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**MID-TERM EVALUATION OF THE
ETHIOPIA SUPPORT TO AIDS CONTROL (STAC)
PROJECT**

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LIST OF ACRONYMS

AAAA Artists Anti-AIDS Association
ADRA Adventist Development Relief Agency
AIDS Acquired Immune Deficiency Syndrome
AIDSCAP AIDS Control and Prevention Project
AIDSCAP-E AIDSCAP Ethiopia Country Office
CA Cooperating Agency
CCF Christian Children's Fund
CDC Centers for Disease Control
COTR Cognizant Technical Representative
DAC Department of AIDS Control
DAY Development Aid for Youth
DEA Division of Epidemiology and AIDS
EPI Expanded Program for Immunization
ESHE Ethiopian Health Project
FGAE Family Guidance Association of Ethiopia
FHI Family Health International
FSIT Focus Site Intervention Team
GC Gonococcus, the causative organism of gonorrhea
HIV Human Immunodeficiency Virus, the causative organism of AIDS
IEC Information, Education and Communication
IHAUDP Integrated Holistic Approach-Urban Development Project
MCH/FP Maternal Child Health/Family Planning
MOE Ministry of Education
MOH Ministry of Health
MPH Masters in Public Health
MPSC Multi-Partner Sexual Contacts
MSIE Marie Stopes International/Ethiopia
NACID Nazareth Children's Center and Integrated Community Development
NGO Non-governmental Organization
NRIH National Research Institute of Health
OIT USAID/W Office of International Training
OSSA Organization for Social Services for AIDS
OYB Operating Year Budget
PACD Project Assistance Completion Date
PIO/P Project Implementation Order/Participants
PP Project Paper
PSI Population Services International
PVO Private Voluntary Organization
REDSO USAID Regional Economic Development Services Office
RLA Regional Legal Advisor
SCF/USA Save the Children Federation/USA
STAC Support To AIDS Control Project

STD Sexually Transmitted Disease
SYG Save Your Generation Anti-AIDS Association
TIR Targeted Intervention Research
TDA Tigrey Development Association
TGE Transitional Government of Ethiopia
USAID/E USAID Mission in Ethiopia
USAID/W USAID Washington
WHO World Health Organization

MID-TERM EVALUATION OF THE ETHIOPIA SUPPORT TO AIDS CONTROL (STAC) PROJECT

SECTION I. EXECUTIVE SUMMARY

Purpose of the Evaluation and Methodology

The purpose of this mid-term evaluation was to document the status of project implementation of USAID/E's Support to AIDS Control (STAC) Project (663-0010) and to evaluate whether the objectives of the project will be achieved by the project completion date. The evaluation report also identifies constraints to achieving project objectives and includes recommendations for improving overall performance.

Key Findings and Conclusions

General

*The evaluation team noted that significant accomplishments can be seen as a result of the STAC Project activities. Yet, when the actual outputs achieved are compared against the original implementation plan, it becomes clear that management problems have caused serious delays in project start-up and implementation. A major factor was the reorganization of MOH and its Department of AIDS Control (DAC).

STD Prevention and Control

* The upgrading of STD clinical services was impaired by: a nine month delay in initiating the refurbishment of health facilities; a lack of laboratory testing to determine the effectiveness of the STD treatment regimens in use; delays in obtaining necessary equipment; sub-optimal community outreach IEC activities; and, a lack of access to STD client profile information because targeted intervention research was not initiated. At the time of this evaluation, only three of the four focus sites were delivering improved STD management, with some outreach/IEC activities occurring through local NGOs but not through MOH centers. While the Focus Site Intervention Teams (FSIT) theoretically provide a good mechanism for coordinating the project activities, their success has been variable and they had not yet been formed in two of the sites.

Support for Information, Education and Communication (IEC)

* The primary target groups for IEC activities are youth (both in and out of school), men and women who have multiple sexual partners, and people with STDs. These are appropriate targets given the present stage and characteristics of the HIV epidemic in Ethiopia (moderate, urban-based prevalence). While many IEC activities have been carried out under the STAC

Project, overall implementation is many months behind schedule. Materials have not been reproduced in the targeted focus sites. Information collected in the baseline surveys, however, had not been used to help design appropriate IEC interventions.

Condom Promotion and Condom Social Marketing

*The PSI condom social marketing program is exceeding its projected monthly targets. While additional condoms were obtained by USAID via transfer from excessive condom stocks in Pakistan, two of the seven million condoms that arrived were not appropriate for sales distribution because they were discolored and unacceptable to users. The STAC Project finances only a portion of the PSI social marketing program. A substantial portion of the costs is being supported with other sources. It is unclear how long other supporters of DKT will continue funding this project.

Increased NGO/PVO Involvement

* Launched in May 1993, the competitive grants program received proposals for evaluation by the grant review committee in July 1993. The first four projects to be funded were authorized to begin in January 1994. The process took six months from the time proposals were submitted until the start dates of the first ones to be funded. AIDSCAP conducted pre-award financial reviews of the first four NGOs to receive competitive agreements, but then gave advance checks to these organizations before verifying that corrections of the deficiencies of the financial systems had been made.

Behavioral Research Grants Program

* The termination of 40 faculty at Addis Ababa University and a mutual reluctance by both the MOH and the University of Addis Ababa to work together on behavioral research contributed early on to delays in initiating a research agenda. Currently there are no funded behavioral research projects underway. Considerable AIDSCAP staff resources have been expended to try to resolve the unresolved impasse on behavioral research.

Surveillance and Research

* The 1994-95 Workplan describes a more limited scope of STD surveillance activities than was anticipated in the 1993-94 Workplan. This is due to the fact that WHO has altered its recommendations on the need and methodology for extensive sentinel surveillance and the feeling within the MOH that the research activities that were originally identified are no longer relevant.

Preventive Commodities

*Materials for the prevention of HIV transmission in the health care setting have been distributed in an inconsistent pattern. No training has occurred on standard safety practices or disposal of wastes.

Project Management

* There were significant delays in start-up and implementation of project activities caused by factors beyond the control of USAID/E and AIDSCAP-E staff. Funds advanced to the MOH, which were commingled with WHO funds in the DAC account, were found to be improperly

managed when the account was transferred from the DAC to the central MOH Budgeting and Accounting Office and were subsequently frozen while the account was audited and redone.

The June 1994, draft report of a USAID/E financed assessment of TGE financial management systems, which included those of the MOH and MOE, found sufficient fundamental weaknesses to conclude that the accountability environment was too low to guarantee adequate management of USG funds. Neither the USAID/E Controller nor the REDSO Legal Advisor who cleared the STAC Project Authorization and Agreement, were aware that AIDSCAP-E planned to and entered into sub-agreements with the Ministries of Health and Education.

Key Recommendations

STD Prevention and Control

* The Regional Health Bureau staff, particularly the STD/AIDS Coordinators, should assess the implications of the drug sensitivity studies for STD management in that area and introduce the use of spectinomycin or norfloxacin for first line GC treatment if GC drug resistance is widespread.

* During the next year of the program, options for sustaining and expanding project financed STD services should be explored and other donors sought to provide further assistance at these sites.

* The AIDSCAP STD Technical Advisor should clarify the role of the NRIH and evaluate its current capacity to carry out that role. The responsibilities and scope of work at each tier of the laboratory system should be clearly defined. A fourth laboratory should be established in the Medical School at Gonder to facilitate the inclusion of STD management in the medical school curriculum.

IEC Activities

* Baseline data from KAP surveys should be analyzed and used to develop appropriate IEC messages.

* Development of the IEC kit to be used by the providers who treat STD patients should be high priority.

* If the HIV text book for secondary schools is a success, the production run of 50,000 copies should be increased and a distribution plan developed to expand the coverage.

* AIDSCAP should take the lead and seek to increase collaboration and coordination among the IEC implementing agencies. While the FSITs serve this purpose at the field level, there is a need for a similar mechanism at the central level to increase the sharing of IEC methods and materials, such as those of the MOE.

Condom Promotion and Condom Social Marketing

* To avoid condom stockouts and a negative programmatic outcome, PSI and USAID should make sure that additional supplies of condoms are identified as soon as possible, purchased, shipped and made available for use throughout the life of project so that stocks do not run short and have to be rationed. This information should be reviewed on a quarterly basis.

Increased NGO/PVO Involvement

* With the completion and signing of the remaining NGO sub-agreements, AIDSCAP staff should focus on monitoring and facilitating the implementation of the projects both technically and administratively. Activities should include both field visits by AIDSCAP staff to NGO offices and project sites, as well as meetings held at regular intervals for staff from all the participating NGOs.

Behavioral Research Grants Program

* The Behavioral Research Unit at AIDSCAP Headquarters should continue to explore options for supporting behavioral research in Ethiopia, including utilizing consultant staff, and developing interventions that follow USAID guidelines which allow the payment of research allowances to government employees under specific conditions.

Surveillance and Research

* Consolidating surveillance forms may lead to increased compliance with the surveillance system. Methods to strengthen the Regional Health Bureaus' capacity to collate and analyze data should be explored. USAID's support under the ESHE Project for improving the Health Information System should assist with this goal.

Preventive Commodities

* All future training sessions of health clinic staff should include sessions on decreasing HIV transmission in health care settings and the appropriate disinfection and disposal of biohazardous materials and annual workplans should include activities and funds to resolve such problems.

Project Management

* The STAC Project PACD should be extended for one more year, until September 1996, to allow sufficient time to complete the planned activities, find other donors to support on-going work in three focus sites, and roll over STAC Project activities in the Southern Peoples Region (Awassa) into the ESHE Project. This extension may require additional funding for AIDSCAP management costs, drugs and supplies, and for limited NGO support.

* The AIDSCAP sub-agreement with the MOH should terminate on September 30, 1994 as scheduled. All unspent funds from all central, regional and health center levels should be returned to AIDSCAP for reprogramming. A new agreement should be developed between AIDSCAP, the MOH and USAID/E that allows AIDSCAP-E to directly finance costs related to MOH STAC Project activities.

* AIDSCAP with USAID/E assistance should renegotiate the sub-agreement with the MOE to either: a) provide funds to the MOE on a reimbursement basis; or, b) to allow AIDSCAP-E to directly finance costs related to MOE STAC Project activities.

Lessons Learned

* Project implementation arrangements developed and followed by centrally-funded projects might not be appropriate to specific country situations. Plans to have cooperating agencies or contractors sub-grant to host government agencies should be cleared by Controllers and RLAs. Financial management procedures concerning sub-recipients should be reviewed and approved by USAID Mission Controllers in advance. Informal liaison should be established between CA/contractor accountants and USAID Mission Controllers.

* If host country procurement is planned under a project, those procedures should be reviewed during the PP design and incorporated into the implementation plan.

* Whenever there is a sequential series of steps that are necessary to effectively achieve a goal, it is important to assess how critical each activity is to the implementation to the next activity and whether it is necessary to delay the start of the next activity.

SECTION II. BACKGROUND

The purpose of this mid-term evaluation was to document the status of project implementation of USAID/E's Support to AIDS Control (STAC) Project (663-0010) and to evaluate whether the objectives of the project will be achieved by the project completion date. The evaluation report also identifies constraints to achieving project objectives and includes recommendations for improving overall performance.

USAID/E signed the Support to AIDS Control (STAC) Project with the Transitional Government of Ethiopia (TGE) on September 28, 1992. The project was amended on September 28, 1993, to provide addition funds, to expand the coverage area for STD services, and extend the Project Assistance Completion Date (PACD) to September 30, 1995. In collaboration with STAC, USAID/E also provided OYB transfers in FY92 and FY93 to the USAID/W centrally funded AIDS Prevention and Control Project (AIDSCAP) to augment the resources and number of implementing agencies involved in HIV-AIDS prevention in Ethiopia.

Recognizing that the project was behind schedule, USAID/E also asked for a recommendation concerning the extension of the PACD.

While the evaluators have extensive expertise in design and management of STD programs in developing countries (P. De Lay) and in design and implementation of USAID health and population projects (J. LaRosa), neither have expertise in accounting. The USAID/E Controller, therefore, was asked to provide assistance from the Chief Accountant to conduct a review the AIDSCAP-Ethiopia financial management procedures as a part of the evaluation exercise.

In August 1994, the two outside evaluators spent two weeks in Ethiopia meeting with representatives from the implementing agencies: USAID/E Mission, the Ministry of Health (MOH) and Ministry of Education (MOE), AIDSCAP-Ethiopia Office, the WHO/Ethiopia Office and participating NGOs. In collaboration with government counterparts in the Division of STD/HIV/AIDS of the Ministry of Health and the Americas Desk in the Ministry of External Economic Cooperation, the evaluators were also able to directly observe activities in the project's four primary implementation focus sites of Awassa, Nazareth, Mekele, and Bahir Dar. The six days spent in the field added considerable understanding to the environment in which the project is being implemented.

The purpose of the STAC Project is to reduce the transmission of HIV within the Ethiopian population. The activities financed under STAC and under the complementary AIDSCAP Project focus on the following:

- STD Prevention and Control;
- Information, Education, Communication (IEC) targeted at youth and high risk females;

- Condom promotion;
- Strengthening of public and private institutions;
- Behavioral research;
- Surveillance of HIV-AIDS and STD;
- Overseas long-term training;
- Provision of preventative supplies

The very nature of an evaluation exercise tends to emphasize the obstacles and problems that occur during a project. It often fails to adequately acknowledge the successful implementation of activities. In spite of the difficulties in this environment of constraints, it is important to recognize that much has been accomplished: STD clinical sites have been refurbished; drugs, equipment and supplies have been purchased and distributed; health provider training is being carried out; STD case management has begun to improve; NGO projects have been developed and funded; targeted IEC activities have been initiated at community level; and there has been a dramatic increase in the number of socially marketed condoms. Yet, when the actual outputs achieved are compared against the original implementation plan, it becomes clear that **management problems have caused serious delays in project start-up and implementation.** These problems effected all implementing agencies.

A major factor which caused significant delays was the reorganization of MOH and its Department of AIDS Control (DAC). As an implementing unit with 57 staff, the DAC was considered capable of managing all of the relevant STAC Project activities. But after the agreement between the head of the DAC and AIDSCAP was signed, a reorganization of the Transitional Government of Ethiopia (TGE) began. As a result of the new TGE policy many of the staff were redeployed to the Regional Health Bureaus in a move to decentralize the government services. The remaining staff of three was folded into the Division of Epidemiology and AIDS (DEA). The accounting function was transferred to the central MOH Budgeting and Accounting Office. Even before the staff members were transferred the uncertainties surrounding future employment and potential transfers resulted in a significant slow down of in project activities.

SECTION III. EVALUATION OF TECHNICAL COMPONENTS

The format of Section III follows the Project Elements that are described in the "Amplified Project Description-STAC 1 Amendment", dated September 28, 1993, with the revisions incorporated from Project Implementation Letter No: 4, dated May 18, 1994. The expected outcomes/outputs for this project are individually assessed as to the current status of activities, perceived obstacles for implementation, the feasibility of the proposed activities in the 1994-95 workplan, and recommendations for revisions in the project.

A. STD PREVENTION AND CONTROL:

1. Summary of Major Findings:

* There was a nine month delay in initiating the refurbishment of health facilities at the four focus sites due to: the auditing and freezing of the DAC account for six months; the necessity to tender bids for renovations; and the requirement to follow official TGE procurement procedures to purchase locally made health center equipment.

* The upgrading of STD clinical services has been impaired by: lack of laboratory testing to determine the effectiveness/ ineffectiveness of the STD treatment regimens in use and the need for subsequent modification of the treatment regimes; continued delays in obtaining necessary health facility equipment (gynecologic beds, stools, gloves, speculums, sterilizers, and antiseptics); sub-optimal community outreach/IEC activities; and lack of access to STD client profile information because targeted intervention research (TIR) has not yet been initiated.

* At the time of the evaluation field work, three of the four focus sites were delivering improved STD management with some outreach/IEC activities occurring, mainly through local NGOs with minimal public sector activity. Anecdotal information indicated that because of the upgraded services, especially the provision of effective STD medicines, client health seeking behavior and compliance with follow-up appointments had increased.

* The National Research Institute of Health (NRIH) no longer plays a direct administrative role but continues to provide referral and quality control services and technical support for STD research and clinical management activities throughout the country.

2. Accomplishments Measured Against Expected Outcomes:

National STD treatment algorithms developed, field tested, revised and approved for nationwide implementation STD syndromic treatment guidelines have been adopted from the WHO international recommendations to fit local Ethiopian conditions. Although based on the recommendations made by the technical advisory subcommittee for STDs, drug selection for each syndrome is still controversial. 78% of gonorrhea (GC) cultures tested in Addis Ababa have been found to be resistant to co-trimoxazole, which is the current national treatment guideline recommended therapy for GC. However, because regional laboratories have been unable to perform drug sensitivities for each of the focus sites, treatment regimens outside of Addis Ababa have not been updated. In discussions with clinical providers in Awassa and Nazareth, most urethritis patients who are treated for presumed gonorrhea and chlamydia do not return for follow-up. It is the impression of some of the clinical providers that this is due to treatment failure rather than the patient becoming asymptomatic cured. It is highly probable that treatment of gonorrhea with co-trimoxazole in most areas of Ethiopia is ineffective. Drug sensitivity surveys are scheduled to be completed by December 1994. (See Establishment of Regional Laboratory capability below.)

The STD Committee, which is comprised mainly of STD specialists, has requested that the predictive value of the newly recommended syndromic approach to STDs be determined. This activity, which will focus particularly on validating the treatment algorithm for vaginal discharge, is scheduled to be completed by March 1995. Due to the marked reduction of STD/HIV staff in the central MOH office, the MOH plans to have this necessary research activity carried out by regional staff. An alternative would be to commission an outside research group to carry out the study.

90% of STD patients who are seen at 10 pilot STD Clinics will receive effective STD case management according to national guidelines. Of the ten initial STD sites, four were chosen to be "focus sites" for comprehensive, integrated IEC, STD treatment, and condom promotion activities. All ten sites were selected in early 1993, while an additional ten STD sites were identified to receive support under the STAC-1 Amendment. The evaluation team visited all four focus sites. By late August 1994, in Awassa, 142 STD patients had been seen since services were upgraded in June 1994. These included 32 female patients, many of whom were local "bar ladies." In Mekele, upgraded STD services were initiated before the arrival of all of the USAID supplied equipment and supplies. 438 STD patients had been diagnosed and treated since June 1994. Anecdotal information indicated that due to the provision of free STD treatment drugs, patients were more likely to return for clinical follow-up. In Bahir Dar, the upgraded STD clinical services had not yet begun. This was attributed to the failure to complete the renovations (plumbing) and continued lack of some supplies, i.e., gram stain for the lab, tetracycline for treatment.

In order to truly upgrade STD management services, it was considered critical that the

clinical sites undergo necessary renovations such as painting, installation of sinks, curtains, and roof repairs; and that they be supplied with equipment including lamps, stools, speculums, gynecological beds, and desks, and consumable supplies like STD drugs, reagents, gloves, antiseptic agents, syringes, and needles. Assessments of the refurbishment needs at each of the four focus sites were completed in early 1993. Workplans were drawn up and the administrative process for identifying contractors to perform the necessary renovations was started. At the time the field visits were made to these sites in August 1994, the renovations had been completed in Awassa, Nazareth, and Mekele. Renovations of the Bahir Dar Health Center were scheduled to be finished by October 1994. Furniture and equipment such as stools and gynecologic beds, which were being manufactured locally in Addis Ababa, were expected to be delivered in September 1994. It was unclear how this equipment would be transported to the STD sites. At the time of the evaluation, funds had already been transferred to the Regional Health Bureaus for the refurbishment of the other six STD clinical sites.

Training of STD clinical providers was postponed for approximately seven months due to delays in the refurbishment of the four focus sites and a delay in obtaining the necessary equipment, diagnostics, and STD drugs, which were financed under a USAID Grant to WHO. Training of 33 zonal communicable disease control head and regional STD/AIDS coordinators and clinicians was held from January 31 to February 4, 1994. The 1994-95 Workplan calls for training of additional clinical staff from the initial ten STD sites during the fourth quarter of 1994 and training of health care workers from the second ten STD sites during the first quarter of 1995.

A select group of STD/AIDS coordinators received training in January/February, 1994. The work responsibilities of the STD/AIDS Coordinators includes promoting health education and utilization of condoms, expansion of screening for STDs and HIV, training for capacity building, undertaking operational research, and, most critical, coordinating STD clinical services with public health, NGO, and condom social marketing IEC activities. At the time of the evaluation field work, STD/AIDS Coordinators had not yet been officially designated in Bahir Dar or Mekele.

Focus Site Intervention Teams were proposed in the 1994-95 Workplan as an effective mechanism for coordinating and integrating the targeted IEC activities of government ministries and NGOs, with the social marketing of condoms, and the provision of improved STD clinical services. The members of the FSITs include the Regional/Zonal STD/AIDS Coordinator(s), MOH clinicians, and selected representatives from the Ministry of Education, PSI (the condom social marketing agency), other STAC Project funded NGOs and factories or other groups involved in HIV prevention interventions. The FSITs had only recently been established and were at varying levels of functionality. In Awassa, four meetings had already been held, goals and objectives had been defined, and an action plan had been written and presented to AIDSCAP for approval and funding. In Nazareth, only one meeting had been held. The group had decided to wait for a visit by the AIDSCAP staff before calling another meeting. In Mekele and Bahir

Dar, the FSITs had not yet been formed.

Supplies of STD treatment drugs for the four focus sites began to arrive in May 1994. The pharmacists at each focus site stored these drugs separately and maintained separate inventory controls for them. In Bahir Dar and Mekele, however, not all of the drugs, e.g., tetracycline tablets, had arrived.

Regional Health Departments are now responsible for storing and prepackaging supplies for individual clinical sites. Since the supply of STD drugs had only recently been initiated and the Regional Health Departments did not have much experience implementing these additional responsibilities, it was difficult to ascertain how responsive and effective the drug supply system will be. Clinical staff at Mekele noted that half of the spectinomycin provided had already been used. Spectinomycin is a second line drug which should be used when gonorrhea is resistant to co-trimoxazole. No one at the Health Center knew the mechanism for reporting this inventory status for replenishment. This will be especially important if there are major changes in treatment guidelines after the drug sensitivity studies are completed. The AIDSCAP team planned to address this deficiency by including in the 1994-95 Workplan the training of pharmacy personnel in drug management at each focus site.

NRIH STD Referral Laboratory Refurbished and Providing Effective/Efficient Diagnosis for Treatment of STDs Equipment and supplies for the NRIH were purchased and delivered by WHO under the initial Letter Grant from USAID, dated February 1993. At the time of the evaluation field work they were in storage awaiting the identification of a large enough physical space to replace the existing STD laboratory. The transfer of health care responsibilities to the Regional Health Offices and the proposed upgrading of the Regional Health Laboratories meant that the new role of the NRIH would change to one of providing referral services, quality control and technical support including the procurement of laboratory equipment, reagents and supplies. In addition, with the marked decrease of central HIV/STD technical staff, there would be less probability that extensive surveillance and research activities would occur in the near future at the national level. It is expected that the NRIH will continue to play a prominent role in the training of laboratory technicians, and that it will carry out some research activities, and serve as a referral site for complicated cases. A workshop of laboratory technicians is scheduled for the fourth quarter of 1994. (Also see the Output below which refers to the Five Regional Health Laboratories.)

Nationwide Implementation of STD Treatment Algorithms Accomplished in all STD Treatment Facilities When the chemosensitivity results are completed in December, national STD syndromic treatment guidelines will be revised. It will then be essential to disseminate this information as quickly as possible to all health facilities in the country where STDs are being managed. This will be a responsibility of the MOH Division of Epidemiology and AIDS (DEA) with logistics assistance from AIDSCAP.

An Additional 10 STD Clinics Supplied with Essential Equipment and Supplies, and Initial Training for Clinic Staff (for a total of 20 clinics) The list of the additional STD clinical sites is attached (Annex B). The full range of comprehensive activities, including IEC, condom promotion, and expansion of STD management into other health services, is not planned for these ten additional sites. Assistance will be limited to STD training, some refurbishment of sites, and the provision of equipment and supplies, including STD drugs. A second Letter Grant to WHO has been issued to finance the procurement of drugs and equipment and to refurbish the additional ten STD clinics. It was not clear to the evaluation team, however, that the Letter Grant budget included sufficient funds to cover all the refurbishment requirements.

The Integration of STD Services into MCH/FP Programs Promoted in 4 Focus Areas At none of the four focus sites had an upgraded integration of STD services into MCH/FP programs been accomplished. It is unrealistic to expect the full expansion of the STD services into the MCH/FP program until the STD clinical management services in the primary health clinics, the STD/AIDS Coordinators, the STD drug and supply distribution systems, the clinical site laboratories, and the Focus Site Intervention Teams are all fully functional in each location. The 1994-95 Workplan calls for syphilis case finding in pregnant women with appropriate treatment, and ophthalmia neonatorum prophylaxis in newborns at all four of the focus sites. Procaine penicillin for the syphilis treatment and tetracycline ointment have been received at the four focus site pharmacies. After receiving an orientation to the program, the health care providers from the designated clinics will be initiate the implementation of this activity.

STD Services Extended to 25% of Health Stations in 4 Focus Areas by September 1995 The 1994-95 Workplan calls for drugs and other supplies to be procured and provided to 25% of the health stations in the four focus site areas. Plans to allocate supplies beyond the primary focus site facility had not yet been developed at the time of the evaluation field work. The evaluation team was later assured that there will be no problem in selecting the health sites. Arrangements are to be made in consultation with the STD/AIDS Team from the central MOH, the staff of the Regional Health Bureaus, appropriate health personnel from each focus site along with staff from USAID and AIDSCAP.

The STD Diagnostic Capabilities of 5 Regional Health Laboratories Strengthened Accomplishment of this objective has been delayed due to late arrival of necessary equipment and supplies for performing bacteriologic tests. In addition, Regional Health Laboratories do not exist at each of the focus sites. The current plan, therefore, is to strengthen the most appropriate laboratory in close proximity to the focus site STD clinics in Awassa, Bahir Dar, and Nazareth, rather than the proposed five Regional Health Laboratories. Drug sensitivities and other more sophisticated laboratory tests for the other STD sites are scheduled to be performed in Addis Ababa or at nearby Regional Health Laboratories. However, the feasibility of transporting bacterial cultures over long distances with resulting time delays may invalidate laboratory results. The three

laboratories selected for upgrading are at differing stages of completion. In Awassa, incubators, centrifuges, microscopes, and the necessary consumable supplies had been received, training had occurred and the laboratory was functioning. In Nazareth the laboratory was also operational. In Bahir Dar, the building to house the laboratory was not yet complete. The Mekele Health Center laboratory had undergone physical improvements, but the evaluation team was told that the laboratory space was too small to house the equipment which had been purchased. The Mekele STD staff planned to arrange for a central level MOH staff person to install the laboratory equipment sometime in the future when a new site for the laboratory was identified and prepared.

Training of laboratory staff was postponed seven months due to delay in obtaining necessary equipment, diagnostics, and STD drugs under the Letter Grant to WHO. Training of NRIH and regional laboratory technicians was rescheduled for fourth quarter of 1994 and will probably be a central level activity.

3. Recommendations:

* It should be a major priority to complete the drug sensitivity studies by December. Validating the algorithm for vaginal discharge is less of a priority. Studies are being conducted in a number of African countries, with USAID, EC, and WHO assistance, which seek to validate and refine STD syndromic management, including risk profiles to improve the management of vaginal discharge. This data should be made available to the Ethiopian STD technical advisory subcommittee.

* Under the WHO Letter Grant, equipment, consumable supplies and drugs will be provided to the remaining 16 STD clinical sites. It is unclear, however, if the WHO Letter Grant will include allocation of funds for clinic renovations at all of these sites. If the WHO budget is not sufficient, separate funds should be included in the 1994-95 Workplan to allow for AIDSCAP financial management of the refurbishment of these clinics.

* The 1994-95 Workplan calls for training in September of additional STD clinical staff from the initial ten identified STD sites. Regional drug sensitivity studies for gonorrhea will not be completed until late December. The September training should proceed but alternative treatment options for GC should be presented at the workshop, so that when the new guidelines for GC treatment are finalized, these can be distributed to the clinical sites and appropriate changes in therapy can occur. Thus, a second training activity would not be required. Monitoring and refinements of the treatment standards could be performed during site visits by the technical staff from MOH/DEA and from AIDSCAP technical advisors.

* With the decreased number of STD staff at the central level of the MOH, the role of the Regional STD/AIDS Coordinator becomes even more critical. The Ministry of Health DEA should request that a STD/AIDS Coordinator be identified and officially designated in Bahir Dar and Mekele as soon as possible. AIDSCAP's Technical Coordinator and the external STD Technical Advisor should make an intensive effort to assist and support the activities of the

STD/AIDS Coordinators, particularly in Bahir Dar and Mekele.

*** While the FSITs theoretically provide a good mechanism for coordinating the project activities at each of the focus sites, their success has been variable; they had not yet been formed in two of the sites. The evaluation team noted that other health committees already existed in some of the focus sites, but the FSITs, with their focus on HIV/AIDS prevention, did not seem to duplicate the work of the other committees. The most developed FIST in Awassa had defined objectives and developed a scope of work to carry out an assessment of the HIV/AIDS situation. The other FSITs should be encouraged to define objectives and develop workplans. AIDSCAP should provide support for operational costs for the FSITs to optimize their ability to bring together various representatives in a collaborative program. Before the end of the project, ways to integrate the agenda of the FSITs with the agendas of other health committees should be developed.**

*** Both MOH/DEA and AIDSCAP staff should closely monitor the supply and logistics system over the next 6-12 months. Training of Regional and Health Center staff in logistics management should be included as part of the training activities during the remainder of the project.**

*** During the scheduled visit of the AIDSCAP STD Technical Advisor in September, an evaluation of the current capacity of the NRIH should be made which would include checking on the status of the equipment and supplies that are in storage and clarifying the role of the NRIH. Until adequate laboratories can be made functional in all four focus sites, there will be an on-going need for the NRIH to provide essential laboratory support.**

*** After dissemination of the drug sensitivity results, Regional Health Bureau staff, particularly the STD/AIDS Coordinator, will need to assess the implications for STD management in that area. If GC drug resistance is widespread, then the use of spectinomycin or norfloxacin will be required for first line GC treatment. Since only 20 STD treatment sites and 25% of their surrounding health stations will receive supplementary STD treatment drugs, a revision of the treatment guidelines could result in a shortage of available drug supplies. Possible options to address this are: explore with the EC the possibility of increasing their drug provisions under the expanded primary health project; explore with the USAID/E ESHE Project design team the possibility of providing additional support for STD drug procurement.**

*** During the next year of the program, options for sustaining and expanding project financed STD services need to be explored. Other donors should be sought to provide continuing assistance at these sites.**

*** Prophylaxis for ophthalmia neonatorum can begin immediately, now that the antibiotic ointment has arrived and appropriate health units have been identified. Syphilis screening requires access to RPR capability, either at the Health Center or Regional Health Lab. This should be the first priority in order to eventually implement full syphilis management for antenatal patients.**

* During the next visit by the AIDSCAP STD technical advisor, a health station needs assessment should be performed in each of the focus site areas and a list of criteria for selecting 25% of the health stations to receive STD drugs should be developed.

* It is essential to clearly define the responsibilities and scope of work at each tier of the laboratory system. The research and referral testing to be performed at the NRIH should be distinct from those laboratory activities to be done at the respective Regional Health Laboratories and at the STD clinical sites. Once these responsibilities are defined then the most appropriate equipment, supplies and training can be determined. In Bahir Dar, for example, the current plan is to provide incubators to the laboratory at the Bahir Dar Health Center. However, there is no plan to provide culture media and to initiate bacteriological services at the Health Center. If it is deemed feasible, a fourth regional laboratory could be strengthened. It is recommended that a health laboratory be established in the Medical School at Gonder to facilitate the inclusion of STD management in the medical school curriculum.

A possible schematic for responsibilities at each tier is shown below. This could be tailored to the individual focus sites:

NRIH	Drug sensitivities HIV confirmatory testing Specialized ELISA (Chlamydia, etc.) Training of senior laboratory staff
Regional Health Laboratories	VDRL/RPR Bacterial cultures with limited drug sensitivity, HIV testing Dark field Microscopy Training of laboratory staff
STD Clinical Sites (Health Centers)	Wet mount Gram stain KoH prep Urinalysis RPR
STD Clinical sites (Health Stations)	Physical exam with history only Referral as necessary

B. SUPPORT FOR IEC HIV/AIDS PREVENTION AND CONTROL

1. Summary of Major Findings:

* The primary target groups for IEC activities are youth (both in and out of school), men and women who have multiple sexual partners, and people with STDs. These are appropriate targets given the present stage and characteristics of the HIV epidemic in Ethiopia (moderate, urban-based prevalence). IEC interventions of NGOs, and TGE ministries are being carefully designed to be appealing and elicit behavior change from the sub-project target groups. In addition to development of posters and leaflets, activities include peer education, live drama, radio and video productions and special "condom nights" celebrated in bars and hotels in major urban areas.

* While many IEC activities have been carried out under the STAC Project, overall implementation is many months behind schedule. Materials have not been reproduced in the targeted focus sites (see below).

* Development, production and distribution of the MOE AIDS prevention activities are behind schedule (see below).

* Many of the NGO projects include baseline surveys to collect KAP data on the target population before the interventions are introduced. Information collected in the baseline surveys, however, had not been used to help design appropriate IEC interventions.

2. Accomplishments Measured against Expected Outcomes:

MOH-MOE IEC Materials Development Workshop--A five-day workshop on HIV-AIDS communication materials development was held in Nazareth, Ethiopia in November 1993. Thirty-four participants included 11 from the MOH and 18 from the MOE. The workshop was arranged by AIDSCAP with two trainers from PATH. Participants developed prototype materials including leaflets and posters. It was expected that the MOE and MOH participants would pretest, translate into the local language, and reproduce these materials for their respective areas. For the MOH personnel this follow-up activity was delayed due to the inability of the MOH to transfer funds from the central level to the Regional Health Bureaus in a timely manner. The transfer of funds finally occurred in June 1994, but none of the focus sites had utilized these funds at the time of the evaluation team visits. The evaluation team was not able to meet with any MOE officials in the field. Schools were not in session and MOE officials were out of town or out of their offices during visits to Awassa and Mekele.

While follow-up production activities had not been carried out yet, the workshop report indicated that the capacity of the participants to design and test IEC materials was significantly enhanced.

MOH Central Level IEC Activities--With assistance from AIDSCAP and PSI the MOH IEC Division of the Department of AIDS Control was able to produce a video film and several radio dramas on HIV-AIDS prevention before being reduced to a one-person operation. At the time of the evaluation field work, HIV-AIDS IEC responsibilities were being transferred from the AIDS Control Division to the Health Education Division. It was not clear what role the Health Education Division would play in the implementation of the Project IEC interventions.

MOH Regional Level IEC Activities--In the Regional Health Bureaus, HIV/STD IEC Coordinators were being designated to manage Project activities. The evaluation team observed that implementation at this level was significantly delayed.

MOH STD Clinical Site IEC Activities--These activities were deliberately delayed until the STD clinical sites were refurbished and the drugs and clinical supplies were delivered. MOH health workers at this level expressed the need for video monitors and recorders to facilitate the planned IEC activities. The team noted that purchase of this equipment had been included as part of the 1994-95 Workplan.

MOE In-school Youth IEC Activities--The development and production of a text book on HIV-AIDS for secondary school students was several months behind schedule. The delay was due to the MOE decision to change of language of the book from Oromigna to English, because English was deemed more appropriate. The evaluators were told that they could see a draft of the text, but it was never provided by MOE officials.

The MOE component was one of the most difficult to evaluate since little activity had taken place and no materials were provided. The team was able to look at a copy of the program of the five-day workshop to be held during the last week of August to launch the MOE program. It was noted that AIDSCAP has not been invited to participated in the workshop except to give an introductory address. MOE officials were not available for discussions during the focus site field visits.

3. Recommendations

* Baseline data from KAP surveys should be analyzed and used to develop appropriate IEC messages.

* A collection of video tapes on HIV-AIDS available at the AIDSCAP-Ethiopia Office are loaned to government agencies and NGOs. AIDSCAP serves as a resource center for information about HIV/AIDS. A plan should be developed and implemented to transfer these resources to an appropriate organization before the project ends.

* Development of the STD IEC kit, to be used by the providers who treat STD patients, should be an IEC priority.

* If the HIV text book for secondary schools is a success, the production run of 50,000 copies should be increased and a distribution plan should be developed to expand the coverage.

* AIDSCAP should take the lead and seek to increase collaboration and coordination among the IEC implementing agencies. While the FSITs serve this purpose at the field level, there is a need for a similar mechanism at the central level to increase the sharing of IEC methods and materials, especially those of the MOE.

C. CONDOM PROMOTION AND CONDOM SOCIAL MARKETING

1. Summary of Major Findings:

*The PSI condom social marketing program is exceeding its projected monthly targets. While additional condoms were obtained by USAID via transfer from excessive condom stocks in Pakistan, two of the seven million condoms that arrived were not appropriate for sales distribution because they were discolored and unacceptable to users.¹ USAID and PSI need to identify sources for additional condoms as soon as possible to guarantee that adequate stocks remain available for the program.

* The STAC Project finances only a portion of the PSI social marketing program. A substantial portion of the costs is being supported with other sources. It is unclear how long other supporters of DKT will continue funding this project.

* Unlike other African countries, the knowledge and use of condoms in Ethiopia is widespread and supported by public and private entities. Resistance and claims that they promote promiscuity were not very evident.

* While condoms prevent both pregnancy and infection when used correctly and consistently, they are primarily perceived as a contra-infective. This might have a negative impact if condoms are heavily promoted as a family planning method.

2. Accomplishments Measured Against Expected Outcomes:

Condom distribution at STD focus sites--It was expected that 400,000 condoms per month would be distributed free at the MOH STD clinical sites. At the time of the

Before accepting the offer of USAID condoms transferred from Pakistan, USAID requested that G/PHN/P/CLM provide information on the manufacturing dates and the results of the quality assurance tests for the proposed shipments of condoms. The information in its entirety was never passed to USAID/E. Of the seven million condoms that arrived from Pakistan, two million of them were discolored and not acceptable for sale under the social marketing program. Seven million condoms had to be sorted by hand to separate unacceptably discolored ones from the rest.

evaluation field work, only 280,000 were available and being distributed. The lack of sufficient numbers of condoms is probably a reflection of the inadequate management logistics system of the MOH, which results in problems in distributing the condoms to these sites, and in receiving reports on supplies expended.

A proposed solution, which appears to have been implemented in Mekele, is to utilize the PSI distribution system to transport MOH condoms to the STD clinical sites.

PSI Condom Sales--This appears to be one of the most successful components of the STAC Project. Sales continue to climb and monthly projections are being met and exceeded. Product recognition is high. Product availability continues to expand to new outlets. This is the one component that has not been delayed. It should also be noted, however, that the condom social marketing program was already underway when the STAC Project began.

The evaluators were told about "condom nights" carried out in several urban areas sponsored by local municipalities, the MOH and PSI with volunteers from anti-AIDS clubs and MPSC peer educators. PSI IEC staff (not funded under the AIDSCAP sub-agreement) were present in Mekele at the same time as the evaluation team, to work with a secondary school anti-AIDS club and to collaborate with the MOH STD/AIDS Coordinator in conducting HIV-AIDS IEC training.

3. Recommendations

* To avoid condom stockouts and a negative programmatic outcome, PSI and USAID should make sure that additional supplies of condoms are identified as soon as possible, purchased, shipped and made available for use throughout the program so that stocks do not run short and have to be rationed. This information should be reviewed on a quarterly basis.

D. INCREASED NGO/PVO INVOLVEMENT IN HIV/AIDS PREVENTION AND CONTROL

1. Summary of Major Findings:

* Launched in May 1993, the competitive grants program received proposals for evaluation by the grant review committee in July 1993. The first four projects to be funded were authorized to begin in January 1994. The process took six months from the time proposals were submitted until the start dates of the first ones to be funded.

* A tremendous amount of work was required to develop the NGO grants program including: soliciting proposals; establishing the grant review committee and guidelines for the review process; evaluating 23 proposals individually and then as a committee; advising NGOs of committee members' observations, comments and suggestions; carrying out a second review

of resubmitted proposals; determining which NGOs would receive the funds; developing and soliciting approval of draft sub-agreements from AIDSCAP regional and headquarters offices and USAID/E; and authorizing Letters of Intent and signing finalized sub-agreements.

* AIDSCAP conducted pre-award financial reviews of the first four NGOs to receive competitive agreements, but then gave advance checks to these organizations before verifying that corrections of the deficiencies of the financial management systems had been made.

* As part of the review process, preference was given to local NGOs because it was felt that the international groups could access other resources if they wanted to initiate HIV-AIDS prevention activities.

2. Accomplishments Measured Against Expected Outcomes:

The NGO Grants program was designed and organized with participants from the MOH, USAID/E, AIDSCAP and the NGO community. Members from representing each group participated on the grants review committee.

Through competitive, non-competitive and rapid response mechanisms, AIDSCAP has awarded grants to NGOs to finance HIV-AIDS IEC prevention interventions aimed at the STAC Project target groups (in- and out-of-school youth, MPSCs and demobilized soldiers). Sub-agreement recipients are listed below along with the main target group, project dates and amounts:

- * **The Nazareth Children's Center and Integrated Community Development (NACID):** Demobilized Soldiers; 1/94--9/95; \$32,976
- * **GOAL-Ethiopia:** Youth, MPSCs; 1/94--9/95; \$34,998
- * **Family Guidance Association of Ethiopia (FGAE):** Youth, MPSCs; 1/94--9/95; \$37,540
- * **Christian Children's Fund (CCF):** Youth, MPSCs; 1/94--9/95; \$33,949
- * **Marie-Stopes International/Ethiopia (MSIE):** Youth; 8/94--9/95; \$39,986
- * **Development Aid for Youth (DAY):** Video Viewers, General Population; 5/94--9/95; \$16,475
- * **Save Your Generation Anti-AIDS Association (SYG):** Youth; 3/94--5/94; \$1,910
- * **Integrated Holistic Approach-Urban Development Project (IHAUDP):** Youth,

Demobilized Soldiers; 3/94--6/94; \$3,279

- * **Ethiopian Aid: Youth; 3/94--8/94; \$407**
- * **Organization for Social Services for AIDS (OSSA): Telephone Callers, Taxi Drivers; 3/94--7; \$4,187**

The following projects were fully developed and sub-agreements were being finalized for signing:

- * **Save the Children Federation/USA (SCF/USA): Youth; 9/94--9/95; \$11,114**
- * **Tigray Development Association (TDA): Youth; 9/94--9/95; \$20,000**
- * **Family Guidance Association of Ethiopia (FGAE): Youth; 9/94--9/95; \$5,010**
- * **Artists Anti-AIDS Association (AAAA): General Population; ??; \$5,000**

Four training/workshop activities were carried out which included NGO participants:

"Effective Strategies for Behavior Change for AIDS Prevention": October 18--21, 1993; 24 NGO participants

"On Training of Trainers (TOT) Workshop": March 14--18, 1994; NGO participants with MOH and MOE staff

Half-day Seminar on Financial Accounting of USAID/FHI/AIDSCAP-Ethiopia: March 29, 1994; participants from sub-recipient agencies

"Evaluation Skills and Techniques Workshop": June 27--July 1, 1994; participants from NGOs, MOH and MOE

The evaluation team visited a small sample of the NGO projects and observed dramas and received copies of IEC materials that were developed under the projects. The quality and appropriateness of these materials could not be fairly judged, however, since neither evaluator is a native Ethiopian. The dramas, which were simultaneously translated by a person sitting next to each evaluator, were entertaining and informative.

While the overall impact of these NGO project interventions could not be evaluated because most activities have only recently begun, many of the NGOs included the collection of baseline data as a start-up activity. As a result, there will be an opportunity over the next 18 to 24 months to collect follow-up data and analyze the effectiveness of the IEC activities and add "lessons learned" in Ethiopia to those that have been documented in other African countries. (See section B above for the list of NGO projects.)

The process of reviewing NGO proposals, advising NGOs of comments, reviewing resubmissions, drafting and soliciting approvals for sub-agreements, negotiating agreements with NGOs, signing letters of intent and then sub-agreements, was a long and grueling process. It involved a multitude of participants from the review committee members who were from AIDSCAP/E, the MOH and USAID/E, to the AIDSCAP Regional Office staff in Nairobi, Kenya, to the AIDSCAP Headquarters in Washington, DC, to the FHI Headquarters in North Carolina. Since Ethiopia was one of the first AIDSCAP countries to launch such a program in Africa, the process was a learning experience for all those involved. It has since been streamlined, so that technical review stops with the Regional Office staff. AIDSCAP Headquarters, however, is still responsible for conducting financial reviews.

3. Recommendations

* Ethiopia is not the only country where AIDSCAP has been asked to develop and award sub-agreements to NGOs. It would be beneficial to have a meeting or seminar with those who participated in this exercise in Ethiopia and appropriate representatives from AIDSCAP Regional and Headquarters Offices, to discuss the process and the problems and to define a new and more decentralized procedure to streamline the process and reduce the amount of time required to initiate an program of NGO sub-agreements even further. This new procedure should be applied soonest to all countries where AIDSCAP is awarding sub-agreements to NGOs.

* With the completion and signing of the remaining NGO sub-agreements, AIDSCAP staff should focus on monitoring and facilitating the implementation of the projects both technically and administratively. Activities should include both field visits by AIDSCAP staff to NGO offices and project sites, as well as meetings held at regular intervals for staff from all the participating NGOs. AIDSCAP staff are aware that these activities should be scheduled and carried out. Semi-annual meetings of all the NGOs are planned. One was carried out between December 1993 and September 1994. Field visit schedules have also been prepared, but the draft schedules that were shown to the evaluators called for the AIDSCAP staff to be away from home three to four weeks per month. At the time of the evaluation field work, the Accountant had not made any visits to sub-recipient agencies. A more reasonable travel schedule that includes all staff members should be developed and at regular intervals it should be reviewed and adjusted to make sure that attention is given to those NGOs that need the most attention.

Meetings of the sub-recipients should focus on sharing of methods and materials and lessons learned, identifying common problems and their solutions. This group could also be tapped to identify additional activities and potential organizations, especially for rapid response grants.

E. BEHAVIORAL RESEARCH GRANTS PROGRAM:

1. Summary of Major Findings:

* The termination of 40 faculty at Addis Ababa University and a mutual reluctance by both DAC and the University of Addis Ababa to work together on behavioral research contributed early on to delays in initiating a research agenda. Currently there are no funded behavioral research projects underway.

* Considerable AIDSCAP staff resources have been expended to resolve the impasse on behavioral research.

2. Accomplishments Measured Against Expected Outcomes:

A long-term collaborative, behavioral research agenda will be defined and initiated between Ethiopian and US research institutions A priority-setting workshop on HIV-AIDS related research was conducted in Nazareth in May 1993. Prioritized lists of epidemiologic, health and social services, and biomedical research were drawn up. A proposal for the AIDSCAP Thematic Grants Program was submitted to the AIDSCAP Headquarters Technical Review Committee, but was rejected on technical grounds. This proposal would have established an on-going relationship between Addis Ababa University and the University of Michigan.

A Behavior Research Grant Program established and up to 6 small grants awarded to Ethiopian research institutions A Behavioral Research Review Committee/Working Group has been created and has met once. However, the University has now stated that it requires salary supplementation for faculty who serve as investigators. In-kind contributions such as computers, per diem, etc., were considered inadequate compensation. The Behavioral Research Unit at AIDSCAP Headquarters has stated that its interpretation of AIDSCAP and USAID regulations prevents supplementing salaries.

The STD Targeted Intervention Research Project has been delayed because the Principal Investigator, Dr Workneh, has been involved with his other multiple responsibilities as a staff member of the Division of Epidemiology and AIDS. The naming of a second Principal Investigator is described in the 1994-95 Workplan.

Research capability and expertise of the NACP strengthened; NACP assumes backstopping role in the behavioral research program With the marked reduction in the MOH central level HIV-AIDS staff from 57 to 3, this outcome will only be accomplished if responsibility is given to appropriate staff from the Regional Health Bureaus. As the TGE decentralization plan takes effect, the STAC Project focus must shift to the regional level.

NACP coordinates a behavioral research project on street children; National Workshop of quantitative and qualitative behavioral research methodology conducted and proceedings published These proposed activities are currently on hold until negotiations with the University of Addis Ababa are complete.

3. Recommendations:

* The Behavioral Research Unit at AIDSCAP Headquarters should continue to explore options for supporting behavioral research in Ethiopia, including utilizing consultant staff, and developing interventions that follow USAID guidelines which allow the payment of research allowances to government employees under specific conditions.

* Operational behavioral research should be targeted to the regions and should be based on MOH, MOE and NGO behavior change interventions rather than discrete research studies.

* Special assistance to proceed with the street children activity should be sought from the Behavioral Research Unit at AIDSCAP Headquarters.

F. SURVEILLANCE AND RESEARCH

1. Summary of Major Findings:

* The 1994-95 Workplan describes a more limited scope of STD surveillance activities than was anticipated in the 1993-94 Workplan. This is due to the fact that WHO has altered its recommendations on the need and methodology for extensive sentinel surveillance and the feeling within the MOH that the research activities that were identified are not relevant.

2. Accomplishments Measured Against Expected Outcomes:

Short-term epidemiologic training abroad for one person Two participants have already been trained and third is scheduled to leave for the same course before the end of 1994. Ato Bekele Shanko from the MOH undertook training at the CDC from October 5-26, 1992. Ato Tedese Fissehaye undertook the Epidemiologic Intelligence Course at CDC from October 4-29, 1993. And Ato Taddesse Haile Yesus is scheduled to participate in the same course in October 1994.

Review and update of national HIV surveillance guidelines New STD/AIDS surveillance forms have been developed. Not all of the focus sites have received these. Responsibility for STD/HIV/AIDS surveillance has been transferred to the Regional Health Bureaus and some are in the process of redesigning these forms to suit the regional requirements. It is unclear who at the MOH will be charged with collating Regional data into a national database.

Strengthening of six sentinel surveillance sites; Improving the capacity of five central and 16 regional surveillance staff in the collection of HIV-AIDS and STD surveillance data to support program planning and evaluation at the national and regional levels The current plan by the MOH is to only support four sentinel surveillance sites for HIV prevalence in antenatal clinic attenders: Metu in Region 4, two sites in Addis, and Bahir

Dar. The AIDSCAP 1994-95 Workplan proposes to perform antenatal clinic RPR screening at the four focus sites.

HIV/STD surveillance strengthened in the STAC focus areas The Ministry of Health DEA plans to perform sentinel surveillance at only one of the four focus sites and at three other "non-focus" sites.

3. Recommendations:

* It would be useful to evaluate the impact of the short-term epidemiologic training on their current work responsibilities. What were the opportunities for sharing this training with other MOH staff?

* Health care providers have consistently complained of the need to fill out multiple surveillance forms for different health problems (STD/HIV, EPI, other communicable diseases). Consolidating surveillance forms may lead to increased compliance with the surveillance system. Methods to strengthen the Regional Health Bureaus' capacity to collate and analyze data should be explored. USAID's support for improving the Health Information System should assist with this goal.

G.1 PREVENTIVE COMMODITIES

1. Summary of Major Findings:

Materials for the prevention of HIV transmission in the health care setting have been distributed in an inconsistent pattern. No training has occurred in standard safety practices or proper disposal of wastes.

2. Accomplishments Measured Against Expected Outcomes:

Appropriate supplies (gloves, syringes, needles, etc.) provided to the 20 STAC-1 STD clinics and five regional laboratories The first Letter Grant to WHO which financed the procurement of basic supplies to decrease HIV and other communicable disease transmission in health care settings, included the purchase of sterile and non-sterile gloves, needles and syringes. The second Letter Grant to WHO authorized the procurement of additional supplies including aprons, autoclaves, and face masks. Immunization staff at Bahir Dar reported that they were unable to obtain alcohol or other soaking solutions for initial decontamination of infected skin piercing equipment. Similar complaints were voiced by staff at the other three focus sites.

100% of health workers trained in standard safety practices at 20 clinics and at the 5 regional laboratories No training has occurred on standard safety practices or disposal of biohazardous wastes. Visits to the focus sites, particularly Bahir Dar, confirmed that

there were no systems in place for appropriate disposal of contaminated needles, syringes or other materials.

3. Recommendation:

* All future training sessions of health clinic staff should include sessions on decreasing HIV transmission in health care settings and the appropriate disinfection and disposal of biohazardous materials.

* If biohazardous materials are not being properly disposed of at the focus site clinics and laboratories, AIDSCAP should address this issue in the annual workplan list of activities and budget.

* AIDSCAP staff should closely monitor the supply and distribution of preventive commodities at each of the focus sites to insure that health provider staff have adequate access to materials to decrease nosocomial infections.

G.2 LONG-TERM TRAINING

1. Summary of Major Accomplishments:

* As of this date two candidates have been scheduled to attend Tulane University as MPH candidates.

2. Accomplishments Measured Against Expected Outcomes:

4-5 health educators trained in communications at Masters level The USAID/E buy-in to AIDSCAP inappropriately included support for long-term training. The Cooperative Agreement with AIDSCAP precluded long-term training activities. In order to provide this service, G/PHN/HN/HIV-AIDS worked with the Office of International Training (OIT) to provide an alternative mechanism for placing long-term participants.

3. Recommendation:

* USAID/E should identify candidates and prepare PIO/Ps for long-term training. PIO/Ps should be sent to G/PHN/HN/HIV-AIDS to be processed.

SECTION IV. EVALUATION OF PROJECT IMPLEMENTATION AND MANAGEMENT

A. AIDSCAP Implementation and Management

The dedication and hard work of the AIDSCAP-Ethiopia staff is evident in the number of grants and sub-agreements that have been developed and signed, the workshops that have been carried out and the accomplishments that have been noted in the distant focus sites in rural Ethiopia. Becoming familiar with USAID and FHI-AIDSCAP regulations, while setting up a new office and then moving it three times in 18 months, contributed to the delay in implementation of project activities. As is often the case with the development of USAID projects, the original implementation plan assumed a more rapid initiation of STAC activities than was actually feasible.

Quarterly Report

The AIDSCAP Regional Office for Africa and the AIDSCAP-Ethiopia office made available to the evaluation team an extensive set of documents pertaining to every phase and activity of the project. Of particular note is the quarterly report prepared by the AIDSCAP-Ethiopia Resident Advisor. This was the most comprehensive summary of progress and activities related to STAC project implementation. One way to make this report more useful for monitoring the achievement of project outputs, would be to specifically incorporate into the report a section that identifies the outputs to be achieved under the AIDSCAP Cooperative Agreement, quantifies the progress made over the quarter toward achievement of the outputs and show the cumulative achievement since the project began. By including more quantitative information, such as the number of people trained at the workshop that took place during the reporting period and whether they worked for an NGO or the MOH, the value and usefulness of this comprehensive report would increase even further and would serve as the basis for the USAID six month PIR (Project Implementation Report).

MOH Sub-Agreement

USAID/E made AIDSCAP-Ethiopia acutely aware of the urgency to initiate the STD activities with the MOH. Funds were advanced (\$150,000) to the MOH/DAC under a Letter of Intent several months before the sub-agreement was signed. During the evaluation the team discovered that the USAID Controller was not aware that AIDSCAP had signed a sub-agreement with the MOH/DAC to provide funds directly to the MOH on an advance basis. Standard USAID practice is to pass funds to TGE agencies only on a reimbursement basis. AIDSCAP was not aware of this USAID/E practice.

The advance that AIDSCAP gave to the MOH in April 1993 has not been liquidated. A status report provided by the AIDSCAP accountant dated August 24, 1994, documents the problems

he encountered in reviewing the MOH ledgers to prepare a financial report on the status of the USAID-AIDSCAP funds. The fact that the funds were commingled and a portion of the ledgers were in disarray made the task more difficult. The report indicates that of the \$150,000 advanced to the MOH over a year ago, \$31,750 has been expended, \$60,227 was transferred to Regional Bureaus for financing refurbishing of health centers and programmed IEC activities, and \$58,023 is the balance that should be on hand in the MOH.

The AIDSCAP-MOH sub-agreement, under which the advance was made, has a total budget of \$385,750. The original agreement, signed on October 1, 1993, covers the period January 1, 1993 to June 30, 1994. On June 30, 1994, the sub-agreement was amended and the completion date extended until September 30, 1994. In summary, the present AIDSCAP-MOH agreement is due to expire in one month. The MOH can account for almost \$32,000 of expended funds, but it is not known how long it will take to account for the \$60,000 that was disbursed to the Regions. The evaluation team determined that funds programmed to refurbish health establishments had been spent, while funds for IEC which were sent to the Regions in June 1994, had not.

* It is recommended that this project be closed out on the September 30, 1994, termination date and all unexpended funds from the central level and Regional Health Bureaus be returned to AIDSCAP.

* A new agreement between AIDSCAP, the MOH and USAID/E should be developed to facilitate the completion of the project activities, with AIDSCAP directly disbursing the local currency funds on behalf of the MOH central office, Regional Health Bureaus and/or focus site health centers and laboratories. The REDSO RLA concurred with this recommendation to change the implementation arrangements in his e-mail (A. Vance e-mail to J.LaRosa) of August 25, 1994.

In addition to the financial management problems, MOH project activities were delayed as a result of MOH bureaucratic problems regarding procurement of locally manufactured furniture and equipment.

MOE Sub-Agreement

Under the AIDSCAP sub-agreement with the MOE \$11,000 was advanced. It was expected that some of these funds would be expended during the last week of August when the MOE conducted its first workshop under the project. The MOE was able to open a separate bank account for project funds after several months of bureaucratic delays. The MOE, however, has no track record to demonstrate its ability to adequately manage project funds. The June 1994, draft report of a USAID/E financed assessment of TGE financial management systems, which included those of the MOH and MOE, found sufficient fundamental weaknesses to conclude that the accountability environment was too low to guarantee adequate management of USG funds.

*AIDSCAP should not provide any further advances to the MOE. USAID/E should assist AIDSCAP to renegotiate the MOE sub-agreement to either:

- a) provide funds to the MOE on a reimbursement basis; or,
- b) to allow AIDSCAP-E to directly disburse funds for MOE activities under the STAC Project.

Financial Management Review

The evaluation team requested assistance from the USAID/E Controller to review the financial management procedures that AIDSCAP was following in implementing sub-agreements with NGOs as well as with the MOH and MOE to make sure that they were in line with standard USAID practices and to make recommendations if areas for improvement were identified.

The Chief Accountant of the USAID Controller Office met three times with the AIDSCAP accountant and also attended a meeting with the MOH staff of the Accounting and Budget Division. The review revealed that AIDSCAP staff did not fully appreciate the importance of following standard USAID procedures. An example is the requirement to open a separate bank account for all USAID project funds. Most of the NGOs and the MOH had commingled USAID-AIDSCAP funds in accounts with other monies. In the meeting with the MOH accountant it was revealed that the commingling of USAID funds with those of WHO and other donors had taken weeks to unravel and resulted in the freezing of the bank account and the five month delay in providing project funds to MOH Regional Bureaus.

The AIDSCAP Accountant conducted pre-award financial reviews of NGOs that were selected to receive competitive grants for HIV-AIDS prevention activities. While deficiencies were identified in the financial management systems, advances were given to these NGOs without verifying that the problems had been resolved. The AIDSCAP Accountant had not made any visits to sub-recipient field sites, even though NGOs were not complying with sub-project requirements to open separate bank accounts and provide monthly financial reports.

*It is recommended that AIDSCAP Headquarters review the financial management requirements under the USAID cooperative agreement and verify that country offices are in compliance.

*It is also recommended that if AIDSCAP enters into any more sub-agreements with NGOs, the AIDSCAP-E Accountant should conduct a pre-award assessment and make sure financial management system deficiencies are corrected before any funds are advance to the NGO. The accountant should also make field visits to project sites, focusing on NGOs that are not meeting reporting requirements. The accountant should also verify that deficiencies in the financial management systems that were reported on pre-award assessments have been resolved.

B. USAID Project Management

Letter Grants to WHO

Under the STAC Project, USAID has issued two letter grants to WHO to purchase project commodities to support the MOH STAC activities. The first Letter Grant was delayed due to bureaucratic problems, and lack of adequate communication and follow-up. The evaluation team was advised that a problem has also recently arisen with the second Letter Grant to WHO.

The delay in processing the Letter Grant led to the delay in procurement and arrival of STD medicines and laboratory equipment, which prompted a postponement in project activities that were originally programmed to coincide with the arrival of supplies, equipment and pharmaceuticals. This was a significant cause of the delay in the project implementation plan.

*USAID should make every effort to determine if a problem does in fact exist with the second Letter Grant and resolve it soonest. USAID staff should also take steps to follow the paperwork for the next order as it progresses through the WHO system. Given the experience to date, it is likely that another problem will arise. A plan should be made to detect and resolve problems in a timely fashion.

Participant Training

USAID also experienced problems in managing the long-term training component of the STAC project. Since the AIDSCAP project does not include a provision for long-term training, this had to be arranged separately by USAID/E and USAID/W. G/PHN/HN/HIV-AIDS has offered assistance that will allow two participants to enter an MPH program in September. Future placements of long-term participants should be planned with more advance notice and with contingency plans based on the USAID funding and contracting cycles. Unless USAID/E has a mission training project under which these participants could be included, there does not appear to be an easier way to manage this activity.

AIDSCAP Monitoring

When USAID/E transferred OYB funds to the AIDSCAP Cooperative Agreement, it was assumed that AIDSCAP would have the knowledge and capability to manage all the AIDSCAP STAC activities in a timely fashion in accordance with USAID regulations. While AIDSCAP has made progress in improving its overall knowledge of USAID regulations, establishing regional and country offices, recruiting and training staff, issuing letters of intent and sub-agreements, USAID/E should continue to monitor implementation actions and provide assistance in dealing with the MOH and MOE when requested.

* Not only the USAID technical officers, but the USAID Controller and Executive Officer should be consulted and kept informed of AIDSCAP country office activities that pertain to their work.

*When AIDSCAP procedures are not in compliance with USAID/E procedures, USAID/E should advise the AIDSCAP-E Country Office of the problem and also notify the USAID/W Cognizant Technical Representative (COTR) in the G/PHN/HIV-AIDS Division, who is responsible for project management and liaison with AIDSCAP Headquarters.

STAC Project Counterpart

USAID/E advised that a waiver for the TGE 25% counterpart contribution can be justified. Until such a waiver is obtained, however, it is essential that monitoring of counterpart funding be performed. Counterpart monitoring is not being carried out at this time.

S E C T I O N V **RECOMMENDATIONS FOR** **USAID/E ACTION**

A. Extend PACD

It is recommended that the STAC PACD be extended one year, until September 30, 1996, to allow for the completion of the STD/HIV activities programmed in the STAC Project and Amendment. A PACD extension is also recommended to allow for a gradual and well-planned close out of selected NGO sub-agreement activities and the focus site activities not included in future USAID projects, and the AIDSCAP-Ethiopia office. Because of the delays in implementation, many activities which may occur during the extension period are already funded under STAC. However, this extension may require additional funding for AIDSCAP management costs, drugs and supplies, and for limited term NGO support.

B. Actions to Improve Performance

* To expedite the effective implementation of the technical components, increased use of AIDSCAP external Technical Assistance would be advised.

* Additional training of USAID, AIDSCAP, NGO, and TGE staff on basic USAID regulations would improve compliance and streamline the effective implementation of the technical components.

* As the Regional Health Bureaus take on more of the responsibilities for implementing health activities, we should consider ways to improve their capacity for logistics/supply management, efficient monitoring of activities, and reporting to AIDSCAP and central Health/Education staff.

* Sustained access to supplies (STD drugs, condoms, reagents) is critical to the successful implementation of many of the STD/AIDS prevention interventions. This is true during the Life of the Project and afterwards.

C. Actions to Improve Management

* The AIDSCAP sub-agreement with the MOH should terminate on September 30, 1994 as scheduled. All unspent funds from all central, regional and health center levels should be returned to AIDSCAP for reprogramming. A new agreement should be developed between AIDSCAP, the MOH and USAID/E that allows AIDSCAP-E to directly finance costs related to MOH STAC Project activities.

* AIDSCAP with USAID/E assistance should renegotiate the sub-agreement with the MOE to either: a) provide funds to the MOE on a reimbursement basis; or, b) to allow AIDSCAP-E to directly finance costs related to MOE STAC Project activities.

* If AIDSCAP enters into any more sub-agreements with NGOs, the AIDSCAP-E Accountant should conduct a pre-award assessment and make sure financial management system deficiencies are corrected before any funds are advance to the NGO.

* The USAID/E Controller should be copied on all correspondence related to AIDSCAP management of sub-agreements and activities with TGE agencies and NGOs, should participate in semi-annual project implementation reviews, and should liaise with AIDSCAP-E accounting staff to keep them advised of relevant USAID procedures and practices.

* USAID/E should justify a waiver of the counterpart contribution to the STAC Project.

D. Activities to address in the ESHE Project

* Health care providers have consistently complained of the need to fill out multiple surveillance forms for different health problems (STD/HIV, EPI, other communicable diseases). Consolidating surveillance forms may lead to increased compliance with the surveillance system. Methods to strengthen the Regional Health Bureaus' capacity to collate and analyze data should be explored. USAID's support under the ESHE Project for improving the Health Information System should assist with this goal.

* Given the important role played by AIDSCAP in providing resource materials and facilitating information exchange and development of NGO STD/HIV prevention programs, USAID should **made sure that this function is assumed by one of the agencies involved in implementing the new ESHE Project** so that these resource materials will still be available to NGOs after the close of the AIDSCAP office.

* As the Regional Health Bureaus are assuming increasing responsibility for implementing health activities, their capacity for logistics/supply management, efficient monitoring of activities, and reporting to the central level MOH staff needs to be strengthened.

SECTION VI. LESSONS LEARNED FOR USAID/W AND AIDSCAP HQ

A. Technical Interventions

* Multiple activities in the STAC Project were contingent upon the successful completion of prior critical procurements and other activities. In some instances it is justified, if not essential, to delay an activity until all of the "pieces are in place." For example, training of regional and health center laboratory staff was postponed until the arrival of equipment and supplies which were essential to a successful and useful training in laboratory techniques. However, some critical activities were inappropriately delayed because of failure to receive all components. For instance, initiating STD services in Bahir Dar was postponed because gram stain had not arrive. Whenever there is a sequential series of steps that are necessary to effectively achieve a goal, it is important to assess how critical each activity is to the implementation of the next activity and whether it is necessary to delay the start of the next activity.

B. Country Office Management

* Financial management of AIDSCAP country office activities needs greater attention including training of staff, compliance with standard USAID procedures, and monitoring of activities in the field.

* Ethiopia is not the only country where AIDSCAP has been asked to develop and award sub-agreements to NGOs. It would be beneficial to have a meeting or seminar with those who participated in this exercise in Ethiopia and appropriate representatives from AIDSCAP Regional and Headquarters Offices, to discuss the process and the problems and to define a new and more decentralized procedure to streamline the process and reduce the amount of time required to initiate an program of NGO sub-agreements even further. This new procedure should be applied soonest to all countries where AIDSCAP is awarding sub-agreements to NGOs.

* While USAID Controllers are not responsible for monitoring AIDSCAP Country Office activities, they should be copied on any correspondence from AIDSCAP that concerns management of funds, including financial management reviews that are conducted by the AIDSCAP accountants. It is recommended that USAID Controllers informally monitor AIDSCAP financial management practices to make sure they are in conformance with USAID Mission financial practices.

C. Decentralization

* AIDSCAP has made a limited effort to decentralize project management by allowing the Regional Office for Africa to sign off on technical proposals, rather than send them to Headquarters for approval. Approval for the financial plans, however, still rests with Headquarters. Regional and Country Offices do not have sufficient financial information to manage country programs. Requests from the field offices for the financial data have not been filled. AIDSCAP should strengthen field capabilities in financial management and delegate greater authority to field staff in order to decentralize and streamline the operations.

ANNEX A.

LIST OF PERSONS CONTACTED

USAID/E

Walter North, Acting Director
Carmela Green-Abate, STAC Project Manager
Victor Barbiero, GDO
Carl Lewis, Controller
Belai Eyesus, Chief Accountant

AIDSCAP-E

Mulunesh Tennagashaw, Resident Advisor
Medhanitu Mamo, Accountant
Fekerte Belete, NGO Coordinator
Mulugeta Ersemo, Technical Coordinator

MOE Central Level

Awash Gebru, AIDS Supervisor, Dept. of Educational Programs
Setotau Yemam, Physical Education Co-curricular Activities
Yohamese Godana, Senior Expert Health Education

MOH Central Level

Dr. Workneh Feleke, Head of HIV/STD Team
Dr. Mulugetta, Senior Expert Laboratory and Blood Transfusion
Worz Amsale, IEC Expert

MOH Regional Bureaus and Focus Sites

Awassa

Dr. Sahlemariyam, Southern People's Region HIV/STD Coordinator
Dr. Tadele Gebeyehu, Head of Southern People's Region Health Bureau
Dr. Lensamo Yera, Awassa Health Center Director
Dr. Mulu Gedi, Awassa Health Center Physician
Solomon Sorsa, Coordinator, So. People's Regional Laboratory
Kassahun Alemaychu, Awassa H. Center Pharmacist
Ashenafi Argeta, Zonal Health Department
Dr. Wolde Yohannes G/Tsadeh, Textile Factory Physician

Nazareth

Dr. Aseged Woldu, Oroomia Region AIDS/STD Coordinator
Tayech Lema, AIDS/STD Coordinator, East Shoa Zonal Health Dept.
Dr. Fekaku Adugna, Medical Director, Haile Mariam Mamo Hospital
Dr. Daniel Areg
a, HIV/STD Coordinator, Haile M.M. Hospital
Seifu Tefera Fanta, Laboratory Head, Haile Mariam M Hospital
Bekele Dagmay, Chief Pharmacist, H.M.M. Hospital
Tsehai G/Gongiz, Nurse, Nazareth Soap Factory
Shasmu Araya, NACID Health Coordinator

Mekele

Dr. Berhane K/Marium, Regional Health Bureau, Disease Prevention and Control Dept.
Almaz Bekell, Health Education Division Coordinator
Dr. E. Yasu Habtu, Mekele Hospital Physician
Dr. Tsegay Legesse, Mekele Health Center Director
Negus Bexele, Mekele Health Center Health Education Officer
Abrham Aregani, M. Health Center Health Assistant
Kidaremarriam Alasuged, M. Health Center Family Planning Unit
Awatash Adhanen, M. Health Center Laboratorist
Aros Haile, M. Health Center Laboratorist
Berhane Gebeyehu, M. Health Center Druggist
Araya Zerihun, CEO Tigray Development Association
Wray Whitten, TDA Consultar
Tekle Haile Selassie, TDA Senior Project Officer
Kidane G. Egzrabirhil, TDA Unit Head, Project Prep. and Monitoring
Israel, PSI Mekele District Coordinator

Bahir Dar

Mr. Ato Admassu-MEEC
Mr. Fekadu Challa, Family Guidance Association
Dr. Gebre Asmanmaw, Head of Disease Prevention and Control Dept.
Dr. Aysheshum Adem, Head of Communicable Disease Control Team
Dr. Girma Teferra, Director of Bahir Dar Health Center

Other Organizations

Tadesse Ejigu, CCF HIV/AIDS Project Coordinator
Lulseged Mengiste, CCF Health and Training Manager
Shooaatsehaye Belehu, IHAUD Project Director
Biruck Hondimu, IHAUD Program Senior Health Instructor
Likeyelesh Bazssa, IHAUD Health Programme Officer
Teshome Wakene Buta, PSI IEC Coordinator

ANNEX B LIST OF STD CLINIC SITES

FOUR INITIAL:

Nazareth
Mekelle
Bahir Dar
Awassa

SIX ADDITIONAL STD CLINIC SITES:

Debremarkos
Arbaminch
Hosanna
Gondar
Robe
Jinka

ESSENTIAL EQUIPMENT AND SUPPLIES FOR ADDITIONAL 10 STD CLINIC SITES:

Axum
Finote Selam
Gambella
Debretabor
Buno Bedelle
Asayita
Dila
Yirgalem
Asossa
Goba