approval process. The team strongly supported the continuation of the AIDSTECH coordinator position, and recommended that AIDSTECH develop a more extensive research agenda and offer more expertise if it intends to increase its emphasis in behavioral research.

In the Dominican Republic, AIDSCOM activities were progressing well under the direction of a dynamic resident advisor and in collaboration with a very strong host country government team. Valuable information should be forthcoming from an extensive survey of the gay community. AIDSTECH has a sub-agreement for an STD intervention that includes an extensive survey among female sex workers, which is progressing very well. The AIDSCOM resident advisor has provided timely and relevant expertise to the project. While AIDSTECH and AIDSCOM are collaborating as research moves through various phases, the project raises issues about the difference in the two approaches of AIDSCOM and AIDSTECH in the behavioral research area. AIDSTECH technical activities were delayed, in large part due to the Brooke amendment. The team strongly supports the mission's proposal for a part-time AIDSTECH local coordinator.

In conclusion, the team believes AIDSCOM and AIDSTECH are far ahead of any other agencies offering assistance in their field of operation. Despite the enormous gaps in knowledge about how to prevent and control the spread of AIDS, USAID designed a project which on the whole has proven to be sound and the contracting institutions have fielded an impressive amount of appropriate technical assistance in the first two years. As the project moves through its third year, it is hoped that the evaluation team's observations, findings, and recommendations will help to make future efforts even more effective.

I. INTRODUCTION

This is the first interim evaluation of two major components of the AIDS Technical Support Project (AIDS T/S) which commenced in September, 1987 and is scheduled for completion in September 1995, at a total cost of \$68 M. The components of the project being evaluated are a five-year, \$15 M contract between the U.S. Agency for International Development (USAID) and the Academy for Educational Development, Inc. (AED) for a Public Health Communication Project (AIDSCOM), and a five-year, \$28 M Cooperative Agreement with Family Health International (FHI) for a Technical Support Project (AIDSTECH). AIDSCOM makes extensive use of the institutions strengths of AED's subcontractors, Porter Novelli, Johns Hopkins University, the University of Pennsylvania, and Prism. The two components, AIDSCOM and AIDSTECH, together are designed to strengthen the capacity of developing countries for preventing and controlling the spread of AIDS through changed health practices, access to condoms and support services, HIV surveillance, and a safe blood supply.*

Four consultants were selected for the evaluation, which took place between September 5 and October 18, 1989. The background of the consultants included health policy analysis, health systems management, social psychology, community psychology, behavioral research, research methodology, interventions for behavioral change, and communications research, development, and evaluation. The consultants met first in Washington and Raleigh for orientation by USAID officials and staff of the two primary contracting institutions, AED and FHI. Three-person teams then travelled to the Philippines, Uganda, and Kenya, and two consultants to the Dominican Republic. Three-person teams consisted of two consultants and one staff member from USAID S&T/H/AIDS. The Team Leader made follow-up visits to FHI and AED immediately following the Dominican Republic Trip in an effort to verify perceptions gained in the field. Later feedback on early drafts of the report from USAID and contracting institution staff assisted the team in making final revisions.

It should be noted that the "Program Management Assessment of A.I.D. HIV Prevention Program" (Jim Kelly, March 1989) which focused on the management relationship among USAID, AIDSCOM, and AIDSTECH, made many observations and recommendations which are echoed in this evaluation.

*Throughout the report, when references are made to both AIDSCOM and AIDSTECH, the term AIDS T/S is used. When general references are made to one or both, the term "project" is used. When general references are made to AED or FHI, the term "contracting institution" is used. References to AIDSCOM personnel includes both prime contractor and subcontractors, who are integrally involved in AIDSCOM operations.

II. BACKGROUND

AIDS presents a unique challenge to USAID and the two contracting institutions for AIDS T/S. Since transmission of the HIV causative agent is primarily sexual, programs must confront a topic that is highly intimate and sensitive, little understood, and frequently polarizing in public discussion. Groups at high risk of HIV infection are often those very groups that are alienated from the mainstream of communities and have few contacts with public sector health delivery systems. Preventive measures frequently must include changed sexual practices and condom use, which are difficult to publicize because of political, cultural, or religious opposition.

A. USAID AIDS Strategy

The World Health Organization's Global Programme on AIDS (WHO/GPA) provides leadership for the efforts of the international public health community in its response to the problem of AIDS. The cornerstone of USAID assistance policy for prevention and control of HIV infection and AIDS in developing countries is its vigorous support of the WHO/GPA. However, WHO/GPA is focused on establishing, coordinating, and evaluating programs, and relies on other donors to provide technical assistance to countries in the development and implementation of their programs. USAID therefore plays a critical role in directing technical expertise in-country, drawing on its unparalleled network of resources in health, population, and education programs. The primary vehicle for responding quickly to particular needs of host countries is the AIDS Technical Support Project (AIDS T/S), of which AIDSCOM and AIDSTECH are a major component. Since the agreements were signed, needs assessments have been conducted by AIDSCOM in 43 countries and by AIDSTECH in 33 countries. Follow-up activities have been undertaken in most of them.

B. Scope of Work for Evaluation Team

The challenge of this evaluation is to synthesize the two years of experience of this vastly complex undertaking based on visits to four countries in three regions, and to succinctly characterize emerging strategies, assess progress toward the USAID goals, signal problem areas, and identify changes or actions which will make the project more effective.

The written scope of work contains nearly fifty questions, each of which raises substantive issues. The evaluation team schedule did not permit an opportunity to pursue all issues in depth. Most notably, this evaluation includes neither an internal organizational analysis nor a financial management assessment of the two projects. Visits to the contracting institutions prior to field visits were limited to one day each of highly programmed orientation, at the end of which the team left immediately for the subsequent leg of their trip. However, overall project management is assessed based on documents, the orientation sessions, field observations, and discussions with the contracting institutions during de-briefings by the Team Leader immediately following the fourth country visit.

Finally, the range of activities underway by AIDSTECH was narrower in the countries visited than are underway worldwide. Thus the scope of work was also narrowed, specifically in non-behavioral areas.

Three central questions which emerged from both the written scope of work and discussions with USAID officials served as the focus for this evaluation:

1. Design of overall AIDS T/S project: will the current focus of activity and the overall strategy get us to where we want to be five or ten years from now?

The concern reflected in this question is whether we are overlooking important strategies and areas of activity. Issues to be examined include the emerging focus on behavioral change, the emphasis on peer programs, the decreasing emphasis on assistance related to blood supply and surveillance, and the role of sexually transmitted disease (STD) services. Also to be examined are the effect of buy-ins, use of sub-agreements and other strategies on project design; the use of two separate institutional agreements for AIDSCOM and AIDSTECH; and the relationship with WHO/GPA.

2. Management: Are the two institutions calling on the right kind of expertise to support the current focus of activity, and is the expertise being effectively deployed in the field?

The concern expressed is how effectively the contracting institutions are mobilizing and applying vast expertise accumulated through years of international development assistance. Issues to be examined include use of short-term as opposed to resident consultants, staffing, efficiency of operations, clarity of goals and objectives, documentation, communications with the field, and coordination with all interested parties.

3. Program performance in the field: are we learning from current field activities, and are the lessons being shared and applied elsewhere?

This question reflects the concern that all activities be sufficiently relevant to contribute to the systematic evolution of effective strategies for preventing the spread of AIDS. Issues to be examined include the potential of on-going activities for producing effective prevention and control programs; and the effectiveness of monitoring, evaluation, and dissemination tools to ensure that results of activities are integrated into coherent in-country strategies, and shared outside the country.

III. DESCRIPTION OF AIDSCOM AND AIDSTECH PROJECTS

AIDSCOM and AIDSTECH constitute an unusually wide-ranging effort of research and technical assistance, touching multitudes of cultural and social groups within many countries in every major region of the world. It draws on an immense repertoire of strategies which have evolved from many years of domestic and international experience in health, population, education, and related disciplines. However, these strategies must undergo considerable fine-tuning for adaptation to local circumstances and new strategies must be devised to meet the unique challenge of AIDS.

This effort is also a major component of USAID's vehicle for responding quickly and effectively to technical assistance needs of developing countries as they plan and implement their AIDS control programs. The effort has two components: public health communications (AIDSCOM), and technical and program support (AIDSTECH).

The original contract and cooperative agreement are based on the following goals and objectives.

A. Goal

Prevent and Control the Spread of HIV Infection in developing countries.

B. Purpose

AIDSCOM - Develop and demonstrate effective strategies and methods in communications.

AIDSTECH - Support developing countries in prevention and control of AIDS.

C. Strategy

AIDSCOM - Apply the strategic and methodological frame of reference for communications, detailed in the Contract and based on accumulated USAID experience, in support of a successful communication strategy for AIDS.

AIDSTECH - Develop an institutional base capable of mobilizing broad support; flexible enough to respond to the new and evolving AIDS problem. Develop a critical mass of personnel who can quickly respond to needs; a specialized institution capable of providing long-term AIDS support in all regions.

D. Activities

AIDSCOM - a) sustained operations research in up to 5 emphasis countries in each of three regions; b) technical assistance in development of communications programs, including research, social marketing, training, communications management, and behavioral analysis; c) dissemination of findings; d) other activities.

AIDSTECH - a) technical support in such specialty areas as program design/administration, epidemiology, morbidity surveillance, HIV screening, and health financing; b) applied research, including surveys and surveillance, operations research, delineation of transmission modes, field testing of interventions; c) training; d) provision of equipment and commodities; and d) information dissemination.

IV. EVALUATION METHODOLOGY

A. Framework

In general, the expectations against which the project was evaluated were drawn from the terms of the Contract and Cooperative Agreement. In addition, the team departed from an assumption that the two components, AIDSCOM and AIDSTECH, constitute part of a single USAID strategy for providing timely assistance to countries for implementing programs described in WHO/GPA plans. Thus the team often looked for coherency in the approach of both projects. Visits to the field provided the opportunity for consultants to assess performance against expectations, and to extract from field experiences recommended changes in project design and management.

B. Indicators for Measuring Progress

The consultants relied on certain indicators to measure the success of project components, drawing on the expectations reflected both in documents and interviews with USAID staff.

1. Soundness of overall project design
 - o relevancy of current activities for reaching USAID goal
 - o clarity of objectives toward which activities are directed
 - o importance of activities not being pursued at present
 - o degree to which major strategies support current activities
 - o efficiency of major strategies
2. Efficiency and effectiveness of management by the contracting agencies
 - o progress toward objectives
 - o adequacy and balance of staffing
 - o ability to manage and disseminate information
 - o timeliness and appropriateness of field support
3. Quality of program performance in the field
 - o appropriateness in context of host country
 - o consistency among project activities within an overall country strategy
 - o progress toward stated objectives
 - o value of activities for achieving USAID goal
 - o quality of built-in measures, feasibility of replication

- o adherence to accepted theory and practice in the professional field

C. Desirable Characteristics of Project Activities

Since the evaluation was conducted in so many locations by different combinations of consultants and field visit participants, it was necessary to operate from a fairly uniform set of underlying assumptions about the features which AIDS T/S project activities should exhibit. The compilation of the following list of desirable characteristics is an effort to clarify those assumptions.

1. Characteristics that expand the body of knowledge of AIDS world-wide

- o Built-in evaluation mechanisms to ensure that experience is reduced to "lessons learned"
- o Documentation of both process and results.
- o Direct application of results into other activities in the same country
- o Constant synthesis of all experiences and continuous up-dating of evolving strategies for prevention and control of AIDS
- o Timely and widespread dissemination of process and results, including technical publications, workshops, conferences
- o Translation of experience into expertise which can be offered to other recipients

2. Characteristics that ensure appropriateness in developing countries

- o Assessment of financial feasibility and other sustainability issues for the host country for tested interventions
- o Long term vision beyond life of project activity in order to integrate results into host country health plans
- o Integration into host country infrastructure
- o Development of institutional capabilities
- o Sensitivity to cultural and social environment
- o Responsiveness to the perceived needs and concerns of key decision-makers in host countries

3. Characteristics that promote effective use of resources

- o Provision for cohesive country strategy where multiple projects are being conducted
- o Coordination with all relevant parties: missions, WHO, etc.
- o Stimulation of participation by USAID missions leading to stronger partnerships in the field

V. OBSERVATIONS AND CONCLUSIONS

A. Project Design

WILL THE CURRENT FOCUS OF ACTIVITY IN THE FIELD AND THE OVERALL USAID STRATEGY GET US WHERE WE WANT TO BE FIVE OR TEN YEARS FROM NOW?

"Project design" was defined by the evaluation team to mean the focus toward which field activities are directed, combined with the major strategies adopted by USAID to deliver AIDS T/S services. The task of characterizing the activities of a world-wide, complex program based on visits to four countries proved monumental. The original focus of activity described in project documents was necessarily broad and flexible because so little was known at the outset, and documents could provide only general guidance. Furthermore, while there have been shifts in emphasis of activity over the past two years, they are not easy to detect through interviews and a few country visits.

Nevertheless, during field visits the team did perceive and analyze significant patterns in current activities in four countries. During brief meetings at the end of the field visits the team leader made an effort to check perceptions with staff of the two institutions in order to determine the degree to which they can be generalized to other countries. In addition, the team was able to determine that the major strategies are essentially unchanged, but that they may present difficulties in moving toward the overall project goal.

USAID deserves enormous credit for its foresight in designing so ambitious a project as AIDS T/S in the face of a disease with so few answers, so many sensitivities, and so devastating an impact on all nations. While the team recommends changes and clarification of current direction, the project design overall was sound enough to ensure high quality performance in program activities with great potential for helping to prevent and control the spread of HIV infection.

1. Focus of activity and major strategies

a. USAID Documents

- o The primary focus of activity envisioned for AIDSCOM was sustained operations research leading to the development and demonstration of a range of public health communications methods, and technical assistance in delivering communications programs. The principal objective was to develop a behavioral change methodology to reduce sexual transmission of HIV.
- o The nearly endless variety of activities envisioned for AIDSTECH translated into multiple points of focus, including technical support in program design, surveillance, screening, and health financing, as well as commodities provisions and applied research. The principal objective was to support countries in the development and operation of AIDS programs.

- o Both projects were expected to engage in information dissemination activities.
- o The overall strategy was to support the WHO/GPA effort, and to use AIDS T/S as the vehicle for USAID to assist countries to implement plans submitted to WHO/GPA.
- o Two contracting mechanisms were used for communications and technical support activities, AIDSCOM and AIDSTECH.
- o The total Life of Project (LOP) funding was to be provided centrally and through buy-ins from missions and regional bureaus.
- o The communications project was executed in the form of a contract, and assistance is provided directly through short and long term consultants and resident advisors.
- o A cooperative agreement was used for the technical support project with the expectation that the institution would develop a critical mass of personnel capable of responding quickly to requests for assistance around the world. A mechanism for assistance would be execution of sub-agreements with agencies and institutions in the host country.
- o Other strategies evident in documents and interviews include institution-building for host countries and sustainability of interventions.

b. Field visits

Supporting data for the following observations are contained in the four country reports.

- o Activities adhere to medium term plans developed within the framework of WHO/GPA. These plans are very general, however, and not detailed enough to guide judgments about appropriateness or priority of AIDS activities.
- o AIDSTECH states in its strategy document that its primary objective is the reduction of sexual transmission of HIV, which continues to be a primary objective of AIDSCOM. However, both projects are responsive to local variations in mode of transmission (e.g. needle-sharing among intravenous drug users in Thailand, transfusions with unscreened blood.)

- o In Latin America, the Caribbean, and Asia, AIDS T/S is heavily involved with groups at high risk of HIV infection like commercial sex workers, drug users, and homosexual men, due to the patterns of HIV transmission. These are groups about whom little is known, with whom government agencies generally have few positive contacts, and toward whom the community is frequently hostile.
- o In Africa, since risk is so diffuse throughout the population, AIDS T/S activities are organized around whichever socio-economic, cultural, or other grouping of the population offers the greatest potential for channeling communications and services.
- o Interventions around which both AIDSCOM and AIDSTECH activities are organized include persuasive communication interventions (e.g. media-based, or interpersonal, such as peer education/counseling) and environmental change interventions (e.g. condom distribution, improved access to STD services and treatment).
 - Peer education interventions are being supported in many countries by both AIDSCOM and AIDSTECH for several reasons. Individuals trained to provide HIV/AIDS risk reduction information and materials (including pamphlets and condoms) to their peers may be able to locate and distribute information to individuals at risk more efficiently, and may be more effective in promoting risk reduction, than individuals who are not perceived as peers. This may be especially true for individuals at high risk of HIV infection such as commercial sex workers, IV drug users and men who have sex with men. In some settings or cultures, other sources of information (such as physicians) may have greater access to and greater credibility with individuals at risk, however, KAP surveys, in-depth interviews, and evaluations of the peer education/counseling interventions will examine these issues.
 - Improved treatment and prevention of STDs is another focus of AIDSTECH and AIDSTECH activity. Relatively recent evidence suggests that STDs are a cofactor in HIV infection, and thus effective STD treatment should help reduce HIV infection. STD clinics are also a setting in which HIV/AIDS risk reduction information and materials may be effectively and efficiently distributed to individuals at risk of HIV.
- o Behavioral research and the investigation of factors that influence sexual transmission have become a major focus of activity for both AIDSCOM and AIDSTECH. Several types of

behavioral investigations are being conducted in the field; some types are exploratory and geared toward improving our understanding of sexual practices in the population so that effective media messages and behavior change interventions can be developed (for example, cross-sectional KAP surveys that examine a broad array of psychosocial variables to determine which factors are important to sexual behavior and behavior change; focus groups and in depth interviews geared toward gaining further insight into attitudes, beliefs and practices regarding sexual behavior and barriers to HIV/AIDS risk reduction; etc.); other types of investigations are aimed at evaluating the impact of interventions on sexual behavior (particularly condom use). This type of research is variously called "applied behavioral research", "operations research", and "evaluation research".

- o The different types of research should, and often do, complement each other so that results of broad, exploratory investigations provide a conceptual framework for the development of interventions to change behavior. The effectiveness of the interventions in changing behavior can then be evaluated. It is, however, difficult to discern a cohesive research agenda which overarches both AIDSCOM and AIDSTECH, within which these broad behavioral research activities are taking place.
- o For AIDSCOM, the emphasis seems to be more on exploratory research and the examination of behavior change models and hypotheses through analysis of data from focus groups, in-depth interviews and KAP surveys. AIDSCOM is now in the process of using findings from these studies to develop country specific HIV/AIDS prevention messages in some countries. Although in depth preliminary investigations have not been conducted in all countries, peer education/counseling interventions have been developed in several places. Evaluation of the effectiveness of these interventions is still in the very early planning stages.
- o For AIDSTECH, the level of activity in behavioral research is more predominant in the countries visited than might be expected from the AIDSTECH scope of work, where technical support areas predominate. Among research topics listed, behavioral research is far less referenced than, for example, assessment of prevalence, incidence, and transmission modes of HIV. The team was informed that a behavioral scientist with the necessary expertise was being hired to oversee such research.
- o Regardless of the differing mandates of AIDSCOM and AIDSTECH that generate behavioral research activity, field research for both are remarkably similar, as are some of the interventions. AIDSTECH supports research to develop and

test specific interventions, such as improved STD services and condom use. AIDSCOM supports research to develop behavioral change methodologies, and develops and tests interventions as a means of shaping the methodologies. In the Dominican Republic and the Philippines, where both AIDSCOM and AIDSTECH operate, all research staff and consultants interviewed expressed the same desire to use the research as a unique opportunity to learn as much as possible about target populations. Since these are the individuals who ultimately shape the quality and scope of research, the research activities of both projects are virtually indistinguishable. However, their support differs, since AIDSCOM staff are directly involved in implementation, while AIDSTECH provides some technical assistance and uses a sub-agreement process in which a host country representative is the project director.

- o Individual research projects have stated objectives. However, the voluminous references and discussion about research in USAID project documents and the July 1989 TAG meeting report do not contain the necessary precision in terminology, clarity in use of labels for different kinds and different phases of research, and concise scope of work for contract institutions, to furnish uniform guidance for field research activities. It was difficult to see the relationship between documents and literature on research, and the decisions in the field which determine the length of questionnaires, number of variables, purpose of information, analytical framework, and selection of research and interviewing techniques.
- o There did not yet appear to be much purposeful activity to develop evaluation plans for measuring the impact of interventions, comparing effectiveness of different research techniques (e.g. use of peer interviewers) and extracting strategies which can be applied elsewhere.
- o There has not yet emerged a focus on AIDS financing as a discrete activity. There are projects such as blood testing and donor screening which have comparative cost issues integrated into them. However, there are a range of issues that might be addressed systematically by cost analysis and financial forecasting. These include alternatives for low-cost condom supply and cost projections for current AIDS control strategies, if AIDS financing were an activity undertaken in a comprehensive manner.
- o From the perspective of the field in the three countries visited where AIDSTECH operates, the focus of activity for technical, non-behavioral interventions is diffuse; that is, it was difficult to identify an agreed-upon order of priority.

- o In countries visited there was not much AIDSTECH activity related to strengthening surveillance capabilities. Although the AIDSTECH scope of work includes such technical assistance, host governments were not drawing heavily on AIDSTECH as their source of support in this area.

2. Difficulties presented by original strategies

- o The relationship of WHO/GPA to the AIDS T/S effort is not very close in at least two of the countries visited.
 - AIDS T/S and host country activities move quickly to respond to needs as they arise and as opportunities open up. On-going program operations need decisions and funding commitments to be made quickly. WHO/GPA activities move at a slower pace, and the planning effort seems formalized and generic in nature.
 - The ability of AIDS T/S or host countries to exert direct and timely influence over the use of the considerable funds of WHO/GPA on a country-specific basis appears extremely limited in two of the countries.
 - An illustration of the relationship is that the USAID/Philippines Mission learned in the newspaper of a major Asia Pacific AIDS Conference held by WHO in Manila, only the day before the week-long conference began. AIDSTECH and AIDSCOM Coordinators were scheduled to visit the Philippines the following week, and they too were unaware of the Conference.
- o Use of two contracts for AIDS T/S has allowed two experienced institutions to shape major components of USAID's AIDS control effort in areas where each has particular expertise not found in the other. However, there are disadvantages, especially in areas of overlap in the scope of work.
 - Separate contracts increase the task of coordination already inherent in a global program, to ensure coherent strategies. They demand continuous communications at high levels of the two institutions, since each has decision-making authority. They also demand close communications between the two USAID offices which have management responsibility for the contracts.
 - In areas of overlap, there is a danger of each institution producing similar behavioral interventions based on methodologies which may be too dissimilar for comparison. For example, the focus of activity is merging for AIDSCOM and AIDSTECH, principally in the

area of behavioral research intervention and evaluation. Basic research involves complex and time-consuming developmental and implementation phases which require constant attention. Consistency in philosophy and underlying methodologies of the two contractors is essential. Very close collaboration is needed between the offices managing the contracts.

-- Persons interviewed in the field stated that the use of two contracts is confusing, especially where both institutions seem to be offering the same assistance and the Mission must still monitor separate contracts.

o Implicit in AIDS T/S strategy is a systematic approach to development and demonstration of successful interventions, the corollary of which is that AIDS T/S staff and contractors may require a certain degree of control over the quality, validity, and direction of their activities. However, other equally desirable AIDS T/S strategies contain built-in conflicts with the concept of a systematic approach, as outlined below.

-- The use of sub-agreements as a mode of delivering AIDSTECH services is an excellent means of empowering talented professionals within a reasonably short time to conduct needed activities. However, sub-agreements can limit control over methodologies, management, or use of project results. The following three situations illustrate the limitations:

o For example, if host country management is weak as it is in the Philippines, multiple projects operate in isolation and may never become a coherent whole, integrated into future operations.

o Furthermore, reliance solely on host country expertise to conduct research under a sub-agreement may not always be realistic. AIDS, unlike other health issues such as child survival and family planning, is a new problem and much remains to be learned about its prevention and control. Behavioral research is an especially complex field, and few research teams can successfully study it alone. In the Dominican Republic, the continuous presence and timely intervention of the experienced AIDSCOM resident advisor has been critical to ensuring the quality and validity of techniques being used under an AIDSTECH sub-agreement.

- o In the Philippines, as another example, a research project under a sub-agreement appears to be of high quality. However, two additional projects are being undertaken by different contractors. There is no single source of expertise for all three, to oversee and assure the quality of the developmental and implementation phases, and later to synthesize the results of all three.

- The strategy of institution-building with host country professionals while delivering AIDS T/S services is the only means of ensuring that AIDS efforts are sustained. However, this strategy clearly needs to be modified where AIDS T/S must assure the validity and quality of methodologies, and integrated management of multiple projects. Transfer of skills can occur through complete delegation of responsibility to the host country through sub-agreements. However, skills may also need to be - or are more effectively - transferred through the continuous provision of expertise in the field, and by requiring closer collaboration with other efforts. (See Kelly report, pp. 6-8).

- The strategy of developing sustainable interventions was stressed during the orientation session with USAID. However, in the short term it may be inconsistent with the research and development strategy of AIDS T/S: AIDS T/S is testing interventions--even costly ones--to build up a sufficient body of knowledge and experiences for devising future AIDS programs. Sustainability may not be the goal by which each of these interventions should be measured. (See Kelly report, pp. 6-8 for similar observation.)

- The strategy of mission and regional bureau buy-ins in the countries visited seems to stimulate more active participation in AIDS efforts than might have occurred if AIDS T/S had been solely centrally funded. However, this strategy also means that the entire AIDS T/S program of services is significantly shaped by the individual needs of missions and bureaus, reflected in the goals and objectives of Program Implementation Orders (PIO/Ts). These needs diminish the degree to which AIDS T/S can adopt a systematic approach on a world-wide basis.

- The use of a cooperative agreement for AIDSTECH to develop an institution capable of quickly mobilizing technical assistance upon request is a very desirable goal. However, the expectation that AIDSTECH can transform itself into a rapid response team may conflict with the task of systematically selecting, researching,

and demonstrating effective long term interventions, as well as with the use of sub-agreements which provides funds but relies more on local expertise.

3. Conclusions

- o The focus on applied behavioral and intervention research, peer programs, and STD clinics is appropriate. The major mode of transmission for HIV continues to be sexual transmission. The only workable interventions are those with the greatest promise for changing sexual behavior, an extremely sensitive topic politically, culturally, socially, and emotionally. For research to result in successful interventions, it must explore both the health and sexual behavior and belief systems of target groups, and the surrounding environment in which interventions would take place. Peer outreach offers one of the best hopes for providing credible agents of change, and STD clinics are one of the few vehicles that have potential for reaching significant segments of groups at high risk of HIV infection.
- o Research, especially in the area of exploratory, behavioral research, has not yet been reduced to a coherent, articulate strategy encompassing both AIDSCOM and AIDSTECH efforts.
- o Evaluation research does not seem to have been given sufficient emphasis, although it is vital to the assessment of the degree of success of efforts and to improvement of management and planning. There is as yet little activity on systematically evaluating impact and sharing lessons learned from interventions.
- o It was not possible for the team to discern the order of priority of all remaining, non-behavioral activities such as AIDS financing and strengthening of surveillance capabilities.
- o Modifications and clarification on some of the project strategies may help AIDS T/S to function more effectively, e.g. WHO/GPA support, institution-building, use of sub-agreements, etc.
- o The use of separate contracts is advantageous for so complex and large an operation. However, such an approach also requires increased attention at the highest levels of contract management if USAID wants to ensure that similar approaches to behavioral theory and research are employed by both AIDSCOM and AIDSTECH, and that effective coordination of methodologies and activity occur in countries where both are engaged in the same work.

B. Management

ARE THE TWO INSTITUTIONS CALLING ON THE RIGHT KIND OF EXPERTISE TO SUPPORT THE CURRENT FOCUS OF ACTIVITY, AND IS THE EXPERTISE BEING EFFECTIVELY DEPLOYED IN THE FIELD?

The task of managing the AIDS T/S project is enormous. Significant time and resources are required because of the large amount of funds involved, the requirement that part of the \$43 Million come from missions and regional bureaus who want accountability, the premise that it supports WHO/GPA, the necessity of responding to host country needs and obtaining local approval, and the highly individualized interventions that will apparently be required to address HIV transmission in each country.

As noted in the section describing the scope of work, this evaluation did not include an on-site assessment of internal organization or financial management of the two projects. Nevertheless, it was possible to make the following observations and conclusions about project management based on the detailed orientations, voluminous documents, visits to the four countries, and de-briefings with the Team Leader. Supporting data is contained in the country reports.

It was clear from the two day-long orientation sessions by AED and FHI that the highest level of management in both institutions are very involved with project directors in providing leadership for AIDS T/S, especially in the major effort to mobilize the kinds of expertise required for each area of field activity. The extent to which these efforts are successful was observed in the field. It appeared that AIDSTECH has encountered more difficulty than AIDSCOM in providing appropriate and timely expertise due to its vast scope of work.

With respect to managing information, both institutions have readily available and voluminous documentation at the central level, oriented around informing interested parties about AIDS T/S activities. At the field level, documentation exists but not yet in a format easily shared with peers in other countries for purposes of replicating experiences.

Senior management of both institutions should be commended for reaching the level of performance described in the next section. This evaluation was well-timed to take advantage of two years' of practical experience, enabling the team to recommend some options for strengthening project management and more effectively using expertise overseas.

1. Project Management

a. Overall direction

- o It was apparent from documents made available to the team that both institutions commit a significant amount of time, energy and resources complying with contract requirements, including coordination, information, justification, presentations, and documentation. This effort is reflected in approval procedures for hiring, executing sub-agreements,

and other decisions routine and ad hoc meetings, phone calls, and letters; project documents for mission buy-ins; and routine and as-needed reports, statistics, and financial data. Relationships between AIDSCOM and AIDSTECH, with missions and regional bureaus, the two USAID contracting offices, WHO/GPA, CDC, NIH, and other interested parties generate continuous and formalized communications.

- o During the first year, both institutions were absorbed in staffing up the projects and initiating needs assessments in over 40 countries around the world.
- o The second year has been heavily focused on fielding short and long term consultants as well as resident advisors.
- o AIDSCOM and AIDSTECH benefit from extensive involvement of senior management of AED and FHI with respect to overall direction and leadership of these two projects.
- o The two project directors did not yet have deputies, although such positions are apparently to be filled soon. Clearly the projects require such different skills, abilities, and job organization that two high-level professionals can be justified. Administrative management requires significant time in the home office, while program planning and evaluation needs considerable time in the field.

-- Day to day operations of these global programs generate enormous personnel, informational, and logistical tasks which require constant attention to people and details, and continuous intake and organization of data; and a lot of time in-house, with some visits to the field to check perceptions and understand practical working conditions.

-- The scope of the programs require broad professional vision; synthesis of a very wide range of technical interventions and communications strategies in order to detect and shape direction; and ample time in the field to monitor, guide, and evaluate performance.

b. Skills deployment

- o AED expanded beyond its accumulated experience in developing countries to bring into AIDSCOM people with experience in U.S. AIDS programs. This kind of expertise has been especially valuable for peer program development which is prevalent in AIDS T/S. However, it is not clear to what extent AIDSCOM has designated staff with planning and evaluation design experience to ensure strong direction and oversight of a systematic approach to the critical phase of extracting, sharing, and applying lessons learned.

- o PHI has a wide range of expertise available to carry out its technical activity. However, because of the large number of project monitors, technical staff, and outside consultants who may be brought in by AIDSTECH to any single country, it was difficult for the team to assess sufficiently of in-house expertise for AIDSTECH to assure continuity in each of many technical areas. However, a consultant epidemiologist was used in Dominican Republic for a one-time technical assessment, where on-going assistance was apparently desired, possibly reflecting insufficient expertise in-house in that area.
- o AIDSTECH has a wide range of operations and other research expertise available to it, with the exception of applied behavioral research. A repertoire of behavioral research expertise and an agenda have not yet been sufficiently developed for AIDSTECH to be as directly involved in research as AIDSCOM is. AIDSCOM has in-house as well as outside expertise for pursuing at least part of its research agenda, reflected in the vast accumulation of conceptual models, literature surveys, and other documents. Still, as noted above it is difficult to determine what skills are available to ensure development of evaluation plans, field research designs, and measures for the interventions AIDSCOM is fielding.

c. Information management

- o There is extensive documentation available at both institutions, which is important for informing interested parties about scope and direction of AIDS T/S.

-- AIDSTECH documentation is data-oriented, reflecting constant tracking of multiple activities in a methodical manner. A wide range of objective data is readily available as is information about current technical strategies. However, there is little in-depth information describing AIDSTECH methodology or philosophy toward behavioral change to reduce sexual transmission of HIV, currently a major objective for AIDSTECH.

-- A large part of AIDSCOM documentation is philosophically oriented, reflecting constant synthesis of conceptual information underlying research and communications strategies. Analyses and surveys of programs and research on AIDS are reduced to documented form, as are AIDSCOM approaches to behavioral change and communications. There is little information yet about the comparative impact of strategies and programs on behavior.

- o Field experience is just reaching the level where other staff and contractors would greatly benefit from lessons learned. However, explicit plans have not yet been formulated for systematic distilling and disseminating of such information at the program planning and implementation level. Existing AIDS T/S documentation contributes to information dissemination but in a highly generalized fashion, and regional and global AIDS conferences offer learning opportunities, but only for those able to attend. Documentation of process underlying research projects is available in some areas and will be valuable for future information-sharing, but it is not a directed activity as yet.
- o The enormous volume of information-generating activity related to coordination and administrative demands of the project may divert the time and energy required for more systematic information-sharing to promote application of lessons learned among program-level people of different countries and regions.

2. Field management

- o The exhaustive list of categories of available technical assistance and the use of sub-agreements that characterize the cooperative agreement for AIDSTECH appear to be very difficult to manage, and are complicated by delays in project start-up. Increasing use of local coordinators may help to alleviate the burden.
- Initiation of AIDSTECH activities have experienced delays in all three AIDSTECH countries visited, caused by the length of time required for developing projects, and for approving sub-agreements. Only six of fourteen projects were fully underway. AIDSTECH believes the sub-agreement process reflects in part the natural evolution of program development. It also meets a need for accountability of funds. Approval requires input from USAID central and mission levels, the host country agencies, and FHI. The team was unable to isolate a particular phase of project approval as being unnecessary or particularly cumbersome; rather, some Mission and host government personnel interviewed believe the process causes unproductive delays. It appeared that the initial project development phase was shortened where more AIDSTECH assistance was given to host country agencies.
- Some delays in the Dominican Republic have been caused by the Brooke Amendment. Still other delays appear to result from turnover in AIDSTECH or host country staff responsible for the project.
- It is difficult to use staff with technical expertise in a resident advisor position, since AIDSTECH activities are so varied. The approach has been to use project monitors and

technical staff or consultants on a short term basis, although more attention is now being given to the use of part- or full-time local coordinators (e.g. Dominican Republic, Philippines, Kenya).

- Use of Short term, multiple consultants and project monitors has led to miscommunications. The research unit director in the Dominican Republic AIDS program believed that he had been given a go-ahead last February by an AIDSTECH consultant to initiate activities for blood screening under a sub-agreement which is only now being finalized. Developmental work was carried out for several weeks before being halted.
- The impact of average staff turnover rates are magnified in situations where multiple staff and consultants are used for multiple projects and tasks as is the case with AIDSTECH. Lack of continuity caused by changes in staff and consultants as has occurred in some of the countries visited, and the absence of a local coordinator or resident advisor, combined with delayed start-up, can result in less than optimum project agreements. For example, the surveillance project was being finalized in the Dominican Republic even though the situation appeared to have changed considerably since the project was first contemplated. The underlying data system was problematic, and the host country staff expressed the need for follow-up assistance on some related activities provided previously by AIDSTECH.
- o AIDSCOM management is considerably easier because of the narrower focus of activities, and funds are not transferred as they are for AIDSTECH but it is not trouble free.
 - Resident advisors with communications expertise can double as local coordinators and managers. Use of multiple consultants for different phases of research and development is far less confusing when a resident advisor or primary technical expert oversees the entire project. The sub-agreement mechanism is not used, and assistance is provided by staff, consultants, or local contractors.
 - Absence of strong host country management can interfere with AIDSCOM management, however, as in the Philippines where the contribution of a resident advisor and the effort to carry out institution-building both suffered. The AIDSCOM country manager had to greatly increase the amount of time he spent in-country.

3. Conclusions

- o Both AIDSCOM and AIDSTECH appear to have responded remarkably well to the enormous administrative and logistical

challenges posed by this large and complex project during the first two years, with significant support of senior management of both institutions.

- o Project deputies will expand the pool of senior management expertise and should result in sufficient attention to both in-house and field operations.
- o It is difficult to assess balance of skills in AIDSTECH because of the vast scope of technical assistance they are expected to provide, but they need more skills in applied behavioral research if they are to continue in this area. AIDSCOM may need more planning and evaluation design expertise when it moves ahead with systematic extraction and application of lessons learned.
- o Management of extensive information appeared effective, but it does not yet extend to systematic in-country and cross-country information analysis and dissemination.
- o Field management is far more problematic for AIDSTECH because of the multiplicity of projects, the transfer of funds, the lengthy sub-agreement process, and lack of local coordinators.

C. Program Performance

The following section of the report presents observations, conclusions and recommendations from site visits to four countries which provide the supporting data for many of the observations related to project design and management. Each evaluation team member visited at least one country.

1. Summary of observations

- o The team was impressed with the overall quality of field activities, almost all of which are clearly an integral part of any future AIDS control program. They are far ahead of any other agencies offering assistance in their area of operation, and probably unique in research and communications activities.
- o Five years is a short time frame for these kinds of field activities to come to fruition.
- o All activities are virtually carried out in response to host countries since they were preceded by needs assessments, and adhere to WHO/GPA plans. Activities are generally but not always integrated into host country infrastructure where counterparts exist.
- o Staff and consultants received very high praise from host country governments and USAID missions.

- o As described earlier under Project Design, there is a strong focus of activity on behavioral research by both AIDSCOM and AIDSTECH, and two common interventions in addition to public information campaigns are peer programs and strengthening STD clinics.
- o More on-site, continuous, on-going technical assistance and coordination would clearly be welcome. It is especially needed in the area of applied behavioral research, and is particularly noticeable with respect to AIDSTECH activities.
- o AIDSTECH activities have been seriously hampered by delays based on a variety of factors related to funding, host country staff turnover, the process for sub-agreements, and the lack of local coordinators. Of fourteen projects, only six were sufficiently underway for the team to assess in the three countries visited.
- o There is a frequent lack of information exchange within countries and between countries.
- o Field staff, consultants, and contractors did not uniformly build operations research into each intervention, or provide for process documentation. These are prerequisites to developing a proven behavioral change methodology.
- o Field staff, consultants, and contractors always did not reflect either consciously or in their work, the theory, methodology, and philosophy underlying behavioral research which is articulated by AIDSCOM central staff and extensively described in documents.
- o Those who are responsible for research projects within the same country do not necessarily operate from the same methodological base in their work, or reflect a desire to share methodology, even in the Philippines where AIDSTECH is the common funding source, raising questions about how we will describe concisely what we learned in one country five years from now.

2. Philippines

a. Background

Norine Jewell, Jeffrey Harris, and Robert Simmons conducted interviews and made site visits in the Philippines between September 12 and 22, 1989.

The commitment of the Government of the Philippines to AIDS prevention and control was reflected in the initiation by the Department of Health (DOH) of some modest activities in early 1987, prior to mission funding. The infusion of the \$2M in June 1988 by the mission for a two year period dramatically expanded

the scope of these efforts but strained the ability of the DOH to provide strong managerial control over the AIDS T/S project. Nonetheless, DOH continues to support AIDS efforts, and senior DOH staff serve as project managers while others participate in training and support services.

The most significant constraints to progress toward a coherent country strategy for AIDS prevention and control were identified as follows:

- o Two year time frame within which all funds must be spent;
- o Absence of strong managerial control over AIDS activities by DOH;
- o Absence of more detailed and practical plan to implement the DOH mid-term plan, within which projects must operate;
- o Absence of DOH initiative to mobilize other donor support.

b. Executive summary

The critical question facing the mission is whether to continue supporting AIDS activities when funds run out in June, 1990. The evaluation team strongly recommended to the mission that it continue its support. However, the team also recognized the mission's critical need for a broader donor base and stronger in-country management of the AIDS project if its support is to continue. Following is a summary of observations by the team:

- o The quality of the AIDS T/S project activity in the Philippines is high, and the principal AIDS T/S advisors are very well regarded. Improvements must be made in certain areas, but they are achievable. Three major areas for improvement are strong managerial direction; more detailed plans for activities which look beyond June 1990, including expansion or elimination of certain activities; and a cohesive methodology and coordination of all research and surveillance activities.
- o There is substantial potential for HIV infection in the Philippines which makes it essential that current project activities not be impeded by funding disruptions.
- o The Government of the Philippines (GOP) is supportive of AIDS prevention and control activities, and this support should be encouraged, although PVOs and NGOs should also be brought into the program. While the inability of DOH to exert stronger direction and leadership may be disappointing, it is understandable given the pressure of health problems with more immediate impact than AIDS, and given the intensity of an ambitious two-year, \$2 M effort. Contacts initiated with PVOs and NGOs in an early seminar should be reactivated.
- o The project activities related to screening sexually transmitted diseases have great potential for effectively reducing HIV transmission in the highest risk group identified to date. These

activities need to be continued over the long term, although they must be reassessed and brought together under stronger management if they are to realize their full potential.

- o Continuation of mission funding will give a far greater return for the \$2M investment than the two year period in which those funds are spent, even if other donors were to replace mission support.

c. Findings and conclusions

(1) Country strategy

AIDS T/S activities in the Philippines have all been undertaken within the framework of the DOH Five Year Medium Term Plan for AIDS, which was completed in early 1988 with assistance from both AIDSCOM and AIDSTECH advisors as well as from WHO/GPA. Thus a coherent country strategy was reasonably ensured at the outset.

However, unless stronger managerial direction is provided in the very near future, project activities will not realize their full potential, the country strategy will be fragmented, and the USAID Mission may not continue its support. Continued mission support is also contingent upon broader donor assistance.

The DOH had an active AIDS Prevention and Control Committee during 1987-88, led by an official who provided strong direction. Now, however, there is little managerial direction of activities, and the AIDS prevention committee has not kept pace with the need of the project activities for timely review and approval.

Accountability for AIDSTECH projects rests with the directors of various DOH units who receive the project grants, and accountability for AIDSCOM activity rests with a high-level public information and health education office. However, the expansion of project activities beyond the ability of DOH to manage properly, and turnover in AIDSTECH staff, AIDSCOM resident advisor, and DOH AIDS Coordinator, have weakened in-country management.

Certain AIDSTECH activities described in more detail below are, therefore, operating more independently, and more in isolation from the larger strategy originally planned. A clear vision is lacking for how results of many of these activities will be integrated into ongoing DOH programs. There is no AIDSTECH resident advisor. The AIDSCOM resident advisor has been given conflicting guidance regarding her role, receives little support or attention from DOH, and is not called upon to use her communications expertise to assist the DOH unit responsible for AIDSCOM activities.

Finally, until recently, the DOH did not welcome or seek other donor assistance. While the nature of USAID assistance is invaluable to the development and implementation of effective AIDS prevention and control strategies, broader donor assistance is critical to sound country strategy for practical and political reasons. There is a significant administrative and political burden involved in donor assistance for so comprehensive and

challenging a program, and the USAID mission can no longer sustain it alone. The DOH has requested a donor meeting, and has initiated a process for operationalizing the Medium Term Plan in preparation for the meeting.

(2) Technical (non-behavioral) activities

(a) HIV/AIDS-related monitoring

The planned AIDSTECH support for an AIDS management information system has been delayed because of lack of DOH absorptive capacity, and does not seem to have a clear purpose. The DOH capacity for surveillance of HIV incidence and AIDS prevalence is barely adequate at present and is likely to be inadequate to meet future needs. Furthermore, there is currently no central location for compilation and sharing of the varied behavioral data collection instruments and data being developed in the Philippines. There is therefore duplication even with only AIDSCOM and AIDSTECH involved. This will get worse as more donors become involved.

(b) STD strategies

CDCS upgrading of sexually transmitted disease (STD) clinics

STD treatment facilities, public or private, may well be the most important sites for AIDS prevention in the Philippines today. First, STD treatment facilities provide an excellent opportunity to educate and counsel sex workers, their clients, and others who practice high-risk sexual behaviors. Expeditious diagnosis and management of STDs may limit their effect as a co-factor in HIV transmission.

This project is intended to upgrade Clinics to provide high-quality detection of syphilis and gonorrhoea during licensing examinations as well as provide clinical management for sex workers and others presenting with symptomatic STDs. The project is appropriate in scope. However, there does not appear to have been a management-level decision to actually implement the plan and begin providing the improved services. CDCS has no real authority over these locally funded clinics. Increases in staff are needed but apparently not planned. Finally, the vast majority of STD diagnosis and treatment, even for sex workers, is provided by private clinics. These private providers must be reached.

RITM study of STDs among sex workers in Manila

This study is using state-of-the-art diagnostic technology to develop data on the prevalence, etiology, and antibiotic susceptibility patterns of STDs among sex workers presenting for licensing examinations. Collection of such data is an essential first step in planning a larger-scale program for STD diagnosis and therapy in the Manila Health Department.

The study is progressing nicely. Early results are showing substantial levels of infection with treatable pathogens among these asymptomatic women. This finding suggests that licensing examinations can play an important role in STD control. Anecdotes suggest a very positive response among the sex

workers to the improved services, attendance is up, and a number of women have expressed a desire to pay for the services even though payment has not been solicited.

While this study was apparently not originally intended to be based in this clinic, it is not currently integrated into the routine of the clinic. It seems unlikely, therefore, that the upgraded services will continue after the study ends. Continuation would require substantial training and increases in staff, as well as a willingness to change on the part of the Manila Health Department.

BRL upgrading of blood transfusion HIV screening

Although blood transfusion is currently only a very minor mode of HIV transmission in the Philippines, it is likely to increase in importance as infection levels increase. This program will provide for prevention of such transmission in public blood banks, which provide approximately 30% of the transfusions in the country.

This upgrading effort appears to be well-integrated into a larger-scale program of general upgrading of blood transfusion services. Equipment is arriving in a timely fashion. The reagents being provided are of Japanese manufacture.

Blood pooling to reduce the costs of blood transfusion screening for HIV

Blood pooling, if it is found to be practical in the Philippines, would substantially reduce the costs of HIV screening of blood transfusions. BRL is eagerly awaiting the results of the study, so that this technology can be implemented in government blood banks.

RITM/BRL assessment of the role of blood transfusions in HIV transmission, the future potential of such transmission, and the costs of prevention

This study would provide definitive estimates of the extremely low level of HIV infection in the blood supply and good estimates of the costs of prevention of potential HIV transmission through blood transfusion. It would also attempt to use hepatitis B and syphilis sero-prevalence data to estimate likely future HIV sero-prevalence.

The study has faced multiple delays including delays in AIDSTECH consultant visits. Hepatitis B and syphilis are poor epidemiologic models for HIV infection in the Philippines, and this exercise seems unlikely to provide any real insights about the potential future role of HIV transmission via blood transfusion. It did not appear that BRL had plans to make use of the study results when interviewed by the evaluation team.

(3) Behavioral intervention activities

The Government of the Philippines asked for assistance in several areas; those are used to frame evaluation observations:

To develop effective planning and management systems for the
Philippines AIDS Program

AIDSCOM and AIDSTECH were instrumental in the DOH's writing of the Medium-Term AIDS Prevention and Control Plan for the Philippines.

AIDSCOM is engaged in a broad communications effort. Their consultants are particularly well regarded. In the face of DOH management design problems, as mentioned above, they must be credited with extraordinary success in moving projects ahead.

Gary MacDonald received particularly favorable comments time after time. Also, research subcontractors often spoke of Michael Ramah and Mary Debus as being efficient, competent and instructive.

AIDSCOM must be credited with overcoming one major obstacle that AIDSTECH did not confront: The DOH did not have an array of social scientists or behavioral health communication specialists to become their local counterparts, providing a ready made management infrastructure. For the largest part, it became necessary for AIDSCOM to locate, mobilize and manage subcontractors who would get the projects under way.

In September 1988, AIDSCOM organized a meetings with other organizations--i.e., organizations with interests in the AIDS epidemic and journalists--that could both extend and support AIDS program activities and, importantly, help ensure sustainability of the accomplishments. Follow-through has been lacking, however; this will be explained in the next three paragraphs.

A strong need still exists for systematic consulting or training activity to improve the planning or management skills in DOH regarding the development of a coherent AIDS effort. The reality is that AIDSCOM technical advisors seem to have served mainly as on-site operations managers for specific projects.

AIDSCOM has employed a resident advisor, Dr. Nora Quebral. She is experienced, shared many insights and expressed herself very concisely regarding analysis of communication and management issues. She is a talented professional and a good resource for the DOH, but her experience is not being used effectively. The coordinator's effectiveness is also dependent on DOH support: while the evaluation team was in Manila, the phone in the AIDSCOM resident advisor's office was removed. While AIDSCOM provides the coordinator with a budget for Xeroxing, supplies and travel, it may be difficult to eke it out to cover added demands such as Xeroxing of voluminous questionnaires and documents to meet requests from non-AIDSCOM agencies or groups, or provide liaison with AIDSTECH activities in Olongopo and Angeles, which seems indicated in view of AIDSCOM's considerable expertise in behavioral research in the Philippines and regional projects' formulation of such research.

When AIDSCOM consultants are in Manila, they arrange meetings and ensure that proceedings of meetings are distributed; when they leave town, communication and information exchange among the different actors virtually shuts down. Better use of the resident advisor's experience, and more support for her office would sustain momentum created by consultants.

Although formation of functioning, sustainable liaisons with various concerned PVOs and NGOs, including the mass media, would be invaluable, no managerial mobilization on a continuing basis is observable. A meeting was held in September 1988 to ascertain interest, but a working management plan for ongoing collaboration and coordination still is not evident.

To build program capacity and improve staff skills in HIV prevention methodology

AIDSCOM has supplied a resident advisor, as mentioned above. There also is a part-time AIDSCOM media consultant, who has a full-time position with the Manila Chronicle. The resident advisor has minimal DOH staff support, however, in the form of secretarial assistance and an individual who prepares press releases. AIDSTECH has a sub-agreement with the Research Institute of Tropical Medicine (RITM) which contracts with Kabalikat to conduct research leading to improved STD services as a means of preventing the spread of HIV. Further sub-agreements were underway for similar purposes with the city of Olongapo.

AIDSCOM has held informational meetings for health officials, organizations concerned with health and the AIDS epidemic and journalists.

The study of health behavior processes (psychological and sociological aspects, mainly, but also cultural) is relatively new, particularly concerning sexual behaviors. The same is true of social service marketing. AIDSTECH has been supplying packets of offprints of relevant research articles that will help meet this need, as will a new series of training manuals that AIDSCOM has begun to supply to its subcontractors. Ideally, all USAID-supported subcontractors would get all materials provided by both AIDSCOM and AIDSTECH.

Members of the RITM/Kabalikat team who are working with commercial sex workers in a Manila neighborhood under an AIDSTECH sub-agreement seem interested in both training and other means of gaining insights about improvements in counselling, educational interventions and behavior-change processes. AIDSCOM has supplied this effectively elsewhere; see the Uganda report as an example. Since RITM/Kabalikat are AIDSTECH contractors, here is a case where cross-agency collaboration could be very useful.

Training about communication program management--as opposed to management of small projects--is vital to mid-term success. AIDSCOM advisors have demonstrated theory and techniques through project involvement, e.g., helping set up research or a health advertising campaign, but the need for training regarding a larger, integrated systems approach becomes predictable as communication activities evolve. Not all of this training expertise must be imported. Much of it can be handled by local institutions. However, this problem may not be addressable until the DOH can designate persons who would be participate in training.

The effectiveness of the AIDSCOM training session for journalists can be ascertained by a "bulge" of almost three months of increased reportage showing improved accuracy. However, from a managerial perspective, all the training programs should have observable or measurable performance benchmarks to enable testing of end-results; a scheme such as management by objectives (MBO)

or instructional objectives was not evident. (As examples, see Carol Weiss, Evaluation Research, Englewood Cliffs, NJ: Prentice-Hall, 1972; Robert F. Mager, Preparing Instructional Objectives, 2nd ed., San Francisco: Fearon, 1975, or Robert E. Simmons, Communication Campaign Management, White Plains, NY: Longman Inc., 1990.) It is not adequate to report only numbers of participants, topics and anecdotal observations, such as that a program was "beneficial" or "well received."

To develop and implement background research among "sentinel" populations perceived to be at risk of HIV infection

One of the signal achievements of AIDSCOM has been the completion of its basic social/behavioral research program, in conjunction with Trends Inc., among vital sentinel groups relevant to the AIDS epidemic.

The Trends Inc. organization clearly is competent, and the expertise of AIDSCOM consultants Michael Ramah and Mary Debus should be acknowledged; they helped pilot the work to swift completion and imparted technical knowledge that will benefit the contractor and others in the future.

One Trends Inc. questionnaire that was demonstrated was monumentally long; discounting the repetition of English questions in Tagalog, it probably would have been nearly 40 pages if in one language only. While such long questionnaires are tempting in order to maximize the capture of "base line" data regarding the sexuality of "sentinel groups," there is reason to suspect that such protracted interviewing may affect interviewees' attention and, more critically, quality of response--a factor that may become obvious as correlation and regression analysis are applied to the data later, since response variance often is affected. (A similar tendency toward a very long questionnaire was observed by members of the evaluation team in the Dominican Republic.)

The AIDSCOM technical advisors arranged meetings in both the United States and in the Philippines to discuss and help interpret the data.

AIDSCOM is making reasonable headway with the development and testing of a health process model. Models reduce bewildering large masses of information or data into plausible explanatory schemes about process; they are vital to management and planning, and they make research more efficient. The Trends Inc. research was characterized as KAP (knowledge-attitude-practice) studies, but AIDSCOM is undertaking relational statistical analysis to determine whether the data uphold the process model. This could provide major benefits eventually and offer insights to help refine future information, education and communication (IEC) planning. Across different nations in which AIDSCOM/AIDSTECH are involved, KAP studies will have limited utility in planning, as compared to research based on the AIDSCOM process model or other ones, such as health belief models, motivational models or other health decision models. The need for systematic exploration of data through models is vital to managerial efficiency; this would be a good reason for urging that the AIDSCOM model be used as a basis for whatever research is yet to be conducted as part of USAID's support for AIDS prevention and control.

Research in AIDSCOM/AIDSTECH projects also should explore what enabling factors external to the individual are necessary in order for the individual to act upon information and change the targeted behavior; behavior change is not simply a personal, cognitive process. The in-depth interviews by RITM/Kabalikat are likely to provide good insights on enabling factors, provided theory can be used to alert interviewers to the existence of such factors.

Our evaluation team found that Asia Research Organization and a group in Olongopo were virtually beginning anew with formulation of questionnaires on sexual behaviors and condom use--an area in which researchers at Trends Inc. already had gained considerable experience working with AIDSCOM technical advisors. Not enough attention is being paid to the sharing of health behavior theory and research expertise and materials, either among subcontractors or between AIDSCOM and AIDSTECH field operations. This contributes to redundancy in effort and delays. It also reduces the opportunities for implementation of comparable measurement instruments or items, which can make possible comparative data analysis across studies in the future.

Initiative, itself, by research partners may not solve the problem. The research project manager at Asia Research Organization reported he had been unable to get the questionnaires despite several calls to DOH.

Attention should have been given uniformly to respondents' use of specific mass media vehicles (i.e., not just "TV," but what station or program); this was done by Trends in print media questions but not for broadcast media. Such information would facilitate precise ways of selecting media outlets that would reach targeted audiences; it is not enough to know someone listens to AM radio station at 2-2:15 when there are some 30 AM stations in Manila to which he/she might be listening. Without that information in questionnaires, planners must use data from audience research services to make selection by approximation. This is a problem that might need to be discussed with AIDSCOM/AIDSTECH subcontractors, including ones in other countries.

The Trends Inc. research questionnaire that was presented to the evaluation team would have been better if it had probed respondents' judgments about the utility and trustworthiness of health information sources--particularly interpersonal sources--since that affects both use and persuasiveness. (An example that shows why the issue is worth investigating: Robert Norton and Jim Hughey, "Understanding the Exigency in Order to Craft the Rhetorical Response; Health Promoting Behavior Relating to the AIDS Virus in a Low Prevalence State," presentation to the Speech Communication Assn., 1987.)

Specification of knowledge outcomes and testing for them at the conclusion of training or campaign activities is not overly difficult. However, a great deal of thought needs to be given to how measures of behavior change can be validated. In the United States, for example, self-reporting of changes in sex behavior seems to be questionable; with so many people in specific segments saying they are practicing safer sex, STD rates should be dropping, particularly in sentinel groups.

To design, develop and implement communications campaigns about HIV infection, AIDS and their prevention for the general public and the special "sentinel" audiences

Research has been completed in sentinel groups by Trends Inc., and AIDSCOM has provided help in interpreting the data and use of the findings to focus strategy for a paid advertising campaign that would begin with the general population and then extend to the sentinel groups (young adults, sex workers, men who have sex with men, and overseas workers). Campaigns Inc., a firm whose principals have worked with J. Walter Thompson and that has had other health-related accounts, has been contracted to handle the creative activity, production and media placement; Trends Inc. is handling research pretesting on messages. The evaluation team was told the general population campaign segment will begin in January 1990, for a three-month run. AIDSCOM media consultant Horacio G. Severino has presented a written plan for promotional activities with the media, leading up to the paid advertising campaign.

AIDSCOM technical advisors were instrumental in gleaning the data and focusing on a communication strategy, with specific plans for the different segments of the advertising campaign. The over-all plan would compare favorably with anything to be found to date in the United States.

The presentation made to the evaluation team by Campaigns Inc. demonstrated a commendable level of competence, both in terms of management and creative design. The team's use of end-result objectives (like behavioral objectives in education or terminal objectives in Management by Objectives) makes it easy to determine the relevance of messages, and should make evaluation relatively easy. The campaign is heavily oriented toward TV, which conforms with research findings; even substantial percentages of commercial sex workers were found to watch television, for example. Prototype materials are under development; alternative versions of TV ads will be pretested by Trends Inc. prior to initiation of the campaign.

The DOH has provided text for informational booklets that will be produced in English and national dialects. Campaigns Inc. has the graphic design under way.

Initiation of the campaign for the general public, and the sentinel segments as well, is contingent upon establishment of a hotline service; the aim is to encourage audience members to call in for facts or for referral to further information. During the second week of the evaluation team's visit, the Population Center Foundation (PCF), which is identified as the sole supplier for the hotline service, was making final revisions on its proposal, which then subject to managerial approval processes. PCF has had extensive experience operating a "Dial a Friend" population control program hotline.

As a collateral, supportive activity, Ninoy Marcelo, a well-known editorial cartoonist, has produced prototype strips for cartoon booklets that would be produced as part of the campaign to present the AIDS messages to young adults.

A decision was made to conduct a campaign which has an "umbrella" of general information, with a message strategy with four elements: "Anyone can get AIDS," "AIDS is spread primarily through sex," "You can't tell if someone has AIDS just by looking at them," and "For more information, call the National AIDS Information Service at (phone number)." Under this umbrella, the campaign will elaborate messages to vital sentinel groups.

The DOH--particularly due to promotional activity orchestrated by Dr. Dayrit as AIDS program manager and then by his successor Enrique Hernandez--had got good coverage over time, particularly in newspapers and tabloids, but also in TV and on radio. Because the Trends Inc. data indicated awareness problems in the general population, AIDSCOM chose to build the mass campaign around the theme "Anyone can get AIDS." While we acknowledge that strategy always is open to debate, we submit that awareness-building might have been more suitably built upon the notion that inappropriate sexual and drug abuse behaviors are what put you in harm's way in the AIDS epidemic. Persons who are celibate or are in a stable monogamous relationship and do not abuse drugs are unlikely to get AIDS; messages suggesting the contrary may accentuate tension and may contribute to socially dysfunctional behaviors--e.g., in the United States where fearful individuals have refused to work with HIV-infected persons, have persecuted homosexuals, have attempted to drive HIV-infected children from school, and have fire-bombed a family's home in Florida. This comment centers on the need for health communicators everywhere to shape every possible effort toward helping the public form accurate perceptions of personal risks.

The development of a hotline, part of an information center operation, was to have been carried out by the DOH. When it became apparent they would be unable to do so, AIDSCOM sought a private contractor; it is hoped that the program will be initiated as planned to coincide with the campaign.

It is problematic whether enough brochures are being budgeted. Since the major media cannot discuss sexual practices and condoms without aggravating various factions, these brochures carry the "heavy content"; they are vital to the information effort.

If Chile's experience is taken as a guide, the hotline is likely to get 300 calls or more per week. (The Population Center Foundation in Manila averaged 200 calls a week on family planning.) If the hotline generates a high percentage of requests for brochures, beyond the number of brochures that will be distributed through counselling or training, bars, sex clinics, massage parlors, etc., the supply is apt to run out quickly. Also, planning has to factor in losses, throw-aways, etc.

Various managerial decision clearances in the execution of the campaign might have caused delays; more authorizations might have been made more quickly on-site by the DOH and the AIDSCOM resident advisor who, in this case, is a communication expert with a Ph.D.

Dependence on paid advertising to disseminate AIDS campaign messages handicaps the ability of the program both in reaching all vital groups and repeating the messages often enough to support learning and behavior change.

AIDSCOM and the AIDS program manager need to find ways to get other institutions to share the advertising expenditure burden. (Despite its costs, advertising is important; it provides superior control over message content and quality.)

Mass media in the Philippines reportedly have ceased to provide free advertising, largely due to political abuses in the past. Consequently, use of an advertising framework is more costly than in the United States, where the government's media campaign was predicated on Public Service Announcements (free time or space). AIDSCOM and the new AIDS program manager in DOH should consider approaching major advertisers with the idea of their donating time or space in exchange for "Sponsored by..." or "Time donated by ..." mentions in recognition of public service. Different organizations also might be encouraged to contribute to printing of DOH/AIDSCOM posters and brochures or even licensed to reprint them. Campaigns Inc. staff members have good ideas about things that might be done to stretch the budget--but it is not their responsibility to implement them.

Without a public relations component, the AIDS program will need heavy funding to keep messages consistently before target publics. PR recognizes that by working with journalists, media owners and managers, community groups and influentials, it is possible to disseminate information effectively and at minimal cost.

Although public relations is an institution that some people in health regard with suspicion, it has advantages that suggest it should be incorporated in the AIDSCOM activities in the Philippines and elsewhere. Most of the early activities of the DOH relating to AIDS were essentially PR activities--and relatively effective. This did not get institutionalized as a cost-effective part of the AIDSCOM plan, however. To be optimally effective, it is not sufficient to hold the occasional workshop or "press event," and send out publicity notices; to be effective, such activities have to be sustained day after day.

AIDSCOM media consultant Severino told the evaluation team that he and Enrique Hernandez, the former AIDS program manager, had begun to formulate a major strategy. That plan was not committed to paper. Severino reported this master plan was not committed to paper; a less comprehensive plan of activities was." However, it should be recognized that implementation would require full-time staffing of at least one person; this person also could manage other public relations activities. Having a publicist like Peter Resurreccion on the staff is important, but is not equivalent to providing the level of management support needed to accomplish this. However, the cost of paid advertising to do the same job would, without doubt, exceed the salary that would be involved.

d. Major recommendations

- (1) Immediately offer AIDSCOM and AIDSTECH assistance to DOH to operationalize components of the Medium Term Plan.

A prerequisite to stronger managerial direction at DOH is a practical plan for operations with clearly articulated objectives. The DOH commitment to operationalizing the Medium Term Plan offers an ideal opportunity for both AIDSCOM and AIDSTECH to address some of the problems outlined above. Specifically, use an operations plan to do the following:

- o Reassess current STD activities to develop a long term strategy, providing for integration of the RITM experience, involving private STD services possibly through a grant to the Philippine medical or other professional association, and consider providing an AIDSTECH residing advisor and increasing the regularity of on-site visits by FHI.
- o Draw upon the AIDSCOM resident advisor's expertise to develop a comprehensive communications plan which places the current public information campaign in a more appropriate context along with other strategies such as inter-personal communications, and provides an opportunity to develop the existing campaign beyond its premature end date to a more logical, long term campaign based on extensive use of the research.
 - (2) Explore with the DOH the following alternatives for stronger in-country management:
 - o DOH contract for project management, possibly using funds freed up from discontinued AIDS T/S activities.
 - o DOH create the position of a special project manager with staff to work out of the DOH Secretary's office as is apparently done for such programs as child survival, to ensure direction throughout the DOH at all levels and in all bureaus where AIDS activities are located; the AIDS Coordinator could function under the direction of such a manager.
 - (3) AIDSTECH should provide someone to give immediate managerial direction to its activities
 - o The person should secure more vigorous coordination among their project activities, and particularly ensure consistency in research methodologies among their own research efforts, and with AIDSCOM.
 - (4) AIDSCOM should clarify tasks of resident advisor
 - o AIDSCOM should work with the resident advisor and DOH to agree upon a revised job description that 1) provides her with the authority to effectively coordinate activities, and 2) makes use of her vast communications experience.
 - (5) The Mission should consider wrapping the AIDS activities up with other health activities in order to develop a bilateral health project sufficiently large to merit mission project staff.
 - (6) Focus support on compilation, analysis, and reporting surveillance and behavioral data. A centralized system might also improve coordination of seroprevalence monitoring by NAMRU, RITM, and BRL. AIDSTECH could provide such assistance, but WHO is providing it in most countries.

- (7) Reassess and develop a long term STD strategy, drawing on the RITM experience and obtaining participation of physicians who provide STD care. One possibility would be via an AIDSTECH PVO/NGO grant to the Philippine Medical Association or other professional association.
- (8) Pursue Japanese support for the BRL upgrading of blood transfusion screening, since reagents are of Japanese manufacture.
- (9) Determine whether DOH wants to continue the study on Assessment of Role of Blood Transfusions in HIV transmission, future potential of such transmission, and cost of prevention, and plans to make use of the results.
- (10) Behavioral interventions by AIDSCOM and AIDSTECH
 - o Both AIDSCOM and AIDSTECH should attempt to maximize information exchange among the various subcontractors and other funded participants in the AIDS program in order to minimize inefficiency and a sense of "team involvement." This is essential where AIDSCOM and AIDSTECH are involved in similar or complementary activities.
 - o Both AIDSCOM and AIDSTECH might consider organizing "demonstration field days," as is done in agricultural diffusion, to give groups of interested persons opportunities to visit activity sites and observe what is being done and how in different places e. g., a visit to the STD program in Olongopo would be worthwhile to show how enthusiasm and organization interact.
 - o AIDSTECH should work with AIDSCOM to establish and fund a clearinghouse operation for documents and data; service and outreach would be principal activities.
 - o To facilitate information dissemination, education, and condom marketing both AIDSCOM and AIDSTECH should consider how they might interest and incorporate private physicians and clinics.
 - o AIDSCOM should consider financing a contract position in DOH for up to two years to facilitate AIDS program networking and cooperation with the mass media, other NGOs and PVOs. The goals would be to gain increased contact with the public without resorting to advertising expenditures, and to expand the resource base of the DOH AIDS program.
 - o AIDSCOM and AIDSTECH both should combine their efforts in secondary analysis of the data collected on behavioral indicators and be prepared to disseminate the results, especially where findings contribute to theory that has broader applications.

- o Considering the high cost of supplying condoms for the AIDS prevention program should utilization ever reach desired levels, AIDSTECH should consider ways of using the data from the condom marketing studies to interest one or more firms in expanding operations in the Philippines and/or giving other support, including financing, to the condom marketing program.

3. Uganda

a. Background

Robert E. Simmons, Christine Galavotti and Lois Bradshaw worked in Uganda from September 25 to 29, 1989.

The first cases of AIDS reported in Uganda were in 1983 in Rakai District. That number grew to 9,145 by the end of June 1989. The vast majority occurs in the 15-40 age group. The male to female ratio is 1:1. Eleven percent of the cumulatively reported cases are aged 0 to 5.

A national serosurvey was completed in 1988, but results have not been fully analyzed and released. It is estimated the number of HIV-infected persons is between 457,350 (based on 50 to 1 ratio regarding known AIDS cases) and 914,500 (based on 100 to 1 ratio) in Uganda's 17 million population.

The National AIDS Control Programme (NACP) was established 1986. The National Committee for the Prevention of AIDS (NCPA), made up of both government and non-governmental organization (NGO) members, is the primary advisory body for formulating policy.

Uganda has a relatively extensive array of Information, Education and Communication (IEC) activities. The Ministry of Health has supported a widespread effort using both major mass media and small media, particularly posters. Moreover, other than activities supported by USAID and AIDSCOM, UNICEF is working on AIDS education in schools, and the Red Cross is working with youths, in first aid training and in schools, making use of field offices in districts and linkages with 400 schools.

b. Executive Summary

USAID has supported and complemented the NACP and its program since its inception. The USAID/Uganda mission identified activities to bring about behavior change and designed the Private Sector AIDS Education and Prevention Project based on a peer educator model. USAID signed cooperative agreements with two NGOs, the Federation of Uganda Employers (FUE) and the Experiment in International Living (EIL). In 1988, AIDSCOM was asked to provide technical assistance for this project. The USAID/U mission and AIDSCOM contractors work closely with NACP.

The decision to focus on development of trainers of trainers (TOT) and counsellors to deal with AIDS control and prevention, rather than a mass media approach, is both insightful and consistent with the Ugandan reality. The Ministry of Health provides reasonably extensive coverage of AIDS information through both large media (newspapers, television and radio), as well as small media (mainly posters). However, all Ugandan mass media confront serious problems as vehicles of health information that would not recommend them as a

focus for AIDSCOM activity. For example: (a) high illiteracy--especially outside of urban areas; (b) the limited number of newspapers--all cities are virtually dependent on Kampala, which has five publications; (c) the high cost of newspaper access, for example, 150 shillings an issue where a skilled worker may earn 1,000 shillings a month; (d) the high cost of radio batteries, which are vital where electricity is not available--a common condition; (e) the limited number of households reached by TV, reflecting the cost of sets, broadcast signal strength and availability of electricity; and (f) the cost and poor supply of paper, all of which must be imported, for printing.

Moreover, participation from the training of trainers and counsellors design permits greater participation by various agencies NGOs in the over-all effort.

The design shows promise of reaching large groups of people, with a strong likelihood of secondary and tertiary diffusion in both urban and rural areas. The use of trainers and peer educators to discuss and reinforce behavior change with coworkers, friends and neighbors is a good approach. In Uganda, mass communication may prove to be a helpful adjunct to interpersonal interventions.

Funding delays appear to be a substantial problem that merits AIDSCOM's attention. EIL reported that the Ministry of Planning has been as much as a whole financial quarter late in releasing funds, requiring a loan from EIL's parent organization. Other subcontractors like FUE do not have sufficient "financial float" to offset such delays in the Ugandan government's release of shilling payments. Also, FUE has been unable to establish an out-of-country dollar account. Moreover, delays in release of shilling payments complicates planning in another way: inflation erodes the buying power of local currency.

AIDSCOM training in-country for both FUE and EIL has consisted of (a) basic training on AIDS; (b) suitable methodologies such as education and prevention counselling within a TOT model; (c) evaluation criteria and materials, and (d) media development (including the use of focus groups for concept development and testing).

AIDSCOM has transmitted an implicit message to its two major subcontractors, FUE and EIL: "We trust you; tell us what we can do to help." This not only established good working relationships, but also improved confidence and initiative; it appears to improve the prospects for the sustainability of the activities. Particularly complimentary remarks have been made about AIDSCOM technical advisors Ken Dunnigan and Dace Stone.

AIDSCOM has done a commendable job in Uganda in making the subcontractors aware of the need for incorporating explicit managerial objectives and evaluation procedures in the development of training and other educational materials.

AIDSCOM has encouraged and received feedback and direction from FUE and EIL; an example is a retreat conducted recently.

In September 1989 AIDSCOM subcontractors began receiving a series of booklets dealing with health behavior, condom promotion strategies, adaptation of counselling strategies. Although AIDSTECH is not operating in Uganda, the mission also receives and distributes packets of research article offprints prepared by Family Health International (FHI).

c. Observations and Conclusions

(1) Experiment in International Living (EIL)

EIL was charged in its contract with these first-year objectives: (a) to employ and train EIL staff, (b) to procure audio-visual equipment, other equipment and vehicles, (c) to recruit eight social groups or organizations with which EIL would contract training, (d) to coordinate the development and production of training materials. EIL has its staff--a country director, an administrator/trainer, a trainer/manager and office staff--in place, trained and evidently operating well. One more trainer may be employed and trained. Equipment has been acquired. EIL has conducted training with eight organizations. EIL also has been conscientious in collaborating with FUE in the development of materials; publications still are in the draft stage.

EIL also was to develop a subcontract with The AIDS Support Organization (TASO) and serve as the funding pass-through for TASO and the National Resistance Army (NRA) project. TASO has operations well under way. The NRA project is in an early stage.

Development of an AIDS film is another project that was put under the EIL umbrella. A treatment and script have been developed and critiqued by both EIL and FUE, both of which are supposed to use the film. While the evaluation team was in Kampala, sites for filming were being selected and actors were being auditioned. The film project has added to demands on EIL for managerial oversight; the same is true for FUE.

EIL has demonstrated initiative in asking AIDSCOM to provide "upgrading" of training in four areas--team-building, listening skills, time management and advanced training and skill-building--to make operations in Uganda more effective.

EIL's training activities with eight organizations is likely to reach about 2,500 persons. In addition, there may be possible rediffusion potential.

The EIL group is clearly competent and dedicated. (In fact, this seems to be a hallmark of all the NGOs working with AIDSCOM in Uganda.)

AIDSCOM's initial training not only appears to have been effective in terms of content, but also was cited by EIL and FUE as providing models, e. g., role-playing, for the subcontractors' conduct of training activities.

(2) Federation of Uganda Employers (FUE)

The objectives established for FUE were (a) to increase the capability of FUE to develop AIDS education and prevention programs as integral parts of the health and safety programs of member employers; (b) to assist member employers in the development of long-term company-financed AIDS education and prevention programs; and (c) to train employees of member companies to be in-house staff trainers of counselors for AIDS education and control programs. FUE has two trainers and needs one more. The third trainer may be a female; because the other trainers are males, this can be important to providing suitable and accessible support for female employees. FUE has acquired a vehicle and is in the process of obtaining a new headquarters. Computer equipment has been ordered; it should help with the need for high quality production of educational materials. AIDSCOM trainers have consulted with FUE at regular intervals regarding training, evaluation and other assistance. FUE is continuing work on a "Facts about AIDS" booklet, which exists in draft form, a condom booklet and, in collaboration with EIL, a trainer's manual; the draft materials appear to be appropriate and of high quality. FUE has completed training with 19 organizations and five more organizations are targeted for fall 1989. Development of the program, establishment of cooperation and the conduct of training have taken much more time than originally anticipated, and the need for follow-up support has become evident.

AIDSCOM consultants reportedly have been very responsive to FUE needs and have cooperated rather than trying to impose activities on the subcontractor. Ken Dunnigan and Dennis Weeks were each cited as particularly helpful, especially during a recent retreat.

AIDSCOM has encouraged FUE and EIL to collaborate in production of media materials; collaboration seems friendly and productive.

AIDSCOM has provided assistance with the development of evaluation instruments; FUE has used the forms and found the feedback helpful in refining activities.

d. Major recommendations

AIDSCOM programs in Uganda definitely merit continued funding support. If possible, an addition to funding by AIDSCOM or USAID/W (or both) is also merited to shore up activities by addressing needs that were not identified or articulated in the original plans. In-country resources appear to be limited.

The USAID/U mission should seriously consider programming OYB funds for AIDS activities, beginning in fiscal year 1990, if possible.

In view of the multiple projects operating in Uganda and the coordination load that the USAID mission has had to undertake, AIDSCOM should consider providing at least a half-time resident advisor.

One stated goal of AIDSCOM/AIDSTECH has been to diffuse the experience gained in AIDS control and prevention programs in different countries. Development of an infrastructure to compile and disseminate such information merits immediate attention, since it also affects the efficiency of both management and project activities.

AIDSCOM should provide more support for the documentation of training activities and results--e. g., having someone sit through sessions in order to record and transcribe proceedings. Also, incorporation of behavioral objectives in the training manual could contribute to making both training and evaluation more specific.

Both EIL and FUE find that follow-up calls are necessary after training to reinforce or clarify earlier training and meet requests for the upgrading of skills. This offers opportunities to improve the effectiveness of training and to evaluate over a longer term the effectiveness of training plans and procedures. However, AIDSCOM budgeting of activities must take this into account. More funds may be needed to support interim reinforcement and monitoring activities.

Although training evaluation instruments that were developed with the help of consultant Susan McCombie are useful, more emphasis should be placed on assessing how training and counselling affect (a) personal predispositions to change, and (b) comprehension of viable implementation procedures that persons must learn. From a management point of view, evaluations would be more meaningful if the research were based on at least a quasi-experimental design, utilizing some control group (such as a matched work force that was not exposed to training) that could be used in comparisons. Moreover, some effort should be made to assess the impact of training on change over time. One economical approach might involve the use of a panel design; this is similar to forming one or more focus groups that would be re-interviewed periodically, with shifts between interviews being analyzed. Also, the evaluation instrument regarding the training presentations could be obtained more managerially useful information if they incorporated items from validated instruments developed to evaluate instruction, like those in U.S. universities.

AIDSCOM's health behavior process model, which formed a framework for research in the Philippines, could be used as a pattern for research in Uganda and other countries to help obtain data that not only can be used for national planning but also support cross-national analysis.

AIDSCOM should discuss with EIL and FUE how their strategies might be modified to reach more females directly and also involve journalists more extensively. The first point recognizes women constitute 50 percent of the Uganda AIDS cases; the second could produce additional coverage of the epidemic and prevention activities.

As in U.S. community health programs, AIDSCOM might consider encouraging FUE and EIL to their training sessions, to confer status to both organizations and persons who participate. This would reinforce their motivation, and perhaps encourage other individuals to seek out persons who are mentioned as "opinion leaders" on AIDS control and prevention.

AIDSCOM should consider providing an ethnographic consultant. In view of the large number of ethnic groups in Uganda, there is a great need for ethnographic research to gain insights about norms and cultural sensitivities regarding sexual behavior and barriers to behavioral change. Ethnographic interviewing of participants in training activities at different stages can provide vital information about reasons for non-implementation, implementation and continuation or discontinuation of sexual practices that are salutary to the prevention or control of HIV infection.

AIDSCOM should attempt to establish contacts with other social science researchers working in Kampala; at least one group is working on ethnography-based research on sexual behaviors.

More funds are needed for the development and production of educational materials. Also, support for desktop publishing by subcontractors, particular in the form of training, may be a realistic way to ensure the quality of the materials, a need identified by FUE due to its clients' expectations.

Because of the stress of work with persons who are victims of a lethal disease, AIDSCOM should consider providing psychological support at least on a periodic basis, to help workers cope with their own emotional issues and to prevent "burnout." Help to develop a peer group support system should be invaluable to all parties involved.

USAID/W should investigate whether AIDSTECH might be invited to provide limited technical assistance in STD/HIV testing and diagnosis as well as financing to ensure sustainability.

4. Kenya

a. Background

Robert E. Simmons, Christine Galavotti and Lois Bradshaw worked in Kenya from October 2 to 6, 1989.

The first AIDS case reported in Kenya was in 1984. By the end of March 1989 (the most recent report at the time of the evaluation team's visit), 5,949 cases had been reported.

The general spread pattern is heterosexual, with a male/female ratio of 1.3 to 2.0. The peak age categories are 25-29 for men and 20-25 for women. The seropositivity rate among female commercial sex workers in the Pumwani slum area in Nairobi has been found to be as high as 85-90 percent.

The Kenya AIDS Control Program:

In fall 1985, the Kenya Ministry of Health (MOH) established the National AIDS Committee (KNAC) advisory body.

The Kenya National AIDS Control Program (KNACP) is coordinated through the AIDS Program Secretariat.

Various groups and international organizations are active in supporting AIDS activities in the country: USAID, WHO, UNFPA, UNICEF, the European Economic Community, the Belgian government, Ford Foundation, World Vision, the University of Manitoba, Canada, the African Medical and Research Foundation (AMREF), the Crescent Medical Aid (CMA), the Kenyan Red Cross, and the National Council of Churches in Kenya (NCKK).

AIDS has been given extensive coverage in media and schools.

Progress has been made in the HIV screening of blood.

b. Executive Summary

AIDSTECH has been active on projects in Kenya since January 1988; its projects include the following: (a) an evaluation of AIDS rapid assay tests, (b) development of a blood bank data management monitoring system, (c) an intervention with truck drivers, an intervention with high-risk groups in Mombasa, (d) a KAP study with adolescents, (e) an education and counselling program of the Crescent Medical Aid Group among commercial sex workers in a suburb of Nairobi, and (f) workshops on AIDS for family planning providers.

The first project above has been concluded successfully. The second is progressing. The others have been delayed by administrative problems outside of AIDSTECH's control. To explain, AIDSTECH's efforts in Kenya must be evaluated within the national context. At the outset, when the AIDS problem was identified, the government treated it as a politically sensitive issue: The government believed the international press was blaming Kenya for the epidemic, and, beside national pride, there were obvious concerns about the adverse impact of news coverage on international tourism and other business. With the organization of the government AIDS program, the government has taken a progressive, proactive stance. However, the KNAC has undergone reorganization and the addition of subcommittees and clearance procedures; these things have added to the time required to get projects approved. Sexual behavior research still seems to be a sensitive issue; getting a proposal approved for a laboratory project is much easier than for sexual research. Furthermore, participants in HIV/AIDS activities still get confusing signals from the government. For example, shortly before the evaluation team arrived, Kenya's President Moi was reported as stating that persons infected with HIV should be isolated.

AIDSTECH contracted a resident coordinator, Dr. Barry Levy, who resigned after about a year; his replacement is Lois Lux, a health specialist with about five years' experience in Kenya.

c. Observations and conclusions

(1) Virus Research Center, Kenya Medical Research Institute (KEMRI)

One project to test three rapid assay tests and to develop a protocol manual for test application was completed promptly and efficiently. The protocol manual is being developed.

Dr. Peter M. Tukei, director of the Virus Research Center, was pleased with AIDSTECH support, and was especially complimentary regarding FHI advisor Sheila Mitchell. She was available at every stage ("always with us"), he said, and provided coordination with similar activity in Ghana that made possible a joint, comparative presentation at the Montreal AIDS conference.

Dr. Tukei reported that FHI forms for monthly accounting were easy to follow and could be related to KEMRI accounting procedures.

The analysis of the rapid assay tests has considerable importance for HIV monitoring in other countries. It provides evidence that such tests have cost advantages, can be utilized under adverse circumstances (even where distilled water must be provided along with test kits), and can be run quickly and with fewer samples (one or two) than would be economical with the Elisa machines.

Good progress is under way on the second project, a blood bank management information system. A computer programmer experienced with d-Base III, a data base software program, had been hired. Computer equipment had been ordered, and although delivery had been delayed by customs problems, that problem was on the verge of resolution. Lab assistants were collecting data from existing records to test the data base programming for suitability. This project will be valuable in the correlation of information, including about blood donor histories and STD and HIV correspondence factors.

(2) African Medical and Research Foundation (AMREF)

AMREF is supposed to develop a project (a) to provide AIDS and STD education and condoms to truckers and their sexual partners at sites along the Trans-African Highway, and (b) obtain evaluation by means of focus-group discussions and KAP surveys.

The AMREF proposal was still stalled at the time of the evaluation visit; it has not received approval from the KNAC. Dr. David Nyanwya, the designated AMREF project director, said he and a colleague have undertaken some preliminary interviewing at a truck site outside Nairobi.

The proposed project is sound. However, since AIDSTECH has put a one-year limit on the project, with prospects of a second year renewal, and the scope and budget are considerably smaller than AMREF envisioned initially, the truck driver intervention does not seem to have high priority with AMREF.

(3) Mombasa/Coast Province AIDS Committee

This project entails a 18-month project to provide AIDS education and distribute condoms to high-risk groups in Mombasa-- particularly, (a) in two STD clinics and four health centers, (b) at selected bars and night clubs, (c) at three work places and (d) in selected communities where sex workers provide services to multiple partners in their homes.

Another project proposes a KAP study among adolescents.

The projects are not under way. The province medical officer was trying to work out how funding could be received; Nancy Lamson, AIDSTECH's coordinator for Anglophone Africa, was attempting to help find a solution while the evaluation team was in Mombasa.

Although the basic research instrument for the first project has been cleared by the KNAC, it needs further development. The same is true of the proposed research design, both for baseline research and later data collection. In the first case, questions are too often vague. The obtained information would not be sufficient to either give management adequate indicators about what specific information needs should be addressed or determine whether the program has specific impacts on either learning or sexual behavioral change. In regard to the second point, even setting aside the liabilities of convenience or purposive sampling, the proposed sample sizes are so small as to create analysis problems.

The generalizability of experiences working with STD clinic clients in this project also may be questionable, since Ganjoni Clinic staff report only 20 percent of the area's prostitutes are registered and being seen on a regular basis. Clinic staff explained that 50 percent of all commercial sex workers in bars and clubs are under 18 years of age and therefore not required to be registered and subject to weekly STD screening. Efforts to attract such minors to the clinic caused a public outcry due to a perception that the clinic was condoning prostitution among the youths.

(4) Crescent Medical Aid (CMA)

This project proposes to train and support the CMA's 16 community based distributors (CBDs) in their STD and HIV prevention work. The purpose is to prepare the CBD members to provide improved STD and HIV prevention education and counselling to individuals and groups through eight health centers serving low-income areas around Nairobi, e. g., in Pumwani.

This project is not officially under way, but CMA already is working in areas where considerable numbers of commercial sex workers live and work.

The project concept, using CBD workers in STD/HIV education and condom distribution, has good potential to promote behavioral change in a high-risk population, especially in view of the credibility of the Crescent Medical Aid and interpersonal influence processes. The subcontractor (CMA) and the CBD staff are well qualified.

The evaluation team found that the CBD workers are a valuable source of information about health beliefs and behaviors of their clients; this could be investigated as a basis for planning. For example, CBD workers revealed that commercial sex workers in their areas had begun using condoms with clients, but not with husbands or boyfriends, which parallels U.S. findings. This holds implications for the planning of training or counselling, since it affects the probability of STD/HIV transmission. With ethnographic training, the CBD workers might be able to help build the base of information about sexual behaviors in the sentinel group that is being served.

Other studies being conducted in this population--particularly by Plummer and Ngugi at the University of Nairobi--may provide external information to help plan or evaluate the intervention.

d. Major recommendations

Over-all, AIDSTECH activities in Kenya are well managed, have good potential, and merit continued support. The first AIDSTECH resident advisor, Dr. Levy, played a crucial role in getting project plans shaped up. The new advisor, Ms. Lux, is essential to the establishment and advancement of AIDSTECH activities in Kenya.

Although it is acknowledged that AIDSTECH has no control over the KNAP and KNAC other than through friendly persuasion, it must be recognized that delays in getting projects approved and funded affect the potential of the programs. For example, the CBD members are ready for training now, but may lose that enthusiasm if training is delayed. Furthermore, since they already are doing impromptu AIDS education and condom distribution, the potential for a systematic evaluation of the effectiveness of the AIDSTECH-sponsored project may become compromised since the impact of the project will be increasingly confounded (intertwined) with the impact of the impromptu activities.

Dr. Therese Mulandi, the KNAC coordinator, needs to be supplied regularly with up-to-date information on AIDSTECH project activities, i.e., site reports and, where appropriate, activity updates.

KEMRI'S efficient completion of the rapid assay test evaluation left some funds. AIDSTECH might consider using the money to support quality control and assessment studies. This idea already is under discussion; it merits implementation.

There is a need for a mechanism to guarantee diffusion of information about the KEMRI evaluation of rapid assay HIV tests to parties that will not have obtained the information through the Montreal conference or scholarly publications. For example, AIDSTECH is not operating in Uganda, where AIDSCOM programs also are concerned with seropositivity testing; it was not clear that the information about the Kenya research was in circulation in the neighboring country.

Work to get the AMREF proposal approved by the KNAC's subcommittees seems largely at an impasse. If the new AIDSTECH resident advisor cannot help negotiate a solution for the impasse, the project proposal is unlikely to move forward. AIDSTECH might consider alternatives, such as another sponsor for a truck driver intervention. One possibility is the Federation of Kenya Employers.

Information about USAID-sponsored activities in other countries could be helpful to the planning and implementation of activities in Kenya. For example, members of the Mombasa group who are concerned with a work place intervention were unaware of similar programs already well under way in Uganda that might provide model plans, evaluation procedures and materials. Also, access to questionnaires from other AIDSTECH/AIDSCOM sexual behavior

studies, such as the one supported by AIDSCOM regarding young adults in the Philippines which was based in careful pretesting with focus groups, could provide guidance for the proposed KAP study among adolescents in Mombasa.

AIDSTECH needs to meet with the Mombasa group to redefine the evaluation methodology and data collection instruments.

AIDSTECH has not, as yet, developed a coherent research agenda for its projects in Kenya that involve behavior-change components. Assuming that USAID is concerned with applied or operations research on behavior change in order to reduce HIV transmission, AIDSTECH needs to take a proactive stance in developing and overseeing the research agenda, and designing and testing behavior-change interventions. Data collection should be relevant to interventions proposed, going beyond KAP surveys, especially where they ask overly broad questions about knowledge and attitudes and sexual practices. Questions about individual needs, values, motivations, relationships and environmental or enabling factors are more instrumental to the understanding of how to change behaviors.

AIDSTECH research regarding sexual behavior and change processes could make a greater contribution in the long run if it were coordinated with and comparable to the AIDSCOM health process model insofar as possible.

In the evaluation of the impact of interventions on risk-reduction among members of sentinel groups, KAP studies also are less useful than quasi-experimental research designs that incorporate comparison groups, e.g., comparison of exposed and unexposed groups, or ones that follow cohorts of subjects over time (the comments on panel research in the Uganda section are one example). Such research planning needs to be discussed with subcontractors up front, and considered in the development of the interventions.

Although careful documentation, evaluation, and follow-ups of training activities are essential, evaluations of the Kenya education and condom distribution programs should go beyond this to develop behavior research protocols including instruments, data-collection procedures and analysis plans, and examine the impact of interventions on risk behaviors.

At present, AIDSTECH does not appear to have the behavioral and operations research capability to meet the needs cited in the previous paragraph. AIDSTECH must move quickly to remedy this deficiency, so as not to lose opportunities.

The interventions planned with Crescent Medical Aid can provide good information about sexual behaviors among individuals who are at high risk; every effort should be made to systematize the collection, recording and analysis of that information. AIDSTECH might consider providing an ethnographer to help collect and summarize the experiences of the CBDs working with these men and women.

Interviews indicated that although condoms may be available in the country for programmed activities, the supply activity is erratic; AIDSTECH

needs to help develop a system that make possible increasingly accurate estimation of needs of local projects and agencies, and analysis of distribution.

5. Dominican Republic

a. Background

The AIDS case rate in the Dominican Republic is one of the highest in Latin America and prevention efforts are faced with formidable economic and cultural obstacles. Prevention activities began in 1985, with a small number of seroprevalence/surveillance and general population KAP studies conducted out of the Health Ministry Office. In 1987, the program for control of sexually transmitted diseases and AIDS, PROCETS, began with a staff of three. A Medium Term Plan for AIDS prevention during the three-year period from 1989-91 was developed by the National AIDS Commission and PROCETS, with assistance from WHO/PAHO, AIDSCOM and AIDSTECH.

PROCETS has the advantage of strong and able leadership from Dr. Ernesto Guerrero and a core of talented and dedicated staff. PROCETS has created an innovative not-for-profit organization, COIN, through which outreach activities can be conducted with commercial sex workers, gay men, agricultural workers in the batayes, arrestees and high risk youth. The Adoritrices nuns are also operating through this organization in their work with commercial sex workers. Other PVOs have also worked closely with PROCETS.

Thus, when AIDSCOM and AIDSTECH began providing technical assistance in 1988, the Dominican Republic already had an active AIDS prevention program with many strengths upon which to build.

b. Executive summary

The quality and appropriateness of project activities are generally high. Activities take place within a structured government program (PROCETS) which has strong direction and leadership with talented staff who have introduced innovations into the program, and who quickly incorporate technical skills offered by AIDSCOMTECH.

AIDSCOM efforts are integrated into the government program, and counterparts gave very high praise to the resident advisor. AIDSCOM functions independently on certain undertakings such as the research into the gay community, and they therefore need to consider how such functions in the future can be taken over by host country personnel. The AIDSCOMTECH non behavioral projects are appropriate within the country's AIDS plan but during the interim in which funding delays occurred, there were changes in the AIDS program which now necessitate careful assessment before these projects are finalized. The PROCETS director apparently was unaware of the range of technical assistance available from AIDSTECH for assessing financial implications of the AIDS program and he should be provided with more information. The female sex worker research projects supported by AIDSTECH are progressing well, have some innovative features, and are closely coordinated with AIDSCOM whose resident advisor is intimately involved.

The flow of assistance from AIDSTECH is characterized by multiple visits made by several different staff or consultants directly from the U.S., which makes it difficult to ensure accurate monitoring of needs and changing events in-country. The mission has proposed a local part-time coordinator for AIDSTECH, which the evaluation team supports. AIDSCOM and AIDSTECH approach research activities differently in the Dominican Republic, raising serious questions about future quality and comparability of research projects in the country. AIDSCOM provides continuous technical direction through its resident advisor and AIDSCOM contractors, while AIDSTECH relies primarily on PROCETS staff to carry out research and to select and supervise contractors. A cohesive strategy for research needs to be adopted, regardless of the source of support.

The mission greatly prefers to support the country's AIDS program through buy-ins to a centrally-funded project rather than develop a bilateral project as long as they feel confident that AIDSCOMTECH services are appropriate to their needs. However, their continued support will require a part-time coordinator for AIDSTECH using buy-in funds earmarked for that position.

c. Observations and conclusions

(1) Country Strategy

The host country AIDS program organization is well structured to receive and manage technical assistance. However, the assistance offered by AIDSCOMTECH as a whole, does not reflect a cohesive approach: implementation of AIDSTECH-supported activities has been plagued by problems related to processing funding arrangements in a timely manner; there have been delays in start-up of project activities; project components appear fragmented, without an appropriate level of coordination; some technical assistance has not had continuity in follow-up. In addition, the overlap with AIDSCOM in the area of behavioral research and interventions has potential for interfering with a coherent research agenda for the country.

(2) Technical (non-behavioral) activities

AIDSTECH projects for blood screening and surveillance have been delayed in part as a result of the Brooke Amendment. However, the sub-agreement process requires time for project development, host country and USAID mission and central office approval, and in-house AIDSTECH review and approval, thereby making projects very vulnerable to delays of any kind.

The proposed surveillance project did not appear to be totally responsive to the needs, in part because there is no continuous AIDSTECH presence to monitor changing conditions during the lengthy period required from project development to start-up. PROCETS staff expressed a desire for follow-up and continued support for the one-time technical assistance provided last year by Dr. Pollock; and there were complaints about the inefficiency of the reporting and analysis process for already existing HIV information. The proposed surveillance project in its current form does not directly address these issues.

The use of multiple staff and consultants for AIDSTECH activities is a source of confusion to the staff. For example, the research unit director thought he had been given authority last February by a consultant on the blood screening project to initiate activities and make commitments to professionals who make up the advisory group. He had a record of attendance at meetings, presumably to back up any expenditures incurred, and copies of preliminary instruments for data collection which had been developed before he was informed that the project had not yet been authorized.

The PROCETS Director said he was not aware that he could receive assistance through AIDTECH in health care financing. AIDSTECH staff apparently did describe such assistance, but it may have gone unnoticed due to lack of AIDSTECH presence to raise the issue in the host country at opportune moments and in contexts which might evoke more response. The director expressed a desire to assess the costs of many existing and proposed interventions in order to better weigh options for funding sources and for alternative interventions; to estimate expanding costs of caring for AIDS patients; to explore the feasibility of cost recovery for various existing and proposed interventions; and generally, to identify methods for assessing cost issues on an on-going basis.

The multiplicity of technical assistance areas available through AIDSTECH and the strategy of funding through sub-agreements any of a variety of technical interventions, makes it nearly impossible to use a resident advisor with a particular area of technical expertise. The mission has proposed diverting buy-in funds to pay for half of a local AIDSTECH coordinator.

There is as yet no long-term STD strategy, even though the two AIDSTECH high risk intervention projects are ultimately aimed at strengthening STD services. There is great interest in at PROCETS at reducing STDs and some data analysis has been done to show the link with reduced HIV infection. However, the interest most recently translated into a decision by PROCETS to divert scarce communications resources toward an STD campaign. A long-term STD strategy could ensure that such efforts make the best use of resources.

(3) Behavioral activities: research, communication and education

(a) Public education

AIDSCOM has placed a resident advisor with sound communication training and experience in the Dominican Republic. The expertise of the resident advisor is recognized and valued by the PROCETS staff. There have been two foci of the electronic media campaign: a radio campaign directed toward lower class audiences and a television campaign directed toward middle class audiences. The ad agency, Y & R/Dameris, has developed a number of creative posters for diverse audiences; these have required some revisions by the resident advisor to increase cultural appropriateness. In addition, several electronic billboards displaying the AIDS hotline number are in place throughout Santa Domingo. The AIDS hotline is operated by rotating medical interns and receives approximately 37 calls a day.

PROCETS staff feel that the theme of the media campaign for 1990 should focus on STD control, because of the finding of significant coinfection of HIV and STDs. This has led to some conflict with the AIDSCOM resident advisor who feels that AIDS prevention should be separated from the social stigma of STDs. This conflict presents the opportunity for controlled operational research on the content of two different public information approaches. Operational research on the effects of different messages must be built into the design of education campaigns if meaningful information is to be transferred to other countries.

This conflict also presents an important opportunity for institution building by the resident advisor. Working with PROCETS staff to teach them principles of persuasive communication will have long-term benefits for the program. The resident advisor stated that he has trained five people in pretesting procedures. It will be important for him to progressively emphasize a teaching role with his program counterparts, such as helping them to work directly with the ad agency, and to assume a less directive role so that dependence on his expertise is gradually diminished.

The hotline appears to be a weak link in the public education program. Although it is likely that it is used primarily by middle and upper income people, it could serve as a useful indicator of message impact. It appears that the data are not now being used in any systematic way. AIDSCOM should take a role in assisting with coordinating training, establishing quality control procedures and monitoring the data that are collected.

(b) KAP study and communication strategy for gay/bisexual men

In general, the plan for development and implementation of the KAP study and the communication/education strategy for gay/bisexual men is excellent. The contractor for the survey, Computematodos, seems competent and sensitive to the target group. Focus groups were appropriately used to identify significant characteristics of the target group. AIDSCOM's assistance has been valuable in helping PROCETS (1) develop a systematic, proactive strategy with clearly defined stages of activities; (2) target specific surveys and interventions to risk groups, such as gay men, rather than more globally to the general population; (3) make use of previously untried methods, such as focus groups. It is clear that AIDSCOM has the expertise for providing an appropriate level support for this kind of activity.

The survey instrument is quite extensive and appears to serve the goals of providing basic, descriptive information about the "phenomenology" of sexual behavior and also guiding the development of prevention approaches/messages. However, large exploratory studies can result in an overwhelming volume of data that are often not used, in addition to placing such a burden on respondents that response rates are reduced. There was no indication from interviews that explanatory models, based upon health behavior theories, existing literature on gay male KAP, or AIDSCOM's own process model, were used to provide limitations or structure to the conceptual topics measured in the instrument. Survey questions should be selected to measure discrete conceptual categories that have been justified a priori, based upon their usefulness for meeting the survey goals.

In addition, the AIDSCOM resident adviser and contractor did not seem to be aware of any prior literature search conducted for the development of the KAP instrument. For instance, in the U.S., one of the major findings of studies of gay male sexual behavior is that perceived social norms are a significant predictor of compliance with "safe sex" recommendations. Although it may be argued that such findings may not be applicable across cultures, such results, and associated models, should be made available as a reasonable basis for the development of initial focus group questions or KAP survey topic categories. The resident adviser and contractor had not taken this particular finding into account in their project.

Analyses for the resulting data should also be planned ahead. There did not appear to be any written plans for the specific analyses that will be conducted. AIDSCOM should assist COMPUMETODOS and PROCETS staff in designing appropriate analyses.

Finally, if the methodology from this study is to be transferable to other countries, it will be important to conduct a process evaluation of the design, implementation and problems encountered. AIDSCOM should assist PROCETS staff in overseeing this documentation process.

(c) KAP study and communication strategy for women with multiple partners

Although a number of peer health educators are working among the female sex workers, the KAP study upon which communication strategies will be ultimately based has not yet begun. COIN and the project principal investigator, another independent contractor, are coordinating the survey. Focus groups have been used as a basis for developing the interview schedule. A careful process of screening and training the peer interviewers is underway. The quality of the information obtained from the interviews should be quite good, using these methods.

Focus group results revealed that sex workers do not use condoms with their "husbands" or steady partners, which was apparently surprising to PROCETS staff. Yet research with prostitutes in the U.S. has described this and found it to be a significant predictor of HIV infection. As noted for the KAP study of gay males, it would be useful if staff could have been provided with an extensive review of the existing research literature as background for development of this project. Also, PROCETS staff mentioned that the regular technical assistance of an anthropologist with training in the belief systems and customs of risk groups, such as sex workers, and knowledge of ethnographic, qualitative research would be valuable.

AIDSTECH is providing funding and some technical support for this project. However, there is some confusion among PROCETS staff about their role and it is not clear that they have made any substantive contributions, beyond providing funding and some general monitoring. Under a collaborative agreement with AIDSTECH, the AIDSCOM resident adviser has provided significant technical assistance in designing the interviewer screening criteria and reviewing the survey instrument. The design of this project appears to be considerably influenced by the resident adviser.

Research and interventions such as this project require regular, ongoing monitoring and assistance. AIDSTECH does not appear to have the professional applied behavioral research staff or a body of carefully conceptualized explanatory models upon which interventions would be based. Thus AIDSTECH should be commended for coordinating with AIDSCOM to maintain consistency in the D.R., and to capitalize on AIDSCOM research expertise and the background of their subcontractors.

However, the experience raises an issue for USAID strategy. Behavioral research and interventions require regular monitoring and ongoing technical support, if quality products are to result. Technical assistance visits every few months will not be effective, especially for countries with few research-trained personnel. Regular monitoring of contractors is also necessary. It is clear that the AIDSTECH-supported research has been enhanced because of the consistent availability of the AIDSCOM resident advisor. A resident advisor, or at least frequent, regular technical assistance, should be provided in those countries conducting behavioral research, if USAID or project staff want to ensure systematic development of behavioral change interventions, or consistency in AIDS research methodologies.

(d) Condom instructional material

Condom instructional materials were developed based upon the results of an in-depth study of condom use by commercial sex workers. Instructional stickers, along with condoms, have been placed in motels especially designed for brief sexual liaisons, and in brothels.

The prototype for the stickers were adequate for the intended audiences, commercial sex workers and their clients, but not for others who use the same motels.

It is very important that operational research be built into the design of intervention projects such as this if generalizable results about program impact are to be obtained. There was no evidence of plans to conduct impact studies, such as limiting initial distribution of the stickers and then assessing evidence of that condoms were used. AIDSCOM should help PROCETS staff explore feasible evaluation designs for each intervention.

(e) Training

AIDSCOM has arranged for the training of trainers of peer health messengers using a two-week workshop on participatory teaching-learning methodology. This was well received by PROCETS staff and representatives of PVOs. Subsequently, manuals for experimental training have been developed.

Training for peer health messengers, counselors and others involved in individual health education is crucial for motivating sustained behavior change among those engaged in risk behavior. Technical assistance in this training is an appropriate focus for AIDSCOM activities. Mass communications may reach more people and raise awareness, but individual counseling has the potential for producing long term attitude and behavior change, assuming that health

educators/counselors have been given adequate training and supervision. Because the design, development, and evaluation of training materials are labor intensive activities, AIDSCOM should consider assigning a full-time staff member to this role.

- d. Major recommendations
- o Implement proposal by USAID Mission to hire someone locally who would serve as half-time AIDSTECH coordinator.
 - o AIDSTECH should assess their current technical, non behavioral strategy in order to up-date proposed projects which have been delayed, e.g., ensure that flaws in existing surveillance activities are taken into account. This assessment should include renewed discussion with the PROCETS Director about the range of activities that could be undertaken in the area of health care financing, financial feasibility of interventions, and cost recovery of different services.
 - o Although AIDSCOM and AIDSTECH are collaborating on the AIDSTECH intervention, consideration might be given to having behavioral research and interventions in the D.R. coordinated and supported by AIDSCOM. If necessary, AIDSCOM may need to expand its resources, or the commitments of its subcontractors, to support the expansion of these activities. In part because of the limited amount of applied behavioral research expertise and lack of a continuous professional staff presence, AIDSTECH should consider limiting its involvement in behavioral research and interventions in the D.R., and concentrate on further development of assistance in needed areas, such as health care financing and support/training for STD detection and treatment. The current overlap of AIDSCOM and AIDSTECH activities could interfere with development of comparative AIDS research in the Dominican Republic despite efforts to collaborate.
 - o The importance of operational research built into the plan for each IEC activity cannot be overemphasized. Whenever possible, intervention methods/messages identified through focus groups or KAP surveys should be evaluated for impact using experimental or quasi-experimental designs. This is most likely to result in products which are exportable to other countries. This goal may be achieved by the end-of-project indicators and criteria developed by AIDSCOM and AIDSTECH.
 - o KAP surveys should be limited and focused to answer specific conceptual questions, specified from the start. An analytical framework for each survey should be prepared before a survey is finalized, listing the purpose of each question and

describing how information is to be used. Technical Advisory Group recommendations suggest specific survey foci, such as investigation of factors that predict how behavior change is effected and information that can be used to help design education materials. Survey questions that are not defensible in terms of their clear usefulness in meeting such specific objectives will likely yield data that is not used. In guiding the selection of appropriate questions to meet these kinds of objectives, AIDSCOM should provide a thorough background review of the research literature on variables such as predictors of behavior change that might suggest intervention approaches (such as attitudes and perceived social norms), rather than just outcome measures.

- o Budget restrictions may encourage the tendency to try to cover too many variables in one study. A reassessment of whether budgets for research are adequate, in view of realities discovered since AIDS T/S went in the field, is needed.
- o Process evaluation should be an integral part of the design of all interventions, rather than just planning to repeat KAP surveys with the target group after a period of time. AIDSCOM should provide guidance to country program staff in understanding the importance of and implementing ongoing documentation/monitoring systems for each intervention (such as the number of sex workers successfully and unsuccessfully reached by each mensajera). Such data will not only provide evidence of program problems and successes, but will be useful for other countries wanting to replicate the interventions.
- o AIDSCOM and AIDSTECH staff, particularly those in resident positions, need to develop a conscious technique for implementing their role in institution-building. While they may need to implement or direct some program components initially, they must give conscious thought to bringing in host country staff as quickly as possible, (assuming that there are available counterparts.) It is a challenge for AIDS T/S to assert a certain degree of control over research to ensure systematic development of proven methodologies, yet in the long run to place responsibility on host country counterparts to ensure institution-building.

VI. RECOMMENDATIONS

A. Project Design

- o The AIDS T/S agenda, particularly non-behavioral activities, should be reviewed, narrowed, and prioritized in concrete terms so that the features of the project design are clear, and the contracting institutions can more accurately assess whether the mix of staff expertise matches the balance of priorities. Observations from the Kelly report are relevant here and should be reviewed. (pp. 12-19 and 25-26)
- o Changes in the agenda should be formalized in contract amendments form.
- o USAID and the contracting institutions should agree on a coherent research agenda for AIDS T/S if the results of all behavioral research are ever to be synthesized. "Coherent" includes standardized use of research jargon, precise terminology, and direct links between the agenda described in documents and decisions made in the field that determine scope and length of survey instruments. Observations from the Kelly report are relevant there and should be reviewed. (pp. 8-10) The following issues are especially pertinent and should be resolved.
 - Should AIDSTECH enter more heavily into applied behavioral research either directly or through sub-agreement where AIDSCOM has more developed methodologies, and has amassed considerable expertise?
 - If so, how will AIDSTECH ensure that research methods have a basis for comparison with AIDSCOM research, especially within the same country? (e.g. surveys among sex workers in the Philippines)
 - How will the use of sub-agreements by AIDSTECH build in assurances of validity and quality of research, including requirements for technical direction from AIDSTECH staff or local contractors?
 - How will the overall AIDS T/S expansion of behavioral research activity affect other needed technical assistance to strengthen the capacity for strong AIDS efforts within host countries?
- o Both projects should now develop and implement an articulate plan for activities focused on extracting and applying lessons learned from interventions. Professionals with planning and evaluation design experience should be assigned this task. The plan should start with specific guidelines to ensure that field personnel build in measures for every intervention, and document the process used for

developing the interventions. Resulting activities should be systematic and according to a timetable.

- o The role of AIDS T/S, particularly AIDSTECH, in future world-wide AIDS surveillance efforts should be specified. If AIDS T/S is to make any contribution at the country-specific level, certain activities should already be underway, such as evaluation and upgrading of data collection, reporting, and analysis capabilities; methods for selection, testing, and reporting on sentinel populations; training and equipment related to informational activities. The time lag is significant between strengthening country-specific capabilities and achieving a regional and world-wide surveillance capability.
- o USAID should explore ways in which WHO/GPA and AIDS T/S resources can be more closely related to each other on a country-specific basis.
- o AIDSTECH should consider preparing a more explicit description of technical assistance in AIDS financing that can be offered to host country program directors to help them answer concrete and practical financial questions now, which will arise in the next few years. Questions would include how much it will cost to continue to operate existing AIDS strategies, how much condoms will cost if targets for condom use are met, what cost recovery mechanisms are used elsewhere. This offer of technical assistance may need to be marketed so its value is better understood.
- o USAID should determine how best to ensure that the overlap of AIDSCOM and AIDSTECH activity, primarily in research, interventions, and evaluations related to sexual behavior, does not impede the systematic development of behavioral change methodology. Consideration might be given to assigning contract responsibilities within USAID by functional area rather than by contract institutions.
- o USAID and the two institutions should clarify the built-in conflicts of AIDS T/S strategy described above in which institution-building, use of sub-agreements, goals for sustainability, and use of mission and regional buy-ins seem to be conceptually inconsistent with any strategy aimed at systematic development of proven interventions by AIDS T/S, which implies far more control over research and development activities than the other strategies would allow. Observations in the Kelly report are relevant here (pp. 6-10).
- o Clarification should be integrated into an evaluation framework within which the final project evaluation should take place in three years.

B. Project Management

- o An examination should be made of existing coordination and administrative burden on both projects with a view to reducing demands which result in so many meetings, communications, and reports. Time, energy, and resources should be diverted to the task of systematic, long term information-sharing and application of lessons learned among professional staff, consultants, and host country personnel.
- o The team supports the movement toward hiring deputy directors who should concentrate on day to day operations as described above, freeing up project directors to systematically plan, evaluate, and shape future direction of AIDS T/S.
- o The AIDSTECH scope of work must be reduced to a more manageable size. This should occur through the agenda clarification recommended above.
- o The team supports the AIDSTECH move toward the use of more local coordinators as is being done or contemplated in Kenya, Philippines, and the Dominican Republic, as a means for achieving faster decision-making and enhancing sustainable programs.
- o AIDSTECH should select and analyze the process for approval of certain sub-agreements which took varying lengths of time to become operational to determine whether it is possible to shorten the time period. It should detail the trade-offs, such as more staff time to assist host countries in document preparation and field visits to meet with authorities involved in the approval process.
- o Once the long range plan referred to above is launched, providing systematic information-sharing and application of lessons learned, AIDSCOM and AIDSTECH staffing should ensure that responsibility for this function is institutionalized.
- o More managerial attention should be given in every project to both the clarification of objectives and an effective methodology for evaluation. Without objectively stated criteria for intended end-results and a structured evaluation research agenda to determine whether the objectives are met and can be attributed to a particular project, the basis for both the assessment and sharing of AIDS T/S experiences and achievements is problematic--especially in behavioral interventions. Moreover, a deficiency in this management area restricts the feedback that can be used to make future planning more efficient.

C. Program Performance

Country-Specific recommendations are found in each country report. In this section, an effort is made to synthesize recommendations that seem to be most common across all countries. Performance is generally rated very highly by the team. Many weaknesses stem from defects in the Project Design. Therefore, recommended improvements in the design such as a narrower, prioritized agenda of technical activities, a coherent research agenda which clarifies the role of AIDSTECH, and a long-range, articulate plan for extracting and applying lessons learned, will ultimately promote even better performance.

- o Consideration should be given to use of more local coordinators and resident advisors or other mechanisms for continuous, on-the-ground oversight and assistance. If the contractors cannot field more staff because they have reached the limits of their resource capabilities, then the question must be consciously addressed by USAID and the two contractors whether the existing number of country interventions is more desirable than fewer interventions with more resources allocated to each. The question is complicated by the mission buy-in strategy which has dictated the degree to which the contractors can limit the number of interventions.
- o The delays which have plagued many AIDSTECH projects need to be reduced, in part by implementing the recommendation under Project Design calling for a clarification and narrowing of agenda, the recommendation under Project Management for analyzing the sub-agreement process, and the recommendation above calling for use of more local coordinators.
- o AIDSCOM and AIDSTECH should provide field personnel with more explicit guidelines for the development and implementation of applied behavioral research projects in order to ensure that (1) they are consistent with models, theories, and philosophies expressed in AIDS T/S documents, and (2) that they contain the requisite evaluation designs, built-in measures, and process documentation that will permit extraction and application of lessons learned. Such guidelines can be prepared following implementation of the recommendations under project design calling for a coherent research agenda and resolving the issue whether AIDSTECH should continue to expand its applied behavioral research activities, and calling for an explicit plan for information dissemination.

ANNEX 1

Scope of Work

REVISED
AIDS TECHNICAL SUPPORT PROJECT INTERIM EVALUATION

I. BACKGROUND

The project entitled AIDS Technical Support is implemented principally through a Cooperative Agreement between the U.S. Agency for International Development (USAID) and Family Health International (FHI) of Research Triangle Park, N.C. and through a contract between USAID and the Academy for Educational Development, Inc. (AED) of Washington, D. C., with its subcontractors, the Annenberg School of Communications, Johns Hopkins University, Porter/Novelli, and the PRISM Corporation. The project commenced with obligation of funds in September 1987 and the Project Assistance Completion Date (PACD) is September 30, 1995. The total estimated cost of the project is \$68,000,000, of which \$31,000,000 is expected to be Mission or Regional Bureau project funds. The portion of the project implemented by FHI is known as AIDSTECH and that implemented by AED, the public health communication component, as AIDSCOM.

The AIDS Technical Support Project is designed to strengthen the capacity of developing countries, and their health delivery systems in particular, in AIDS prevention and control through technical assistance, applied research, and procurement. The project complements the World Health Organization's Global Program on AIDS (WHO/GPA) by providing additional technical and commodity resources to those LDCs which request assistance. AIDSCOM develops and demonstrates effective public-health communication strategies, prevention counseling approaches, and methods for marketing condoms. AIDSTECH provides technical assistance and training in high-risk behavior change, identifying effective and affordable methods for keeping blood supplies free of HIV, monitoring the pandemic, and improving the logistics of condom distribution. AIDSCOM and AIDSTECH staff provide developing countries with appropriate technical assistance for establishing programs to inform people about HIV infection and how it is spread, to help people understand and practice risk reduction, and to ensure safe blood supplies.

The project paper calls for two interim evaluations to provide a detailed assessment of project organization and development, project management, project outputs, and to make recommendations for project improvement. This is the first of these interim evaluations.

II. PURPOSE OF THE EVALUATION

The general purposes of the interim evaluation are to: (1) assess the organization and development of the project from its inception up to the time of the evaluation; (2) assess the efficiency of both AIDSCOM's and AIDSTECH's management in such areas as planning, budgeting, staffing, documentation and

communications; (3) review the overall performance of the project in terms of outputs and reassess the appropriateness of planned outputs; (4) assess the effectiveness of the project's working relationships, that is, between AIDSCOM and AIDSTECH, with the WHO/GPA and other donors, and with other projects and host country governments; and (5) prepare recommendations for changes or actions to improve the effectiveness and efficiency of the project.

III. EVALUATION PLAN

A. Evaluation Team

The team, consisting of three professionals, will be responsible for reviewing and revising/refining the scope of work and for conducting the evaluation with the CTOs, and for preparing and writing a draft and final evaluation report. A draft evaluation report will be provided to the CTOs for comment prior to its finalization by the evaluation team. The three members of the evaluation team will have the following expertise:

- Team Leader
Public Health Administration Specialist
- Epidemiologist
- Communications Expert

The team members will have professional working experience in LDCs and the team members who travel to the Dominican Republic will be Spanish-speaking.

Contractor is requested to contract, coordinate and make travel and accommodation arrangements for the three team members, pending the standard clearance procedures with involved USAIDs. Contractor is responsible, through the Team Leader, for the typing and reproduction of the evaluation report.

Contractor will identify candidates for the evaluation team, and will submit their names and specialities to the project Cognizant Technical Officers (CTOs) for their concurrence that the proposed individuals are suitable for the assigned task. In the event the prospective candidates are not selected or are otherwise unable to serve as members of the evaluation team, Contractor will then identify other alternative candidates.

B. Evaluation Timetable

1. The evaluation will be conducted in September and October 1989 in Washington, D. C., Research Triangle Park, N.C., the Philippines, Dominican Republic, Kenya, and Uganda.
2. The team will meet in Washington, D. C. for an initial planning meeting to:
 - clarify scope of work;
 - design the evaluation process;
 - develop a plan of action;
 - draft an outline for the evaluation report.

Team members will spend time interviewing AID/W staff and at AED interviewing staff and reviewing documents. Team will go to Research Triangle Park, N.C. to interview FHI staff and review documents.

Timetable: September 5-8, 1989

3. Over a five-week period, two of the three team members, plus one AID/W staff person, will make site visits to four countries as follows:
 - Philippines: Communications Expert and Team Leader

Timetable: September 11-22, 1989

- Kenya and Uganda: Communications Expert and Epidemiologist

Timetable: September 25-October 6, 1989

- Dominican Republic: Team Leader and Epidemiologist

Timetable: October 9-13, 1989

4. The Team Leader will be responsible for the preparation of the evaluation report, bringing together reports of other team members.

Timetable: Team member reports due to Team Leader within 5 days following end of final site visit; draft of final report due to CTOs within 10 days following end of Dominican Republic site visit; CTOs to return comments to Team Leader within one week; final evaluation

report due within one week following receipt of CTO comments.

IV. SCOPE OF WORK

Major areas to be considered for this assessment fall under the broad categories of: (A) project design; (B) project management and implementation; and, (C) project performance. Suggested key questions in each of these categories follow.

A. Project Design

1. Are the original assumptions still valid?
2. Is the project appropriate in terms of its planned outputs?
3. How has scope of work changed?

B. Project Management and Implementation

1. How is the project structured? Is the current internal management structure of each of the contractors appropriate for successfully carrying out goals and objectives? Is the scope of work for each now clear?
2. Are AIDSCOM and AIDSTECH each structured to achieve maximum effectiveness and efficiency? Are they adequately and appropriately staffed? Does staffing reflect the most effective utilization of expertise available in the United States? Are there gaps in expertise? Do they have enough consultants, and do consultants possess the right skills? Are consultants adequately prepared before going to the field? Has the staff exercised sound technical, fiscal and management skills in implementing the project?
3. Is current short-term technical assistance responsive /adequate to tasks requested? frequent enough? consistent enough? Is it timed appropriately? Should more long-term technical advisors be placed in the field?
4. Is project documentation adequate? Are subagreements for in-country activities timely, clear and in adequate detail?
5. Is the project making the best use of available resources? Have project expenditures been in line with projected costs in the budget?
6. Are current methods of financial tracking adequate? Are there appropriate financial controls in the field to track expenditures? Is there adequate expenditure feedback to missions on their "buy-ins?" Has "buy-in"

process slowed or inhibited implementation, and if so, how?

7. How well has the project worked with Missions, WHO/GPA, other donors, host country governments, NGOs and others? How well have AIDSCOM and AIDSTECH worked together at headquarters and in the field ?

8. What is the relationship of the A.I.D./contractor program activities in-country to WHO/GPA national plans?

C. Project Performance

1. What are major activities being carried out? Do they represent an appropriate response?

2. Has the project developed or is it developing models and methodologies which can be replicated in other sites?

3. Have in-country and regional training efforts been sufficient and appropriate? Is there enough participant travel, and are selected sites for training useful? Have participants benefitted from attending the International AIDS Conferences and are AIDS programs strengthened by Conference attendance? Which type of training (in-country, third country or regional, international) seems to be the most beneficial?

4. Is provision of commodities adequate? Are commodities provided in a timely way and in sufficient quantity? Should commodities be high priority?

5. Are materials production and information dissemination activities adequate? Are the right people receiving the right materials?

6. Are there currently "lessons learned?" Are adequate monitoring/evaluation tools in place to ensure measurement of interventions/ effectiveness and to refine methodologies?

7. Is there clear movement toward development and implementation of coherent in-country programs for AIDS prevention and control?

8. How have research components performed? Are they structured to move forward the state-of-the-art?

9. Are guidelines developed by AIDSCOM and AIDSTECH compatible with and non-duplicative of WHO/GPA's guidelines?

ANNEX 2

Persons Interviewed

ANNEX 2

Persons Interviewed

Washington, D.C.

Dr. Jeffrey Harris, AIDS Coordinator
A.I.D./S&T/Health

Dr. Lois Bradshaw, Deputy AIDS Coordinator
A.I.D./S&T/Health

Robert Wrin, Outgoing AIDS Program Staff
A.I.D./S&T/Health

Ken Bart, Director
A.I.D./S&T/Health

Clifford Block
A.I.D./S&T/Education

Brad Langmaid, Assistant Administrator (Acting)
A.I.D./S&T

Nicholas Studzinski
A.I.D./Asia Near East Bureau

Paula Feeney, Chief of Health, Population and Nutrition
A.I.D./LAC Bureau

Dr. William A. Smith, Director
Academy for Educational Development

Dr. Glen Margo, Director
AIDSCOM

Pia Chesnais

Michael Ramah

Dace Stone
Johns Hopkins University

Michael Helquist

Katherine Carovano

Gary MacDonald

Raleigh, North Carolina

Dr. Malcolm Potts, President
Family Health International

JoAnn Lewis, Vice President of Programs
Family Health International

Dr. Peter Lamptey, Director
AIDSTECH

Sharon Weir, Research Associate
AIDSTECH

Dr. David Sokal, Epidemiology Specialist
Family Health International

Sheila Mitchell, Laboratory Specialist

Jim Spilsbury, Project Coordinator for
Francophone Africa
AIDSTECH

Ellen Weiss, Project Coordinator for
Latin America
AIDSTECH

Paul Giannone, Project Coordinator for
Asia and Near East
AIDSTECH

William Schellstede, Senior Vice President
Family Health International

Robert Hughes, Vice President of Administration
Family Health International

Lynda Cole, Associate Director, Administration
AIDSTECH

Nancy Lamson, Project Coordinator
Anglophone Africa

Diane Cattoti, Program Officer

Philippines

William Johnson, Chief
Health and Nutrition Division/USAID

Dr. Kenneth Farr, Health Officer/AIDS Project Manager/USAID

Dr. Rosendo R. Capul, M.P.H.
Public Health Advisor

Dr. Nora C. Quebral, Resident Advisor
AIDSCOM

Dr. Manuel M. Dayrit, Chief
Public Information and Health Education Service
DOH

Dr. Erlinda Querrero, AIDS Registrar

Dr. Ofelia Monzon, Consultant
Research Institute for Tropical Medicine

Ms. Teresita Marie Bagasao
KABALIKAT

Dr. George Petersen
WHO

Dr. Edwin Godwin, Epidemiologist
WHO

Ms. Yoly Villanueva-Ong, President
Campaigns, Inc.

Gene Farol, Creative
Campaigns, Inc.

Bong Osorio, Management Supervisor
Campaigns, Inc.

Dr. Magdalena de Jesus, Division Chief
Health Manpower Development
and Training Services, DOH

Bong Quirante, Accounts Executive
Asia Research Organization

Ms. Rosario A. Henares, President
Asia Research Organization

Dr. Jesus Abella, Chief
Communicable Disease Control Services
DOH

Dr. Tomas Maramba, Acting Director
Bureau of Research and Laboratory
DOH

Dr. Generoso Espinosa, M.P.H.
City Health Officer
Olongapo City

Dr. Curtis Hayes, Scientist
NAMRU

Capt. G.L. Navarro Jr., Commanding Officer
U.S. Naval Hospital, Subic Bay

Dr. Eloisa Tlocson, Medical Advisor
DOH

Maria (Loy) Corazon Teoxon, Medical Specialist
DOH

Dr. Conrado Lorenzo, President
Population Center Foundation

May Corpuz, Project Division Officer

Wynny Aberoelia, Project Officer
Dial a Friend

Richard J. Gordon, City Mayor

Horacio Severino, Public Relations Advisor
AIDSCOM

Peter Resureccion, Staff AIDS Publicist
DOH

Kenya

David Oot, HPO
USAID/Kenya

Dr. Peter M. Tukei, Director, Virus Research Laboratory
Dr. Jack Nyamongo
Kenya Medical Research Institute (KEMRI)

Dr. David Nyamwaya, Director, Dept. of Health Behavior and Education
African Medical and Research Foundation (AMREF)

Mr. Mohammed Hanif, Administrator
Mrs. Fawzia Hassan
Crescent Medical AID (CMA)

Mrs. Elizabeth Ngugi
Dept. of Community Medicine, University of Nairobi

Dr. G. Obwange, Province Medical Officer (Province Commissioner's office)
Dr. Esther M. Getambu, Secretary, Province STD Committee
Dr. K. Mandilaya, Chief Pathologist, Coast Province General Hospital
Mr. Anderson P. Kahindi, Health Education Officer, Municipal Council of
Mombasa

J. Kirima
Dr. S.A. Jivanjee, Physician, Coast Province General Hospital
Mombasa/Coast Province AIDS Committee

Dr. Odongo, Coast Province General Hospital
Dr. Lugugo, Ganjoni Clinic
Coast Province General Hospital and Ganjoni Clinic

Dr. Therese Mulandi, KNAC Coordinator
Dr. Peer Sieben, WHO/GPA Team Leader
Kenya National AIDS Committee

Art Danart, Director
Vic Barbiero
Joe Wiseman
Regional Economic Development and Service Organization (REDSO)

Jane Adar, AIDS Coordinator
Maendeleo AIDS Program

Ms. Lois Lux
AIDSTECH Resident Coordinator

Ms. Tina Wiseman
UNICEF

Uganda

Mr. Paul Cohn, HPO
USAID/Uganda

Mr. William Salmond, Country Director
Ms. Viola Mukasa, Trainer/Manager
Experiment in International Living (EIL)

Mr. Joel Kaswarra, FUE Director
Mr. Mike Mahigigi, Training Director
Mr. Francis O. Rwakagiri, Trainer
Federation of Uganda Employers (FUE)

Mrs. Noerine Kaleeba, Director
The AIDS Support Organization (TASO)

Dr. Ben Mbonye, Director of Medical Services
National Resistance Army (NRA)

Mr. Faustin Misaruiu
Uganda Television

Dr. Don Sutherland, WHO/GPA Team Leader
Dr. Randy Moser, U.S. Centers for Disease Control
Dr. Joel Lewis, U.S. Centers for Disease Control
World Health Organization/NACP

Mr. John Riber, producer
AIDSCOM film project

ANNEX 3

References

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