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**Process Evaluation
of the AIDS
Technical Support
Project (ATSP)**
(Project No. 936-5972)

Health Technical Services Project



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**PROCESS EVALUATION OF THE
TECHNICAL SUPPORT PROJECT
(ATSP)**

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Preface

This process evaluation of the AIDS Technical Support Project (ATSP) (Project No. 936-5972) was carried out at the request of the Office of Health and Nutrition, Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, United States Agency for International Development. The evaluation was conducted during the period of January 22 through February 29, 1996, in Washington, D.C.; Atlanta, Georgia; Geneva, Switzerland; London, England; and New York, New York. The Team was comprised of six professionals with experience in team leadership, strategic planning, evaluation, policy, public health, medicine, behavioral science, communication, and HIV/AIDS.

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Substantive Appropriateness

Acronyms

AED	Academy for Educational Development
AFAO	Australian Federation of AIDS Organisations
AFR	Africa Bureau, USAID
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Program
AIDSCOM	AIDS Public Health Communications Project
AIDSTECH	AIDS Technical Support Project
ANE	Asia and Near East Bureau, USAID
ATSP	AIDS Technical Support Project
AWI	AIDSCAP Women's Initiative
BCC	Behavior change communications
BRU	Behavioral Research Unit
BuCen	U.S. Bureau of the Census
CA	Cooperating Agency
CAPS	Center for AIDS Prevention Studies
CBO	Community Based Organization
CDC	Centers for Disease Control
CDIE	Center for Development Information and Evaluation, USAID
COTR	Contract Officer's Technical Representative
CSW	Commercial Sex Worker
DHS	Demographic Health Surveys
FPLM	Family Planning Logistics Management Project
FHI	Family Health International
FY	Fiscal year
HAPA	HIV/AIDS Prevention in Africa
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development (World Bank)
ICRW	International Center for Research on Women
IPPF	International Planned Parenthood Federation
IQC	Indefinite Quantity Contract
LAC	Latin America and Caribbean
LOP	Life of Project
NCIH	National Council for International Health
NGO	Non-governmental organization
NIAID	National Institute of Allergy and Infectious Diseases
NIH	National Institutes of Health
OE	Operational Expense
OYB	Operating Year Budget
PACD	Project Assistance Completion Date

PASA	Participating Agency Service Agreement
PATH	Program for Appropriate Technologies in Health
PHN	Population, Health and Nutrition Center, USAID
Pop Council	Population Council
PP	Project Paper
PPC	USAID Bureau for Policy and Program Coordination
PSC	Personal Services Contractor
PVO	Private Voluntary Organization
RFP	Request for Proposals
SOMARC	Social Marketing Contraceptives Project
SOW	Scope of Work
STD	Sexually transmitted disease
TAG	Technical Advisory Group
UN	United Nations
US	United States
USAID	United States Agency for International Development
USDH	United States Direct Hire
USG	United States Government
USIA	United States Information Agency
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID/W	United States Agency for International Development/Washington
WHO/GPA	World Health Organization/Global Programme on AIDS
WHR	Western Hemisphere Region
WID	Women in Development

Acknowledgments

The evaluation team wishes to thank the staff of the HIV-AIDS Division for their thorough preparation of background materials and documents and for the time they gave from their busy schedules for interviews with members of the team. The HIV-AIDS Division is known for its exceptional dedication to work, as well as its contagious capacity for fun and laughter. The team found this reputation to be fully justified.

This evaluation relied on the extensive information gained during the course of over fifty interviews with representatives of ATSP Cooperating Agencies (CAs) and other knowledgeable informants. The team is extremely grateful to all interviewees who gave generously of their time to answer a wide range of questions and who often provided the team with additional background materials and documents. The thoughtful comments and constructive recommendations offered have been extremely valuable for the Team's analysis.

Finally, this evaluation was greatly facilitated by the excellent support of the Health Technical Services Project. In particular, the team thanks Judith Oki, Team Planning Facilitator, Denise Lionetti, Project Director, and Melinda Garges, Project Assistant.

Executive Summary

A. INTRODUCTION AND OVERVIEW

The AIDS Technical Support Project (ATSP) is an extraordinarily large and complex USAID project initially authorized in 1987. During its nine-year life as USAID's primary programmatic response to the HIV/AIDS epidemic, this umbrella project, managed by the HIV-AIDS Division¹ of the Global Bureau, has obligated over \$260 million. The project has had two distinct phases, beginning with a start-up or learning phase (Phase I) from 1987 to 1991, with two major implementing entities (AIDSCOM and AIDSTECH) and five smaller Cooperating Agency (CA) activities. Prompted by a concern that resources were spread too thin to have a measurable impact, the ATSP was redesigned in 1991. The second phase (Phase II) of the ATSP, which began in 1992 and will terminate in August 1997, has a single major implementing entity (AIDSCAP), and also funds thirteen other CA activities.

This process evaluation of the ATSP has been commissioned in order to examine the degree to which the strategies, structures, and management procedures of the ATSP, as a whole, have been responsive to the epidemic, and have supported the achievement of project objectives. This evaluation has focused largely on Phase II of the ATSP and hopes to provide lessons learned and recommendations that can be used in the design of the next stage (Phase III) of the Global Bureau's and USAID's programmatic response to addressing this insidious and devastating disease that have not yet been effectively checked.

This evaluation builds on a midterm evaluation of AIDSCAP conducted in 1995 and evaluations of some of the smaller CA programs. It will be supplemented over the next year by end-of-project evaluations of AIDSCAP and all other ATSP CA activities. These evaluations will include careful reviews of whether these CAs have met their contract "deliverables." This process evaluation, therefore, has not focused on CA deliverables or the impact of individual CA projects. It is focused on the ATSP-wide program and macro-level issues.

The evaluation was carried out in January and February of 1996 by a six-person team. The Team gathered data through interviews with over 50 key informants, a review of key project documents, and responses to a questionnaire sent to 30 USAID overseas missions.

B. THE DESIGN OF THE PHASE II ATSP PROGRAM

The Phase II design of the ATSP was novel, ambitious, and even audacious in two fundamental ways. First, in attempting to achieve its stated project purpose—to expand access to HIV prevention and control programs in developing countries—a new entity was created, the AIDS

¹HIV-AIDS Division of the Office of Health and Nutrition, USAID, PHN Center, Bureau for Global Programs, hereinafter referred to as the Global Bureau

Control and Prevention Program (AIDSCAP) which had unusually wide program and management responsibilities for a USAID-funded CA. AIDSCAP's program responsibilities were:

- **Global in nature:** With primary focus on design and management of new programs in 15 priority countries and technical support for a host of associate country programs. AIDSCAP would be the one and only entity funded to provide worldwide support to USAID missions in addressing HIV/AIDS;
- **Technically all-inclusive:** With responsibility for all elements (biomedical, behavioral, policy, evaluation) of a core package of three primary and three supporting technical components, i.e., a “comprehensive” program response to HIV/AIDS prevention; and
- **Multi-functional:** In order to encourage the rapid integration into program operations of new knowledge from research and the evaluation of project interventions, AIDSCAP was given both operational and learning functions. AIDSCAP had day-to-day operational responsibility for ongoing programs across the globe. At the same time, it was responsible for carrying out path-breaking behavioral research, evaluating its own activities, and being a center of state-of-the-art knowledge about HIV/AIDS—“a center of all truth and knowledge” regarding AIDS.

The Phase II design was path breaking in a second major way. Drawing on the best information available at the time, the Project Paper (PP) Amendment prescribed a comprehensive package of “proven” technical interventions to address HIV/AIDS. The three primary technical strategies: 1) increased access to and use of condoms; 2) behavioral change communication; and 3) STD treatment, were combined to provide a synergistic effect, postulated to have greater impact than that of a single intervention.

USAID was the first donor to prescribe and globally implement an articulated technical strategy for HIV/AIDS prevention and control. This strategy drew on the Agency's substantial experience with condoms (from family planning programs) and behavioral change communication (from family planning, child survival, and other health programs). At the same time the Agency took a risk by including STD treatment in the strategy. In this area the evidence of successful impact on HIV/AIDS was less certain, and USAID had little previous experience.

Most of the activities described in the PP Amendment were to be carried out by AIDSCAP. Other CA programs were mentioned only incidentally; except for a plan to work with other donors to create a new organization, the International HIV/AIDS Alliance. This new organization would support NGO programs worldwide.

C. KEY CONCLUSIONS

The evaluation team analyzed the operational and substantive appropriateness of the ATSP project design and the manner in which it is being implemented. It reviewed progress in the establishment of the International HIV/AIDS Alliance and, at the request of the HIV/AIDS Division, assessed the relationship of the ATSP and the Division with WHO/GPA and UNAIDS. Finally, it analyzed the impact of structural, procedural, and managerial influences on the capacity of the project to achieve its project purpose and four project outputs. The most important conclusions from each of these sections of the report are briefly outlined below.

1. Structural Appropriateness

The ATSP: The umbrella-like structure of the ATSP Project was ideally suited to giving USAID the opportunity to respond flexibly to the growing body of information and experience about a new emerging problem area—HIV/AIDS. The concentration of USAID resources in one unit (approximately 60% of all funds earmarked for HIV/AIDS were managed by the HIV/AIDS Division of the Global Bureau) helped give that unit the capacity to influence USAID missions and to provide global leadership.

AIDSCAP: The Phase II project structure centered the management burden of a very complex global program on a single institution. After the competitive bidding process was completed, this institution turned out to be a non-profit entity which had never managed a program of comparable complexity or size. In fact, AIDSCAP was larger than its “mother” institution—Family Health International (FHI).

It is clear that FHI (and its subcontractors) have struggled with this extremely large management burden and unusually wide span of control. In the judgment of the HIV/AIDS Division staff, the areas of responsibility which appear to be most effectively carried out are areas where FHI had preexisting institutional expertise—i.e., biomedical and family planning experience. These areas of relative strength also seem to reflect the background of technical expertise of the AIDSCAP senior staff. The areas of responsibility where performance has been less strong, according to Division staff, are areas where FHI came to the project with less institutional experience and capacity, i.e., behavior change communications, behavioral research, and policy. Leadership positions for these AIDSCAP units were initially filled by employees of subcontractors or individuals recruited specifically for AIDSCAP, not senior FHI employees. There was significant turnover in these positions early in the project.

Establishing a new program with this unusually heavy management burden and span of control may have fully absorbed AIDSCAP's management capacity, especially early in the project. It may also have discouraged AIDSCAP managers from being “flexible” to mission demands or “open” to new intervention paradigms.

With expectations for impact, AIDSCAP tended to become an intervention- and operations-focused organization. In this context, learning activities such as behavioral research, pilot contextual approaches to HIV/AIDS, and programmatic collaboration became lower priorities.

USAID: The decisions on the structure and functions of AIDSCAP, which concentrated more responsibility in a single CA than previous USAID Global Bureau programs, were driven as much by USAID management concerns (such as limiting the number of USAID management units) as by technical considerations (ensuring that the highest quality of information and technical advice about this relatively new disease would be available for programs throughout the world from a single source).

The design anticipated that the management of one large project would be more efficient than the Phase I bi-modal management structure, especially in reducing internal USAID documentation (procurement, budgeting, reporting). These management efficiencies were realized initially but have been lost in recent years due to the mid-stream conversion of AIDSCAP from a cooperative agreement to a contract, and the introduction of field support budgeting.

The conversion from a cooperative agreement to a contract has had a significant negative impact on the capacity of AIDSCAP to carry out its program on schedule. It has reduced risk-taking and flexibility which are essential to a program addressing a new problem area where knowledge of the disease and how to prevent it are in their infancy, compared to other Agency programs. It has also significantly increased the documentation workload of USAID staff.

The introduction of field support budgeting was a major "time-consuming distraction" in FY95. Combined with major budget cuts in FY96, field support budgeting is threatening to undermine the very viability of the AIDSCAP program, since funding for many core functions may not be available.

Other ATSP CA Activities: Although 85% of ATSP resources have been devoted to AIDSCAP, HIV-AIDS Division managers have taken advantage of the remaining resources and the flexibility inherent in the ATSP umbrella-like structure, to fund new CAs. These activities are not duplicative of AIDSCAP activities and are probably best carried out by specialized organizations. Many of these CAs (UNDP, IPPF, ICRW, BuCen, UNICEF, Pop Council) have supported valuable behavioral or biomedical research or tested alternative models for addressing the epidemic and have added a great deal of value to the overall ATSP program effort.

HIV-AIDS Division coordination of the ATSP has been primarily administrative in nature and the Division has not provided requirements, incentives, or mechanisms for AIDSCAP and the 13 CAs to build programmatic bridges or to learn from each other. The Division has not viewed the ATSP as a programmatic whole, and therefore, the ATSP is little more than a sum of its parts.

a. ATSP Responsiveness to Field Mission Needs

Most USAID field mission personnel are not aware of the other components of the ATSP umbrella. With few exceptions, they view the HIV-AIDS Division portfolio as synonymous with AIDSCAP, and have little or no information on the results of most other CA activities or the availability of their services.

Considerable friction was initially created by what missions perceived as the "Washington-only" design of AIDSCAP and the rather set program approach AIDSCAP initially expounded, especially for comprehensive country programs. Missions now feel that AIDSCAP has become more responsive to mission and country needs.

Similarly missions initially felt that AIDSCAP was very centralized and bureaucratic in decision making. This complaint is now heard less often as decentralization in decision making and increased delegation of authority is occurring within AIDSCAP.

All regional bureaus and many missions have utilized the AIDSCAP buy-in or OYB transfer mechanisms to finance designated country or regional level activities. Only seven missions have established bilateral HIV/AIDS projects which do not utilize AIDSCAP as the primary implementing agency. This homogeneity demonstrates that the Phase II design was successful in reducing the number of separate USAID management units.

b. Evaluation

No single evaluation system has been created for the ATSP as a whole. Therefore the HIV-AIDS Division will not be able to evaluate the impact of the umbrella ATSP program. However, the results of final evaluations of each CA grant or contract will be available over the next year to help guide the detailed design of Phase III.

Evaluating the impact of HIV/AIDS interventions is particularly complex and difficult given the nature of the disease (i.e., many people do not know their HIV status) and poor reporting due to continuing stigma in some quarters. Behavioral change, the heart of prevention interventions, is also very difficult to measure and not certain to endure. USAID knows less about HIV/AIDS than other technical areas (family planning, child survival, etc.) where it has had longer program history and where it has been able to aggregate and report significant program results. Given these realities, the HIV-AIDS Division (and Agency leaders) should be careful not to over promise results to Congress or to advocacy groups.

USAID's and FHI's attention to measuring the impact of AIDSCAP's comprehensive country programs was almost certainly contributed to the lack of flexibility initially perceived in the AIDSCAP program. The adherence to the core package approach may have been due to the desire to gather and aggregate data from the comprehensive country programs for evaluation and reporting purposes, as well as certainty that a single recipe would achieve impact in all locations.

The five-year time frame to establish and evaluate AIDSCAP sub-projects and country programs, is extremely tight. Even with a one-year extension, the Evaluation Team is concerned that without a major commitment of both financial resources and staff time, the rich data potentially available from the AIDSCAP effort will not be adequately analyzed and disseminated.

c. Links to USAID Portfolio

The ATSP Phase II designers did an excellent job of utilizing USAID's in-depth experience in family planning to design some of the components of AIDSCAP. ATSP buy-ins to Office of Population projects have been management-efficient ways to avoid unnecessary duplication and to encourage some family planning CAs to incorporate HIV/AIDS into their programs—at least on a pilot basis.

The HIV-AIDS Division has not focused attention, until recently, on urging USAID to consider HIV/AIDS as a “development issue” rather than a “public health” issue. It is instructive that this broader approach to dealing with HIV/AIDS is more common in entities such as UNDP, UNICEF, and USAID's Africa Bureau (AFR), which do not receive their funding via sector or problem-specific functional accounts.

d. HIV-AIDS Division Management of the ATSP

The evaluation team asked ATSP CAs to evaluate the HIV-AIDS Division management of their agreement and the ATSP as a whole. The CAs gave the Division consistently high marks for technical guidance and global leadership, and consistently low marks for communication of overall ATSP status, issues, and opportunities, and for facilitating cooperation and teamwork within the ATSP. The Division's ability to help resolve operational problems was largely dependent on their project manager's knowledge of “the USAID way” of operating.

These marks may be explained in part by the composition of the HIV-AIDS Division leadership and staff (usually characterized as highly motivated, technically qualified, and technically focused, but relatively inexperienced in USAID operations), and by the management style of an overburdened and understaffed unit, which had little time for staff supervision, staff training, and internal coordination

2. Substantive Appropriateness

The technical focus of the Phase II program reflected a confidence that, in 1990, the public health community knew what worked in HIV/AIDS prevention and the program was ready to move from an experimentation phase (Phase I) to an implementation phase (Phase II). Most knowledgeable observers believe that the three core strategies selected at the time of redesign were, and still are, appropriate and important components of any comprehensive HIV/AIDS program. Since process and outcome data from individual AIDSCAP sub-projects is not yet

available, it remains intuitive that an ideal program will combine multiple reinforcing strategies to maximize cumulative impact.

STD diagnosis and treatment is now recognized as an essential biomedical strategy for HIV/AIDS prevention and reproductive health. The recent Mwanza study (see pg. 43) illustrates the potential impact of a syndromic approach to STD treatment, similar to that supported in field programs by AIDSCAP. In addition, the development and testing of STD diagnostics remains critical for the reduction of STDs in asymptomatic women.

Some AIDSCAP sub-projects have suffered from the lack of consistent access to STD drugs and condoms. The assumption of the Phase II design that these commodities would be provided from non-ATSP sources, has not been valid in many cases. This has seriously undermined the potential impact of these sub-projects.

While the three core strategies are still essential, they are no longer considered sufficient to make a sustainable impact on HIV transmission. There is now less certainty on how to achieve results from HIV/AIDS interventions than in 1991. There is a need to expand support for a broader response to HIV/AIDS to include the following substantive areas and approaches:

- Developing contextual interventions for HIV/AIDS prevention: The Phase II focus on individual behavior change is too simplistic an approach to a problem rooted in the context of strong social, cultural, and economic determinants. Although the AIDSCAP midterm evaluation noted the general absence of contextual interventions within the project, AIDSCAP and other CAs are still uncertain about what interventions are feasible, affordable, and relevant to achieve a sustainable impact on the epidemic. This uncertainty needs to be acknowledged without looking for quick programmatic solutions.
- Supporting a more "community-organizing" approach to HIV/AIDS: In many countries community action is at the center of innovative and successful responses to HIV/AIDS. Given the complex socioeconomic and cultural context of HIV transmission, community-based groups are often best able to initiate appropriate responses to the epidemic, as well as to work with vulnerable and marginal populations. In the process of community mobilization, there is an opportunity to develop genuine local ownership and commitment to AIDS initiatives. Among the ATSP programs, only the Alliance and, to a limited extent, AIDSCAP, have supported community-organizing approaches to HIV/AIDS.
- Reaching beyond traditional "at risk groups" to reduce women and girls' vulnerability to HIV/AIDS: Despite the escalating incidence of HIV/AIDS among women, ATSP programmatic responses have remained too peripheral and under-resourced. Three CAs (ICRW, IPPF, AIDSCAP) have relatively small programs to specifically address women and girls'

prevention needs. It is now appropriate to build on these and other pilot activities and devote greater attention and resources to issues of gender and HIV/AIDS prevention.

- Supporting more expedient development and testing of vaginal microbicide: The timely development and testing of anti-microbials is largely constrained by limited financial and human resources, not by any significant conceptual or feasibility problems. Given the absence of a strong U.S. constituency for microbicide research, continued USAID leadership in microbicide development is a likely prerequisite for the timely development of new prevention technology, which could revolutionize HIV prevention efforts globally.
- Linking HIV/AIDS prevention and care: The ATSP has funded prevention and control interventions but has explicitly excluded care initiatives for those affected by the epidemic. The underlying concern was that care activities would drain financial resources and thereby detract from priority prevention efforts. For communities now living with a mature epidemic, prevention and care are inseparable concerns. Cost-effective care activities should not be automatically excluded from the purview of Agency programs. Unfortunately, unlike other donors, USAID's strong position against funding care has left it with few models or pilot activities to draw upon to plan for when and how to integrate prevention and care activities effectively and efficiently.

3. The International HIV/AIDS Alliance

The establishment of the Alliance was a worthy multi-donor objective embarked upon after careful analysis and consultation. The program, with some conceptual similarities to the International Planned Parenthood Federation (IPPF) in the field of family planning, appears to fill an important void by providing flexible assistance to small, community-based organizations, and by supporting the process of community mobilization. The Alliance has now been created with the support of the ATSP, and its program appears to be off to a promising start. Program impact and sustainability can only be measured after several additional years of activity.

However, many of the assumptions related to funding sources and funding modalities appear to be off target. One hopes that a review of these assumptions is a primary focus of the donor evaluation of the Alliance, now being carried out, and that the subsequent evaluation recommendations concentrate on how to increase the chances for the long-term financial viability of the Alliance.

4. ATSP Relationship with WHO/GPA and UNAIDS

Valuable collaboration between WHO/GPA and the HIV-AIDS Division or ATSP CAs has occurred in the areas of data collection, evaluation, biomedical and behavioral research, and condom social marketing and supply. These collaborations occurred due to personal contacts

and through coordinated planning carried out by the HIV-AIDS Division and WHO/GPA. There are a few minor reports of duplication of effort at the global level.

The U.S. government, with technical support from the HIV-AIDS Division, should take this unique opportunity to influence several issues related to the functions of the new UNAIDS. These issues include: intra-UN system funding; global research priorities, country-level coordination, rationalization of resources across countries; and evaluation.

D. STRUCTURAL, PROCEDURAL, AND MANAGERIAL INFLUENCES ON THE CAPACITY TO ACHIEVE THE PROJECT OBJECTIVES

Project success for USAID has been measured by whether a project achieves its purpose and all or most of its project outputs, as described in the project logical framework. (See page 70)

Project Purpose: Following this methodology, our review of structural, procedural, and managerial influences concludes that the ATSP has an opportunity to achieve its project purpose—"to expand access to HIV prevention and control programs in developing countries" by "increasing the number, quality, and coverage of HIV prevention and control programs."

The mere size of this largest of bilateral HIV/AIDS projects and its global focus made it likely that it could have a major impact on the number and coverage of HIV programs. While the ATSP is primarily associated with AIDSCAP, the program has actually funded a variety of activities carried out by other CAs, which have contributed importantly to increased coverage and the testing of alternative models.

This team has not been charged with evaluating the technical quality of ATSP-funded activities, and therefore cannot assess whether the quality of prevention programs has improved because of the ATSP. It is clear, however, that improved quality was an essential consideration in the design of the comprehensive program approach, advocated globally by AIDSCAP. This approach is now accepted as providing greater impact than previous single intervention or piecemeal approaches.

Once the AIDSCAP program was underway, however, it seems that operational needs became predominant as the comprehensive model was implemented in 15 priority and three major associate countries. Most of the behavioral research carried out by AIDSCAP and most of the biomedical research funded in Phase II of the ATSP, has not been available to influence the quality of Phase II interventions.

Output #1 - "Ten to fifteen full-scale HIV prevention and control programs... conducted leading to documented changes..." It seems very likely that this very important output, which addresses the heart of the Phase II ATSP program, will have been achieved at the end of the AIDSCAP and the ATSP Phase II programs. This is an extraordinary accomplishment. USAID defined a "comprehensive approach" to HIV/AIDS prevention and has attempted, in a concerted way, to

implement this approach on a global scale. AIDSCAP has the structure and the resources to get this job done. While this team and others will cite deficiencies in program strategy, design, and execution, these comments should be kept in balance with the many benefits that the program is providing.

The structure and procedures established to achieve this particular output were novel and therefore had significant teething problems. Structures and procedures were appropriate at the time the Phase II project was designed, and contributed very significantly to the likelihood that this output would be achieved. There is concern, however, that the sub-projects funded through this structure may not be sustainable at their present levels of effort once AIDSCAP is completed.

Output #2 - "Application of behavioral research findings to communication strategies in priority countries..."
It appears unlikely that this output will be achieved. At best, the research results of a smaller than anticipated number of medium-term research activities will be available for later sub-project modifications or, more likely, for use in Phase III.

Both AIDSCAP and the HIV-AIDS Division implicitly demoted behavioral research as a priority as they became embroiled in the realities of managing a complex program which included both field and central bureau responsibilities. One can hypothesize that the ATSP behavioral research program would have been more successful if it had been carried out by specialized research—oriented CAs such as ICRW, with AIDSCAP willingly integrating research results, as appropriate, into programs and sub-projects.

Output#3 - "Global PVO/NGO federation (the Alliance) contributing to developing and expansion of HIV prevention and control activities in priority and non-priority countries." In a broad sense, this very general output indicator has been achieved. The Alliance has been created and funded and, with its initial projects, "is contributing" to the expansion of prevention and control activities. ATSP (and other donor) resources and guidance have been instrumental to this initial success. While the program appears to fill a valuable niche, the financial sustainability of the Alliance appears to be in question—a topic being addressed in a multi-donor evaluation of the Alliance, presently underway.

Output#4 - "Improved policies, especially with respect to condom distribution and mass media communications, in priority and non-priority countries." The structure, processes, staffing, and management of the ATSP policy effort appear to provide no serious constraints to the opportunity for Output #4 to be achieved. Greater HIV-AIDS Division attention to policy and improved internal coordination for program-wide policy concerns should be considered for Phase III. It will be very difficult for the AIDSCAP final evaluation to determine whether "improved policies" are indeed in place because of AIDSCAP efforts. While some policy activities have been short-term in nature, most are long-term (adoption and use of methodologies, models, and analyses) and their results may not be readily apparent. The degree to which the program has

“missed opportunities” for policy change will also be hard to ascertain unless these missed opportunities affect the viability of AIDSCAP program interventions.

E. KEY QUESTIONS FOR THE FUTURE

Of the many questions and issues addressed in this process evaluation, one stands out as a major issue being considered in the design of the Phase III ATSP: What should the structure of the Phase III program be? Should it be similar to Phase II or quite different? What have we learned about the strengths and weaknesses of the Phase II structure?

Drawing from the text of this evaluation, the following appear to be the major strengths and weaknesses of the Phase II structure with a major keystone entity (AIDSCAP).

1. Strengths

- The concentration of funds in a central USAID unit provides an opportunity to demonstrate global leadership and to engage the Agency in a new problem area.
- This approach ensures consistency throughout USAID in following a primary technical strategy for dealing with HIV/AIDS.
- The keystone organizational approach concentrates technical staff and should ensure quality control.
- Program knowledge of how to best carry out the three technical and supporting strategies of this comprehensive program is found in a single institution; rather than disbursed among a variety of CAs each with expertise in a particular core or contributing activity (STDs, condoms, policy, etc.).
- Working alone, the keystone organization ideally can ensure that all of the key activities of a comprehensive program are present, properly balanced, sufficiently funded, and designed to achieve synergy between the program components.
- The process of program evaluation is centralized.
- The keystone organization should be able to use state-of-the-art technical knowledge and learning from new research to influence operational interventions in the field.
- The number of USAID management units is reduced.

2. Weaknesses

- Many of the theoretical strengths of the keystone project approach have been very difficult to attain in practice.
- Program responsibilities (central and field) are extremely broad for a single institution or consortium to carry out effectively. Success in carrying out these multiple responsibilities rests heavily on the management capacity, style, and procedures of the keystone organization. For example, AIDSCAP’s centralized procedures and style, at least in the first half of the project period, were not conducive to timely and flexible

decision making for field activities. However, they may have been valuable for quality control.²

- The program was initially perceived to be unwilling or unable to adapt its model to the specific needs and constraints of priority countries. Programmatic rigor may have become program rigidity.
- Although AIDSCAP was asked to be an operational institution as well as a “learning” institution, its primary focus has been on its operational activities. Certain learning functions, such as behavioral research, have clearly had less priority than originally anticipated and probably would have been better performed by a specialized CA.
- Over the life of AIDSCAP, the program has been perceived to be slow to integrate or test new approaches suggested by experience elsewhere, or by new knowledge about the epidemic.
- AIDSCAP was asked to have “top of the line” expertise in many technical and managerial specialties (three core and supporting strategies, project design, management of a wide network of regional and country offices, etc.). Areas which received less priority and less funding had a significant turnover in leadership or long delays in filling vacancies.
- The keystone organization is often caught in the middle of technical or operational disagreements between USAID field officers who traditionally manage field activities and the HIV-AIDS Division, which has formal management responsibility for all AIDSCAP activities.
- The field support budgeting process threatens to undermine the viability of this approach since the level of funding from field missions for many core functions may fluctuate significantly from year-to-year.
- Effective use of the keystone model requires a procurement mode which encourages flexibility, risk-taking, and adaptability. This model is extremely difficult to implement as a USAID contract.

3. Conclusion

This evaluation team recognizes that it was not asked to review all the relevant information needed to make a firm recommendation on the structure for Phase III of the ATSP. This would require a much broader study of the implications of the downsizing of the Agency, which is presently occurring, as well as a clearer understanding of how field mission personnel believe the new phase should be structured. However, as indicated in the list of key recommendations which follow in brief, we do strongly believe that the setting for the Phase III design is very different than Phase II (in 1991), therefore the structure of Phase III should be different than Phase II. For

²The three-layered AIDSCAP structure (headquarters, regional, field) resembled the USAID structure but did not mirror USAID’s more decentralized project approval and decision making processes.

these reasons we venture forward to outline the differences we see in the setting today and provide a list of recommendations for Phase III. As requested, we have also listed additional recommendations for the remaining 18 months of the Phase II ATSP program. A full list of detailed recommendations is found in Section VII of the report.

F. ATSP RECOMMENDATIONS FOR PHASE III

As the ATSP authorization terminates in 1997, a new phase of USAID HIV/AIDS activities is being considered. The Phase II strategy, designed in 1990, is in many ways outdated. A new strategy would be desirable even if the ATSP authorization was not terminating at this time.

A new strategy is needed because:

- The impact of the epidemic is greater than anticipated in 1991. A much wider population is now understood to be vulnerable to the disease. At the same time the societal and economic impacts are deeper and more systemic than anticipated.
- HIV/AIDS is now understood to be an extraordinarily difficult public health problem (as both a chronic and an infectious disease). The epidemic has not been and is not being prevented on any significant scale. There is no single proven formula for bringing about the sustained behavior change needed to limit the disease. Various combinations of biomedical, behavioral, and policy changes may be effective, but need to be tailored to specific countries and specific contexts within those countries.
- HIV/AIDS is here to stay. Therefore, increased donor attention to capacity building, sustainability, and continuity of efforts in the developing world is required.
- HIV/AIDS is now also recognized as a significant development problem and not simply a public health problem.
- USAID's financial and staff resources are diminishing. USAID is likely to be less dominant among the donors addressing HIV/AIDS in most developing countries in the future. Carefully coordinated donor strategies and country strategies will be needed.
- Overall donor resources available for HIV/AIDS have plateaued and may decrease during Phase III. New funding sources (local government, NGO, private sector, philanthropic) and an increased focus on low-cost and sustainable actions will be needed.

1. **Operational and Programmatic Recommendations for Phase III** (Please see Section VII for a more detailed list of recommendations.)

1. **Broad Participation:** Ensure broad participation of a wider group of individuals, organizations, and institutions in the design and during the period of program implementation of the new ATSP.
2. **Realistic Program Duration:** USAID's vision of its Phase II response should not be artificially limited to the five- to eight-year period of a USAID Strategic Objective. Results in this SO should be seen as benchmarks of a long-term response. Phase III objectives, which should include building in-country capacity and sustainability, will require a long-term commitment.
3. **Limited Role of the Global Bureau:** The Phase III structure should be more decentralized than in Phase II. USAID-funded activities should be geared less to a central strategy and more to country-specific needs and capacities. The HIV-AIDS Division should focus on more traditional Global Bureau functions such as technical leadership, research with potential global applicability, donor and USG coordination, best practices, and lessons learned from global experiences. It should not normally include management of country program implementation.
4. **Flexibility Is Essential:** A flexible ATSP-like SO structure should continue to be used. Activities should be designed so that relatively flexible procurement modalities (grants and cooperative agreements rather than contracts) can be used. Global Bureau grants should be of modest size so that implementing agencies can focus on technical matters with limited management responsibilities. Funding a predominant keystone CA does not seem appropriate for both technical and management reasons.
5. **Greater Synergy and Coordination:** Program coordination and interchange of findings/results among the CAs in the Phase III portfolio should be a specific objective of COTRs and the HIV-AIDS Division.
6. **Comparative Advantage:** USAID is unlikely to have the resources to support all elements of a multi-intervention strategy in most countries. It should focus on supporting those elements of country or local strategies where the U.S. has special expertise and which smaller USAID missions can manage. (See suggested list in Section VI)
7. **Evaluation:** The HIV-AIDS Division should not over promise the results of Phase III. The emphasis needs to shift from demonstrating impact to include a more reflective evaluation and analysis of what is being learned.
8. **Country-level donor coordination:** USAID should strive to encourage a broader range of funding organizations at the country level (more donors, foundations, private sector entities,

voluntary agencies). Coordination becomes increasingly important under these circumstances.

9. **The Alliance:** USAID should continue to support the Alliance financially and encourage structural and programmatic improvements.
10. **UNAIDS:** USAID should continue supporting and working closely with UNAIDS, especially, in deciding research priorities, recommending best practices, and stimulating global policy discussions. USAID missions should support the role of UNAIDS in coordinating UN agencies in country; and should actively support whatever country-specific structure is most appropriate for country-level coordination.

2. Substantive Recommendations for Phase III

1. **ATSP Technical Approach:** Phase III should expand support for a broader response to HIV/AIDS beyond the current AIDSCAP technical strategies, and build on lessons from the pilot activities of other CAs.
2. **Contextual Interventions:** The ATSP approach to HIV/AIDS prevention should be broadened to include "contextual interventions" that aim to identify and change the relevant social, cultural, economic, and political factors that support AIDS-prone behaviors.
3. **Gender Focus:** The ATSP must reach beyond narrowly defined "at-risk groups" to address the much larger population of women and girls who are vulnerable to HIV infection.
4. **Prevention and Care:** USAID should abandon its rigid "prevention only" policy, so that programmatic prevention and care linkages can be made when necessary to ensure the success of prevention programs.
5. **Community-organizing Approach:** The ATSP should include a "community-organizing" approach to AIDS prevention and care. This approach would put greater control in the hands of communities to define local priorities and to assume central responsibility for program development, as well as implementation. This community focus would not be in lieu of, but would complement, activities carried out by the government and private sector.
6. **Microbicide Development:** It is recommended that USAID develop a strategy for microbicide development that recognizes the unique role of the Agency in leveraging a product that will be appropriate for women in developing countries.
7. **STD Diagnosis and Treatment:** A syndromic approach to STD treatment should be pursued aggressively. At the same time, the development and testing of STD diagnostics and treatment algorithms for the reduction of STDs in women should remain a priority.

8. **STD Drugs and Condoms:** Phase III should ensure some mechanism for regular supply of STD drugs and condoms to future ATSP projects.
9. **Biomedical Research And Interventions:** Several biomedical research areas and interventions may be relevant for Phase III, ending perinatal transmission, tuberculosis prevention and control, vaccine development and testing, and cost-effective biomedical treatments for HIV-infected individuals.

3. **ATSP Recommendation for the Next 18 Months**

1. **Evaluation of Phase II Results:** The single highest budget priority for AIDSCAP over the next 18 months is to ensure that data and “lessons learned” are collected, analyzed, and disseminated. Dissemination of key results and lessons from all ATSP activities should be carefully planned and should be the shared responsibility of the CAs and USAID.
2. **Present and Discuss Lessons Learned by Theme:** As the ATSP activities are coming to an end, the HIV-AIDS Division and the CAs should establish venues for the CAs to share, compare, contrast, and analyze their results and lessons learned by theme.
3. **The Alliance:** The Division should ensure that the Alliance meets with the donor evaluation team to make known USAID’s vision of the Alliance (original and current) and USAID’s views of Alliance activities to date.
4. **UNAIDS:** Work closely with UNAIDS over the next 18 months to resolve several “teething problems” which relate to functions and funding.
5. **HIV-AIDS Division Staffing:** Identify a program specialist or program assistant to carry out many of the bureaucratic tasks which were added to the workload of the AIDSCAP COTR when that activity was converted to a contract.

I. Introduction

A. PURPOSE OF EVALUATION

The purpose of this process evaluation of the AIDS Technical Support Project (ATSP) is to examine the degree to which the strategies, structures, organizational cultures, and mechanisms of the ATSP have been responsive to the epidemic and are supporting the achievement of project objectives. This evaluation was conducted in January through March 1996, approximately 18 months before the termination of the ten-year authorization period of the ATSP, and as planning for a new program was being initiated.

The specific outcomes requested from this evaluation are:

- Lessons learned to help future planning and implementation
- Guidelines for new project design and program structure
- Recommendations for structuring and managing the HIV/AIDS portfolio.

This process evaluation will be followed by final project evaluations of AIDSCAP and each of the smaller 13 Cooperating Agency (CA) programs presently encompassed within the ATSP umbrella project. These evaluations will include careful reviews of whether the CAs have met their grant or contract "deliverables." This process evaluation, therefore, is not focused on CA deliverables or the impact of individual CA projects. It is focused on the ATSP-wide program and macro-level issues. The individual CA programs and the approaches they represent are not

Key ATSP Dates

AIDS Technical Support Project (ATSP) Project No.: 936-5972

1. **January 21, 1987 – Concept Paper**
Approved for AIDS Public Health
Communication Project
\$12 million
2. **May 1987 – Authorization**
AIDS Technical Support Project:
Public Health Communication
Component
936-5831 (later changed to 936-5972)
PACD FY '95; later included under
ATSP
3. **May 5, 1987 – Amendment #1**
PACD to 9/30/95
Authorization \$38 million (central
funds; LOP ceiling \$69 million
(regional and bilateral funds)
4. **April 15, 1991 – Amendment #2**
Authorization to \$179 million (core
funding
LOP ceiling to \$319 million (includes
\$140 million of regional and bilateral
funds)
PACD to 9/21/97
5. **August 23, 1993 – Amendment #3**
Authorization of life-of-project core
funding to \$237 million; decrease
regional and bilateral funds from \$140
to \$32 million)
6. **January 26, 1994 – Amendment #4**
Increase life-of-project funding to \$262
million

examined in any significant detail by the Evaluation Team except for AIDSCAP (which absorbs 85% of ATSP funds) and the International HIV/AIDS Alliance (distinguished by being one of four “outputs” in the ATSP PP Amendment.)

B. BRIEF HISTORY OF THE AIDS TECHNICAL SUPPORT PROJECT

It has been approximately ten years since USAID developed its first response to the international HIV/AIDS epidemic. The past decade has seen significant changes in the worldwide epidemiology of HIV/AIDS, as the epidemic has advanced into new geographic regions and affected larger numbers of women and men in developing countries. Many individuals and organizations have dedicated tremendous effort toward reducing the spread and impact of HIV/AIDS, and have gained invaluable experience and insights regarding AIDS prevention. At the same time, there has been growing appreciation for the difficulty of preventing this disease, which is rooted in complex issues of sexuality, poverty, gender inequality, and discrimination. The worldwide impact of HIV/AIDS as a public health and development problem is still in its infancy and will undoubtedly require long-term strategies and sustained commitment.

Since 1986, USAID has been a world leader in the global response to HIV/AIDS. In September 1986, the Agency provided its first grant to the World Health Organization’s Special Programme on AIDS (later the Global Programme on AIDS). Within the next year, USAID drafted its first policy guidance on AIDS and launched the umbrella AIDS Technical Support Project (ATSP), a worldwide program focused on HIV/AIDS prevention. Phase I of the ATSP (1987-1991) included support for two principle components: 1) the AIDS Public Health Communications Project (AIDSCOM), a \$19 million contract with the Academy for Educational Development (AED); and 2) the AIDSTECH Project, a \$28 million cooperative agreement with Family Health International (FHI). Phase I also provided funding to several smaller CA programs. The overall ATSP Phase I project purpose was to “support countries in formulating and implementing expanded and improved programs for AIDS prevention and control.”

In 1990, USAID undertook an internal review and redesign of the ATSP. A major objective of the ATSP redesign was to develop a more strategically focused program that would have a measurable impact on HIV incidence upon project completion. This was prompted by a concern that under the previous project “resources were spread too thin to have a measurable impact on HIV incidence.” To enhance the potential for measurable impact, the redesign technical strategy focused on the prevention of the sexual transmission of HIV and the use of “proven interventions” based on lessons learned during the previous three years of implementation. As described in the ATSP Project Paper Amendment No. 2, the four proven interventions are “increasing demand for condoms, increasing access to condoms, partner reduction, and diagnosis and treatment of sexually transmitted diseases.”

Phase II of the redesigned umbrella ATSP (1992-1997) includes support for one large keystone component, the AIDS Control and Prevention Project (AIDSCAP). This \$168 million cooperative agreement was awarded to FHI to support the local capacity of developing countries to prevent and control HIV. It also provides funding to several smaller programs with other CAs, who have unique missions, capabilities, or linkages. A list of the current ATSP CAs is found immediately below. USAID contributions to WHO/GPA and UNAIDS are independent of ATSP, but are planned and managed by the HIV-AIDS Division who also manage the ATSP.

As Phase II of the ATSP approaches completion (August 26, 1997), the HIV-AIDS Division is conducting a thorough review of the ATSP, as well as a broader examination of the evolving field of HIV/AIDS prevention. The review process was designed to ensure the participation and input of many informed individuals and organizations working in both international and domestic HIV/AIDS arenas. The "process evaluation" communicated in this report represents one component of the overall review process.

Current ATSP Cooperating Agencies

Bureau of the Census
Centers for Disease Control
Family Health International (AIDSCAP)
International HIV/AIDS Alliance
International Planned Parenthood Federation
John Snow International (FPLM)
MACRO International Inc. (DHS)
National Council for International Health
National Institute of Allergy and Infectious Diseases
The Population Council
Program for Appropriate Technologies in Health
United Nations Children's Fund
United Nations Development Programme
United States Peace Corps

C. EVALUATION METHODOLOGY

The AIDS Technical Support Project (ATSP) is an extraordinarily large and complex USAID project. The ATSP was initially authorized in 1987. During its nine-year life approximately 20 CAs involved in Phases I and II have expended over \$260 million. Three of these CAs have dominated the program: AIDSTECH and AIDSCOM during Phase I (1987-1991) and AIDSCAP during Phase II (1992-1996).

The evaluation team faced a considerable task in structuring their work to respond to the multiple issues included in the evaluation scope of work (Annex 1) in the limited time available.

In consultation with the HIV-AIDS Division leadership, the team decided to approach the scope by carrying out the following analyses:

- Project Operational Appropriateness, Section II
- Project Substantive Appropriateness, Section III
- A review of The International HIV/AIDS Alliance, Section IV
- A review of the ATSP Relationship with WHO/GPA and UNAIDS, Section V.

Using these analyses a summary chapter (See Section VI) was then prepared which assessed the impact of structural, procedural, and managerial influences on the capacity of the revised project to achieve its Project Purpose and its four "Project Outputs."

The data gathering and analysis phase of the evaluation was carried out in January and February of 1996 when the full evaluation team was assembled. Data was collected via:

- Interviews with over 50 key informants. Team members traveled to Atlanta, Geneva, London, New Haven, and New York (as well as across the Washington metropolitan area) to conduct these interviews. Telephone interviews were conducted with individuals that could not be visited by the Team. A list of persons interviewed or contacted during the evaluation process is found in Annex 3. To ensure continuity in data gathering, a list of core questions was prepared by the full team. Portions of this list were used, as appropriate, in interviews conducted by the various team members. The list of core questions is provided in Annex 5.
- Review of project documents provided by the HIV-AIDS Division and by the Cooperating Agencies. A list of materials reviewed is found in Annex 2. Given the limited time available for primary data collection, the team benefited enormously from the previous in-depth evaluations of most of the CA projects.

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- Responses to a questionnaire sent to 30 USAID missions or offices overseas. (The questionnaire and a list of respondents is found in Annex 6.)

Based on the findings of the data gathering and analysis phase, the team members prepared, debated, and agreed upon sets of conclusions and recommendations related to each major evaluation component. The team also agreed upon cross-cutting conclusions and recommendations. The team presented these draft conclusions and recommendations in briefings with USAID staff and CA officials in late February and benefited from a number of comments and corrections provided orally at the briefings and later in writing.

A draft evaluation report was prepared in March and was transmitted to all of the ATSP cooperating agencies, key USAID officials, including all interviewees. The draft report was transmitted with a cover letter from the HIV-AIDS Division Chief which invited comments and corrections and offered to include any responses verbatim in an annex to the evaluation report. The final report was prepared after receipt of the comments from several sources. Only one respondent organization asked that its comments be included in the evaluation report and these valuable comments are found in Annex 7.

II. Project Operational Appropriateness

A. PROGRAM STRUCTURE

1. Phase I (1987-1992)

USAID's initial response to the HIV/AIDS epidemic in 1985-86 was to transfer funds (\$2.5 million/year) to WHO/GPA to support coordination, surveillance, and planning activities. However, as the scope and impact of the epidemic gradually became more apparent, the Agency realized that it should also respond directly to needs being identified by the Global Bureau and field missions. The initial Agency AIDS policy stressed that missions should use existing field projects rather than create new bilateral projects to address AIDS. Supporting this policy, two new Global Bureau projects with worldwide scopes, AIDSCOM and AIDSTECH, were quickly designed and sequentially authorized in 1987 within a single umbrella project structure—the ATSP.

AIDSCOM was designed by the Global Bureau's Education Office in order to draw upon, and make available to field missions, program knowledge in behavior change communications gained from Agency-funded projects in child survival, family planning, and drug awareness.

The purpose of AIDSCOM was "to develop and demonstrate effective strategies and methods in communications. The project strategy was "to 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" (AIDSCOM Mid-term Evaluation, 1989).

Principle activities were: a) sustained operations research in up to five emphasis countries in each of three regions; b) technical assistance in development of communication programs, including research, social marketing, training, communications management, and behavioral analysis; c) dissemination of findings; and d) other activities." (AIDSCOM Mid-term Evaluation, 1989)

AIDSTECH was designed by the fledgling AIDS unit in Global's Office of Health, now the Office of Health and Nutrition. Its project purpose was "to support developing countries in prevention and control of AIDS." The AIDSTECH strategy, as described in 1989 was:

"to develop an institutional base capable of mobilizing broad support; flexible enough to respond to the new and evolving AIDS problem; to 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."

AIDSTECH activities were:

"technical support in such specialty areas as a) 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 e) information dissemination."

These projects were designed at a time when the Agency, its collaborating institutions, and host country counterparts were all in a "learning mode." At the same time preventative action was felt to be urgently necessary. These organizations were "building their boat while sailing it... and while taking sailing lessons" (attributed to WHO/GPA director Jonathan Mann and extended by Bill Lyerly, Africa Bureau, USAID (AFR)).

AIDSCOM and AIDSTECH were well designed to allow USAID to respond to the epidemic at the field level. The projects provided assistance to experimental and pilot activities and the scope of assistance was very broad and flexible. In addition, the projects were administratively easy for USAID missions to utilize.

The AIDSTECH and AIDSCOM sub-projects were the first donor activities in most countries which dealt directly with at-risk groups such as commercial sex workers and men who have sex with men. They served to educate USAID staff as well as host-country governments about these vulnerable populations, and to open the door to longer-term contact and collaboration.

The initial AIDSTECH focus on blood screening, a form of transmission recognized by ministries of health and most medical establishments as within government purview, was often used to open the door to discussions and eventually to activities which addressed more sensitive aspects of the epidemic.

The AIDSTECH and AIDSCOM activities were often the only donor-funded AIDS prevention activities in a country. They served to provide information and optimism about the potential for broader responses to the epidemic. These efforts left behind:

- Case studies of pilot activities and interventions carried out in collaboration with governments, NGOs, and the private sector (e.g., AIDS in the workplace)
- Examples of communication materials and media campaigns
- Greater host government willingness to address AIDS issues

- Some improved institutional capacity, especially among NGOs
- A network on contacts later used by FHI to jumpstart AIDSCAP activities in some countries.

Less positively, the program structure and design lacked strategic focus. Activities were "piecemeal" and resources were too small to have more than marginal (and demonstrative) impact. In addition, AIDSCOM and AIDSTECH had overlapping scopes of work in the area of "behavior change communication," a duplication which was recognized by USAID but not resolved. The overlapping responsibilities led to confusion and open rivalry between implementing organizations. As stated in the final AIDSCOM/AIDSTECH evaluation, the bi-modal approach "occasioned confusion and inefficiency and engendered competition between the two projects."

During Phase I the ATSP was also used to finance the activities of a small group of CAs which had distinct roles which supplemented and did not significantly duplicate the work of AIDSCOM and AIDSTECH. The Bureau of Census (BuCen) gathered and published global data on the epidemic; National Institute for Allergies and Infectious Disease (NIAID) provided research grants and support to research partners overseas; and Centers for Disease Control and Prevention (CDC) provided technical support to missions, especially in surveillance and epidemiology. While there was no duplication of effort, there was also no apparent effort to engage these CAs in a broader coordinated effort to address ATSP "program" objectives. The whole of the ATSP was simply the sum of its parts.

2. Phase II (1991-1997)

According to interviews with USAID staff, the decision to redesign the ATSP in 1990-1991 was due to: a) a growing realization in USAID management that rivalry between the major Phase I CAs was seriously eroding potential project impact as well as Agency credibility; b) a desire to have a more strategically focused program which could have a measurable impact on the spread of the epidemic; c) an increasing certainty in the public health community that an appropriate package of cost-effective interventions had been identified through Phase I research and pilot activities.

The redesign process was led by the chief of the HIV-AIDS Division, working with the "AIDS Cluster," a working group which included representatives from three Global Bureau Offices (Health, Population, Education) and the AIDS coordinators from the regional bureaus. This was essentially a USAID/Washington (USAID/W) group, and did not include field mission personnel or representatives from outside USAID/W. Nevertheless, the broad representation from within USAID/W was quite unusual for that time, "revolutionary" in the terms of one participant.

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The redesign was done quickly. Once the decision to redesign the ATSP was made, it was felt that the process had to be concluded quickly so that, after competitive bidding was completed, FY91 funds could be used for Phase II, rather than terminating Phase I programs. This palpable need to move quickly led to the key decision to revise the existing ATSP rather than request Agency approval for a new project. In practical terms this meant retaining the existing project authorization, ten-year time frame, and goal and purpose statements. This decision effectively limited Phase II activities to the remaining five years of the original ATSP authorization period.

Several "circumstantial" factors also strongly influenced the redesign:

- Increasing levels of USAID funding were being earmarked for HIV/AIDS by Congress. The earmark had increased from \$2.5 million in FY86 to \$20.6 million in FY90;
- There was continued concern within the Agency that mission demand for HIV/AIDS earmarked funds would not approximate the Congressionally-mandated supply of funds. If USAID did not demonstrate that it could absorb these resources, a higher proportion might be earmarked for WHO/GPA or for other USAID programs (i.e., Child Survival);
- Senior management was focused on reducing the number of management units (or separate projects) throughout USAID; and
- The number of U.S. direct hire (USDH) technical staff in the Agency was being gradually reduced.

According to USAID staff involved with the redesign, only three structures were seriously considered for the revised ATSP:

- A unipolar, keystone, or flagship model managed by the Global Bureau
- A second attempt at a bipolar model, with separate responsibilities for biomedical and behavioral interventions
- Regional projects focused on Africa, Latin America and the Caribbean, and Asia.

The bi-polar option was rejected for being too similar to the failed model for Phase I and because it demonstrated no reduction in the previous number of management units.

The regional option was rejected for structural and technical reasons. Structurally, USAID "regional" projects are traditionally managed by their respective regional bureaus. The Global Bureau wanted to maintain control of the Agency's HIV/AIDS portfolio, in part to ensure that a

cohesive, technically-appropriate approach was applied consistently throughout the Agency. Technically, it was argued that HIV/AIDS was not fundamentally different from one region to the next. The regions were in different stages of a single epidemic. The technical responses to the epidemic would not vary significantly in the different regions.

The unipolar, keystone model was determined to be most appropriate. It addressed management concerns by:

- Reducing the number of management units in the HIV-AIDS Division from two to one, and requiring fewer USDH staff as project managers;
- Creating a structure that could encourage field mission demand to use HIV/AIDS funds while ensuring in the short-run that Congressionally-mandated funds could be obligated by a large, multi-dimensional central program; and
- Creating a structure where all major responsibilities for a comprehensive program could reside with one CA.

Technically, the model was seen to be advantageous because it:

- Gave the responsibility for designing interventions with biomedical and behavioral components to a single institution;
- Ensured quality control as the primary model was being implemented and made it easier for new learning to be integrated into organizations; and
- Eased the task of establishing a program-wide evaluation system to report results of worldwide HIV/AIDS activities to Congress.

The Phase II unimodal structure with both central and field responsibilities for a global program has placed unprecedented responsibilities and resources in the hands of a single USAID-funded implementing agency—AIDSCAP. The AIDSCAP structure is the most managerially complex of all Global Bureau projects.

Central Responsibilities: AIDSCAP is responsible for central bureau project functions typically divided among a host of more specialized cooperating agencies. According to its designers, AIDSCAP was to be a “center of all truth and knowledge.” These functions include:

- Providing a locus of state-of-the-art technical expertise and best practices in several technical areas: STDs, condoms/social marketing, behavioral change communication, and policy

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- Carrying out or financing behavioral and other research of global interest and significance
- Conducting program wide evaluation and reporting.

Field Responsibilities: At the same time AIDSCAP is responsible for major field-level responsibilities:

- Designing, monitoring, and evaluating “comprehensive multi-year programs” in 15 priority countries throughout the world
- Providing short-term technical support to a host of associate country programs.

These tasks are normally performed by separate contractors or grantees and are designed and monitored by USAID mission staff in each country.

As one senior public health specialist told the Evaluation Team, “AIDSCAP was asked to do too many things: strategy, project design, evaluation, implementation, to be center of learning and a center of technical excellence.” There is no evidence that USAID seriously studied the administrative feasibility of the Phase II structure during the project design. Although most Project Papers prepared in field missions must contain an administrative feasibility analysis, this is not common among Global Bureau projects. The revised ATSP PP almost certainly would have failed this feasibility test.

AIDSCAP’s funding mechanism originally required a combination of Global Bureau funds for core operations and funds from field missions or regional bureaus (provided through “buy-ins” or “add-ons”) for direct field activities. Field missions have therefore been asked to transfer a significant portion of their budget (and their traditional field management authority) to the Global Bureau. This approach functions most smoothly if before the program is initiated there is a common understanding of the proposed program approach and structure among the participating USAID entities. Many field missions, and at least one regional bureau, did not feel that this prior consultation was adequate. Early in the program some missions felt that they had too little authority, and AIDSCAP too much, in the design of a country program financed primarily with mission funds. A few missions (e.g., Zambia, Caribbean Regional Program) consequently opted out, deciding to carry out their own bilateral programs independent of AIDSCAP.

The Phase II structure placed a huge management burden on a single institution—which after bids were reviewed, turned out to be a non-profit entity who had never managed a program of comparable complexity or size. Indeed AIDSCAP was larger (and perhaps more complex) than

its “mother institution, Family Health International. FHI’s winning bid also included nine subcontractors, which would help shoulder the burdens of this complex program design. While these institutions have certainly contributed to carrying out project responsibilities in their areas of specialization, the responsibility for overall program management has rested with FHI. Indeed, coordination of the work of nine subcontractors may have increased FHI’s overall management burden.

It is clear that FHI has struggled with this extremely heavy management burden and unusually wide span of control (as would any Private Voluntary Organization (PVO)). The midterm evaluation found the AIDSCAP management structure to be too centralized and multi-layered and strongly recommended decentralization, delegation of some decision making, and reduced field reporting requirements. USAID staff familiar with the project also indicated that FHI’s management style tends to be centralized and hierarchical, contributing to a perception of AIDSCAP as rigid and bureaucratic.

Although a final project evaluation of AIDSCAP (including project impact) will be carried out in the future, areas of AIDSCAP responsibility, which USAID staff believe are most effectively carried out, are areas where FHI had prior institutional expertise and commitment based upon its biomedical and family planning experience—especially biomedical interventions such as STD diagnosis and treatment, biomedical and epidemiological research, and condom promotion. These areas of strength also seem to reflect the background and technical expertise of the AIDSCAP senior staff.

The responsibilities where AIDSCAP performance is perceived by USAID staff to be less strong are areas where FHI came to the project with less institutional experience and capacity: behavior change communications, behavioral research, and policy. Initially, the leadership positions for these technical areas were filled by employees of subcontractors or individuals recruited specifically for AIDSCAP (i.e., not senior FHI employees). The first three technical areas, coincidentally, had turnover of senior leadership early in the project or lengthy periods while leadership positions were not filled.

Two members of the AIDSCAP Technical Advisory Group (TAG) volunteered to the Team that they felt AIDSCAP had not taken sufficient advantage of the talents and capacities of subcontractors, and that FHI seemed reluctant to give effective responsibility and decision-making authority to non-FHI employees of AIDSCAP.

A growing number of smaller CAs have been funded under the Phase II ATSP program umbrella. Several of these small CA programs have been particularly timely and innovative, and probably would not have been created or continued in the absence of ATSP funds. For example: ICRW’s research on women and AIDS; the Population Council’s research on microbicides; IPPF’s integration of HIV/AIDS into family planning activities; and UNDP’s and UNICEF’s

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exploration of new approaches to HIV/AIDS interventions. These CA programs have been additive and have not duplicated AIDSCAP program activities. In the Evaluation Team's judgment, responsibility for these discrete activities was correctly parceled out to separate CAs with specialized expertise and delivery mechanisms, rather than adding them to AIDSCAP's Scope of Work (SOW).

Some CA activities were the fruition of needs recognized by the HIV-AIDS Division (e.g., STD diagnostics network); others represented unsolicited proposals for financial support (e.g., microbicides research). Some originally-funded CAs were dropped after critical evaluations or when USAID funds were no longer essential.

Funding for the 13 smaller CAs presently constitutes about 15% of the ATSP budget, roughly the same proportion allocated to the smaller CAs in Phase I. AIDSCAP absorbs the remaining 85%, the same proportion AIDSCOM and AIDSTECH absorbed in Phase I. When "excess" or "additional" HIV/AIDS funds become available to the Division at the end of a fiscal year, we are told that these funds have almost always been allocated to AIDSCAP rather than to any of the smaller CAs.

As in Phase I, while there was no duplication of effort between AIDSCAP and the smaller CAs, the HIV-AIDS Division did little to encourage programmatic cooperation among, or between, the CAs. The whole of the ATSP was still essentially the sum of its parts.

B. LIFE OF PROJECT

The ATSP project was structured from its initiation to encompass the complete portfolio of the HIV-AIDS Division, with the exception of transfers to WHO/GPA. The project authorization was broadly written and has, over nine years, been amended (four times) to increase the ATSP's obligation ceiling from an initial \$ 38 million to \$ 264 million.

The ATSP initially utilized almost all USAID funds for HIV/AIDS, and in its ninth year this one project still encompasses an unusually high proportion (55%) of total funds expended within USAID to address a single program area³. In most other program areas (with the exception of family planning) field missions and regional bureaus manage most Agency funding, while the Global Bureau manages less than 25 percent of the Agency total. The size of the ATSP and its management by one USAID unit has given the program unusual opportunities for leadership

³The FY 95 HIV/AIDS target was 11% of the \$119,686,000, of which \$27,750,000 was transferred to WHO/GAPA. Of the remaining funds (\$91,936,000) a total of \$50,821,742 was directly allocated to the ATSP (\$35,993,884) or was transferred to the ATSP (\$14,877,998) via mission buy-ins.

within USAID, and unusual visibility and authority outside the Agency. The ATSP is the single largest project in the Global Bureau, and probably the largest within all of USAID.

This programmatic leadership within USAID has been particularly important since many field missions initially had relatively little information or experience with AIDS and were often reluctant to transfer mission-managed funds and scarce staff time from their long-term priority programs (child survival, family planning) to a new, and hopefully short-lived epidemic.

Central bureau management of the bulk of the USAID portfolio may have also given the HIV-AIDS Division greater authority in discussions with other donors (such as WHO/GPA) on how donor programs addressing this new disease should best be structured and coordinated.

ATSP funds have been obligated by means of direct agreements between the Global Bureau and the CAs or implementing agencies. This was particularly important in the early years of the epidemic because many field missions obligated most or all of their funds through agreements with their host country government—governments which often denied the very existence of HIV/AIDS in their country. The ATSP structure gave these missions the flexibility to use non-mission Global Bureau programs to carry out activities in their countries without host government countersignature. Importantly, it also gave the missions the flexibility to work immediately and directly with local non-governmental organizations (NGOs) and the private sector entities who had recognized and were prepared to address the epidemic.

With its size and complexity, the ATSP is more properly viewed as a major USAID program than an USAID project. Its structure is similar to USAID's newly instituted "reengineering approach" to programming. In this new system, once the overall objective—the Strategic Objective—has been approved by higher authority, funds can be moved with relative flexibility by program managers from activity to activity within a broad program framework, and new activities can be initiated without lengthy bureaucratic delays. The ATSP was, in effect, a precursor Strategic Objective program, and has been an ideal structure to give the HIV-AIDS Division the opportunity to respond flexibly as the Agency (and the world) learned more about HIV/AIDS and how best to programmatically respond to it.

The authority to add new activities (via agreements with new CAs) or to amend existing activities within the ATSP budget ceiling, has been very decentralized at the level of the HIV-AIDS Division Chief. These CAs have, by and large, been positive additions to the ATSP program and the number of separate management units within the overall ATSP portfolio is within the management capacity of the HIV-AIDS Division. Program flexibility is, of course, not always well utilized. From a purely cost standpoint one can question whether, over the course of the ten-year life of ATSP, three large implementing agencies (AIDSTECH, AIDSCOM and AIDSCAP) should have been created and dismantled. Each organization had major start-up and close-down costs and each had only five years to achieve its objectives. Lessons learned by

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one institution are not necessarily absorbed by a second. Much of the learning about behavior change communications from AIDSCOM may have been lost or undervalued in the move to a single Phase II implementing agency.

There is little debate, however, about the technical appropriateness of changing the focus of the ATSP and its primary implementing agencies in 1991 (moving to Phase II), given changes in knowledge of the epidemic, how to address it, and given the serious problems with the Phase I structure.

Conclusions:

Phase I:

1. AIDSCOM and AIDSTECH were well designed to allow USAID to respond to the epidemic at the field level through: experimental and pilot activities responding to country-level needs and opportunities; flexible program content; and simple administrative and financial mechanisms for USAID missions to use.
2. These early USAID-funded efforts, which were often the only donor-funded HIV/AIDS activities in a country, served to educate USAID staffers as well as host country governments and other entities about HIV/AIDS, placed them in contact with at-risk groups, and served to provide information and optimism about intervention options.
3. These Phase I efforts left behind: greater host country willingness to address AIDS issues; some institutional capacity among NGOs; case studies of pilot interventions; and a network of contacts later used by FHI to jumpstart AIDSCAP activities in some countries.
4. Less positively, the program structure lacked strategic focus, and resources were too small to have more than marginal (and demonstrative) impact.
5. Much of the learning about behavior change communications from AIDSCOM may have been lost or undervalued in the move to a single Phase II implementing agency with multidisciplinary responsibilities.
6. The bi-modal structure of AIDSCOM and AIDSTECH, with overlapping scopes of work (which USAID management did not resolve), led to confusion, open institutional rivalry and program inefficiencies.
7. Other CAs initially funded during this phase (CDC, BuCen, ICRW, NCIH) had distinct roles which supplemented the work of the two major implementing agencies.

Phase II:

In 1990-91, the ATSP was revised in the following setting: a) USAID management was convinced that rivalry between the major Phase I CAs was seriously eroding potential project impact and Agency credibility; b) Agency leadership was focused on reducing the number of management units; c) gradual reductions in USDH technical staff were occurring; d) increasing levels of funding were being earmarked for HIV/AIDS by Congress with requirements for USAID to report on program impact; e) management was concerned that mission demand for HIV/AIDS earmarked funds would not approximate the Congressionally-mandated supply of funds; and f) there was an urgency to design a revised project within the current fiscal year.

1. The unique Phase II design was strongly driven as much by this combination of management concerns as by technical considerations.
2. The Phase II design was essentially prepared "in-house" (within USAID/W). The decision to quickly design a new program limited opportunities for a wider consultative process about both the technical focus of Phase II and the centralized approach to program management.
3. The unipolar or keystone model was chosen for Phase II because it would: a) reduce the number of HIV-AIDS Division management units and USDH project managers; b) stimulate mission demand for use of HIV/AIDS funds; c) establish a program-wide evaluation system; d) give the responsibility for both biomedical and behavioral program components to a single institution; and e) provide a clear model for use throughout the Agency on how best to address HIV/AIDS.
4. The revised structure placed unprecedented responsibilities and resources in the hands of a single USAID-funded implementing agency—AIDSCAP. AIDSCAP was responsible for typical central bureau project functions: such as design, monitoring, and evaluation of "comprehensive country programs" in 15 priority countries, and provision of technical support to a host of associate country programs. This structure was much more centralized than programs in other central bureau divisions or offices. The program has managed an unusually high proportion of overall Agency funds (50-60%) devoted to a single problem area or sector.
5. AIDSCAP's funding mechanism was complex, requiring a combination of Global Bureau and mission funds. More mission participation in the Phase II design and a common understanding of the program approach and structure among all USAID entities, before the program was initiated, would probably have reduced the number of AIDSCAP start-up problems.

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6. The size of AIDSCAP gave extraordinary visibility to the program and may have raised expectations of performance beyond levels that were possible.
7. The revised structure centered the huge management burden of a very complex global program on a single institution—an institution which, after bids were reviewed, turned out to be a non-profit entity which had never managed a program of comparable complexity or size. AIDSCAP was larger (and possibly more complex) than its "mother" institution—FHI. There is no evidence, however, that USAID seriously studied the administrative feasibility of the Phase II structure as the project was being redesigned.
8. Although a final project evaluation of AIDSCAP (including project impact) has not yet taken place, it is clear that FHI has struggled with this extremely heavy management-wide span of control. In the judgement of HIV-AIDS Division staff, the areas of responsibility which appear to be most effectively carried out are ones where FHI had preexisting institutional expertise based upon its biomedical and family planning experience—biomedical research, condoms, and STD diagnosis and treatment. These areas of strength also seem to reflect the background and technical expertise of the AIDSCAP senior staff. The areas of responsibility where HIV-AIDS Division staff believe AIDSCAP performance has been less strong are areas where FHI came to the project with less institutional experience and capacity: behavior change communications, behavioral research, and policy.
9. Establishing a new program with this unusually heavy management burden and span of control may have fully absorbed AIDSCAP's management capacity, especially early in the project, and may have discouraged managers from being "flexible" to mission demands or "open" to new intervention paradigms.
10. A growing number of smaller CA programs (13) have been funded from the ATSP. These programs have been additive to the AIDSCAP keystone project, rather than duplicative, and are most effectively carried out by separate CAs with specialized expertise and delivery mechanisms.

Life of Project:

1. ATSP is a good example of how central bureau leadership has successfully engaged the Agency in a new problem area that some Agency units were initially reluctant to address.
2. The very large size of ATSP and its management by one USAID unit (the HIV-AIDS Division) provided an opportunity for the Agency to demonstrate global leadership and to encourage other donor participation in addressing the epidemic.

3. The overarching ATSP project (really a program) structure was ideal in giving USAID the opportunity to respond flexibly to a growing body of information and experience about a new problem area such as HIV/AIDS.
4. Obligation of funds at the Global Bureau level gave missions greater flexibility in working with NGOs and the private sector than would have otherwise been the case. This was especially important since host government recognition of the problem usually lagged recognition by NGOs and the private sector.
5. HIV-AIDS Division leadership has increasingly taken good advantage of ATSP's flexibility to fund new activities which respond to the evolving needs of the epidemic. These small grants have often been critical in supporting new ideas and alternative models that almost certainly would not have been carried out.
6. Over the past nine years, the ATSP will have been used to create and dismantle three large U.S.-based programs (AIDSCOM, AIDSTECH, AIDSCAP), each with only five years to achieve its objectives. Although this has been expensive, changing the focus of the ATSP and its primary implementing agency in 1991 was appropriate given changes in knowledge of the HIV/AIDS epidemic and how to address it, and the serious problems with Phase I operations.

The five years left in the ATSP authorization for Phase II were an extremely short period to establish a new, complex organization and achieve measurable impact.

1. ATSP Coordination

The ATSP is normally described as "an umbrella project." Projects funded under the umbrella contribute to the overall project goal ("to prevent and control the spread of AIDS in developing countries") and project purpose ("to support countries in formulating and implementing expanded and improved programs for AIDS prevention and control"—Phase I; and "to expand access to HIV prevention and control programs in developing countries"—Phase II). These goal and purpose statements are extremely general and a wide range of projects has been funded under this broad mandate.

Present and prior HIV/AIDS staff told the Evaluation Team that they have viewed the ATSP primarily as a convenient administrative mechanism to finance a variety of activities. The ATSP has not been viewed as a program in which a variety of CAs are chosen to fill critical roles essential to the achievement of carefully conceived program objectives. Although as noted above, the ATSP is administratively a precursor for USAID's new reengineering approach to programming, the ATSP was not managed as a "Strategic Objective program."

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The ATSP "program" was primarily viewed by the people who designed it as the Phase I activities of AIDSCOM and AIDSTECH and the Phase II activities of AIDSCAP. The role of other, smaller, CAs was mentioned only in passing in both the original and in the revised ATSP Project Papers.

HIV-AIDS Division leaders and staff can and do clearly articulate how the activities of each of the smaller CAs can contribute to the achievement of the overall ATSP goal and purpose. For example, BuCen provides an essential data gathering and dissemination function useful to AIDSCAP and to other ATSP CAs as well as HIV/AIDS program planners and evaluators throughout the world. ICRW's path breaking research on women and AIDS fills an important knowledge gap and is potentially useful to all ATSP CAs which focus on service delivery (AIDSCAP, IPPF, Peace Corps).

Nevertheless most Division staffers tend to focus their attention on the individual grants for which they are responsible. The CAs have been essentially managed as individual activities rather than as part of a larger whole. The ATSP has not been structured or managed to provide incentives, mechanisms or funding for CAs to build bridges and learn from each other. Only one USAID agreement (with Peace Corps) requires the CA to work cooperatively with another CA (AIDSCAP).⁴ Most of the programmatic interaction that has occurred has reportedly been because of personal contacts and common interests. For example, ICRW has assisted the International HIV/AIDS Alliance with country needs assessments and program development.

The mechanism established by the HIV-AIDS Division to coordinate the ATSP has focused primarily on administrative rather than programmatic coordination. The principal mechanism—monthly meetings of CAs and HIV-AIDS Division staff—has been used to communicate to the CAs as a group, USAID administrative and financial requirements or policy changes. They have also been used periodically for "show and tell" presentations by CAs describing their activities. The HIV-AIDS Division plans and orchestrates these meetings.

There is remarkable agreement among CAs and USAID staff that these meetings are of marginal value. In recent years the meetings have taken place less frequently (often cancelled by USAID). Attendance has dwindled and less senior CA staff are often sent to note down USAID's new administrative requirements or budget scenario. CAs located outside of the Washington area (New York, Atlanta, London, and Seattle) do not feel their attendance is normally cost effective.

⁴The ATSP grant to UNICEF is another exception. As part of this activity UNICEF receives and pays for technical support from AIDSCAP.

Despite these criticisms, virtually all of the CAs told us they feel these meetings potentially have valuable functions of :

- Bringing program participants together for general information exchange and updates on their programs
- Discussing in more depth substantive topics and issues of common interest to the group. It was recommended that the substantive discussions might focus more "on what you are learning, not about what you have done."

All of the smaller CAs believe that increased synergy and cooperation among the CAs would be useful to their individual programs and that monthly meetings can be structured to foster greater cooperation and learning, and reduce duplication of effort within the ATSP. The Evaluation Team recommends that a first step in achieving these objectives is for the HIV-AIDS Division to share responsibility with the CAs for preparation of agendas and conducting the meetings.

Although some CAs have been invited to participate in AIDSCAP's TAG and Technical Working Groups, many perceive AIDSCAP as "impenetrable" and generally not particularly interested in developing closer programmatic and technical linkages⁵.

Other than the monthly meetings, no formal mechanisms for CA coordination within the ATSP have been established. Even basic, low-cost communication between CAs is underutilized. Progress and technical reports are not routinely exchanged between all CAs either electronically or via hard copy. The HIV-AIDS Division has not established a simple electronic modality to quickly communicate common administrative or programmatic requirements to the family of ATSP CAs.

Conclusions:

1. The ATSP has been seen by the HIV-AIDS Division as a convenient administrative mechanism to finance a variety of activities and CAs. It has not been viewed consistently as a single program entity in which CAs are chosen to play critical roles necessary to achieve an overall programmatic objective. Although the ATSP is administratively a precursor for USAID's new strategic objective programming system, it is not a precursor in its programmatic approach.
2. ATSP coordination by the HIV-AIDS Division has been primarily administrative in nature—communicating ATSP programmatic and financial requirements or USAID policy changes to CAs.

⁵AIDSCAP strongly disagrees with this perception. See Annex 7.

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3. The principal mechanism to carry out ATSP coordination—monthly meetings of CAs orchestrated by USAID—is felt by all participants to be of marginal value and poorly utilized. These meetings can be much more beneficial if responsibility for the agenda is shared by USAID with the CAs and if meetings are focused on substantive topics, as well as operational issues.
4. The ATSP has not provided requirements, incentives, mechanisms, or funding for CAs to build bridges and learn from each other. The HIV-AIDS Division has not played a significant role in facilitating collaboration among ATSP CAs.
5. Many CAs report that they find it difficult to work with AIDSCAP and that AIDSCAP is not receptive to using information or lessons generated by their activities. This may be because AIDSCAP, with its extraordinary breadth of day-to-day program management responsibilities, is much more of an operational entity than a "learning" entity.

2. Evaluation System

No single evaluation system and structure has been created for the ATSP as a whole. The elaborate evaluation system described in the ATSP Project Paper Amendment was a suggested outline for the AIDSCAP evaluation module, not for the umbrella ATSP evaluation. The activities of the other ATSP-funded CAs each have their own objectives outlined in their grant, PASA, or cooperative agreement. Their success in achieving those objectives will be evaluated separately.

The ATSP PP Amendment clearly stated the Agency's desire to demonstrate impact from the AIDSCAP activities. The evaluation system described in the PP included a suggested set of evaluation indicators which mirrored the PRISM evaluation system, which at that time was being introduced and required for use throughout USAID. The HIV-AIDS Division apparently anticipated that this Agency-wide evaluation system could be applied to measuring the success of HIV/AIDS interventions without serious modification.

In recent years, however, evaluation specialists have found that evaluating the impact of HIV/AIDS interventions is particularly complex and difficult given the nature of the disease (many people do not know their HIV status), its long latency period, and minimal testing and reporting due, in part, to HIV/AIDS' continuing stigma in many quarters. Behavior change, the heart of prevention interventions, is also very difficult to measure and is not certain to endure as a successful program outcome. Evaluators are most comfortable with measuring intermediate or proxy indicators such as condom availability and sales, quality of STD management, and policy changes.

The five-year time frame made available for AIDSCAP to design, implement, and evaluate the results of AIDSCAP "comprehensive country programs" is tight. Much of AIDSCAP's first year was focused on setting up its headquarters office, hiring staff (headquarter and country technical advisors), and establishing operational and administrative procedures. The design of country program strategies and implementation plans (two separate stages of activity both requiring USAID approval) has usually required a minimum of six to 12 months. In most countries, sub-project proposals from NGOs, governments, or the private sector have had to be invited, reviewed, often redesigned, and approved. Only then could AIDSCAP funds be released to support these sub-projects. Once the AIDSCAP funds were received, these implementing NGOs, etc., could begin to hire additional staff, buy equipment and materials, and actually start carrying out interventions⁶. In most AIDSCAP countries, actual implementation of sub-project activities normally began during year two or year three of AIDSCAP's five-year life. Since most of these sub-projects require a minimum of three years to show results, the time needed to evaluate sub-projects and to aggregate, analyze, and compare these results on a broader scale, is too short.

The Phase II project designers believed that AIDSCAP's "comprehensive country programs" would normally be country-wide programs. They therefore assumed that country-wide data being gathered by governments with WHO/GPA technical and financial support could be used as baseline data for AIDSCAP activities. This assumption proved to be invalid on two counts: 1) country-wide data had not been collected in most countries by the time AIDSCAP activities began; and 2) in most focus countries AIDSCAP resources were not sufficient to carry out country-wide programs. Although AIDSCAP has tried to gather area-specific baseline data or to extrapolate from other sources, AIDSCAP evaluation specialists are not particularly pleased with the baseline data they must now use for before-after comparisons of project impact.

AIDSCAP evaluation specialists told the team that, with their one-year project extension, they anticipate that most comprehensive programs will provide valuable evaluation results. These results will normally be described using process indicators (number of STD clients treated, staff trained, condoms sold, etc.), and using outcome indicators (improved knowledge about HIV/AIDS, incidence of STDs among specific populations, trends in safer sex behavior, etc.) Impact data on HIV incidence over the project period will not be available.

The first AIDSCAP priority country program is scheduled for closure in May 1996. The remaining 17 priority and major associate country programs will be closed over the next 15 months, with the last scheduled to close soon before the AIDSCAP contract expires⁷. This will

⁶See AIDSCAP's comments in Annex 7. Sub-project implementation occurred much faster in countries where AIDSTECH and AIDSCOM activities were continued with AIDSCAP funds.

⁷See AIDSCAP comment, Annex 7. In a few countries such as Indonesia, the AIDSCAP-supported programs will continue with other implementing agencies after the AIDSCAP contract terminates. In these countries AIDSCAP will probably carry out sub-project evaluations and not full impact evaluations before the contract terminates.

allow precious little time to compare, fully analyze, and aggregate the wealth of information that should be made available. Despite the technical limitations in the baseline data or the results data which will be collected, the AIDSCAP data will be among the best (and only) information available to date on intervention results. As importantly, AIDSCAP will have a wealth of information on what was learned from the *process* of implementing comprehensive country programs; which should also be analyzed and disseminated. Therefore, this team echoes the conclusions of the midterm evaluation team—AIDSCAP (and USAID) should devote increasing attention and resources to ensuring that this valuable data is properly collected and analyzed before the AIDSCAP project terminates.

Finally, this team believes that USAID's focus on evaluation results and on measuring the impact of AIDSCAP comprehensive country programs has almost certainly contributed to the lack of flexibility perceived initially by field missions and outside organizations in AIDSCAP program operations. The lack of flexibility may well have been due to the desire to gather aggregate data from comprehensive country programs for evaluation and reporting purposes, as well as the certainty that a single recipe would achieve impact. If so, this is a very unfortunate example of how the flexibility needed to respond to local conditions has been stymied by USAID's perceived need to demonstrate the aggregate impact of a global program.

Conclusions:

1. No single evaluation system and structure has been created for the ATSP as a whole. Therefore the HIV-AIDS Division will not be able to evaluate the impact of the umbrella ATSP program as a whole. However, results of final evaluations of each CA agreement will be available to guide the detailed design of Phase III.
2. Evaluating the impact of HIV/AIDS interventions has been particularly complex and difficult and is likely to remain so during Phase III. The HIV-AIDS Division (and senior Agency leaders) should be careful not to over promise results to Congress or to advocacy groups.
3. The time frame for AIDSCAP to establish and evaluate comprehensive country programs is extremely tight. Even with a one-year extension, this Team is concerned that without a major commitment of both financial resources and staff time, the rich data potentially available from the AIDSCAP effort will not be adequately analyzed and disseminated.
4. USAID's and FHI's attention to measuring the impact of AIDSCAP's comprehensive country programs contributed to the lack of flexibility perceived initially in the AIDSCAP program. The "core package approach" may have been due to the desire to gather and

aggregate data from country programs for evaluation and reporting purposes, and the certainty that a single recipe would achieve impact in all countries.

3. ATSP Responsiveness to Field Mission Needs

a. General

This brief assessment of the responsiveness of the ATSP project to field mission needs is based on discussions with technical officers in the ANE, AFR, and LAC regional offices; questionnaire responses from 12 missions; a telephone interview with one mission; and information provided by two team members, who serve or have served, in field missions and are familiar with the program. The field mission questionnaire and list of respondents is found as Annex 6.

Most USAID field mission health or PHN officers are not aware that the ATSP umbrella project with its many components exists. Yet all are familiar with, and have a good understanding of, AIDSCAP. Many field missions have little or no information on the results of other CA activities or the availability of their services. Exceptions appear to be the Peace Corps PASA, ICRW (in countries where they carry out field research), and CDC (especially in Africa). In general, they view the HIV-AIDS Division portfolio as synonymous with AIDSCAP.

Although USAID technical staff in field missions typically say they are overwhelmed with paper, there is value in alerting them to the breadth of the ATSP portfolio and the diverse roles and objectives of all the CAs involved. Periodic updates, perhaps brief summaries of the Division's semi-annual portfolio review, would keep most field officers current.

The HIV-AIDS Division should review with their regional counterparts and representative field staff specifically what kinds of information would usefully flow from the Division to missions, and how that information might be used during the remainder of Phase II and during Phase III. For example, technical officers or their mission colleagues may be particularly interested in ICRW research findings, but less interested in biomedical research findings. They may find updates of the emerging role of UNAIDS valuable for their in-country donor coordination discussions and plans. All who are planning new activities will want state-of-the-art information about HIV/AIDS to make informed design decisions and will want to know a good deal about CAs that can potentially provide services to their country program.

b. AIDSCAP

As mentioned earlier, Some friction with missions has been created by what they perceive as the Washington-only design of AIDSCOM/AIDSTECH (Phase I) and AIDSCAP (Phase II). The concern is expressed well in the AIDSCAP midterm evaluation:

*"There is a lingering resentment by USAID missions that AIDSCAP is just another attempt by USAID/W to impose a program on them for which they then are to be responsible without having had any input (USAID missions have been consulted on AIDSCAP plans in their countries). Surely the designers of this Program must have known of the historic tensions in USAID between centrally-managed projects and field missions, which are almost always and almost uniformly suspicious of—not to say antagonistic to—such Washington initiatives. Yet that factor seems to have been overlooked in the design of this Program."*⁸

It is particularly unfortunate that lack of consultation with missions during the Phase II design process may have impacted negatively on initial AIDSCAP relationships with field missions. Two factors were common in the design of both phases of the ATSP: 1) the designers were under enormous pressure to complete their design quickly; and 2) the principal designers had little or no field mission experience. As noted above, the Phase II design was viewed by some as "revolutionary" in the breadth of USAID/W participation. Apparently, in this case, however the involvement of the regional bureau officers cannot substitute for some direct mission involvement (through questionnaires and/or review of initial drafts) in Global Bureau project design.

Many missions initially termed the comprehensive country program design fostered by AIDSCAP as a "cookie cutter" approach, a term that unfortunately, is still often used. AIDSCAP was viewed as "too rigid" in its early days of country program design, too unwilling to adapt "its" model to the realities of the local environment. Missions may not have realized that the AIDSCAP model was the model carefully delineated in the Project Paper Amendment and in the subsequent Request for Proposal (RFP). The rigidity perceived by missions also reflected a strong desire in the HIV-AIDS Division to focus Phase II interventions and to apply and evaluate the impact of a model which was strongly felt to be cost effective and technically appropriate.

As mentioned earlier, the structure of the Phase II program required missions to contribute all of the funding for the AIDSCAP field activities in their country. Some missions, therefore, found it difficult to relinquish full control of the design of "their program" to AIDSCAP. In some country designs, missions were equally as "rigid" as AIDSCAP was perceived to be and refused to compromise their relatively isolated views of what interventions would be most effective.

As AIDSCAP programs moved into high gear, many missions expressed concern about the centralized nature of AIDSCAP decision making and delays in AIDSCAP headquarters' review and approval of proposed sub-projects. Compared to other Global Bureau projects, AIDSCAP seemed to have a particularly slow and centralized approach to making decisions on field

⁸Management Review of the AIDSCAP Project, page III-15

program matters. The need for more decentralized decision making and increased delegation of authority to AIDSCAP country offices was highlighted in the midterm evaluation. Based on information provided to this Evaluation Team, it appears that decentralization and delegation of authority is occurring.

The multiple responsibilities included in the design of AIDSCAP, with both central and field implementation responsibilities, has led inevitably to conflicts within USAID on who should give directions to AIDSCAP. Should technical direction come from the Global Bureau specialists or from a mission PHN officer? AIDSCAP has often been caught in the middle of technical or operational differences and has been accused of being "unresponsive" at times. Two recent examples were cited to the team of newly-arrived mission directors who insisted on major changes in ongoing AIDSCAP programs that the previous mission director had strongly supported.

Despite some initial friction, mission perceptions of the AIDSCAP program today are based on the quality of their working relationship with AIDSCAP country field offices, an AIDSCAP regional office, or AIDSCAP headquarters—depending on where the dominant point of contact lies. Most AIDSCAP country programs are now designed flexibly and, in fact demonstrate a remarkable diversity of adaptations to a basic model. The HIV-AIDS Division has become more willing to accept variations from the original technical model and has accepted that not all country programs would have all three core technical strategies. For example, at the request of the USAID missions an STD component was not included in the Zimbabwe program and surveillance was included in the Senegal program. AIDSCAP has also used a variety of approaches in responding to unique country circumstances. The Tanzania program, for example, funds the NGO component of the national HIV/AIDS program working through unique "clusters" of NGOs. AIDSCAP has used a regional "areas of affinity" approach in Southeast Asia.

In sum, after a rocky start, AIDSCAP and field missions appear to be working very well together.

Conclusions:

1. Most USAID field mission personnel are not aware that the ATSP umbrella project exists. They recognize and relate to AIDSCAP, as they did previously to AIDSTECH and AIDSCOM.
2. Many field missions have little or no information on the results of most other CA activities, or the availability of their services. With few exceptions they view the HIV-AIDS Division's portfolio as synonymous with AIDSCAP.

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3. Considerable friction with Missions was created by what they perceive as the Washington-only design of AIDSCOM/AIDSTECH (Phase I) and AIDSCAP (Phase II). But missions' perceptions of the program are now based on their working relationships with AIDSCAP country field offices, an AIDSCAP regional office, or AIDSCAP headquarters, depending on where the dominant point of contact lies.
4. Missions now feel that AIDSCAP is much more responsive to mission/country needs, although they feel that a rather set way of addressing AIDS prevention was initially expounded by AIDSCAP, especially for comprehensive country programs.
5. Similarly, missions felt that AIDSCAP was initially very centralized and bureaucratic in decision making. This complaint is reportedly now heard less often as decentralization in decision making and increased delegation of authority is occurring within AIDSCAP.
6. The design of the AIDSCAP program, with field activities formally managed from USAID/W, inevitably led AIDSCAP to be sandwiched between two bosses: 1) the mission technical officer or mission director; and 2) the HIV-AIDS Division COTR and his/her technical advisors. USAID missions and HIV-AIDS Division personnel were not immune from demonstrating the same inflexibility that they criticized in their contractor.

4. Links to a Broader USAID Portfolio

The designers of Phase II of ATSP made a concerted effort to learn from USAID experience in other sectors. The PP Amendment is rich with examples of how the design was influenced by the experience of the family planning program managed by the Global Bureau's Population Office.

ATSP funds have been utilized in Phase II to buy into several Population Office projects to procure services for condom social marketing (SOMARC), condom logistics management (FPLM and CDC), condom procurement (Wyeth International), and user surveys (Demographic Health Services II). These buy-ins save time, reduce paperwork, and avoid duplication of effort with other Global Bureau programs.

ATSP funds have also been used to buy in and add-on to the Population Office program with IPPF. This grant supports IPPF efforts to introduce HIV/AIDS services into the programs of its primary family planning affiliates in Latin America.

The Women in Development (WID) office is the only other Global office to support the ATSP, by financing the salary of the director of the AIDSCAP "Women's Initiative" for three years.

Funding for the provision of condoms to support AIDSCAP field programs has been an issue between the Offices of Population and Health. Funding for recurrent commodities such as condoms (and STD drugs) was not included in the AIDSCAP cooperative agreement which, according to the midterm evaluation and this Team's understanding, has in some cases limited AIDSCAP's ability to carry out truly comprehensive programs. The Office of Population initially insisted that condoms procured by that office for family planning purposes should not be used for AIDS prevention programs. The ATSP eventually set aside funds for a Condom Emergency Fund which could provide limited amounts of condoms for AIDSCAP sub-projects in extremis (if all other possible sources—host government, other donors—had been exhausted). Some USAID missions bought condoms using their own funds.

All regional bureaus and many missions have utilized the AIDSCAP buy-in mechanism (and the OYB transfer mechanism until the conversion to a contract) to finance designated country or region-level activities. To date only seven missions have established bilateral HIV/AIDS projects which do not utilize AIDSCAP as the primary implementing agency (Ghana, Zambia, Uganda, Malawi, Bolivia, Central America Regional, and Peru). This remarkable program homogeneity demonstrates that the Phase II structure has been effective in reducing the number of Agency management units (separate projects).

Several of the bilateral projects, especially the newer ones, reportedly focus on building the capacity of host country NGOs or government entities. Others take a less holistic approach than the AIDSCAP model, concentrating on policy or on a few specific program components (e.g., social marketing) which are not being adequately supported by the host government or other donors; and where the U.S. and USAID have particular expertise. These may serve as models for the future in countries where several donors and the host government support a comprehensive approach to addressing AIDS, especially if USAID resources are smaller and USAID field programs are less dominant.

The Africa Bureau (AFR) is the only regional bureau which authorized a region-wide HIV/AIDS project during the ATSP time frame. The HIV/AIDS Prevention in Africa (HAPA) project, which was initiated in 1988 almost concurrently with AIDSCOM and AIDSTECH, was used until 1996 as a funding mechanism to support Africa missions and region-wide priorities. HAPA accomplished the following:

- Facilitated the transfer of funds from field mission budgets to AIDSCAP or to other non-ATSP implementing entities;
- Funded PASAs with BuCen for data collection in Africa (which ATSP later extended, to collect worldwide data), and grants for pilot activities; and

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- Encouraged U.S. PVOs to incorporate HIV/AIDS into their portfolios' two-year "starter grants."

There appears to have been little or no programmatic duplication between ATSP and HAPA. Indeed, HAPA funded some pioneering activities (a Zaire social marketing trial for HIV/AIDS condoms, Zambia STD study) which pushed the technical envelope and were valuable to AIDSCAP and the ATSP.

AFR encouraged their small missions to address HIV/AIDS by integrating it into broader maternal and child health or family health projects, rather than by creating stand-alone HIV/AIDS projects. This approach seemed well suited to African countries with very limited numbers of trained health professionals, health infrastructure, and health budgets. Many of the World Bank's HIV/AIDS projects in Africa have similarly integrated HIV/AIDS into broader multi-purpose health sector projects for the same reasons. The debate over whether HIV/AIDS should be addressed as a vertical program by health ministries or as part of integrated health programs is similar to past debates concerning smallpox, malaria, and child survival programs. Hopefully, evaluation data will soon be available from USAID and the International Bank for Reconstruction and Development (IBRD) projects in Africa so that the debate can be more firmly grounded in field experience.

HIV/AIDS as a Development Issue: The Africa Bureau has been the first proponent of studying the broad impact of HIV/AIDS on a nation's economy and society. The extraordinary consequences of HIV/AIDS on the economies and social structures of Uganda and Zambia, for example, make it obvious that the future of these countries is closely linked to the epidemic in many ways.

Conversely, development projects and programs may have consequences for the spread of the epidemic. For example, construction of a dam in a remote region takes laborers (nearly always men) away from home for long periods, which may encourage multiple sexual partnerships, and therefore lead to spreading the epidemic among a local population heretofore relatively unaffected. The devastating potential of HIV/AIDS should be considered as one factor in the design of development projects, perhaps similar to the way environmental impact is considered in the design of all USAID (and now multilateral bank) development projects.

HIV/AIDS-related behavioral research and information from other disciplines point out a different set of broad development issues—human rights, societal violence, gender inequities, poverty—which many feel must be addressed if the epidemic is to be slowed in any significant way.

The UNDP and UNICEF HIV/AIDS units, supported by ATSP grants, have consistently urged that the epidemic be viewed within a broader development and contextual framework (UNDP) or within the context of adolescent health (UNICEF). It is perhaps not coincidental that three entities (UNDP, UNICEF, USAID's Africa Bureau) whose program funding is not provided through earmarked HIV/AIDS functional accounts, have approached the HIV/AIDS epidemic from a broader conceptual perspective.

The midterm evaluation stated:

*"Nowhere, at USAID/W, regional, or country levels has the evaluation team been able to identify mechanisms, whether formal or informal, that would link HIV/AIDS activities to other social and economic development programs supported by the Agency."*⁹

This Evaluation Team was pleased to find that some examples of this linkage do now exist in the Agency, although much more can be done. The Africa Bureau example has already been noted. HIV/AIDS Division staff report that the creation of the Center for Population Health and Nutrition (PHN Center) in the Global Bureau has facilitated the design of several cross-cutting, Center-wide projects (STDs, Policy) with Division staff participation. Division staff have incorporated HIV/AIDS concerns into the design of a new Adolescent Reproductive Health project. On a broader scale, HIV/AIDS staff, under State Department leadership, wrote major sections of a recent USG Interagency "White Paper" on HIV/AIDS¹⁰, which, strongly urges that the full ramifications of the epidemic be considered as an integral part of U.S. diplomacy, development assistance, and public information policies and activities. USAID's recently-issued HIV/AIDS Policy Guidance echoes this philosophy.

However, this Evaluation Team found little evidence that the HIV/AIDS Division has played a leadership role in urging the Agency and Agency staff to view HIV/AIDS other than through vertical program activities, with the exception of participating in drafting these recent policy papers, and interaction with the new PHN Center and its programs. The Division and the ATSP have had more impact on this matter outside of USAID than inside—through its support to UNDP, UNICEF, and ICRW; and its participation in the multi-donor AIDS Economic Development Impact Network.¹¹ Since the HIV/AIDS Division is within an office, that is within a Center, that is within one of eight USAID Bureaus, the Division is somewhat buried in the USAID/W bureaucracy. The Division Chief has little authority or opportunity to directly influence the Agency-wide policy decisions. This role might be carried out by the Agency's super-grade AIDS Coordinator, but the position has never been filled. The HIV/AIDS Division

⁹Management Review of the AIDSCAP Project, page II-18.

¹⁰USG International Strategy on HIV/AIDS, July 1995.

¹¹(This may be due, in part, to the continued vacancy in the Agency's super-grade AIDS Coordinator position, given its intermediate position in the USAID hierarchy.)

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will need the assistance of USAID's PHN Center leadership and the USAID Policy Office (PPC), if greater main streaming of AIDS is to occur within the Agency.

Conclusions:

1. ATSP Phase II designers did an excellent job of utilizing USAID's in-depth experience in family planning to design some of the components of AIDSCAP. ATSP buy-ins to Office of Population projects have been management-efficient ways to avoid unnecessary duplication and to encourage some family planning CAs to incorporate HIV/AIDS into their programs, at least on a pilot basis.
2. Funding for the provision of condoms to support AIDSCAP was initially an issue between the Offices of Population and Health. Funding for recurrent commodities such as condoms and STD drugs was not included in the AIDSCAP cooperative agreement and, according to the midterm AIDSCAP evaluation, has limited AIDSCAP's ability to carry out truly comprehensive interventions in some countries.
3. All regional bureaus and many missions have utilized the AIDSCAP buy-in or OYB transfer mechanisms to finance designated country or region-level activities. Only seven missions have established bilateral HIV/AIDS projects which do not utilize AIDSCAP as the primary implementing agency. This remarkable homogeneity clearly indicates that the Phase II design was successful in reducing the number of separate USAID management units.
4. There appears to be little duplication between the ATSP and the Africa Bureau's region-wide HAPA project. Indeed HAPA funded some research and pilot activities which "pushed the technical envelope" and were valuable to AIDSCAP and the ATSP.
5. The HIV-AIDS Division has not focused attention until recently on urging the Agency as a whole to consider HIV/AIDS as a "development issue" rather than as a "public health" issue. A number of recent examples demonstrate that the Division can play a valuable role in formulating new Agency and USG international policies which encourage a multi-sectoral approach and that the HIV-AIDS Division can influence the design of new PHN center-wide projects.
6. It is instructive that the broader approach to dealing with HIV/AIDS is more common in entities such as UNDP, UNICEF, and USAID's Africa Bureau that do not receive their funding via sector or problem-specific functional accounts. This is an example of how the capacity to approach HIV/AIDS as a multi-sectoral problem and make programmatic

decisions based on development experience and long-term potential benefits, is probably circumscribed by limitations which flow from Congressional functional account earmarking.

5. Impact of Changes in USAID Operational Systems and USAID Organizational Structure on ATSP

Although any organization undergoes structural and operational change during a period as long as the ATSP has existed (nine years), USAID has undergone profound changes. The Evaluation Team asked USAID and CA staff whether any of several enumerated changes had seriously affected the ATSP. Two such changes—1) a change in procurement policy which resulted in transferring AIDSCAP from a cooperative agreement to a contract; and 2) the introduction of field support budgeting—have had significant impact. Other major changes such as reengineering ("too early to tell"), reduction of USDH technical staff, and the Agency's 1994-95 reorganization reportedly have had little impact thus far on ATSP performance.

On February 3, 1994, almost two-and-one-half years into the AIDSCAP five-year program, and at the insistence of the USAID Office of Procurement, the Agency's agreement with FHI was converted from a cooperative agreement to a contract. The midterm evaluation detailed the immediate impacts of this conversion and judged that this conversion was the primary reason that the AIDSCAP program was about one year behind schedule. This conversion appears to have been part of a broader policy change in USAID procurement. As noted in the midterm evaluation, "the Contracts Office sought to effectuate the same type of change in the case of other cooperative agreements—under the same rationale as that followed in the AIDSCAP case."¹²

According to interviews with HIV-AIDS Division, USAID mission, and AIDSCAP staff, the AIDSCAP program is much more difficult to manage under a contract than under a cooperative agreement for the following reasons:

- AIDSCAP can no longer function as "an extension of USAID" with the frequent and easy collegial interaction between AIDSCAP and USAID staff envisaged by the Phase II designees. Close mission collaboration with AIDSCAP in preparing the scope and budget of a "comprehensive country program: or in modifying an existing program is no longer feasible. The two entities must remain at "arms-length" as "contractor" and "contractee."

¹²The General Counsel's Office ruled that the changes were not necessary. Management Review of the AIDSCAP Project, Page III-8.

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- Flexibility and adaptability is reduced. Modifications of the country program must be codified in time-consuming contract amendments.
- Much of the COTR's time is absorbed in rewriting mission-drafted scopes of work and delivery orders so that they are "of contractual quality" and will be accepted for action by the Procurement Office. This has significantly reduced the time the COTR has available for technical and operational matters. Both AIDSCAP and the COTR complain that their contact and "quality time" is now much less frequent than prior to the conversion.
- OYB transfers, bureaucratically the easiest way for missions or regional bureaus to transfer funds to AIDSCAP (essentially, a paperless transfer), are no longer possible. All transfers now require detailed scopes of work and delivery orders.
- Risk taking and experimentation are discouraged. Use of the contract mechanism requires that the scope of work be precise and that a specific product be delivered at the end of the contract period. The degree of certainty now required in preparing contract scopes of work has, according to AIDSCAP and USAID personnel, significantly reduced risk-taking and experimentation in new or amended scopes of work for AIDSCAP.

It is the opinion of this Evaluation Team that the conversion has had a significant overall negative impact on the operations of the AIDSCAP program. HIV/AIDS has been a recognized public health problem for less than two decades. The state of knowledge of the disease and how best to prevent it is in its infancy compared to other sectors (formal education, agricultural research) where USAID has worked for much longer periods. HIV/AIDS, therefore, should have been the last sector in the Agency to be required to use a procurement mechanism which requires certainty rather than experimentation and risk-taking.

a. Field Support Budgeting

The concept of field support budgeting was introduced as one element of a major USAID reorganization, which was planned and implemented in 1994-95. In essence, field support budgeting means that field missions determine what portions of their annual budgets will be transferred to USAID/W for eventual use by Washington-based projects that would support field activities. These funds are then "held back" from missions and transferred directly to Global Bureau projects (saving the steps of allocating funds to missions and then having missions reallocate funds to the Global Bureau). More than in the past this process requires missions to make one-time transfers for its total program early each fiscal year. Although this process is designed to give budget certainty to Global Bureau projects early in a fiscal year, it takes from missions a degree of flexibility they had previously enjoyed in deciding when, and if, to transfer funds to an individual Global Bureau project.

For AIDSCAP this means that missions must agree to fund all field activities and a portion of the AIDSCAP core budget. These costs seem high to missions since they are asked to cover the costs of AIDSCAP regional offices, evaluation personnel at headquarters, and all other costs that directly or indirectly support country programs. During the first three years of AIDSCAP, the Global Bureau financed all core costs, including indirect support costs.

Field support budgeting was initiated by USAID in FY95 with some resistance from field missions and some confusion as to how it would be implemented in practice. In FY96, field support budgeting is even more difficult due to continued uncertainty about Agency funding levels and sectoral allocations within the Agency, and major overall budget reductions. Because of these factors the field support budget process has not been completed eight months into the present fiscal year.

The operational result of this process is unprecedented uncertainty in the HIV-AIDS Division and in AIDSCAP about: the overall level of funding which will be made available to AIDSCAP for field activities, and whether core programs and core staff levels can be continued at prior levels.

Given AIDSCAP's multiple responsibilities, the funding mechanism initially established for the program was already relatively complex for USAID project. The field support budget process, combined with increased budget uncertainty has placed even greater strain on this complex funding process. AIDSCAP and HIV-AIDS Division managers would have preferred to stay with the previous funding mechanism and describe the new field support system as "a tremendous, time-consuming distraction."

While field support may be a valuable concept for future programs, it has been extremely difficult to "retrofit" on AIDSCAP, an ongoing project whose "core" was not designed to be field funded.

b. Other USAID Organizational and Operational Changes

Other organizational and operational changes have not had a significant impact on the ATSP program, according to information received by the Evaluation Team. These include: 1) USAID's major structural reorganization in 1994-95 which transferred some, but not all Washington technical staff from regional bureaus to the Global Bureau; 2) stricter field audit requirements for NGOs who carry out sub-projects; and 3) reengineering.

Both CA personnel and senior USDH staff have, however, noted concern over the continued, gradual reduction in the numbers of USDH technical staff working in field missions and in Washington. Their replacements—"fellows," who mostly serve in Washington on two-to-three-year appointments, and Personal Services Contractors (PSCs), working mostly in field

missions—are universally viewed as well trained, talented, and energetic technical specialists. Their interests are primarily technical rather than managerial. They are often perceived to be on a very fast learning curve and are not experienced in successfully operating within the USAID bureaucratic structure. They don't necessarily know the "USAID culture" or have the networks established within the Agency that USDH staff use to share information and solve problems. Experienced USDH mentors for these fellows are unfortunately in short supply and often have little time to devote to on-the-job training. Government regulations do not allow fellows to attend the orientation training courses offered to new direct hire government employees.

An added complication is that fellows are not allowed to "represent" the U.S. government¹³. They cannot legally "negotiate" with a CA they theoretically manage, and cannot be involved in budget discussions. While CAs generally feel confident with the level of technical support they receive from fellows, they are less positive about the level of operational support they receive.

In sum, one reason the uni-polar project model was selected for Phase II was because it would achieve managerial savings for USAID. HIV-AIDS Division staff report that those saving were indeed achieved during the early years of the AIDSCAP program. However, these savings have been severely eroded by the conversion from a cooperative agreement to a contract and the increasing difficulty in transferring funds from the field to Washington, complicated by the new field support system.

Conclusions:

1. The Phase II design anticipated that management of one large project would be more efficient than management of the Phase I bi-modal approach, especially in terms of reduction of internal USAID documentation (procurement, budgeting, reporting). It appears that these management efficiencies were indeed realized initially. However, they have been lost in recent years due to the mid-stream switch from a cooperative agreement to a contract modality in FY94 and the introduction of field support budgeting in FY95.
2. The conversion from a cooperative agreement to a contract has had a significant negative impact on the capacity of AIDSCAP to carry out its program on schedule. It has reduced risk-taking and flexibility essential to a program addressing a new Agency problem

¹³ Normally the primary technical contact within USAID for a CA is its COTR (Contract Officer's Technical Representative). However, a COTR can only be a tenured U.S. government employee. "Fellows" and PSCs, working for shorter time periods for USAID, cannot "negotiate" with a CA on behalf of the USG, discuss budget matters, or sign off on CA vouchers (among other limitations). When they are the primary technical contact with a CA—as they must be in the HIV-AIDS Division with only two to four USAID or CDC (USG) employees—another staff member must formally be COTR. To avoid confusion, we have, somewhat inappropriately, used the term COTR in all cases for staff members who are the primary technical contact with a CA.

area—where knowledge of the disease and how to prevent it are in their infancy compared to other Agency programs.

3. The retrofitting of field support to AIDSCAP was a "major time-consuming distraction" in FY95, but, combined with major budget cuts in FY96, is threatening to undermine the very viability of the AIDSCAP program since funding for many core functions may not be available.
4. The reduction of the number of USDH technical officers and their partial replacement by less USAID-savvy and less permanent personnel has reduced the HIV-AIDS Division's capacity to resolve operational, financial, and administrative problems affecting some of the CAs in the ATSP portfolio.

6. HIV-AIDS Division Management of the ATSP

The HIV-AIDS Division was born about the same time as the ATSP; both started in 1987. The Division first operated with a Chief (who had been detailed from CDC to USAID for other purposes); a Deputy Chief (an experienced USDH, borrowed from within the Global Bureau); and a secretary. It has, over time, grown to 12 people. As programs were initiated, the staff gradually expanded as the Division leadership obtained qualified personnel wherever they could find them. Operational Expense (OE) funds were scarce to the Agency and therefore were particularly scarce to this new program, while program funds, earmarked by the Congress, were relatively abundant. This led the Division to be staffed primarily by non-career personnel whose salaries and travel were paid from ATSP program funds.¹⁴ These personnel were on detail from CDC or BuCen or hired as "fellows" or "STARS" by intermediaries such as the American Association for the Advancement of Science (AAAS) and the Johns Hopkins University. No more than two USDH, and usually only one, have served in this office at any time. Most of the USDH employees have had field experience in USAID missions. Throughout the life of the ATSP, Division Chiefs have been CDC employees on detail to USAID. Only the most recent Division Chief had previously served overseas or had field experience with a USAID mission.

During Phase II of the ATSP, the structure of the Division was normally:

- Division Chief
- Deputy Chief
- AIDSCAP COTR (Project Manager)
- Five to eight technical staff, each of whom was normally a COTR for two to three CAs. These staff also provide technical backstopping and support to the AIDSCAP COTR
- Administrative staff

¹⁴CDC salaries are an exception and are paid separately with OE funds.

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The evaluation team asked all the CAs in the ATSP to grade the HIV-AIDS Division's performance in carrying out six basic functions of the Division. They were also encouraged to add explanatory comments to their grades. The responses were remarkably homogeneous.

The CAs gave the HIV-AIDS Division highest marks for:

- **Providing technical guidance and support:** While this varied somewhat by COTR (most CAs noted they have worked with at least three COTRs), overall, CAs were very pleased with the high level of technical guidance provided. Some felt, however, that the less experienced COTRs "didn't always know where to stop" and had a tendency to get too involved in the technical details of their work.
- **Providing global leadership and direction in addressing the epidemic:** Respondents said Division leadership has had a clear vision of what needed to be done to address HIV/AIDS and what USAID's role should be. The Division was praised for its work with WHO/GPA, UNAIDS, and other donors. It has reached out beyond the donor community and the ATSP community and has had good communications and positive relationships with a wide variety of key organizations and individuals involved with HIV/AIDS.

The Division received consistently low marks for:

- Communication of overall ATSP status, issues, and opportunities
- Facilitating cooperation and teamwork within the ATSP.

These grades reflect the perceived failure of the one ATSP coordinating mechanism (the monthly meetings) and the relative technical and operational isolation felt by most of the smaller CAs. The Division did not provide incentives, opportunities, or funds to encourage cooperation among the CAs.

The CAs gave the Division mixed marks for:

- Management of grants
- Helping to resolve operational problems.

CAs criticized the rapid turnover in their COTRs, the COTRs' inexperience in how to get things done within the USAID bureaucracy, their lack of experience with USAID documentation requirements, and their inability to discuss budgeting matters. This often resulted in delays on relatively simple things.

Team interviews with non-Division USAID employees reveal that as a whole the Division staff is perceived to be extraordinarily hard working and dedicated ("probably the most dedicated office in USAID/W"). They are also perceived to be "very overworked." The Division is praised for its leadership and technical ability.

Frequent criticisms are that the Division is not staffed with people who have field experience and "is not field oriented." Neither of the two AIDSCAP COTRs have served in a field mission. The present COTR, with excellent experience in USG domestic agencies, has had to manage an extraordinarily complex project without having had prior USAID experience.

The lack of USAID experience reflected in both Division leadership and Division staff may explain why its contacts and networks outside USAID are much better than its contacts and networks within the Agency. These internal relationships will need to improve if the Division is to be successful in encouraging greater "main streaming" of HIV/AIDS within the Agency's development policies and practices.

Conclusions:

1. The revised ATSP structure with its AIDSCAP keystone project placed an unprecedented management responsibility on a single COTR. Although this COTR's bureaucratic workload increased significantly after AIDSCAP's conversion to a contract, the division has not added staff or reorganized staff to help carry out these additional responsibilities.
2. The management responsibilities for the smaller CA programs have been significant and has been largely left to the less senior and experienced members of the HIV-AIDS Division staff.
3. The CAs as a whole have given the division high marks for:
 - Technical guidance and support (although this depends on the individual COTR)
 - Providing global leadership and direction in addressing the epidemic.

They gave consistently low marks to the Division for:

- Communication of overall ATSP status, issues and opportunities
- Facilitating cooperation and teamwork within the ATSP.

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Very mixed marks were provided for:

- Management of grants
- Helping to resolve operational problems. This was largely dependent on the COTR's knowledge of "the USAID way" of operating.

These marks are explained in part, we believe, by the composition of the HIV-AIDS Division leadership and staff (technically qualified and focused, and highly motivated, but relatively inexperienced in USAID operations), and by the management style of an overburdened unit which had little time for staff supervision, training, and internal coordination.

4. The lack of USAID experience reflected in both Division leadership and staff may explain why its contacts and networks outside of USAID are much better than its contacts and networks inside the Agency. While the outside contacts and networks are exemplary, internal relationships will need to improve if the Division is to be successful in encouraging greater "main streaming" of HIV/AIDS within USAID's development policies and practices.

III. Project Substantive Appropriateness

A. BACKGROUND

It has been approximately ten years since USAID developed its first response to the international HIV/AIDS epidemic. In September 1986, USAID provided an initial grant to the World Health Organization's Special Programme on AIDS (later the Global Programme on AIDS). Within the next year, USAID drafted its first policy guidance on AIDS and developed the umbrella AIDS Technical Support Project (ATSP). What little was known about HIV/AIDS prevention in 1987 came largely from small communities within the U.S. and other industrialized countries. USAID's initial response drew on the domestic experience in HIV/AIDS prevention, as well as its own extensive experience in child survival and family planning. In addition, priority was given to technical areas where USAID seemed to have a comparative advantage over other donors including social marketing and communications, operations research, training, and economic analysis and health care financing.

In 1991, the ATSP was redesigned with "a major objective...to have a measurable impact on HIV incidence in the priority countries upon project completion." This was prompted by a concern that under the previous project "resources were spread too thin to have a measurable impact on HIV incidence." It also responded to growing Congressional pressure to demonstrate short-term impact of HIV/AIDS funding on the spread of the epidemic.

To enhance the potential for a measurable impact on HIV incidence, the Phase II technical strategy focused on "proven interventions" based on the lessons learned during the previous three years of implementation. It also called for the "concentration of resources and the development of a targeted "AIDS strategic plan" in ten to 15 priority countries based on the proven interventions," as well as effective support activities in non-priority countries. As described in the ATSP PP Amendment,¹⁵ the four proven interventions are aimed at "increasing demand for condoms, increasing access to condoms, partner reduction, and diagnosis and treatment of sexually transmitted diseases." This substantive approach reflected the opinion of the Phase II designers that the ATSP was ready to move from an "experimentation phase" to an "implementation phase" based on experience and insights into the effectiveness of HIV/AIDS prevention strategies.

Phase II has focused on the modification of individual risk behaviors for the prevention of the sexual transmission of HIV infection. As articulated by AIDSCAP, individual behavior change and the consequent reduction in HIV transmission was to be accomplished by the application of

¹⁵Although the PP Amendment was written for the entire ATSP, it was clearly intended as the strategy to be implemented by a single, large cooperating agency, namely FHI/AIDSCAP. Other ATSP CAs were rarely mentioned in the PP Amendment.

three primary technical strategies and three supporting strategies. The three technical strategies are condom programming and logistics management, reduction of sexually transmitted diseases (STDs), and behavior change communication. The supporting project strategies are behavioral research, policy development, and evaluation. These strategies were to be applied in concert as a comprehensive program. Again, the decision to concentrate resources on a formulated approach in a limited number of countries was intended to maximize project impact on HIV incidence.

B. SUBSTANTIVE APPROPRIATENESS OF THE ATSP

The evaluation team asked interviewees to discuss a range of issues pertaining to the content of the ATSP. The following questions, identified as critical to this evaluation, address the overall substantive appropriateness of the ATSP:

- 1) “Given what was known about HIV/AIDS prevention in 1990, was the substantive approach of the ATSP redesign appropriate (e.g., the focus on sexual transmission; the three-pronged technical strategy)?”; and
- 2) “given what is currently known about the AIDS epidemic, is this substantive approach still appropriate?”

Approximately 50 key informants responded to the above questions, including USAID staff affiliated with the ATSP (past and present), most of the ATSP CAs, and two organizations working in reproductive health and development, but not funded by the ATSP. In addition, information was provided on a number of relevant substantive issues including technical cooperation and collaboration, accessing technical expertise, and biomedical research. The following data, conclusions, and recommendations reflect the experiences and insights of the interviewees, as well as the team’s own review of key project documents.

There is general agreement that the Phase II technical strategies were appropriate given what was known about the biological basis of HIV transmission and the proven effectiveness of condom use, STD treatment, and partner reduction for reducing individual risk of HIV transmission. At the time of the redesign, it was thought that by combining the three individual technical strategies in a comprehensive program, they would achieve a synergistic effect beyond the impact of a single intervention. Most interviewees agree that this was a reasonable hypothesis.

It is appreciated that AIDSCAP is successfully implementing the three technical strategies and is using quantitative and qualitative process indicators to track the progress of sub-projects (e.g., number of people attending educational sessions number of condoms sold through condom social marketing programs). At the end of most sub-projects AIDSCAP will be able to compare outcome data to baseline indicators in order to demonstrate short-term behavior change among

target populations (e.g., condom use; two or more sexual partners in the past 12 months; knowledge of two methods of prevention). In a few sub-projects it may be possible to demonstrate impact on STD prevalence. It is generally agreed, however, that AIDSCAP will be unable to demonstrate national-level impact on HIV incidence in any priority country.

The expectation that, with a comprehensive approach, AIDSCAP would "have a measurable impact on HIV incidence in priority countries upon project completion"¹⁶ is seen to have been unrealistic. Significant difficulties exist in both measuring and achieving impact on the spread of the epidemic. AIDSCAP was designed to rely on biologic impact data from National AIDS Control Programs with WHO/GPA support. In the past three years, these sentinel surveillance activities deteriorated significantly. It seems likely that there were insufficient resources and scope of HIV/AIDS prevention activities for country-wide impact (e.g., AIDSCAP's Brazil program, with an annual budget of approximately \$2 million, is concentrated in only two of Brazil's twenty-six states). An unfortunate effect of the expectation for impact (along with the desire for technical focus in the context of limited resources), is that it drove a programmatic adherence to the three technical strategies with little incentive for experimentation or risk-taking.

Despite the lack of impact data, the three technical strategies of condom promotion, reduction of STDs, and behavior change communication are generally still regarded as appropriate and important components of any comprehensive HIV/AIDS program. Although not formally tested in Phase II, it remains common wisdom that an optimal program will combine multiple reinforcing strategies to maximize cumulative impact. AIDSCAP's process information (as well as outcome data) will provide invaluable insights into what has been learned about how to implement the three technical strategies. As AIDSCAP approaches completion, it should be encouraged and supported to analyze and disseminate the wealth of information gained from the project.

While USAID had acquired considerable experience in condom promotion and behavior change communications, in 1990, the reduction of concurrent STDs was considered a novel and some say radical strategy for HIV/AIDS prevention. Six years later, STD diagnosis and treatment is seen as a critical biomedical intervention that, according to several interviewees, warrants increased attention and resources. The potential of this strategy is frequently highlighted by reference to the Mwanza study, published in 1995, which demonstrated that improved treatment of STDs resulted in a 40 percent reduction in HIV incidence in rural Tanzania. Unfortunately, USAID's own STD/HIV/AIDS programs have been hampered by the lack of consistent access to STD drugs and condoms.

Many people believe that while ATSP strategies are still essential, they are no longer sufficient to make a sustainable impact on HIV transmission. Since 1991, the dialogue regarding HIV/AIDS prevention has changed significantly, becoming more elaborate and reflective of the complexity of the

¹⁶ATSP Project Paper Amendment No. 2, page 1

epidemic. This evolved discourse, which permeated USAID's 1995 AIDS Prevention Conference, was also reflected in many of our interviews. There was a frequent recommendation to expand support for a broader response to HIV/AIDS, beyond the current AIDSCAP technical strategies, and to build on lessons from the pilot activities of the other CAs (e.g., UNDP, UNICEF, the Alliance, ICRW, IPPF, Peace Corps, the Population Council). Specifically, it was recommended that a broader ATSP response include more attention to the following substantive areas and approaches:

- Developing “contextual interventions” for HIV/AIDS prevention
- Supporting a more “community-organizing” approach to HIV/AIDS
- Reaching beyond traditional “at risk groups” to reduce women and girls’ vulnerability to HIV/AIDS
- Supporting more expedient development and testing of vaginal microbicides
- Linking HIV/AIDS prevention and care.

It was recommended that these initiatives, each discussed briefly below, become priority areas for Phase III, to be integrated with the existing technical strategies of condom promotion, reduction of STDs, and behavior change communication. Given the limited and precious resources available for development assistance, it will be essential (and challenging) to figure out how best to include the above substantive areas in a manner that is practical, cost effective, and cognizant of USAID's evolving role in HIV/AIDS relative to other donors and development organizations. In particular, USAID support for a broader response to HIV/AIDS implies the need for collaborative approaches and joint funding with other donors. However, in the words of one experienced ATSP specialist, “If USAID were to proceed with the simplistic approach to the epidemic, it would be a disaster to USAID’s credibility...the epidemic would rage...and it would be a waste of resources.”

1. Developing Contextual Approaches to HIV/AIDS Prevention

AIDSCAP has focused primarily on delivering “proximal” interventions that aim to modify individual risk behaviors. For example, peer education efforts in Cameroon are reported to have reached more than 400,000 people with behavior change communication messages. Baseline data on self-reported behaviors, obtained at the beginning of each sub-project, will be used to evaluate the impact of peer education activities on individual behavior change. An AIDSCAP-supported condom social marketing program in Brazil sold approximately 14 million condoms in

1995, a reported 61% increase over the previous year's sales. This is considered an intermediate or proxy indicator for behavior change involving increased condom use.

It appears that individual behavior change is being impeded by a number of social, cultural, and economic realities in developing countries. For example, in the absence of adequate economic resources, women may be unable to purchase condoms; may be unwilling to jeopardize relationships in which they are dependent; and, in the extreme case, may engage in prostitution for survival. In general, social, cultural, and economic factors both fuel the epidemic and interfere with interventions aimed at individual behavior change. The success of current programs may be limited by the relative weakness of available interventions, such as condom promotion, as compared to the strength of contextual factors that support AIDS-prone behaviors. By analogy, current HIV/AIDS interventions are recognized as the water needed for plants to grow. However, the plants are now seen to be rooted in different soils, determining the effect or benefit of water supplies. Plants will respond poorly in clay and will not grow in stone, regardless of how much water is given. Many now believe that the success of ATSP interventions toward sustained behavior change depends on changing those critical contextual factors that support HIV/AIDS risk behaviors.

The dialogue regarding HIV/AIDS prevention has evolved and become more elaborate, calling for broader contextual approaches. Despite the evolved discourse, however, there have been only marginal programmatic shifts within AIDSCAP.¹⁷ The AIDSCAP midterm evaluation, conducted in late 1994, noted the general absence of "contextual interventions" that would aim to identify and change the social, economic, and political factors that support individual and collective vulnerability to HIV transmission. Many ATSP CAs, including AIDSCAP, express uncertainty about what are the feasible, affordable, and relevant contextual interventions that are appropriate for HIV/AIDS prevention efforts. As one CA cautioned, however, "this uncertainty needs to be acknowledged without looking for quick programmatic solutions." Thoughtful discussions are needed regarding the process for identifying, designing, and evaluating contextual interventions and how these approaches will be integrated with existing technical strategies.

Few interviewees disagree with the importance of contextual factors in HIV/AIDS prevention. Reservations were expressed, however, regarding USAID's appropriate role in supporting contextual approaches to HIV/AIDS prevention, particularly in light of limited financial resources. Some of the reluctance to pursue contextual approaches appears rooted in the use of the terms "short-term" versus "long-term" strategies for HIV/AIDS prevention. Contextual approaches are perceived by some as inherently long-term strategies (e.g., achieving gender equality; eradicating poverty; instituting universal education), and thereby lack immediate,

¹⁷In general, AIDSCAP has had difficulty changing its scope of work within the constraints of its contractual obligations.

achievable objectives or evidence of short-term gains. Alternatively, the time frame for contextual approaches to AIDS prevention was described by many interviewees as a continuum from short- to long-term, in which many interventions may reasonably coincide or be integrated with ongoing projects. For example, one contextual approach might provide women and girls with basic education about their bodies and human sexuality. This intervention would attempt to change cultural norms of female ignorance regarding sexual activity and health; and in combination with HIV/AIDS education, might be more effective than the latter alone. Another intervention might improve women's access to credit and training in order to give them more economic independence within their personal and sexual relationships. Again, these contextual interventions, in combination with the current prevention strategies, may have synergistic effects beyond those currently achieved.

The Agency already supports many relevant development projects outside of HIV/AIDS that work to change the social, cultural, and economic context of people's lives (e.g., girls education programs; women's income generation programs). In such cases, it may be extremely valuable to link existing development activities with HIV/AIDS programs. In addition, the success of HIV/AIDS prevention activities may depend on specific contextual changes that have otherwise demanded minimal attention. For example, "100% condom use" policies in brothels have been critical to changing the context in which commercial sex workers negotiate condom use. Likewise, HIV/AIDS has raised awareness of the need for educational programs for boys and men to challenge cultural norms that accept or encourage sexual behavior that puts them and their partners at risk. Discussions and project data are required to determine how best to develop, evaluate, and report the accomplishments of such programs. It is recognized that such contextual approaches may require new qualitative and quantitative indicators of success, different from those currently used by the ATSP.

When there is uncertainty about what contextual changes are appropriate, a valid strategy is to enable the people who are closest to the problem to decide to experiment with different approaches, and to see what works. The International HIV/AIDS Alliance offers one example of how to develop and test contextual interventions in HIV/AIDS. Founded in 1993 with ATSP financial support, the Alliance supports community action on HIV/AIDS in developing countries. The Alliance has a unique organizational mission and methodology within HIV/AIDS in that it "supports a transference of governance from distant donors to affected communities" by giving communities the assistance to decide how best to respond to the epidemic. Through a process of local priority-setting and decision making, proposals for contextual change can be identified and supported.

2. Supporting “Community-Organizing” Approaches to HIV/AIDS Prevention

Many interviewees recommend that the ATSP explore new methodological approaches to HIV/AIDS, including a shift toward a more “community-organizing” approach to AIDS prevention. Whether in the United States, Uganda, or Thailand, community action is at the center of many innovative and successful responses to HIV/AIDS. Given the complex socioeconomic and cultural context of HIV transmission, community-based groups are often best able to initiate appropriate and innovative responses to the epidemic, as well as to work with vulnerable and marginal populations. A community-organizing approach would put the locus of control in the hands of communities to articulate local priorities and find effective and sustainable solutions. Community-generated initiatives may include university students protesting HIV/AIDS discrimination; churches exploring the future impact of AIDS on the congregation; or parents mobilizing against the (Sugar Daddy) phenomenon. By engaging individuals, including local leaders, in a process of community mobilization and by developing genuine local ownership and commitment to AIDS initiatives, it is more likely that resulting efforts will be embraced and sustained.

Several challenges of community-organizing approaches are recognized. In many communities, HIV/AIDS may not be a high priority. Asking young people to articulate and prioritize their needs is unlikely to generate initial discussions about their health or risk of AIDS. More likely, they are concerned about the money needed to buy cosmetics or school books, the recent changes in their bodies, or the alcoholism and violence at home—all issues which could be related to AIDS. This process, as one interviewee commented, is about “finding them where they are...it isn’t a long way to an AIDS prevention program.” Although women may express more concern about their risk of infertility than HIV/AIDS, this provides an entry to help them see that sexually transmitted diseases are an issue that is important to them.

While this approach gives communities central responsibility for program planning, decision making, and implementation, it still requires careful technical assistance and support. Since 1994, the Alliance has supported the process of community mobilization and capacity building as a core strategy for AIDS prevention and care. The process begins by defining local needs and priorities and identifying community-based organizations with appropriate mandates and linkages. Subsequent steps include local needs assessments, proposal development, and program implementation. The Alliance notes that all stages require significant technical assistance, even more than was originally anticipated. Increasingly, local sources of technical assistance can be found within the same or other developing countries.

Since 1993, AIDSCAP has supported a “Rapid Respond Fund” grants program for NGOs working in HIV/AIDS. To date, the program has provided 174 small grants (\$2,000-\$5,000) to

indigenous groups in 13 countries. The intent of the program is to provide small, flexible funds for local initiatives in HIV/AIDS.¹⁸

3. Reducing Women and Girl's Vulnerability to HIV/AIDS

The HIV-AIDS Division has not had an explicit strategy for reducing women's vulnerability to HIV/AIDS. The ATSP PP Amendment focused on changing individual behavior within narrowly construed "at risk groups" such as commercial sex workers, their male clients, and men who have sex with men. The expectation was that by significantly reducing HIV transmission within these core "risk groups," there would be an indirect impact on HIV transmission to women in the general population. However, epidemiological data from many developing countries (with some notable exceptions, including the Philippines) indicates that the AIDS epidemic has not stayed confined to "risk groups," but is moving to the general population with tremendous impact on so-called "low risk" women. Underlying this progression are many contextual factors that support women's vulnerability to HIV/AIDS, including the power imbalances between women and men and the social construction of gender roles, both male and female.

Several CAs are credited with developing critical activities to meet women's HIV/AIDS prevention needs. In 1989, the ATSP began funding the Women and AIDS Research Program of ICRW. Within the HIV-AIDS Division, this program was seen as a critical first step toward filling a worldwide research gap on women's risk of HIV infection and the opportunities for AIDS prevention. In its first phase (1989-92), the program supported 18 behavioral and social science research studies worldwide. Today, much of the available data regarding the realities of women's vulnerability to HIV/AIDS, as well as recommended policies for gender and AIDS, have come from the Women and AIDS Research Program.

Since 1992, the ATSP has provided support to the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR), for the integration of HIV/STD prevention into family planning programs and services within the broader context of sexual and reproductive health. In such programs, women

"are helped to explore the multiple intersecting issues related to their physical and emotional health within the context of their sexual lives and relationships ... Women in individual counseling and group sessions, as well as adolescents and community members, are given the opportunity to articulate their own concerns about their sexual lives so that services can reflect their realities. Interventions focus on increasing their comfort in communicating with partners, helping women analyze their own situations

¹⁸Also see AIDSCAP comments in Annex 7.

and determine their own risk, and identify personal priorities for pregnancy and STD prevention.”

AIDSCAP's attention to issues of gender and HIV/AIDS prevention lagged the global recognition and response to the problem. The strategic focus on traditional "at-risk groups" excluded women in the general population from many early AIDSCAP projects and led to the general absence of contextual interventions that aim to reduce women's vulnerability to HIV/AIDS. In response to this apparent gap, USAID's Office of Women in Development (WID) supported the formation of the AIDSCAP Women's Initiative (AWI), which in 1994 became an autonomous unit under the program director. Since then, AWI has evolved into an active, albeit small, AIDSCAP component and currently supports a number of activities with the overall objectives of "integrating a broad approach to AIDS prevention for women into all regional and country programs; launching new activities at the community level; and initiating collaboration on research and policy issues with other agencies and organizations." AWI's lessons and contributions to the overall AIDSCAP program may be one important topic for the AIDSCAP final evaluation.

The individual contributions of these CA initiatives are seen as significant and, in the cases of ICRW and IPPF, appear to have benefited from the unique expertise and linkages of these organizations. It was recommended that the ATSP build on these pilot activities and devote greater emphasis and resources to issues of gender and HIV/AIDS prevention. Specifically, it was suggested that Phase III expand support for research, program activities, and policies to meet women's needs in a manner that is sensitive to the realities of women's lives and to the relevant differences between women and men. As one example, STD services need to be made more accessible to women in the general population, taking into account that women may be asymptomatic, may accept vaginal symptoms as part of womanhood, or may avoid traditional STD services. At the same time, interventions are needed that aim to change the gender power dynamics and inequalities underlying women and men's vulnerability to HIV/AIDS. For example, educational programs for boys and men could challenge cultural norms that accept or encourage sexual behavior that puts them and their partners at risk. In reference to HIV/AIDS messages that reinforce traditions of gender inequality, one CA cautioned, "we shouldn't fight short-term battles at the expense of long-term gain."

4. Supporting More Expedient Development and Testing of Vaginal Microbicides

In 1993 the Population Council published a working paper entitled "The Development of Microbicides: A New Method of HIV Prevention for Women." The paper articulated a compelling argument for developing an HIV prevention technology within the personal control of women. At that time, there was a dearth of anti-microbial research, especially on compounds that would not have spermicidal properties. Like contraceptive technology development, microbicide development has witnessed a market failure, lacking private sector interest or

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involvement. Again, as in contraceptive development, USAID now has an exceptional opportunity to play a leadership role in HIV prevention technology development.

There are several reasons why USAID leadership in microbicide development is seen to be an appropriate role for the organization. First, microbicides will be of most benefit to women and couples in stable relationships, for whom condoms are generally not a viable option. And it is largely women in developing countries who are at risk of HIV infection, the constituency that USAID represents and is hurt by the current market failure in prevention technology development. Second, any product that is broadly microbicidal has the potential to prevent not only HIV/AIDS but also other sexually transmitted diseases, which are a significant source of morbidity and mortality in the developing world. Finally, without USAID advocacy, the development of a non-spermicidal microbicide appears unlikely. Recognizing the HIV/AIDS/STD prevention needs of developing country women, it is important to realize that there is no U.S. political constituency advocating for prevention research and technology development.

Since August 1993, the ATSP has provided critical support to the Population Council's microbicide research and development program, from which several promising compounds are emerging. Unfortunately, the expedient development and testing of anti-microbials remains largely constrained by limited financial and human resources, not by any significant conceptual or feasibility problems. While NIAID is currently the primary funder for microbicide research, most of its grant recipients are laboratory scientists with no capacity for clinical testing or product development. As compounds emerge from the laboratory, mechanisms will be needed to bring multiple leads through the sequential stages of testing and product development. In anticipation of clinical trials, the Pop Council is undertaking studies to address fundamental issues of acceptability and sexual communication regarding the use of microbicides, for which they are currently seeking funding. At the same time, the Pop Council is involving women health advocates in the microbicide development process to ensure that any resulting technology will be appropriate and acceptable to women.

It is recommended that USAID develop a strategy for microbicide development that recognizes the unique role of the Agency in leveraging a product that will be appropriate to women in developing countries. By devoting increased attention to microbicide development, USAID has the unique opportunity to make an AIDS prevention technology available to women and to revolutionize HIV prevention efforts globally.

5. Linking HIV/AIDS Prevention and Care

The 1991 ATSP redesign focused solely on HIV/AIDS prevention and excluded care of those affected by the epidemic. The underlying concern was that any care initiatives would drain financial resources and thereby detract from priority prevention efforts. For communities now living with a mature epidemic, prevention and care, as well as the social and economic impact of AIDS are inseparable concerns. It is felt by many that, in this setting, USAID's "prevention only" programs may lack sensitivity, credibility, or maximal efficacy by recognizing only one aspect of an individual's or community's many interrelated HIV/AIDS concerns.

Several arguments are offered for linking prevention and care efforts. It has long been recognized that persons living with HIV/AIDS may be among the best community-AIDS educators and advocates. It remains critical to gain the trust and support of these individuals in the design and implementation of AIDS programs. In turn, their care needs include counseling, nutritional advice, support and legal services, and anti-discrimination policies, not simply access to costly drugs and medical interventions. For community-oriented programs to ignore the diverse needs of individuals living with HIV/AIDS, while working to engage their support, is poor prevention strategy. USAID's prevention efforts are now ongoing in communities in which 30 to 40 percent of adults are HIV-infected. In such settings, educational messages and strategies must evolve to respond to the large community which is already affected. Unfortunately, USAID's strong position against funding HIV/AIDS-related care has left it without models on how to plan for linking prevention and care.

C. OTHER TECHNICAL ISSUES RELEVANT TO THE ATSP

The evaluation team identified a number of technical issues relevant to the ATSP that will be important for the Phase III design. Several of these issues are discussed more extensively in Section II on operational appropriateness:

1. Flexibility of the ATSP in Responding to Emerging Needs of the Epidemic

As a centrally-funded project, the ATSP has displayed unusual flexibility with respect to being able to identify and support new initiatives during the life of the project. In 1989, for example, the HIV-AIDS Division supported ICRW to establish the Women and AIDS Research Program. Within the HIV-AIDS Division, this was seen as a critical first step toward filling a worldwide knowledge gap regarding women's vulnerability to HIV, and identifying prevention strategies to meet their needs. This illustrates the value of flexibility within the centrally-funded project to support smaller "Centers of Excellence" to pursue innovative and pioneering responses to emerging needs of the epidemic. Other examples include, but are not limited to, the Population Council's microbicide research and development program; IPPF/WHR's programs to integrate

family planning and HIV/AIDS/STDs; and Peace Corps' integration of HIV/AIDS into its existing educational programs with rural youth.

2. Technical Cooperation and Collaboration between Cooperating Agencies

The ATSP CAs have worked largely as separate entities without benefit of formal mechanisms for programmatic cooperation and collaboration. Where collaboration has taken place, it has generally resulted from personal friendships or individual initiatives. CAs express interest in having regular fora (e.g., revised monthly management meetings) to examine and debate substantive and technical issues of common interest. Such fora could serve to generate new ideas and opportunities for fruitful collaboration.

3. Access of the ATSP to Technical Expertise

It is seen as increasingly important for USAID to access "the best and the brightest" in thinking about and responding to the international HIV/AIDS problem. As with most ventures, successful components of the ATSP are credited, in large part, to the skills and commitments of specific associated individuals. Perhaps the single most important challenge for Phase III, is to determine who are the right people to involve (specific individuals, as well as types of individuals) and how to engage their participation in program development and implementation. In reference to the ATSP, one interviewee commented, "there is a need for new blood," including people with previously underutilized backgrounds and skills outside the public health sector (e.g., sociologists, organization theorists, WID experts).

One specific question is to how to engage the best, most creative biomedical and social scientists in doing AIDS-related research. On their own, many U.S. scientists are unlikely to do AIDS research that is relevant to developing countries. Mechanisms and incentives are needed to ensure that the benefits of biomedical and behavioral research performed in this country (e.g., vaccine development; behavior change research) can be appropriately applied to the developing world. The NIAID PASA has offered one such mechanism by providing small grants to NIH scientists for collaborative U.S.- developing country research. By virtue of its connections to developing country scientists and institutions, USAID can play a critical role in facilitating these collaborations.

4. Behavioral Research within the ATSP

Behavioral research was identified as a critical supporting strategy in the ATSP redesign. It was intended that behavioral research would contribute to the scientific understanding of sexual behaviors and would inform the three principal technical strategies, particularly behavior change communications. With some noteworthy exceptions, including the Women and AIDS Research

Program, it does not appear that social science research during Phase II has contributed significantly to the basic knowledge of behaviors and contexts associated with HIV transmission.

There are several reasons why behavioral research may not have played the prominent role that was envisioned. Within AIDSCAP, there was significant turnover in the leadership of the Behavioral Research Unit (BRU), making a thoughtful research strategy difficult. AIDSCAP leadership may not have determined how behavioral research would practically feed into behavior change communications or implementation of the other technical strategies. With expectations of impact, AIDSCAP became an intervention- and service-oriented project. In this context, behavioral research appears to have become a lower priority.

5. Biomedical Research and Interventions within the ATSP

Biomedical HIV/AIDS research and interventions have progressed significantly since the 1991 ATSP redesign. Several research areas and interventions may be relevant for Phase III and will require thoughtful discussion and clearly articulated policy in the project redesign. It is recommended that these topics include, but not necessarily be limited to, perinatal transmission, tuberculosis prevention and control, and cost-effective biomedical treatments for HIV-infected individuals. With respect to the later topic, it is suggested that there may now be cost-effective drug regimens that would have significant impact on reducing the social and economic consequences of the epidemic. It is known, for example, that an individual's "viral load" correlates with clinical progression of AIDS, as well as infectivity. By providing HIV-infected individuals with periodic, multi-drug "pulse treatments," it may help them stay healthy, productive, and less infectious for longer periods of time.

Conclusions:

1. In 1991, the ATSP was redesigned with an explicit technical focus. A major objective of the technical focus was to be able to have a measurable impact on HIV incidence in the priority countries upon project completion. This was prompted by a concern that under the previous project "resources were spread too thin to have a measurable impact on HIV incidence." It also responded to growing Congressional pressure to demonstrate short-term impact of HIV/AIDS funding on the spread of the epidemic.
2. The technical focus reflected a confidence that, in 1990, the public health community knew what worked in HIV/AIDS prevention. In the view of the Phase II designers, the ATSP was ready to move from an "experimentation phase" to an "implementation phase," based on proven interventions: increasing demand for condoms, increasing access to condoms, partner reduction, and diagnosis and treatment of sexually transmitted diseases.

3. Phase II focused on modifying **individual risk behaviors** for the prevention of the sexual transmission of HIV infection. The Phase II technical strategies were appropriate given what was known about the biological basis of HIV transmission and the proven effectiveness of condom use, STD treatment, and partner reduction for reducing individual risk of HIV transmission. It was also a reasonable hypothesis that by combining the three individual technical strategies in a comprehensive program, they would achieve a synergistic effect beyond the impact of a single intervention.
4. AIDSCAP is successfully implementing the three technical strategies and is using quantitative and qualitative process indicators to track the progress of individual sub-projects. Process and outcome data from individual sub-projects will provide invaluable insights into what has been learned from implementing the three strategies.
5. The expectation that AIDSCAP would have national-level impact on HIV incidence was unrealistic. Significant difficulties exist in both measuring and achieving impact on the spread of the epidemic. Many national level sentinel surveillance activities deteriorated significantly in the past three years. In addition, it seems likely that there were insufficient resources and scope of HIV/AIDS prevention activities for country-wide impact.
6. The expectation that AIDSCAP would demonstrate impact based on predetermined evaluation indicators drove a fairly rigid adherence to the three technical strategies with little incentive for experimentation or risk-taking. Most critically, the emphasis on demonstrating “impact” and “accomplishments” detracted from the overall ability to evaluate and think critically and creatively about what was being learned.
7. Despite the absence of biological impact data, the three technical strategies of condom promotion, reduction of STDs, and behavior change communication are still appropriate and important components of any comprehensive HIV/AIDS program. It remains intuitive that an ideal program will combine multiple reinforcing strategies to maximize cumulative impact.
8. STD diagnosis and treatment is an essential biomedical strategy for HIV/AIDS prevention and reproductive health. The Mwanza study illustrates the potential of a syndromic approach to STD treatment for HIV/AIDS prevention. In addition, the development and testing of STD diagnostics remains critical for the reduction of STDs in asymptomatic women.
9. Some AIDSCAP sub-projects have suffered from the lack of consistent access to STD drugs and condoms. The assumption of the Phase II design that these commodities would be

provided from non-USAID sources has not been valid in many cases. This has seriously undermined the potential impact of these sub-projects.

10. Many people believe that while the ATSP technical strategies are still essential, they are no longer sufficient to make a sustainable impact on HIV transmission. There is a need to expand support for a broader response to HIV/AIDS to include the following substantive areas and approaches:
 - Developing “contextual interventions” for HIV/AIDS prevention
 - Supporting a more “community-organizing” approach to HIV/AIDS
 - Reaching beyond traditional “at risk groups” to reduce women and girls’ vulnerability to HIV/AIDS
 - Supporting more expedient development and testing of vaginal microbicides
 - Linking HIV/AIDS prevention and care.
11. The ATSP focus on individual behavior change through application of three technical strategies appears to be too simplistic an approach to a problem rooted in the context of strong social, cultural, and economic determinants. “Contextual interventions” would aim to identify and change the relevant contextual factors that support individual and collective vulnerability to HIV/AIDS. The success of ATSP interventions which encourage sustained behavior change may depend on changing those critical contextual factors that support AIDS-prone behaviors.
12. The AIDSCAP midterm evaluation noted the general absence of “contextual interventions” within the project. Many CAs, including AIDSCAP, are uncertain about what are the feasible, affordable, and relevant contextual interventions needed to achieve a sustainable impact on the epidemic. This uncertainty needs to be acknowledged without looking for quick programmatic solutions.
13. The time frame for contextual approaches to HIV/AIDS prevention is a continuum from short- to long-term, in which many interventions may reasonably coincide or be integrated with ongoing projects. In some cases, contextual approaches will require new qualitative and quantitative indicators of success, different from those currently used by the ATSP.
14. When there is uncertainty about what contextual changes are appropriate or most significant, a valid strategy is to enable the people who are closest to the problem to decide to experiment with different approaches and see what works. This is the methodological

approach taken by the International HIV/AIDS Alliance, which offers one example of how to develop contextual interventions in HIV/AIDS prevention and care.

15. In many countries, community action is at the center of innovative and successful responses to HIV/AIDS. Given the complex socioeconomic and cultural context of HIV transmission, community-based groups are often best able to initiate appropriate and innovative responses to the epidemic, as well as to work with vulnerable and marginal populations. A community-organizing approach would put more of the locus of control in the hands of communities to articulate local priorities and find effective and sustainable solutions. In the process of community mobilization, there is an opportunity to develop genuine local ownership and commitment to AIDS initiatives.
16. Despite the escalating incidence of HIV/AIDS among women, as well as the more informed discussions on gender and AIDS, ATSP programmatic responses have remained too peripheral and under-resourced. Several CAs (e.g., ICRW, IPPF, AIDSCAP) have developed programs to begin to meet women and girls' HIV/AIDS prevention needs. It is now appropriate for the ATSP to build on these and other pilot activities and devote greater attention and resources to issues of gender and HIV/AIDS prevention.
17. The expedient development and testing of anti-microbials is largely constrained by limited financial and human resources, not by any significant conceptual or feasibility problem. USAID leadership in microbicide development is an appropriate role for the organization and a likely prerequisite for their timely development. With increased investment in microbicide development, USAID has the singular opportunity to make an AIDS prevention technology available to women worldwide and to revolutionize HIV prevention efforts globally.
18. The 1991 ATSP redesign focused solely on HIV/AIDS prevention and excluded care of those affected by the epidemic. The underlying concern was that any care initiatives would drain financial resources and thereby detract from priority prevention efforts. For communities now living with a mature epidemic, prevention and care are inseparable concerns. In this setting, USAID's "prevention only" programs may lack sensitivity, credibility, or maximal efficacy by unnecessarily recognizing only one aspect of an individual's or community's many interrelated needs. Unfortunately, USAID's strong position against funding HIV/AIDS-related care has left future projects ill-prepared to plan for integration of prevention and care.
19. It is increasingly important for USAID to access "the best and the brightest" in thinking about, and responding to, the international HIV/AIDS problem. Perhaps the single most important challenge for Phase III, is to determine who the appropriate people are to involve

(specific individuals, as well as types of individuals) and how to engage their participation in program development and implementation. In addition to public health specialists, there is a need to include people with currently underutilized backgrounds and skills from other sectors and disciplines.

20. With some notable exceptions, behavioral research during Phase II has not contributed significantly to “improved knowledge of sexual behaviors and the application of this knowledge to communication strategies for behavior change.” With expectations for impact, AIDSCAP became an intervention- and service-oriented project. In this context, learning activities such as behavioral research, new pilot approaches to HIV/AIDS, and information exchange and collaboration became lower priorities.
21. Biomedical research and interventions in HIV/AIDS have progressed significantly since the 1991 redesign. Several research areas and interventions may be relevant for Phase III and will require thoughtful discussion and clearly-articulated policy in the project redesign. These include perinatal transmission, tuberculosis prevention and control, vaccine development and testing, and cost-effective biomedical treatments for HIV-infected individuals.

IV. The International HIV/AIDS Alliance

The “creation of a new international PVO/NGO federation dedicated to global HIV/AIDS prevention and control” is one of the four project outputs of the 1991 ATSP redesign. This output took concrete form as the International HIV/AIDS Alliance, formally established in 1993.

USAID’s original rationale for supporting the creation of this new institution was succinctly outlined in the PP Amendment:

- NGO organizations are needed to supplement weak host government institutions in the effective delivery of HIV/AIDS services.
- Strengthened networks of NGOs are needed to advocate increased government commitment to addressing HIV/AIDS.
- NGOs can often reach “socially marginalized populations” better than government programs.
- NGOs can be a vehicle for leveraging other donor funding and private resources to address HIV/AIDS.

IPPF, which had been successfully established to support small NGOs in the field of family planning, was reportedly an early model for this new institution.

After lengthy consultations, the Rockefeller Foundation, WHO/GPA, USAID and several other bilateral donors agreed that no existing organization had the mandate or capacity to encourage the mobilization of new community organizations or to support the needs of small community-based NGOs,¹⁹ such as:

- Flexible financial support
- Technical assistance
- Organizational and managerial guidance.

These donors, therefore, pledged support for the creation of The International HIV/AIDS Alliance. The Alliance team now consists of a small international secretariat based in London, a Board of Trustees with extensive development experience, and Associate Consultants who

¹⁹ These community-based organizations (CBOs) are typically smaller than the NGOs that USAID, WHO/GPA and other donors have traditionally supported through direct grants.

provide a source of technical expertise and guidance to field programs. The Alliance's mission is to:

“sustain and expand the pivotal efforts of local nongovernmental organizations in developing countries to respond to the causes and consequences of the pandemic, by providing resources including technical assistance, management support and funds.” It “supports a transference of governance from distant donors to affected communities” by supporting priorities established by local community groups rather than by donors.

The Alliance provides this assistance to CBOs through “linking organizations” in each country. A linking organization would typically manage a \$300,000-\$400,000 annual budget, which would cover 1) capital costs; 2) administrative costs; 3) costs of providing technical assistance; and 4) grants parceled out to small CBOs. These CBO grants (normally \$10,000-\$25,000/year) would be free of donor “strings” and would not impose heavy financial management responsibilities on recipient organizations. Ideally, assistance to a particular CBO could be discontinued after three to five years.

A. PROGRAM OPERATIONS

Since it became operational in January of 1994, the Alliance has moved quickly to support 220 projects carried out by 210 NGOs in Bangladesh, Burkina Faso, Ecuador, the Philippines, Senegal, and Sri Lanka. Programs have also been developed in Morocco, Mozambique, and Tanzania. A recent ANE Bureau buy-in will finance activities in several Asian countries. Although this Evaluation Team's role did not include assessing the impact of Alliance activities, the Alliance programs appear to fill an important niche and the new organization seems to be establishing a good reputation among donors.

B. FUNDING FOR THE ALLIANCE

Alliance resources have been provided principally by grants from bilateral donors, including USAID, with a smaller proportion from foundations and the private sector. The Alliance reports that most of the funds received thus far have been in the form of one-year restricted grants, rather than the multi-year unrestricted funds they had been led to expect from initial donor pledges. Donor funds have typically been earmarked for specific countries or activities with few resources available for core funding. These core funds are needed to maintain the small international secretariat and to support initial activities for new country programs (e.g., needs assessments and program development). The level of initial donor pledges has also rarely been met²⁰ and the

²⁰ In some cases donors have elected to provide funds directly to a “linking organization” in a particular country rather than providing support via the Alliance.

Alliance has not found it easy to identify additional private sector or foundation sources of funding. The European Community and USAID are presently the Alliance's largest contributors.²¹ The Alliance reports that this financial situation both threatens its institutional future and reduces its ability to provide flexible assistance to country programs.

In part because of these financial problems, after only two years of operations, some of the European donors have initiated a multi-donor evaluation of the Alliance "to provide donors with information to inform their decisions regarding future support to the Alliance." While the terms of reference were not available to this team, it is clearly premature to evaluate the impact of Alliance programs. It would be more appropriate to assess the validity of several of the assumptions used in establishing the structure and funding mechanisms for the Alliance. These assumptions included:

- Multi-year funding would be provided by donors;
- Donor funding would not be earmarked by countries or program activities and could be used to cover core costs;
- New sources of funding (private sector, foundations) could be located and tapped to finance the Alliance and to increase the overall level of resources devoted to addressing HIV/AIDS; and
- Donors will see value in creating a sustainable new global institution rather than funneling resources to NGOs through direct grants to country-level linking organizations.

Conclusions:

1. The establishment of the Alliance was a worthy multi-donor objective embarked upon after careful analysis and consultation. The program appears to fill an important void by providing flexible assistance to small community organizations and by supporting the process of community mobilization.
2. The Alliance program appears to be off to a promising start. Program impact and sustainability can only be measured after several additional years of activity.
3. Many of the assumptions related to funding sources and funding modalities appear to be off-target. We would hope that a review of these assumptions is a primary focus of the donor

²¹ USAID has contracted a total of \$2,275,000 to the Alliance to date, or 21% of all pledges.

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evaluation now being carried out, and that its recommendations concentrate on how to increase the chances for the long-term financial viability of the Alliance.

V. ATSP Relationship to WHO/GPA and UNAIDS

A. INTRODUCTION

Funds provided to WHO for HIV/AIDS prevention since 1985 have not been a part of ATSP project funds (until FY96), and their use, therefore, falls outside the scope of this evaluation. Nonetheless, the Evaluation Team was asked to review the relationship between the ATSP and WHO's Global Programme on AIDS (GPA) and UNAIDS (formally replacing WHO/GPA on January 1, 1996). The focus of this review is on identifying successful examples of coordination and areas of program duplication. It also makes recommendations for the future relationship between the HIV-AIDS Division and WHO.

B. AREAS OF COORDINATION

In both 1985 and 1986 the U.S. Congress earmarked \$2.5 million in the USAID budget to support the fledgling WHO/GPA, being established by a dynamic American director who maintained excellent contacts with the U.S. Congress. These levels of annual funding grew gradually to a high of \$34 million in 1993. When USAID began to finance bilateral HIV/AIDS activities in 1987, the ratio of USG support was approximately 80% multilateral to 20% bilateral. Over the past decade that ratio has been reversed and USAID now transfers only about 20% of its overall HIV/AIDS budget to UNAIDS. While the overall budget has increased, USAID and WHO/GPA have been competing to a significant degree for the same limited resources being provided annually by the U.S. Congress.

Following Agency regulations on transfers to special multi-donor programs, USAID transfers to WHO/GPA were not formally sub-earmarked by USAID for specific activities within GPA until 1994-1995; and WHO was not required to provide separate reporting to USAID on how these funds were used. Therefore the grantor-grantee relationship found throughout the ATSP did not exist between the HIV-AIDS Division and WHO/GPA. The U.S. government, however, could and did, provide guidance to GPA as a participant to the annual Global Management Committee Meetings, where program funding, priorities, and accomplishments were reviewed. The USG is presently the chair of the Program Coordinating Board of UNAIDS.

WHO/GPA had the initial leadership role in international AIDS and bilateral donors were expected to work within the WHO/GPA-supported national strategic plans. WHO/GPA's role in addressing the HIV/AIDS epidemic focused on:

- Worldwide assessments of the epidemic
- Establishing a global agenda for dealing with HIV/AIDS

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- Raising awareness and encouraging action from government leaders in both the developed and the developing world
- Recommending global policies and norms
- Financing research with potential global implications.

At the country level, WHO/GPA worked almost exclusively with the national government or other public sector agencies. The GPA assisted in:

- Carrying out country-wide assessments of the epidemic
- Supporting the development of a national strategic plan for HIV/AIDS
- Facilitating donor coordination, including donor pledging meetings for national medium-term plans
- Providing technical advice to the public sector for implementing the strategic plan
- Establishing country-level sentinel surveillance systems
- Procurement of commodities needed for public sector programs, such as condoms and STD drugs, through relatively inexpensive sources
- Strengthening government capacity through training.

WHO/GPA felt it was helping to create a country-level environment where bilateral donors could effectively work.

The HIV-AIDS Division and the organizations funded via ATSP (especially AIDSCAP) had mandates that overlapped in some ways with WHO/GPA (e.g., research with potentially global impact, country-level program implementation). There are a number of parallels between the design and operations of GPA and the ATSP:

- Both were conceived of as global initiatives deriving from a central coordinating point.
- Both were intended to operate at country level, with allowance for respective regional structures.
- Both combined technical operations with research capacities.

- Both addressed the HIV epidemic primarily from a public health perspective. Both were initially designed and managed by CDC employees.

Areas of collaboration between WHO/GPA and ATSP organizations or between WHO/GPA and HIV-AIDS Division technical staff were not mandated by funding agreements. Areas where collaboration existed were areas where both parties believed collaboration was in their best interests and in the best interests of their respective constituencies. Collaboration was often, but not always, initiated through personal contacts and technical relationships rather than via organizational fiat.

The major areas of successful collaboration have been:

- Evaluation: Establishing a set of core program indicators of HIV/AIDS for global and country use (GPA, HIV-AIDS Division, AIDSCAP);
- Data Collection: Establishing an HIV/AIDS Surveillance Database (GPA, BuCen); and developing of an AIDS module for Demographic Health Surveys (GPA, AIDSCAP);
- Biomedical Research: Validating and field testing the STD syndromic treatment protocols and algorithms (GPA, ATSP-funded STD Diagnostics Network);
- Condoms: Encouraging countries to accept condom social marketing (GPA, AIDSCAP); condom summits to ascertain global demand and encourage coordination in donor supply to meet the need (GPA, HIV-AIDS Division);
- Behavioral Research: Women and AIDS (GPA and ICRW);
- Research on effectiveness of voluntary counseling and testing as a prevention method; and
- Health Economics.

Most GPA staff interviewed by the Evaluation Team felt that:

- There is an overall lack of coordination between GPA and USAID. For example, some key GPA staff were not aware of the breadth of the ATSP portfolio. They identified the HIV-AIDS Division's program as the activities of AIDSCAP. Any contact GPA has had with ATSP-funded activities, including ICRW and BuCen, has been stimulated by personal contacts and not by suggestions emanating from the HIV-AIDS Division.

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- AIDSCAP's charge is too narrow, for example, not responsive to HIV/AIDS care issues; too focused on NGOs; too "simplistic."
- AIDSCAP has operated too independently at the country level. It has "carried out a predetermined scope of work" regardless of country needs and the presence of other donor activities. It has been relatively isolated "doing its own thing." They did acknowledge that country-level program coordination is a general problem and that none of the donors or participants should be held solely responsible.

A few specific areas were mentioned where adequate collaboration has not taken place:

- Research on the female condom: GPA and AIDSCAP reportedly were not aware of the details of each other's research program until both selected many of the same research participants in Mexico
- Research on Commercial Sex Workers (CSWs).

C. UNAIDS

The USG supported successful donor efforts to restructure WHO/GPA; the United Nations systems' concentration of HIV/AIDS interventions in one organization—WHO/GPA. The GPA program was abolished and UNAIDS was established effective January 1, 1996. The roles and responsibilities of UNAIDS and other UN system participants in the global response to AIDS still require some clarification. Since the chair of the UNAIDS Program Coordinating Board (PCB) is also the Assistant Administrator of USAID's Global Bureau, the HIV-AIDS Division will certainly have a major opportunity to influence several major issues that remain to be resolved. These issues are:

- Funding: While UNAIDS will operate with a global appeal for funds to which the USG will contribute, the manner in which UNAIDS and the six cosponsoring United Nations agencies will organize the distribution of funds remains to be determined. Each of the agencies has some focus within their core program on HIV and it is unclear to what degree funds for these program activities will come from UNAIDS or from the particular agency. This also applies to specific agency projects that have a connection to HIV, such as WHO work on tuberculosis.
- Research: At present UNAIDS is identifying its role in research. It is likely to have a dual function: 1) to provide an overview of research activities, findings, and implications, through mechanisms that link research programs; and 2) to conduct research that has been identified as necessary and relevant for UNAIDS. WHO has established an

AIDS/STD unit, one of whose functions is facilitating and conducting research. By identifying its areas of program activity, WHO is in a position to be able to clearly negotiate its working relationships with other agencies and funders. It is the behavior of allied agencies such as this that will assist UNAIDS in determining its specific function. The HIV-AIDS Division, by establishing its research priorities for the Phase III program, will similarly assist UNAIDS in identifying its priorities.

- **Country-level activity:** A clear focus for UNAIDS is country-level coordination of United Nations system HIV/AIDS activities. However, in some countries UNAIDS may also play a broader role in donor coordination. Within this context, bilateral donors, such as USAID, would do well to review their own behavior at the country level. The AIDSCAP program, largely synonymous with the HIV-AIDS Division program, was viewed by WHO/GPA as very autonomous and self-serving in selecting its areas of concentration in order to meet its singular program objectives. As part of the agreement to establish UNAIDS, there was reportedly also an agreement by bilateral donors to review and alter their behavior at the country level. Aspects to be considered in such a review would include: the capacity of bilaterals to implement programs; areas for cooperation between bilateral and multilateral donors; and the role of bilaterals, given that UNAIDS is adjusting the manner by which UN agencies work together and with governments.
- **Rationalization of resources across countries:** While individual bilateral donors (and USAID increasingly so) do not have the resources or the authority to work in all developing countries, UNAIDS is a global program and might devote part of its attention on those countries (e.g., Myanmar) least likely to receive other donor resources. UNAIDS might play a role in the identification of countries where multilateral funds would be particularly valuable and in encouraging more donor collaboration in deciding both on the selection of countries and the allocation of resources.
- **Evaluation:** WHO/GPA and the ATSP collaborated well together in the areas of data collection and evaluation (BuCen, priority evaluation indicators, DHS-AIDS module). UNAIDS' role in data collection and evaluation remains to be clarified, but it is also an area where continued collaboration would probably prove beneficial.

Conclusions:

1. Valuable collaboration between WHO/GPA and ATSP or the HIV-AIDS Division has occurred in the areas of data collection, evaluation, biomedical and behavioral research, and condom social marketing/supply.
2. These collaborations appear to have occurred as much due to personal contacts as through coordinated planning carried out by the HIV-AIDS Division and WHO/GPA.

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3. There are a few minor reports of duplication of effort at the global level.
4. At the country level, some other donors see USAID programs (viz. AIDSCAP) as somewhat autonomous and self serving, designed primarily to meet USAID needs rather than country (and especially government) needs.
5. The USG should take this unique opportunity to influence several issues related to the functions of the new UNAIDS. These issues include: intra-UN system funding; global research priorities; country-level coordination; rationalization of resources across countries; and evaluation.

VI. Influences on the Capacity to Achieve Project Objectives

A. INTRODUCTION

This section summarizes key structural, procedural and managerial factors which have influenced the potential for the ATSP to achieve its objectives. It draws upon the preceding analyses as well as other information gathered during the course of this process evaluation. This analysis focuses on ATSP project objectives as they are described in the Logical Framework in the Phase II PP Amendment. Logical frameworks have been required for all USAID project designs and evaluations during the life span of the ATSP.²² We believe this analysis should be helpful to the end-of-project evaluation teams in assessing the reasons why AIDSCAP and other CA objectives have been achieved or not achieved.

This section will discuss factors that appear to influence the likelihood that the ATSP project will achieve its purpose and each of the four major outputs, described in the Phase II PP Amendment. The factors considered in this analysis are:

- Project structure
- Project approach and priorities
- Levels and proportions of funding devoted to a program area
- Number and kinds of implementing agencies
- Staffing to achieve the objective
- Sustainability.

B. GOAL

The Phase II design continued the very broad goal statement of the original ATSP without change.

The methodology of the Logical Framework positions the project goal beyond the direct influence of the project. Therefore, project designers did not anticipate that the ATSP could, by itself, bring about a reduction of HIV incidence during its relatively short ten-year life span.

²²The full Logical Framework (logframe) from the ATSP PP Amendment is found on the following page. This Logical Framework differs slightly from the logframe later prepared by the AIDSCAP staff and approved by USAID for use in the AIDSCAP project only.

LOGICAL FRAMEWORK

Narrative Summary (NS)	Objectively Verifiable Indicators	Means Of Verification (MOV)	Important Assumptions
<p>Goal: 1. To prevent and control the spread of HIV infection in developing countries</p>	<p>1.1 Reduction in HIV incidence in given countries over time</p>	<p>1.1 Surveys</p>	<p>1.1 Continued commitment of developing countries and donors to HIV prevention and control</p>
<p>Purpose: 1. To expand access to HIV prevention and control programs in developing countries</p>	<p>1.1 Increase in the number, quality and coverage of HIV prevention and control programs</p>	<p>1.1 Semi-Annual Project Reports containing quantitative and qualitative data generated by subproject evaluations and behavioral research</p>	<p>1.1 Sufficient host country and donor resources remain available</p>
<p>Outputs: 1. Improved design, implementation and evaluation of HIV prevention and control programs</p> <p>2. Improved Knowledge of sexual behavior and application of this knowledge to communications strategies for behavioral change</p> <p>3. Creation of an international federation dedicated to global HIV prevention and control</p> <p>4. Policy Reform</p>	<p>1.1 Ten to fifteen full-scale HIV prevention and control programs in priority countries and HIV prevention and control activities conducted in non-priority countries <u>leading to documented changes in the indicators</u> listed on page 29-30 of Project Authorization Amendment No. 2</p> <p>2.1 Application of behavioral research findings to communications strategies in priority countries <u>leading to documented changes in the indicators</u> listed on page 29-30 of Project Authorization Amendment No. 2</p> <p>3.1 Global federation contributing to development and expansion of HIV prevention and control activities in priority and non-priority countries.</p> <p>4.1 Improved policies, especially with respect to condom distribution and mass media communications, in priority and non-priority countries.</p>	<p>1.1 Country evaluation reports, subproject evaluations</p> <p>2.1 Semi-Annual Reports; research reports; published papers</p> <p>3.1 The Federations' Semi-Annual Report (which should report on the same type of information called for in this project's semi-annual report)</p> <p>4.1 Semi-Annual Reports, country evaluation reports</p>	<p>1.1 Host governments are committed to developing full-scale programs and commit the requisite resources</p> <p>2.1 Communications on behavioral change can have a significant impact on HIV prevalence</p> <p>3.1 Other donors and private individuals and organizations will support an international federation for HIV prevention and control</p> <p>4.1 Developing country governments will accept and implement policy reform recommendations</p>

C. PURPOSE

The purpose statement was changed slightly in 1991 from “to support countries in expanded and improved programs for AIDS prevention and control” to the following statement:

PROJECT PURPOSE: “To expand access to HIV prevention and control programs in developing countries.

PURPOSE INDICATOR: Increase in the number, quality, and coverage of HIV prevention and control programs.

Unfortunately, no targets or baselines were established for the numbers of programs, the quality of programs, or the desired coverage by the end of the project. Because of the lack of rigor and precision in this purpose statement, it will be difficult to measure whether the ATSP has achieved its purpose at the end of the project’s life.

The mere size of this program and its global focus make it likely that it could have a major impact in the number and coverage of HIV prevention and control programs. The ATSP’s visibility, clout, resources, and flexibility to add new activities (an astonishing variety of activities carried out by other ATSP CAs) will certainly help in meeting its overall objectives. Although most ATSP resources have been concentrated on AIDSCAP’s comprehensive program model, to the credit of the HIV-AIDS Division, the ATSP has also provided essential support for the development and testing of several other models. The team believes this has been a very valuable use of ATSP funds.

Specific examples of the number and coverage of HIV programs are cited below, followed by specific examples of activities designed to improve quality.

1. Increase in the Number and Coverage of HIV Programs

Among the ATSP CAs, AIDSCAP obviously has had the primary role in increasing the number and coverage of HIV/AIDS programs. In each of its 18 priority countries it has probably financed an average of 12 sub-projects. The geographic coverage of these sub-projects has been

much less than nationwide, and the populations covered are traditionally, but with many exceptions, comprised of three to four high-risk groups (female and male commercial sex workers, men who have sex with men, men away from home, and people with STDs and their partners).²³ Most of these sub-projects have been urban based.

The coverage of these AIDSCAP activities has been supplemented in smaller, but still valuable ways, by the activities of a variety of other ATSP-funded CAs. Most of these activities focus on other important vulnerable populations.

- IPPF has carried out pilot efforts to incorporate HIV/AIDS counseling and other interventions into the programs of family planning service agencies (mostly NGOs) in their primary Latin American affiliates. These service agencies normally target their services to low-income, reproductive-age women and girls.
- Peace Corps: The ATSP grant to the Peace Corps encourages volunteers to carry out or support HIV/AIDS activities in their schools or villages. The program has the potential to reach a large adolescent population in a structured school setting. Volunteers who are not teachers are encouraged to initiate or support ongoing village or town-based HIV/AIDS efforts, and can feed the lessons learned from these often rural settings into larger donor or government-funded programs.
- UNICEF: ATSP funding has been fundamental in supporting UNICEF headquarters' efforts to urge the inclusion of HIV/AIDS activities in their country programs. Previously UNICEF field offices had normally considered HIV/AIDS as a WHO concern. UNICEF has now decided to incorporate HIV/AIDS into their adolescent and reproductive health activities, rather than address it as a separate problem or a vertical program. UNICEF is presently evaluating the results of a series of pilot activities carried out (with ATSP financial support and AIDSCAP technical support) in five areas of involvement:
 - Youth in schools
 - Out of school youth
 - Mass communications

²³ Sub-project target populations have also included: adolescents, truck drivers, migrant workers, military and police personnel, people seeking maternal/child health and family planning services, post-secondary school students, refugees, hotel employees, industrial zone workers, and private sector health care providers.

- Family and community care
- Sexual and reproductive health.

The results of these pilots will be disseminated to UNICEF country directors and technical staff. HIV/AIDS activities are likely to be included in many new five-year UNICEF country programs or midterm program revisions, according to the grant director.

- UNDP: The AIDS Division of UNDP, established in 1992 as part of the Bureau of Policy and Program Support, has survived and grown primarily due to financial support from the ATSP. This office has not funded projects but has funded “learning” activities (gathering lessons learned from UNDP’s 130 field offices, financing special studies, organizing symposia), and has stimulated networking and horizontal linkages. This office is a primary advocate for incorporating HIV/AIDS considerations into a broader development context. It has encouraged UNDP country offices, other funding organizations, and third world government leaders to address “underlying causes” of the epidemic (gender roles, power relationships, community values and norms) as an alternative to what they call AIDSCAP’s “narrow biomedical approach” to addressing HIV/AIDS.
- The Alliance: As previously described, the Alliance offers a novel paradigm for how to address HIV/AIDS, by funding activities that represent the “felt needs” of small community-based organizations. To receive Alliance support these needs are likely to include HIV/AIDS, but support can go much beyond addressing HIV/AIDS.
- NCIH: Using its ATSP grant, NCIH provides information on HIV and HIV-focused programs to a broad community of U.S. PVOs, developing-world NGOs, and individual scientists and practitioners working on HIV/AIDS. The initial 1988 grant focused on increasing the knowledge and involvement of U.S. PVOs. The second phase grant in 1994 shifted NCIH efforts to strengthening regional networks of NGOs working with AIDS in Africa, Latin America, and Asia. Strengthening regional networks and linking those networks with U.S. PVOs is a valuable and relatively inexpensive way to encourage larger numbers of prevention and control programs, and to improve the quality of these programs.
- BuCen and Macro: The PASA with BuCen collects and disseminates hard-to-find HIV/AIDS data, which is used by AIDSCAP, other donors, and host governments to target interventions on specific regions or specific populations. It is also used by AIDS advocates to urge host governments and donors to increase their support for HIV/AIDS activities. Thus, this data can have an impact on the number and coverage of prevention and control programs.

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An ATSP buy-in to the Population Office's grant to Macro has financed the development and incorporation of an AIDS module in Demographic Health Surveys (DHS). This module is used throughout the developing world. This represents a relatively inexpensive investment in a widely-known and respected data collection instrument.

- **"Another" AIDSCAP activity:** The PVO Competitive Grants Program has been funded separately from "normal" AIDSCAP sub-projects and usually involves different implementing organizations.

The PVO Competitive Grants Program finances winning sub-project proposals submitted by the U.S. PVO community. While the target population focus is normally the same as other AIDSCAP activities, an additional objective is to encourage U.S. PVOs to gain experience in the design and implementation of HIV/AIDS interventions. In competing for these grants, the U.S. PVOs typically design projects in concert with their traditional partners in a country, often an NGO organization that has never focused its attention on HIV/AIDS. Subsidiary benefits of this program, therefore, are the increased priority these U.S. PVOs and their host country counterparts give to HIV/AIDS and, hopefully, an improved capacity to carry out effective programs. Ideally, HIV/AIDS will be added to the list of priority programs that these U.S. PVOs and their host country NGO counterparts will address with their own funds or other sources of donor funding.

2. Increase in the Quality of HIV Prevention and Control Programs

The Evaluation Team was not charged with evaluating the technical quality of the ATSP-funded activities. While we cannot assess whether the quality of prevention and control programs has improved because of the ATSP, we can say that improved program quality was an essential consideration in the design of the comprehensive program approach advocated globally via AIDSCAP. This approach is now accepted as providing greater impact than the previous, more piecemeal, approaches. How much of the results are improved by this model will be more evident as AIDSCAP evaluates sub-project performance and is evaluated itself at the end of the AIDSCAP contract.

The Team has the impression that operational needs became predominant as the comprehensive model was implemented in 18 priority and major associate countries. Most of the behavioral research carried out by AIDSCAP, and research results from other CA activities funded in Phase II of the ATSP, have not been available early enough in the program to influence the quality of Phase II interventions. These results however should be available for use in Phase III.

Examples of ATSP-funded activities that have been designed to improve the quality of HIV prevention and control programs include:

- STD Diagnostics Network (SDI): USAID, through its technical and financial support to UNAIDS, continues to foster the development of rapid, simple, inexpensive STD diagnostics that are suitable for low resource settings. The SDI, based in Geneva, coordinates and monitors a number of Participating Centers who are mandated to work on defined activities necessary for the development of these critically needed diagnostic tests. USAID directly supports PATH as one of these Participating Centers in their work to encourage the widespread use of a rapid simple blood stick test for syphilis (that PATH had previously developed), and for ongoing research to create a simple urine dipstick test for gonorrhea.
- Microbicide Research: The Population Council is carrying out ATSP-funded research on the development and testing of vaginal microbicides, which would make an AIDS prevention technology available to women in developing countries, and could revolutionize HIV prevention efforts globally.
- Collaborative U.S.-Developing Country Research: A PASA with the National Institute of Allergy and Infectious Diseases (NIAID) encourages cooperation on AIDS-related research between scientists in the U.S. and developing countries. Aside from the benefits of keeping NIH scientists aware of developing country needs and the transfer of technical knowledge to developing country scientists, the results of this biomedical research may lead to improvements in the quality of HIV prevention programs. For example, a study in Honduras is testing whether a rapid diagnostics technique for rifampicin-resistant tuberculosis, used in the U.S., can be successfully applied in developing country field settings. If successful, the technique can reduce the time needed to ascertain whether an individual has tuberculosis from 12 weeks to six hours.
- Tuberculosis and HIV: CDC funds initially programmed to finance short-term technical assistance, have been redirected to finance the development and initial execution of a training course on HIV-associated tuberculosis. The course will be given for 15 developing country specialists who will subsequently undertake operational research on linking community-based AIDS care with tuberculosis treatment.
- Data Collection and Dissemination: BuCen and DHS data collection and dissemination activities, previously noted, are obviously also used by planners to improve the focus and quality of HIV prevention and control programs.

D. OUTPUTS

The four outputs and their “objectively verifiable indicators” are fortunately more specific than the project purpose statement. They focus the ATSP on four major and quite distinct objectives: 1) establishment of successful HIV prevention programs which lead to documented changes in

outcome and process indicators; 2) carrying out and applying behavioral research, which also would lead to documented changes in outcome and process indicators; 3) establishment and effective functioning of a new "international federation," which would support NGO and community programs; and 4) improved policies, especially policies that would improve the likelihood that HIV prevention programs would be successful. Each of these will be discussed below.

OUTPUT #1: "Improved design, implementation and evaluation of HIV prevention and control programs."

OUTPUT INDICATOR: "Ten to 15 full-scale HIV prevention and control programs in priority countries and HIV prevention and control activities conducted in non-priority countries leading to documented changes in the (outcome and process) indicators listed on page 29-30 of the Project Authorization Amendment No. 2."

This addresses the heart of the Phase II ATSP program, the establishment of full-scale, "comprehensive" multi-dimensional prevention programs in "priority countries." At the time the ATSP was being redesigned, this approach to addressing AIDS was bold and extremely ambitious. No other donor (including WHO/GPA) had been willing to prescribe and finance a comprehensive package of "cost-effective" interventions. By defining and proselytizing its "comprehensive program," USAID provided global program leadership to governments and to other donors on how to address AIDS, much as UNICEF had provided global leadership for addressing Child Survival.

a. Structure

The AIDSCAP program structure and program approach are described in detail earlier in this report. To avoid duplication, we will simply summarize here our assessment of the advantages and disadvantages of the Phase II structure and its approach to addressing HIV/AIDS.

Advantages:

- Program knowledge of how to best carry out the three technical strategies and the three supporting strategies of the comprehensive program is found in a single institution, rather than disbursed among a variety of CAs, each with expertise in a particular core or contributing activity (STDs, condoms, policy, etc.)

- Working alone, AIDSCAP can ensure that all of the key activities of a comprehensive program are present, properly balanced, sufficiently funded, and designed to achieve synergy between the program components.
- AIDSCAP should be able to combine state-of-the-art technical knowledge with country program and project design responsibilities.

Disadvantages:

- Program responsibilities (central and field) are extremely broad for a single institution or consortium to carry out effectively. Success in carrying out these multiple responsibilities rests heavily on the management capacity, style, and procedures of the primary CA. FHI's centralized procedures and style, at least in the first half of the project period, were not conducive to timely and flexible decision making for field activities. However, they may have been valuable for quality control.
- AIDSCAP is required to be an operational institution as well as a "learning institution." The day-to-day focus has been primarily operational.
- AIDSCAP is supposed to have "top of the line" expertise in many technical and managerial specialties (the three core and three supporting strategies, project design, management of a wide network of regional and country offices, etc.). Some areas inevitably receive less priority and less funding. Program management and coordination is extraordinarily difficult and time consuming.
- Changes in two USAID procedures: 1) the change from a cooperating agreement to a contract procurement mode, and 2) field support budgeting have seriously undermined some of the project's initial structural advantages.

b. Program Approach

Advantages:

- Resources are concentrated on fewer countries (initially ten to 15 priority countries) than in Phase I in order to maximize impact. Nevertheless, non-priority countries (associate countries) are not neglected and can receive smaller levels of technical and financial support.
- Design of "comprehensive programs" rests in a single institution with global responsibilities which should ensure quality control and coordination and ease the process of program evaluation.

Disadvantages:

- The program was initially perceived to be unwilling or unable to adapt its model to the specific needs and constraints of priority countries. Programmatic rigor may have become program rigidity.
- AIDSCAP is often caught in the middle of technical or operational disagreements between USAID field officers, who traditionally managed field activities, and the HIV-AIDS Division, which has formal management responsibility for all AIDSCAP activities.
- Over the life of AIDSCAP, the program has been slow to integrate or test new approaches suggested by experience elsewhere or by new knowledge about the epidemic.

c. Implementing Agencies

In the PP Amendment the “primary implementing Cooperating Agency” was clearly meant to have full responsibility for achieving this output. The primary implementing entity (AIDSCAP), consisting of a lead CA (FHI) and nine subcontractors, was organized to be all-inclusive, and not dependent on any other ATSP CA.

However, the work of some of the other CAs is potentially of significant value to AIDSCAP. These include: ICRW research results and recommendations; Peace Corps field experience with adolescents; IPPF experience with integration of family planning and HIV/AIDS; UNDP and UNICEF experience using alternative paradigms for interventions; and the Alliance’s work with community organizations. Since most AIDSCAP sub-projects were designed in the first half of the project’s life, the experiences of these smaller CAs are more likely to be applied during Phase III of the ATSP.

d. Levels and Proportions of Funding

Although hard data is not available, Output #1 has clearly received the bulk of AIDSCAP (and hence ATSP) Phase II funding. According to HIV-AIDS Division staff, when additional funds were periodically available to the ATSP, AIDSCAP almost always absorbed those funds in order to cover priority and associate program needs. Indeed, instead of ten to 15 priority countries, AIDSCAP reports that it has supported 18 priority or major associate country programs.

Nevertheless, the magnitude of overall funding was insufficient to finance truly country-wide programs as envisaged in the PP Amendment (with a few exceptions in small countries such as Jamaica). A major question for the final AIDSCAP evaluation should therefore be: was the

scale of most AIDSCAP country programs sufficient to “make a major difference” in a country—either in terms of aggregate impact or in terms of creating effective models for replication?

e. **Staffing to Achieve the Objective**

USAID: The HIV-AIDS Division has used a matrix management approach to manage the large and very complex AIDSCAP project. A single COTR, who interacts directly with the AIDSCAP Director, is supported by other Division staff with particular technical skills. According to interviews with Division staff, the bulk of their time has been focused on achievement of this project output. This is because they felt that this output was the most important of the AIDSCAP program, and because they wanted to be responsive to USAID field missions.

Although the design, implementation, and evaluation of field programs is at the heart of AIDSCAP, neither of the two COTRs who have been responsible for AIDSCAP has served in a USAID mission or has other significant overseas experience. One had not worked in the field of international development prior to taking over AIDSCAP management responsibilities. Very few other Division staff have been USDH officers (no more than two at any one time). On the other hand, very few USDH officers have the experience with HIV/AIDS programs, the specialized technical skills, or the extraordinary dedication to addressing AIDS that these COTRs and their technical support staff have brought to the program.

The conversion to a contract and the institution of field support budgeting (both affecting Output #1 more than any other output) have increased the management load of the COTR. Both AIDSCAP and Division leadership recognize that the COTR is now buried in paperwork and has almost no time for discussion and resolution of technical or other operational issues. To effectively carry out all program responsibilities, the COTR needs additional staff support from a program specialist or a program assistant, who can perform many of the bureaucratic tasks.

f. **Sustainability**

The sustainability of this Output (and the total Phase II program) was not seriously addressed in the PP Amendment. The one short paragraph which referred to sustainability in the PP stated:

“Because HIV prevention and control is a new area for international development practitioners, and much still needs to be learned about how to design and implement cost-effective interventions, this project will not aim to achieve overall project sustainability. It will make an effort to achieve institutional sustainability, especially through training, and will attempt to recover costs where possible. It will also require a financial plan for each sub-project...to analyze the source of, and potential for,

resources which would enable the institution to continue the activity after USAID assistance terminates...however, this will not be a condition for funding.”²⁴

The Phase II designers of ATSP in 1990 were hardly more concerned about sustainability than were the Phase I designers in 1987. Both appear to have been primarily interested in achieving immediate impact from project activities, rather than creating systems of sustained service delivery. However, it is debatable whether Phase II’s comprehensive program approach could afford to absorb yet another key/project responsibility—ensuring sustainability. This would have been costly and time-consuming, and would have reduced the number of feasible sub-projects.

This team has not reviewed sub-projects or “comprehensive country programs” to determine whether they are likely to be sustainable. We recommend that the final AIDSCAP evaluation carefully review a representative sample to assess the likelihood that these programs can be sustained at their present level of operations.

This team seconds the recommendation of the midterm AIDSCAP evaluation that “during the remainder of its current contract, AIDSCAP should systematically plan for a transfer of experience and expertise, as well as management and technical materials it has developed, to governmental and non-governmental groups participating in HIV/AIDS prevention and care programs.” In addition, we feel strongly that “AIDS is here to stay” and that the Phase III design must include sustainability of USAID-funded interventions as a critical program objective.

Conclusion:

This Output addresses the heart of the Phase II ATSP program—the establishment of full-scale, comprehensive, multi-dimensional prevention programs in “priority countries.” It seems very likely that this very important output will have been achieved at the end of the AIDSCAP and the ATSP Phase II programs. This in itself is an extraordinary accomplishment. Leading all other donors, USAID defined a “comprehensive approach” to HIV/AIDS prevention and has attempted, in a concerted way, to implement this approach on a global scale. AIDSCAP has the structure, and the resources to get this job done. While this team and others will cite deficiencies in program strategy, design, and execution, these should be kept in balance with the many benefits that this program is providing.

The structure and procedures established to achieve this particular output were novel (even bold and therefore had significant teething problems.) We believe that, on the whole, they were appropriate at the time the Phase II project was designed, and contributed very significantly to the likelihood that this output will be achieved. We are concerned, however, that the sub-

²⁴Emphasis added by authors.

projects funded through this structure may not be sustainable at their present levels of effort once AIDSCAP is completed.

OUTPUT #2: Improved knowledge of sexual behavior and application of the knowledge to communications strategies for behavioral change.

OUTPUT INDICATOR: Application of behavioral research findings to communications strategies in priority countries, leading to documented changes in (outcome and process) indicators.

a. Structure and Approach

The PP Amendment stated that “the targeted communications for behavioral change interventions will become the major element or driving force of the AIDS strategic plan developed for each priority country.” ATSP-funded research would be used to critically influence the design (and redesign) of AIDSCAP behavioral change communications programs. Six priority countries would be singled out as intensive learning sites regarding communications for behavior change...and will receive additional resources for impact evaluation and behavioral research.”

AIDSCAP documents state that their behavioral research program has two objectives: 1) to advance the scientific community’s understanding of high-risk behavior through social and behavioral research (including the contexts and antecedents of behavior); and 2) to provide methods for modification of sexual behavior to be incorporated into AIDSCAP prevention activities.²⁵ The AIDSCAP program included: a) thematic grants (two-to-three-year grants chosen on a competitive basis); b) commissioned research (non-competitive, to cover gaps in knowledge); and c) program-related research (focusing on the design, implementation, and evaluation process).

Since many of these research activities would require two to three years for design and execution (and wouldn’t start before year two of AIDSCAP) it was unlikely from the start that they would influence sub-project design. At best, given the project implementation schedule, they might be used to modify sub-projects in their last year.

²⁵ AIDSCAP: The Technical Strategy, p.50. No date.

The duality of responsibility designed into this program—medium-term, high quality scientific research, versus short-term, program-related research—has reportedly led to a lack of certainty about research priorities. According to HIV-AIDS Division staff, AIDSCAP's four Behavioral Research Unit (BRU) directors differed in their views on where the unit should place its priorities.

b. ATSP Implementing CAs

The PP amendment stated that the “primary implementing CA”—AIDSCAP—would be responsible for this behavioral research. No mention was made of the ATSP grants in FY90 and FY91 to ICRW for behavioral research on Women and AIDS or a continued role for ICRW in the ATSP. The PP's illustrative budget annexed to the PP Amendment continued new funding for ICRW only until FY92.

ICRW specializes in international behavioral research on women, especially research with potential policy implications. Unlike ICRW, AIDSCAP's key subcontractor for behavioral research, the University of California's Center for AIDS Prevention Studies, brought little international experience to the program. However, it had a great deal of U.S.-based behavioral research experience specifically directed towards HIV/AIDS.

Although ATSP funding for ICRW has continued, the ICRW research agenda is apparently not coordinated with the AIDSCAP behavioral research agenda by the HIV-AIDS Division to encourage synergy or to avoid duplication. ICRW is a recently-invited member of the AIDSCAP TAG but its research findings, praised as very useful by UNDP and some other practitioners, have not clearly “fed into” AIDSCAP's operations.

c. Levels and Proportions of Funding

The PP Amendment anticipated that approximately \$11 million (7%) of total AIDSCAP funding would be dedicated to the Behavioral Research program. Another \$2.1 million would be granted to ICRW between FY90-92. These levels demonstrated a relatively high priority for behavioral research. However, according to HIV-AIDS Division staff, the AIDSCAP BRU has been funded at less than half of the anticipated \$11 million. Reportedly, behavioral research funds were re-budgeted for more immediate operational needs.

d. Staffing to Achieve the Objective

AIDSCAP: As suggested in the PP Amendment (and required in the RFP), AIDSCAP included a headquarters-based Behavioral Research director and staff. This unit (the BRU) is structurally separate from AIDSCAP's more-operational Behavior Change Communications unit. The

University of California's Center for AIDS Prevention Studies (CAPS) works under the direction of the Behavioral Research director to carry out project activities. According to HIV-AIDS Division staff, the AIDSCAP BRU unit has had four directors in four years, an extraordinarily high turnover. They believe this reflects the lack of priority (as demonstrated by funding levels) that core AIDSCAP management has given to behavioral research.

The selection of CAPS as a subcontractor and the backgrounds of BRU leaders indicate that priority was initially given to achievement of the unit's long-term objectives. As AIDSCAP moved into implementation, we have the impression that its management (and the HIV-AIDS Division management) became more and more focused on short-term objectives and operational issues. Attention to long-term objectives waned.

HIV-AIDS Division: The Division has included a behavioral research technical advisor on its staff since 1989. The behavioral research advisor has not had formal responsibility for the full ATSP behavioral research portfolio. The ICRW grant has been managed separately by several sequential COTRs.

The HIV-AIDS Division's priority to AIDSCAP behavioral research has also reportedly declined since the redesign of the ATSP. Division leadership has accepted the reduced levels of funding for behavioral research proposed by AIDSCAP, and has reportedly dedicated more time and attention to the ICRW research program than to the AIDSCAP research program.

e. Sustainability

Sustainability is not included as an objective in the description of the Behavioral Research program in the PP Amendment. The research approach has emphasized getting valuable research results as soon as possible by working with developing country researchers who were already qualified and needed only modest amounts of technical guidance. Any capacity building that occurred through the research program would be an extra benefit. AIDSCAP took more of a long-term view than the USAID designers, however, and has included "Capacity Building in Developing Countries" as one of six Guiding Principles for its Behavioral Research Program.

Technical assistance and capacity building were priorities of the ICRW research program. According to one interviewee, who had met with ICRW funded investigators in Zimbabwe and India, ICRW supports "genuine skills transfer and local ownership...[their] technical support is as good as it gets."

Conclusion:

Our process assessment of the Phase II approach to behavioral research and its management concludes that it appears unlikely that this output will be achieved. At best, the research results

of a smaller than anticipated number of medium-term research activities will be available for late sub-project modifications or, more likely, for use in Phase III.

Both AIDSCAP and the HIV-AIDS Division implicitly demoted behavioral research as a priority as they became embroiled in the realities of managing a complex program, which included both field and central bureau responsibilities. One can hypothesize that the ATSP behavioral research program would have been more successful if it had all been carried out by specialized research-oriented CAs such as ICRW, with AIDSCAP willingly integrating the research results as appropriate into late program strategies, late sub-project designs, and sub-project redesigns.

OUTPUT #3: Creation of an International (PVO/NGO) Federation dedicated to Global HIV prevention and control.

OUTPUT INDICATOR: Global federation contributing to developing and expansion of HIV prevention and control activities in priority and non-priority countries.

Section IV of this report deals specifically with the creation and operations of this federation (née Alliance) and therefore we will not repeat those findings and conclusions here. It should be noted, however, that this output indicator is so general that a proper assessment of whether it is being achieved requires a further definition of what is expected. In a literal sense this indicator has already been attained. The Alliance has been created and funded, and with its initial projects, "is contributing to expansion and control activities." ATSP (and other donor) resources and guidance have been instrumental to this initial success. While the program appears to fill a valuable niche, the financial sustainability of the Alliance may be in question. Certain design-stage assumptions concerning funding sources and funding modalities may have been off target. These and other key questions are being addressed in a multi-donor-sponsored evaluation which is presently being carried out. In order not to duplicate that evaluation, this team did not review in depth the structural, procedural, and managerial influences that are affecting the capacity of the Alliance to achieve its objectives.

OUTPUT #4: Policy Reform

OUTPUT INDICATOR: Improved policies, especially with respect to condom distribution and mass media communications, in priority and non-priority countries.

a. Structure and Approach

Policy reform was neglected in Phase I of the ATSP, with the primary exception of modeling carried out by a USG interagency working group (with participation by HIV-AIDS Division staff), BuCen, and AIDSTECH. The models were designed to demonstrate to government decision makers the potential impact of the epidemic and the need for preventative action.

The Phase II design included policy as a prominent feature reflecting USAID's overall growing priority to policy reform. The Phase II design placed responsibility for policy change with AIDSCAP. The PP Amendment did not identify BuCen with previous modeling work carried out with ATSP funds, and no other policy-oriented CA was included in the Phase II illustrative budget (the budget anticipated that BuCen would receive its final funding in FY90).

The policy activities described in the PP Amendment were: a) to apply and customize models for specific countries; and b) to review and address regulatory barriers to program implementation (such as impediments to the provision of inexpensive condoms or limitations on the use of mass media for behavior change communication).

AIDSCAP's initial strategic focus for "policy development" was to "assess existing HIV-related policies, assess the policy-setting environment, educate and involve policy makers in prevention activities, and create collaborative processes to establish policy priorities and implement needed policy support and development programs."²⁶ The policy obstacles to the three primary strategy components (BCC, condom programming, the reduction of STDs) are described as the logical starting point for policy interventions. However, some assistance would also be available to address "a broad range of social and economic factors that contribute to, or thwart the spread of, HIV infection (discrimination, gender roles, employment patterns, care)."

Over the course of the project, AIDSCAP reports that its policy agenda has evolved in response to changing needs. Less time is now devoted to preparing stand-alone, epidemiology-based

²⁶ AIDSCAP: The Technical Strategy, p. 42.

models to sensitize leaders to the need for action. Rather, there is much more interest among leaders in understanding the socioeconomic consequences of HIV/AIDS, and in having practical and feasible means to reduce those consequences. Also, relatively few regulations have been identified which seriously inhibit the AIDSCAP core interventions. More attention is paid to the cost effectiveness and cost sustainability of project interventions.

AIDSCAP policy activities have not been concentrated on a limited number of “problem countries.” Detailed policy agendas have not been prepared for most AIDSCAP priority programs. AIDSCAP’s focus seems to have been more on preparing models, methodologies, and analyses which can be used widely by government and the private sector.

b. ATSP Implementing CAs

Using a broader definition of policy, there are several ATSP CAs, in addition to AIDSCAP, that are contributing to the ATSP policy objectives. BuCen continues to gather and analyze data, which is essential for modeling work and to gain the attention of governments and private sector leaders. NCIH communicates up-to-date information on HIV/AIDS policy matters to a wide range of constituent PVO and NGO institutions in the U.S. and abroad, and also provides fora for discussions of key policy issues. The UNDP grant has helped finance analyses and exchanges on development issues and policies that impact the epidemic, and are in turn affected by the epidemic. Like UNICEF, the IBRD, and WHO/GPA, UNDP believes it has a comparative advantage in urging increased attention to HIV/AIDS by developing country government leaders. ICRW’s behavioral research on women and AIDS concentrates on research with policy and program implications. None of these CAs are solely “policy CAs,” but each can be viewed as contributing to the achievement of the ATSP policy output.

The HIV-AIDS Division staff, largely funded from ATSP funds, has also played a direct role in changing HIV/AIDS policy. It has worked closely with WHO/GPA on establishing policy guidelines for HIV/AIDS, with potential applicability throughout the world. It was also recently drafted two key sections (prevention and donor coordination) of a landmark USG Interagency Policy for HIV/AIDS.

Division staff have also been instrumental in highlighting HIV/AIDS as a principle component of the U.S.-Japan Common Agenda. Through this consultation process, the Japanese government has become willing to invest its donor resources to address HIV/AIDS in developing countries and Japanese officials have become familiar with the ATSP and AIDSCAP strategies and project activities.

Coordination: AIDSCAP initially convened, and has often hosted, an AIDS and Economic Network, which appears to be an ideal channel for communication of policy issues and results.

The Network includes several representatives from the HIV-AIDS Division, many ATSP CAs, WHO/GPA-UNAIDS, the World Bank, and individual specialists from several universities.

c. Levels and Proportions of Funding

No budget line item for policy was delineated in the PP Amendment, nor have policy line items been established by any of the CAs. Therefore, it is difficult to ascertain the levels or proportions of ATSP funding being devoted to policy reform.

d. Staffing to Achieve the Objective

AIDSCAP established a Policy Unit as one of five technical units at its headquarters. The Unit has had consistent leadership for the past three years from a senior policy expert and is staffed by health economists and other policy specialists. AIDSCAP field offices do not include policy specialists and it is not clear that policy issues absorb a great deal of field staff time. Policy issues are normally addressed by the resident technical advisor with technical support from headquarters.

Although the HIV-AIDS Division has a "point person" for AIDSCAP policy work, that person does not play a similar role with other ATSP CAs. The Division has one policy specialist who concentrates on the U.S.-Japan Common Agenda, but who has not worked directly on policy matters with ATSP CAs.

e. Sustainability

Many of the AIDSCAP policy activities can be categorized as: a) the development of models and analytical methodologies (e.g., to measure cost sustainability) that can be used by numerous institutions; b) analyses of the impact of specific policies or changes in policies (e.g., Thailand's 100% condom policy); and c) ad hoc efforts to change a specific policy (e.g., high tariffs and taxes on condoms in Brazil). To the degree these models, methodologies, and analyses are broadly disseminated to interested parties, they will continue to have life and may be "sustained" after ATSP Phase II is over.

In many cases, though, activities of the smaller CAs, whose programs contribute to achieving the ATSP policy output (BuCen, UNDP, NCIH), reportedly cannot be sustained without continued ATSP funding.

Conclusion:

The structure, processes, staffing, and management of the ATSP policy effort appears to provide no serious constraints to the opportunity for Output #4 to be achieved. Greater HIV-AIDS

Process Evaluation of the AIDS Technical Support Project (ATSP)

Division attention to, and expertise in, policy and improved internal coordination of program-wide policy concerns should be considered for Phase III.

It will be very difficult for the AIDSCAP final evaluation to determine whether “improved policies...in priority and non-priority countries” are indeed in place because of AIDSCAP efforts. While some policy activities have been very short term in nature (such as a concentrated effort to reduce Brazilian taxes and tariffs on condoms), most are long term in nature (adoption and use of methodologies, models, and analyses) and their results may not be readily apparent. The degree to which the program has “missed opportunities” for policy change will also be hard to ascertain unless these missed opportunities affect the viability of country-program interventions.

VII. Recommendations

A. ATSP RECOMMENDATIONS FOR PHASE III

As the ATSP authorization terminates in 1997, a new phase of USAID HIV/AIDS activities is being considered. The Phase II strategy, designed in 1990, is in many ways outdated and a new strategy would be desirable even if the ATSP authorization was not terminating at this time. A new strategy is needed because:

- The impact of the epidemic is greater than anticipated in 1991. A much wider population is now understood to be vulnerable to the disease. At the same time the societal and economic impacts are deeper and more systemic than anticipated.
- HIV/AIDS is now understood to be an extraordinarily difficult public health problem (as both a chronic and an infectious disease). The epidemic has not been, and is not being, prevented on any significant scale. There is no single proven formula for bringing about the sustained behavior change needed to limit the disease. Various combinations of biomedical, behavioral, and policy changes may be effective, but need to be tailored to specific countries and specific contexts within those countries.
- AIDS is here to stay. Therefore, increased donor attention to capacity building, sustainability, and continuity of efforts in the developing world is required.
- HIV/AIDS is now also recognized as a significant development problem and not simply a public health problem.
- USAID's financial and staff resources are diminishing. USAID is likely to be less dominant among the donors addressing HIV/AIDS in most developing countries in the future. Carefully coordinated donor strategies and country strategies will be needed.
- Overall donor resources available for HIV/AIDS have plateaued and may decrease during Phase III. New funding sources (local government, NGO, private sector, philanthropic) and an increased focus on low-cost and sustainable actions will be needed.

B. OPERATIONAL AND PROGRAMMATIC RECOMMENDATIONS

1. **Broad Participation:** The strategic objectives and the results framework of the new ATSP (the vision) should be developed in a very participatory (reengineered) manner. The HIV/AIDS Division should also strive to involve a wider group of individuals, organizations, and institutions throughout the period of program implementation, including those outside the public health sphere.

2. **Agency-wide Strategy:** Phase III objectives ideally should be formulated as part of an Agency-wide strategy for addressing HIV/AIDS with the full involvement of regional bureau and field mission representatives.
3. **Realistic Duration:** USAID's vision of its Phase III response should not be artificially limited to the five- to eight-year period of a USAID Strategic Objective. Results in this SO period should be seen as benchmarks for a long-term response. Phase III objectives, which should include building in-country capacity and sustainability, will require a long-term commitment. U.S.-based technical support for HIV/AIDS activities should probably not follow the AIDSCAP, AIDSTECH, and AIDSCOM models, which cannot be sustained once USAID funding terminates.
4. **The Role of USAID's Global Bureau:** The structure of USAID's future activities in HIV/AIDS (Phase III) should be more decentralized than in Phases I or II. Technical knowledge of the epidemic and potential interventions are now much more widespread than in 1991, and a wide variety of interventions, which are funded by a number of actors, are now underway in most affected countries. USAID-funded activities should be geared less to a central strategy and more to country-specific needs and capacities. The Global Bureau's role should not include management of country program implementation (a la AIDSCAP), which should be left to field missions and regional offices. The Global Bureau's HIV-AIDS Division should focus on more traditional Global Bureau functions such as:
 - Verification of the availability to missions of state-of-the-art technical expertise in areas where the U.S. has a comparative advantage
 - Identification of best practices and lessons learned from global experience in addressing the epidemic
 - Biomedical/behavioral and operational research with potential global applicability
 - Donor coordination with UNAIDS; encouraging broader donor involvement (especially Japan and the multilateral banks)
 - Within USAID, provision of technical leadership, which encourages the greater mainstreaming of HIV/AIDS within USAID's development policies and practices, and performing overall program coordination.
 - Encouragement of broad USG agency involvement in addressing diverse aspects of the epidemic (State, USIA, Peace Corps, CDC, NIH).

As USAID reduces its staff and the number of USAID field missions, the temptation for the Global Bureau and its CAs to manage field programs becomes more seductive. A clear lesson from this evaluation is that it is extraordinarily difficult for a CA or a Global division to effectively manage a program that attempts to carry out both central bureau and field project implementation activities. Models that should be considered for field program management include: a) standard USAID field projects implemented by an entity selected competitively by the mission; b) field projects managed by a mission that draws upon global CAs for specific roles, but may also include mission grants to other U.S. or local entities to carry out other program roles; and c) regional projects encompassing several small countries with limited USAID field presence, managed by a regional field office.

5. **Flexibility Is Essential:** A flexible ATSP-like Strategic Objective structure should continue to be used to finance and coordinate Phase III HIV-AIDS Division activities. Flexibility, adaptability, and risk taking are essential in addressing this epidemic; therefore, the HIV-AIDS Division should structure the scopes of these activities so that relatively flexible procurement modalities (grants and cooperative agreements rather than contracts) can be used. These central bureau grants should be of modest size so that the implementing agencies can operate with a limited management span of control and can focus their energies on technical matters rather than on administrative, logistical, or contract management issues. Funding a predominant keystone CA in Phase III does not seem appropriate for both technical and management reasons.
6. **Greater Synergy and Cooperation:** The HIV-AIDS Division should take a very active role in encouraging coordination, collaboration, and interchange of findings/results among the CAs in the Phase III portfolio. The CAs should be equal partners in establishing and managing the coordination structure and, with the Division, should ensure that the key findings and results of ATSP activities are quickly available to USAID field missions. COTRs should play an active role in encouraging partnerships. Structures and procedures should be established within the Global Bureau to ensure effective coordination between the HIV-AIDS Division and other PHN divisions.
7. **Comparative Advantage:** USAID (and AIDSCAP) should ensure that the comprehensive three-pillar intervention model, propagated by AIDSCAP in Phase II, is carefully evaluated, and that its lessons are learned and disseminated to decision makers, community leaders, and technical specialists. In the future, USAID is unlikely to have the resources (nor will it be appropriate) for USAID field programs to support all elements of a multi-intervention strategy. USAID should focus on supporting those elements of country or local strategies (which should be comprehensive approaches) where the U.S. has special expertise and which smaller USAID missions can manage.

In addition to the substantive areas discussed in Section III, these areas of expertise may include:

- Condom social marketing
- Behavior change communication
- Policy dialogue and reform
- Integration of HIV/AIDS with family planning programs, and more broadly within health sector and other development programs
- Program design and evaluation, dissemination of best practices
- Engaging the private sector in addressing HIV/AIDS
- Encouraging joint government/NGO/private sector models for action
- Strengthening indigenous technical capacity and NGO operational capacity
- Fostering international and regional linkages among NGOs.

8. **Evaluation:** Evaluation has proved to be one of the most difficult areas to satisfy. Evaluating the impact of HIV/AIDS interventions is particularly complex and difficult given the nature of the disease (many people are not aware of their HIV status), and poor reporting due to the continuing HIV stigma in many quarters. The HIV-AIDS Division (and Agency leadership) should be careful not to promise more results than Phase III activities can deliver.

The emphasis needs to shift from demonstrating impact to include a more reflective evaluation and analysis of what is being learned. With limited resources for in-country programs and smaller mission staffs, USAID evaluation systems should be modest in scope and management intensity.

9. **Country-level Donor Coordination:** USAID is likely to provide increasingly limited resources and should strive to encourage a broader range of funding organizations at the country level (more donors, foundations, private sector entities, voluntary agencies). Coordination becomes increasingly important under these circumstances.
10. **The Alliance:** The Alliance is a new institution (which USAID helped create) with significant potential. It appears to have solid accomplishments to date but has serious funding problems. This is no time to discontinue support. USAID should continue to support the Alliance financially and encourage structural and programmatic improvements as recommended by a donor-sponsored evaluation, presently underway.
11. **UNAIDS:** USAID should continue supporting UNAIDS (which it helped create). It should encourage clarification of the respective roles of UNAIDS, cosponsoring agencies, and particularly the funding arrangements for their specific programs. USAID and UNAIDS

should have close working relationships especially in deciding research priorities, recommending best practices, and stimulating global policy discussions.

USAID missions should support the role of UNAIDS in coordinating UN agencies in country; and should actively support whatever country-specific structure is most appropriate for country-level coordination.

C. SUBSTANTIVE RECOMMENDATIONS

1. **ATSP Technical Approach:** While the current ATSP technical strategies remain critical components of any comprehensive HIV/AIDS program, they are no longer appear sufficient to make a sustainable impact on HIV transmission. Phase III should expand support for a broader response to HIV/AIDS, beyond the current AIDSCAP technical strategies, and build on lessons from the pilot activities of other CAs. It is recommended that the following be priority areas for Phase III, to be fully integrated with the existing technical strategies of condom promotion, reduction of STDs, and behavior change communication:
 - Developing “contextual interventions” for HIV/AIDS prevention
 - Reaching beyond traditional “at risk groups” to reduce women and girls’ vulnerability to HIV/AIDS
 - Linking HIV/AIDS prevention and care
 - Supporting a more “community-organizing” approach to HIV/AIDS
 - Supporting more expedient development and testing of vaginal microbicides.
2. **Contextual Interventions:** The ATSP approach to HIV/AIDS prevention should be broadened to include "contextual interventions" that aim to identify and change the relevant social, cultural, economic, and political factors that support AIDS-prone behaviors. The present challenge should be to determine what are the feasible, affordable, and relevant contextual changes needed to achieve a sustainable impact on the epidemic. The uncertainty regarding what interventions are appropriate needs to be acknowledged without looking for quick programmatic solutions. A second challenge will be to define the domains and parameters for success of contextual approaches to HIV/AIDS.
3. **Gender Focus:** The ATSP must reach beyond narrowly defined "at-risk groups" to address the much larger population of women and girls who are vulnerable to HIV infection. Specific recommendations are to:
 - Ensure that all future ATSP research, programs, and evaluations are gender sensitive, i.e., they must plan for and provide data on the relevant differences between women and men;

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- Increase programs specifically designed to identify and respond to what women and girls need for HIV/AIDS prevention;
- Support contextual interventions that aim to change the social, economic, and cultural determinants of women's vulnerability to HIV infection; and
- Eliminate HIV/AIDS messages that reinforce gender stereotypes that contribute to women and men's risk of HIV infection.

It is recommended that the existing data and recommended policies from the ICRW Women and AIDS program be fully utilized in planning for Phase III.

4. **Prevention and Care:** USAID should abandon its rigid "prevention only" policy, in order that programmatic prevention and care linkages can be made when necessary to ensure the success of prevention programs. An appropriate and cost-effective definition of "care" has yet to be established but might include counseling, nutrition advice, support and legal services, and anti-discrimination policies—not necessarily access to drugs and medical interventions. In addition, ATSP prevention messages must evolve to respond to the increasing proportion of HIV–infected individuals within target communities.
5. **Community-organizing Approach:** The ATSP should include a more “community-organizing” approach to AIDS prevention and care. This approach would put greater control in the hands of communities to define local priorities and to assume central responsibility for program development, as well as implementation. This community focus would not be in lieu of, but would complement, activities carried out by the government and private sector.
6. **Microbicide Development:** Microbicide development has been shown to be an obtainable goal with tremendous potential to revolutionize HIV/AIDS prevention efforts globally. Unfortunately the expedient development and testing of anti-microbials is largely constrained by limited financial and human resources. Without USAID leadership, the timely availability of a non-spermicidal microbicide appears unlikely. It is recommended that USAID develop a strategy for microbicide development that recognizes the unique role of the Agency in leveraging a product that will be appropriate for women in developing countries.
7. **STD Diagnosis and Treatment:** Phase III of the ATSP should dedicate increased attention and resources to the reduction of STDs for both HIV/AIDS prevention and overall reproductive health. Based on the results of the Mwanza study, it appears that a syndromic approach to STD treatment should be pursued aggressively. At the same time, the

development and testing of STD diagnostics and treatment algorithms for the reduction of STDs in women should remain a priority.

8. **STD Drugs And Condoms:** USAID's STD/HIV/AIDS programs have been hampered by the lack of consistent access to STD drugs and condoms. Phase III should learn from this experience and ensure some mechanism for regular supply of STD drugs and condoms to future ATSP projects. Although the ATSP may not finance drug and condom procurement, it would be poor public health practice to depend on commodities that are not consistently obtainable.
9. **Biomedical Research and Interventions:** Several biomedical research areas and interventions may be relevant for Phase III and need thoughtful discussion and clearly articulated policy in the project redesign. These include perinatal transmission, tuberculosis prevention and control, vaccine development and testing, and cost-effective biomedical treatments for HIV-infected individuals.

D. ATSP RECOMMENDATION FOR THE NEXT 18 MONTHS

The team was asked to provide a separate set of recommendations that would be applicable for the remainder of the Phase II ATSP period (presently between 17-18 months).

1. **Evaluation of Phase II Results:** The HIV-AIDS Division and AIDSCAP should carefully review whether sufficient financial and personnel resources will be available to gather and analyze the valuable data which will start to be available as AIDSCAP country programs terminate (beginning in April, 1995). Data, which will meet program evaluation needs and will provide valuable "lessons learned" for Phase III, will need to be collected and analyzed at the level of sub-projects, country programs, and, in some cases, regional programs. This may be the single highest budget priority for AIDSCAP over the next 18 months. It would be extremely short sighted to under budget or under staff this effort.

We understand that separate end-of-project evaluations or reviews of each of the Phase II CA programs will be carried out. Since the HIV-AIDS Division has no evaluation specialist on staff and has terminated very few CA programs in the past, it should consider adding an evaluation specialist to its staff, perhaps on a part-time basis (i.e., on detail from CDIE or elsewhere within USAID) to ensure that evaluation SOWs are well prepared and evaluation teams are properly staffed; and to coordinate the evaluation/review process for the Division.

2. **Dissemination of ATSP Results:** Evaluating CA results should be seen as only the first step in making these results and valuable "lessons learned" available to a wide array of organizations and individuals. Dissemination of this information should be the shared

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responsibility of both the funding agency (USAID) and the grantee (CA). We believe it would be valuable for each COTR and CA to jointly prepare a brief dissemination plan. This plan might include identification of key information to be disseminated, target recipients, means of dissemination, budget needed, etc.

3. **Present and Discuss Lessons Learned by Theme:** As the ATSP activities are coming to an end, it would be particularly valuable for the HIV-AIDS Division and the CAs to establish venues for the CAs to share, compare, contrast, and analyze their results and lessons learned by theme. Key themes that might be discussed include: service delivery for HIV/AIDS, behavioral research findings, successful policy interventions and tools, and cost-effective interventions.
4. **The Alliance:** The HIV-AIDS Division has apparently decided not to place a representative on the donor evaluation team now reviewing the activities and financing of the International HIV/AIDS Alliance. However, as one of the two major funders of the Alliance, the Division should ensure that it meets with the evaluation team to make known USAID's vision of the Alliance (original and current), and USAID's views of Alliance activities to date. The Division should also participate fully in evaluation team debriefings and carefully review and comment on the evaluation team report.
5. **UNAIDS:** As a new organization, UNAIDS and its "founders" (the donor countries, including the USG, which urged its creation) will need to work closely together over the next 18 months to resolve several "teething problems" which relate to UNAIDS' functions and funding. These issues include: intra-UN system funding; UNAIDS' research priorities; country-level coordination; rationalization of resource allocations across countries; and UNAIDS' role in evaluation.
6. **HIV-AIDS Division Staffing:** Although this evaluation team has not been asked to analyze the HIV-AIDS Division staffing needs, it is clear to us that the Division should immediately find a Program Specialist or Program Assistant (PA). This PA could carry out many of the bureaucratic tasks which were added to the workload of the AIDSCAP COTR when that activity was converted to a contract. Both AIDSCAP and the Division complain that the COTR is currently overburdened with contract-related paperwork, leaving little time to discuss and help resolve important operational and programmatic matters.

ANNEXES

Annex 1: ATSP Evaluation Scope of Work

January 22 - February 23, 1996

- 1. Amendments:** With an initial ATSP authorization in FY 1987, the project Scope of Work (SOW) and funding level have undergone four significant amendments. Were elements of the SOW dropped or significantly revised during the Life of Project (LOP)? What was added in the four project amendments? How were changes in the SOW or funding level determined? Did the modifications address the emerging needs of the epidemic? Were the funding and technical amendments made to the project sufficient for USAID to provide state-of-the art interventions? Has the End of Project Status (EOPS) been modified/attained?
- 2. Project Design/Structure:** What are the noteworthy strengths and weaknesses of the ATSP design? Are there significant gaps and/or redundancies? Under what circumstances/in what environments did the design succeed or fail? Did the structure of the project encourage capacity building and sustainability results? How was the design and subsequent modifications of the ATSP relative to USAID global leadership expectations, both within and outside of the Agency? Have these expectations been valid considering the USAID environment? To what degree is sustainability attainable/in what time frame? If not, why not?
- 3. Project Responsiveness:** How did the ATSP recognize and respond to changing global consensus on the appropriate technical response to the epidemic? Was timeliness an issue in making the changes? Are there findings that can inform future USAID planning and implementation on how to sustain programmatic focus, on an approved set of activities to achieve specific results, while still retaining adaptability to support unanticipated opportunities?
- 4. Customers, Stakeholders, and Partners:** Although the terms customers, stakeholders and partners are part of USAID's reengineering effort, the principles are not new to the Agency. Throughout the LOP of the ATSP, who have been the customers, partners, and stakeholders over time? Have they changed? Have their needs or interests been ascertained—using what tools and, if so, how well have they been met? Could they have been met at all or at better levels?
- 5. Breadth vs. Depth:** One of the central tensions internal to USAID is the balance between funding technical leadership activities, including research, and providing missions and regional bureaus with technical assistance and program implementation. How has the ATSP addressed this tension? What can be learned from this response? How should this response change under existing decentralized funding scenarios? How does a field-based response maintain leadership components and comprehensive and integrated responses to the epidemic?
- 6. Cooperating Agency Roles:** More than 20 Cooperating Agencies (CAs) have received USAID-assistance through the ATSP. Is there a common understanding among the CAs about the goal of the EOPS, and the contribution each CA is intended to make? Has coordination and communication taken place among these CAs? Through what means?

What is the nature of the CA relations in the following areas:

- Roles: intended and perceived
- Team membership: separation/linkage
- Efficiency of relationship: cost effective/outcome-results
- Level of involvement
- Expectations
- Overlap/redundancy
- Influence
- Capacity building: internal/external

7. Donor Relations and the ATSP: Since the 1987 ATSP authorization, the number of donors active in HIV-AIDS prevention has increased. As USAID continues to be the largest worldwide funder of HIV-AIDS prevention activities in developing countries, even with an expanding field of donor activities, the ATSP design has been required to be flexible and modify its approach in order to collaborate and enhance/leverage assistance from other donors to program effectiveness. Has this occurred? Where/how? What could have strengthened ATSP and donor cooperation? What worked well and how can it be replicated?

8. WHO/GPA and the ATSP: The USAID contribution to the WHO/Global Programme on AIDS (WHO/GPA) is significant in the amount of budgetary assistance provided as well as in the (assumed) influence gained by making such a meaningful contribution. Although funded under a separate authorization, the GPA grant is managed by the same division that manages the ATSP. What has been the relationship of ATSP with the GPA portfolio? Since it is likely that USAID will continue to fund multilateral support through UNAIDS, what can be recommended to assure the most positive and productive relationship possible?

9. The ATSP and the Larger Portfolio: How has the ATSP been linked, or not linked, with the larger USAID response to HIV/AIDS, i.e., with bilateral projects or activities, the Office of Population, and the regional bureaus. What have been the elements essential for successful collaboration? What were hindrances?

10. The ATSP and USAID Changes: USAID has undergone profound transformation during the ATSP LOP including, but not limited to:

- The evolution of the Bureau for Science and Technology to the Bureau for Research and Development to the Bureau for Global Programs, Field Support and Research;
- Enhanced mission and regional bureau staff technical capability in HIV/AIDS;

- Decentralized Agency decision making and funding decisions as seen most apparently in the shift of all funding for mission activities to mission budgets, and Global funds limited to covering technical leadership and research;
- Office of Procurement directives, e.g., interpretations of implementation mechanisms, buy-in contracting by mission contracting officers.

All of these changes have had significant influence on intended, perceived, and actual performance of the ATSP. What have been the consequences of these on the ATSP? Could they have been anticipated? Were they quickly and efficiently integrated into implementation and/or amendments? What can be extrapolated from these changes and what are their ramifications for the future?

11. The ATSP and Global Leadership: As a component of its global leadership function, G/PHN/HN/HIV-AIDS provides assistance for such activities as publications, training, conferences and workshops, special studies, ad hoc requests, and information dissemination. Most such activities funded through ATSP occurred through the AIDSCAP contract; such an implementation mechanism is unsatisfactory in that the end result is seen as a product of the contractor/grantee rather than that of USAID. Does the Team have recommendations as to how the HIV-AIDS Division can undertake such tasks through an efficient and effective mechanism?

12. USAID Management: How well did USAID technical direction and monitoring of the project work? Has USAID management of the content and execution of the project been sufficient in amount, quality, and continuity?

Annex 2: Materials Reviewed

The following is a partial list of project documents, publications, and communications that were reviewed or referenced during this evaluation.

Key project documents for each ATSP Cooperating Agency program were compiled and provided for Team use by the relevant HIV-AIDS Division staff members. These documents normally included grant requests, grants, implementation documents, CA-prepared studies, CA quarterly or semi-annual reports, and internal USAID communications.

1. Concept Paper, ATSP, April 21, 1987
2. ATSP Project Authorization, 1987
3. AIDSCOM Project Paper, 1987
4. AIDSTECH Project Paper, 1987
5. ATSP Project Authorization Amendment #1, July 1, 1988
6. ATSP Project Authorization Amendment #2, February 18, 1991
7. ATSP Project Authorization Amendment #3, August 23, 1993
8. ATSP Project Authorization Amendment #4, January 26, 1994
9. ATSP Project Paper Amendment, March 18, 1991
10. A.I.D. Policy Guidance on AIDS, April, 1987
11. USAID HIV/AIDS Policy Guidance, September 1995
12. U.S.G. International Strategy on HIV/AIDS, July 1995
13. Final Report: First Interim Evaluation - AIDSTECH and AIDSCOM Components on ATSP, Norine Jewell, Team Leader. December 21, 1989
14. ATSP Final Evaluation - Phase I, John Snow Inc. June-October, 1992
15. Management Review of AIDSCAP Project, Development Associates, Inc. August, 1995
16. Final Evaluation of the CDC AIDS PASA Agreement, 1993
17. AID Evaluation Summary: CDC AIDS PASA, May, 1994
18. AID Evaluation Summary: IFAR, April, 1993
19. Evaluation of HIV/AIDS Surveillance, Impact Assessment and Modeling, Office of International Health, Public Health Service. No date
20. Evaluation of National Council for International Health Activity, Sallie Craig Huber and Linda Udall, July 23, 1990
21. External Review of the Global Programme on AIDS. Report of the External Review Committee - Executive Summary. October 10, 1991
22. IPPF/WHO HIV/STD Prevention Program: Intermediate Evaluation Results, January, 1995 Evaluation of NIAID-USAID PASA - Findings and Recommendations. Nancy Hardy, August 1992

23. AID Annual Reports to the U.S. Congress on the HIV/AIDS Prevention Program, 1989-1995
24. Semi-Annual Portfolio Review Documents, HIV/AIDS Division. 1987-1996
25. AIDSTECH Final Report, Volumes I-III. Family Health International. 1992
26. Partners Against AIDS: Lessons Learned, AIDSCOM. November 1993
27. AIDSCOM Lessons Learned - AIDS Prevention in Africa. AIDSCOM. November 1993
28. AIDSCAP 1995 Annual Report, 1995
29. AIDSCAP Summary of Accomplishments, 1995
30. AIDSCAP: The Technical Strategy. No date
31. AIDSCAP Women's Initiative: 1994 Annual Progress Report, 1994
32. AIDSCAP Evaluation Tools: Introduction to AIDSCAP Evaluation (Module 1), 1993
33. Various AIDSCAP Quarterly Country Progress Reports
34. A variety of other AIDSCAP reports and summary documents provided to team by AIDSCAP.
35. Several Bureau of the Census (BuCen) Research Notes and Staff Papers
36. Various NCIH AIDS Network Workshop and Seminar Reports and Newsletters
37. UNICEF: Five Final Technical Support Group Meeting Reports
38. Strategic Plan Outline 1996-2000 and other documents. WHO Emerging and Other Communicable Diseases Surveillance and Control Division
39. WHO/Global Programme on AIDS - several Progress Reports.
40. Peace Corps: Teach English, Prevent AIDS, A Teacher's Manual, March 1994
41. UNDP HIV and Development Programme Strategic Programming Areas, Summary Document - Scope of Work 1992-1996
42. AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy, January 1995 (draft)
43. Women and AIDS: Developing a New Health Strategy, ICRW Policy Series, 1993
44. International HIV/AIDS Alliance: Supporting Community Action on AIDS in Developing Countries, Fact Sheets 1995

Annex 3: List of Individuals Contacted

U.S. Agency for International Development (USAID)

Bureau for Global Programs, Field Support and Research (G)

Ann Van Dusen, Senior Deputy Assistant Administrator, DAA/G, Global Bureau, Center for Human Capacity Development
Robert Wrin, Associate Assistant Administrator, G/HCD, Global Bureau, Center for Human Capacity Development

Center for Population, Health and Nutrition, Global Bureau (PHN Center)

Duff Gillespie, Deputy Assistant Administrator, G/PHN/DAA, Center for Population, Health & Nutrition
Dawn Liberi, Associate Administrator, G/PHN/DAA, Center for Population, Health & Nutrition

Office of Health and Nutrition, Center for Population Health and Nutrition, Global Bureau (G/PHN/HN)

David Oot, Director, G/PHN/HN, Office of Health and Nutrition
Robert Clay, Deputy Director, G/PHN/HN, Office of Health and Nutrition
Melody Trott, G/PHN/HN/CS

HIV-AIDS Division, Office of Health and Nutrition, PHN Center, Global Bureau (G/PHN/HN/HIV-AIDS)

Jacob Gayle, Division Chief
Victor Barnes, Deputy Division Chief
Jeanine Buzy
Paul DeLay
Barbara de Zalduondo
Denise Rouse
Karen Morita
Basil Vareldzis
Marc Weisskopf

Office of Population, Center for Population, Health and Nutrition, Global Bureau (G/PHN/POP)

Chloe O'Gara, G/PHN/POP/CMT

Bureau for Latin American and the Caribbean (LAC)

Carol Dabbs, LAC/RSD/HPN
James Sitrick, LAC/RSD/HPN

Bureau for Africa (AFR)

William Lyerly, AFR/SD

Bureau for Asia and the Near East (ANE)

Carol Becker, ANE/SEA/SPA
Carol Rice, ANE/SEA/SPA

Center for Democracy and Governance, Global Bureau

Erin Soto, G/DG

USAID Mission/Abidjan

Lois Bradshaw, REDSO/WCA

Center for Human Capacity Development, Global Bureau

Anthony Meyers, G/HCD

Centers for Disease Control and Prevention (CDC)

Helene Gayle
Jeffrey Harris
Judith Wasserheit
Sam Perry
Melinda Moore
Robert Bernstein
Carl Campbell
Linda Valleroy

U.S. Bureau for the Census (BuCen)

Karen Stanecki
Peter Way

UNAIDS

Peter Piot, Director
Gunilla Ernberg
Purnima Mane
Faustin Yao
David Heyman
Dorothy Blake
Michael Carael
Paul Sato

United Nations Development Programme (UNDP)

Elizabeth Reid
Desmond Cohen

Mina Mauerstein-Bail
James Mulloll

UNICEF

Bruce Dick
Teresa McCann

The World Bank

Wendy Roseberry

AIDSCAP/Family Health International (FHI)

William Schellstede, Executive Vice President, FHI Washington Programs
Peter Lamptey, Senior Vice President and Project Director
Tony Schwarzwald, Deputy Project Director
Sheila Mitchell, Director of Program Management
Elizabeth Preble, Director of Technical Support
Susan Hassig, Senior Associate
Thomas Rehle, Associate Director of Evaluation
Maxine Ankrah, Senior Advisor, Women's Initiative

Academy for Educational Development (AED)

William Smith
Lorraine Lathen

The Health Development and Policy Project

Lori Heise

International Center for Research on Women (ICRW)

Geeta Rao Gupta
Ellen Weiss
Daniel Whelan

International Planned Parenthood Foundation (IPPF)

Julie Becker

National Council on International Health (NCIH)

Frank Lostumbo
Mary Guinn Delaney
Kelly Forrest
Sandra Morgan

National Institute for Allergy and Infectious Disease (NIAID)

Karl Western

National Institutes for Health (NIH)

Sharon Hymnkow

Program for Appropriate Technologies in Health (PATH)

Elaine Murphy

Peace Corps

Shelley Smith

The Population Council (Pop Council)

Christa Coggins

Christopher Elias

David Phillips

The Rockefeller Foundation

Jane Hughes

The International HIV/AIDS Alliance

Jeffrey O'Malley

Ioanna Trilivas

Sarah Lee

Harvard School of Public Health

Jonathan Mann

Yale University School of Public Health

Michael Merson

Tulane University

Carl Kendall

ICASO Central Secretariat

Richard Burzyinski

Annex 4: ATSP Funding Table (FY 87-95)

PROJ #	PROJECT TITLE	AGRMNT #	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 87 - FY 95 TOTAL
5972	AIDS Technical Support		4,341,987	13,154,256	12,268,996	21,229,496	30,959,744	36,326,727	47,380,194	54,180,733	50,821,742	270,663,875
.31	FHI/AIDSCAP (CA & CTR)	A-1031/C-4001					7,915,696	23,078,681	37,187,247	35,811,693	30,169,844	134,163,161
	Buy-Ins (I)						1,135,594	3,032,000	3,118,776	12,162,025	14,568,320	34,016,715
.01	AED/AIDSCOM	Z-7070	1,000,000	2,497,328	1,825,000	3,015,000	2,800,000	735,000				11,872,328
	Buy-Ins		424,680	2,605,022	2,568,150	3,135,453	3,369,647	317,679				12,420,631
.02	FHI/AIDSTECH	A-7057	1,403,317	3,185,175	4,078,968	6,260,781	5,000,000	3,500,000	1,500,000			24,928,241
	Buy-Ins		958,990	3,863,554	1,791,235	2,388,275	4,309,979	333,000				13,645,033
.06	NIAID PASA	P-8079		85,000	85,000	85,000			85,000	200,000		540,000
.08	CDC PASA	P-8080		250,000	500,000	1,000,000	1,000,000	1,052,387				3,802,387
	Buy-Ins (FY 90 includes \$1.011 from TAACS)				350,000	1,472,560	120,207	154,846				2,097,613
.41	CDC PASA II	X-2012						600,000	600,000	540,000		1,740,000
	Buy-Ins							75,000				75,000
.09	BUCEN RSSA	R-8055		235,000	149,000	241,000	157,052	323,059	443,740			1,548,851
	Buy-Ins (OE Funding)						82,039	74,500				156,539
.49	BUCEN RSSA II	R-4004								297,119	570,000	867,119
.13	NCIH/PVO Coord.	A-9006			200,000	118,192						318,192
	Buy-Ins				235,000	14,527						249,527
.43	NCIH (under 936-5929 HRS)	A-1010						161,000	175,000	275,000	275,000	886,000
.15	NAS/Int'l. Forum for AIDS Research	G-9027			100,000	100,000	100,000					300,000
.26	ICRW/Women & AIDS Research	A-0036				500,000	800,000	767,544	320,000	730,000	847,969	3,965,513
	Buy-Ins					75,000			320,000	520,273	259,578	1,174,851
.33	WHO/STD	G-0029				75,000						75,000
.37	Peace Corps PASA	P-1018					900,000			200,000		1,100,000
.44	International Family Health	G-3050							200,000			200,000
.46	UNICEF	G-3024							500,000			500,000
.47	POP Council/Virucides Init.	A-3022							199,431	350,000	450,000	999,431
.50	UNDP	G-4007								1,000,000	500,000	1,500,000
.51	Int'l. HIV/AIDS Alliance	G-4013								500,000	925,000	1,425,000
	Buy-Ins											
.16	CDC (Condom Logistics) RSSA (Buy-In)	R-2052			150,000	150,000						300,000
.40	CDC (Condom Log) PASA (Buy-In)	X-1015					200,000	200,000	225,000			625,000
.25	Ansell Inc./Condom Procurement (Buy-In)	C-1049				1,500,000	999,915					2,499,915
.30	Future's Group/SOMARC (Buy-In)	Z-8043				167,710	500,000	250,000				917,710
.42	IPPF (Buy-In)	A-2018						499,533	500,000	500,000	500,000	1,999,533
.29	JSI/Family Planning & Logistics Mgmt. (Buy-In)	Q-0047				500,000	500,000	250,000	500,000			1,750,000
.35	JSI/MotherCare (under 936-5966 BMNH)	Z-8083					265,000	40,000				305,000

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PROJ #	PROJECT TITLE	AGRMNT #	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 87 - FY 95 TOTAL
.48	Macro/Demographic & Health Surveys III (Buy-in)	C-2012							500,000			500,000
.28	PATH/STD Diagnostics Initiative (under 936-5968)	A-0025				300,000	300,000	300,000	300,000	200,000	150,000	1,550,000
	Other (includes Evals., Fellows, etc.)		555,000	433,177	236,643	130,998	504,615	582,498	706,000	894,623	1,606,031	5,649,585
	Total Core (includes OYB transfers)		2,958,317	6,685,680	7,324,611	14,143,681	21,942,278	32,339,702	43,941,418	41,498,435	35,993,844	206,817,966
	Total Buy-Ins		1,383,670	6,468,576	4,944,385	7,085,815	9,017,466	3,987,025	3,438,776	12,682,298	14,827,898	63,835,909
	TOTAL		4,341,987	13,154,256	12,268,996	21,229,496	30,959,744	36,326,727	47,380,194	54,180,733	50,821,742	270,653,875

- (1) These "buy-ins" represent the transfer of USAID mission or regional bureau funds into ATSP activities.
- (2) From this point to the end of this table, "buy-in" refers to HIV/AIDS division funds transferred to other (primarily Population Office) USAID activities.

Annex 5: Core Questions for Interviews

I. OPERATIONAL APPROPRIATENESS AND USAID MANAGEMENT

1. **Program Structure:** The ATSP was structured initially (1987-1991) with two primary implementing agents (AIDSTECH and AIDSCOM) and several smaller Cooperating Agencies (CAs). The program was managed by two U.S. Direct Hires (USDH) in the Health and Education Divisions of the Global Bureau of USAID. Since the major project redesign in 1991, ATSP has had a single large implementing agency (AIDSCAP) managed by one USDH in the Health Division of the Global Bureau, assisted by three technical specialists (when available). The revised ATSP also includes 14 much smaller CAs managed by various members of the HIV-AIDS Division staff.

How effective have these two structures been in facilitating the achievement of overall ATSP objectives? What have been the strengths and weaknesses of each structure? Which elements of the structures were particularly beneficial; which tended to hinder achievement of project objectives?

2. **ATSP Coordination:** The principal mechanism to encourage ATSP coordination has been monthly CA meetings. Has this mechanism been effective? How has it facilitated intra-ATSP cooperation? Are other mechanisms advisable for the future? Have mechanisms been established to ensure other forms of communication (exchange of progress reports, etc.) among the CAs and with the HIV-AIDS Division?
3. **Flexibility and Adaptability:** As a ten-year project, ATSP has needed to adapt to changes in knowledge about the impact of the HIV/AIDS epidemic, as well as to regional variations in the scope and form of the epidemic. What elements of the ATSP structure and operational mode have facilitated flexibility and adaptability? Which structural and operational elements have hindered flexibility and adaptability? Have there been opportunities for positive ATSP activity which have been missed because of lack of flexibility? Please describe. What changes would you suggest for the future?
4. **Central Functions and Responsiveness to Regional Bureau and Field Mission Needs:** Both the original and the revised ATSP were designed to be USAID's keystone AIDS project—providing support to field mission needs while also financing typical central bureau functions (basic research, repository of state-of-the-art technical knowledge, international leadership, coordination with other donors at the HQ level). On balance, has the ATSP been sufficiently responsive to the field mission needs that you are aware of? Give specific examples. What structural changes might improve ATSP responsiveness in the future? What central functions have proved to be most visible and most valuable to regional bureaus

and field missions? Should some central functions be dropped or de-emphasized in order to give greater priority to field needs?

5. **Evaluation:** Does the ATSP have evaluation systems and structures which will enable the project to describe what has been accomplished? Which evaluation elements are strong? Which are weak? How might they be improved?
6. **Links to the USAID Portfolio:** Has the ATSP taken sufficient advantage of buy-in opportunities with the Office of Population and the Women in Development (WID) project? Was the AFR regional AIDS project needed and useful? Did it and any similar projects compete with the ATSP? Should the ATSP have been adjusted to have more of a development focus, rather than the present health focus? How?
7. **Impact of changes in USAID operational systems and USAID organizational structure:**

Have the following changes over the past eight years had a significant impact of the performance of the ATSP? How?

- Increased delegation of project approval authority to field missions
- Reorganization of USAID (1993-94) with increased technical capacity in the Global Bureau
- Field Support Budgeting (1994) and related changes for missions and regional bureaus to buy into central bureau projects
- Reengineering (1995-present)
- Reduction of USDH staff; increased use of PSCs and fellows
- Increased Inspector General (IG) audit program and tightened audit regulations for indigenous NGOs and other sub-grantees of AIDSCOM, AIDSTECH, and AIDSCAP
- Changes in procurement procedures and regulations.

II. SUBSTANTIVE APPROPRIATENESS

Introduction: These questions seek to determine whether: a) the programmatic focus of the ATSP has been, and is now, appropriate to meet the project goal as articulated in the project design; and

b) there are different substantive approaches that may be necessary to meet the current/future state of the epidemic. “Substance” refers primarily to the overall choices of approach or “paradigm” chosen to achieve the project goal. These include:

- Focus on sexual transmission versus other forms of transmission
- Focus on three major interventions—condoms, STD treatment, behavioral change communication—versus other possible interventions
- The geographic coverage of the ATSP
- The degree of emphasis on biomedical and behavioral research
- The degree of emphasis on policy change.

1. The original 1987 ATSP design had few limits on the kinds of sub-projects and other activities that could be financed by AIDSTECH and AIDSCOM. Was this design appropriate at that time given the state of knowledge of the epidemic?

The 1991 redesign very explicitly focused on sexual transmission and three major interventions. Why were these substantive areas chosen? Why were certain approaches and areas of emphasis de-emphasized or not included (i.e., care, other forms of transmission, gender-specific strategies). Was this, in your view, the appropriate response at the time, given USAID’s comparative advantages, the activities of other donors, and the level of funding available to the program?

2. Did substantive approaches and areas of emphasis change during the life of the ATSP? If so, who perceived the need for this change and why? Were changes made in the substantive approaches and areas of emphasis during the two major phases of the project and by whom? What mechanisms either facilitated or hindered the ability of the overall ATSP and its participating partners to incorporate novel approaches and new areas of emphasis (e.g., unsolicited proposals, institutional capabilities and commitments, the PVO small grants program)?
3. How have the ATSP approaches and activities related to the global response to the epidemic? Has the ATSP shown global leadership or has it been reactive?
4. What has been learned regarding what substantive approaches work and do not work with respect to HIV/AIDS prevention since the ATSP design (1987) and redesign (1991)?
5. Given USAID’s financial resources and institutional strengths and weaknesses, what substantive approaches and activities should be included in a future project?
6. How are decisions made regarding the substantive direction of USAID’s response to the international HIV/AIDS epidemic? Who participates in the decision making process? Are

there ways in which the decision making process could be adjusted to make the ATSP more responsive to the evolving epidemic?

III. COOPERATING AGENCIES

1. Briefly describe what your organization has been expected to contribute to the ATSP (identify in relation to outputs or areas of programmatic focus).
2. In your view, have you been successful in meeting the objectives of your grant/agreement? What has been most successful, what has been least successful? Why?
3. How do you know? What evaluation system do you use to measure results?
4. Are activities or elements of your program sustainable? Will they be continued when ATSP funding terminates?
5. What other ATSP CAs work in the same programmatic area(s)? Do you cooperate? How? Has USAID or the ATSP structure facilitated this cooperation?
6. Could your organization have contributed more to the objectives of ATSP? How? What kept you from doing more (\$, perceived overlap with AIDSCAP or other CAs, lack of interest from USAID)?
7. Has your work contributed, enhanced, or influenced the activities of other CAs in the ATSP family? How has that contribution occurred?
8. The ATSP does not have a Technical Advisory Group (TAG)—although AIDSCAP does. Would a TAG for the ATSP have been useful?
9. USAID Management: How would you rate (between 1-10) the HIV-AIDS Division's performance of the following functions in relation to ATSP:
 - Management of your grant/agreement
 - Management of the overall ATSP project
 - Communication of overall ATSP status, issues, and opportunities
 - Helping to resolve operational problems (e.g., related to USAID regulations)

- Facilitating cooperation and teamwork within the ATSP
- Technical guidance and support
- Providing global leadership and direction in addressing the epidemic.

IV. UN AGENCIES

1. ATSP and specific agency: What is the nature of the working relationship between USAID as a bilateral donor and your multilateral agency as they relate to HIV/AIDS? What do you see as the appropriate roles and responsibilities? Have there been questions of overlap and lack of coordination that have hindered your ability to achieve your agency's objectives?
2. How valuable have USG (USAID) funds been to your program? Has this funding allowed you to leverage additional funds from other sources? How sustainable is your program if/when ATSP funding terminates?
3. Compare ATSP and USAID with the work of other bilateral donors who are addressing HIV/AIDS. Comparative strengths and weaknesses of USAID and ATSP? Comparative strengths and weaknesses of AIDSCAP?
4. Your perception of how well USAID and the ATSP have provided leadership, leveraged resources, provided technical guidance, and have been willing to collaborate. In what areas have USAID and ATSP been most effective? Least effective?
5. What roles have the major ATSP implementing organizations (AIDSCAP, AIDSCOM, AIDSTECH) had in encouraging developing country governments and NGOs to aggressively address HIV/AIDS?
6. What has been the impact of changes in development assistance (both conceptual and financial) upon the work of both your UN agency and the ATSP/USAID?
7. Evaluation: What have been your major results in the HIV/AIDS area? How do you know? How do you document/evaluate? How do you disseminate the successful results and lessons learned?

Annex 6: ATSP Evaluation Field Mission Questionnaire

I. Design and Revision

- a. Was the Mission input requested and incorporated in either the ATSP design and redesign? Should it have been?
- b. Has the ATSP design and redesign responded to the specific needs of your mission/country? In what ways? How has it not responded?

II. Flexibility and Adaptability

As a ten-year project, ATSP has needed to adapt to changes in knowledge about the impact of the HIV/AIDS epidemic, as well as to regional variations in the scope and form of the epidemic.

- a. What elements of the ATSP structure and operational mode have facilitated flexibility and adaptability? Which structural and operational elements have hindered flexibility and adaptability?
- b. What changes would you suggest for the future?

III. Responsiveness to Field Missions

Both the original and the amended ATSP were designed to be USAID's flagship HIV/AIDS project, providing support to field mission needs while also financing typical central project functions, i.e., basic research, repository of state-of-the-art technical knowledge, international leadership, and coordination with other donors at the Washington/HQ level.

- a. On balance has the ATSP been sufficiently responsive to the field mission needs? What structural changes should be considered in the future?
- b. Which of the above central project functions appear to have been the most effective from your perspective? Which the least effective?

IV. ATSP and Other USAID-funded HIV/AIDS Prevention Activities

How has the ATSP been linked with the larger USAID response to HIV/AIDS, e.g., with bilateral projects and regional activities?

- a. Has there been adequate coordination with mission-funded and/or regional activities? What have been the elements essential for successful collaboration/coordination?

V. Impact on Changes in USAID Operational Systems and Organizational Structure

Over the past years USAID has undergone profound transformation including, but not limited to:

- Increased delegation of project approval authority to missions
- Field Support budgeting
- Changes in procurement procedures for missions and regional bureaus to buy into central projects;
- Reengineering.

Have these changes had an affect on the way ATSP-funded activities have been carried out in your country? What adjustments were needed? Were they implemented in a timely manner? What implications of these changes do you see as impacting on future activities?

THANK YOU FOR YOUR TIME!!! Please feel free to add any additional comments.

RESPONDENTS TO FIELD MISSION QUESTIONNAIRE

AFRICA BUREAU:

USAID/SENEGAL
USAID/KENYA
REDSO/ESA
USAID/TANZANIA
USAID/NIGERIA
USAID/MOZAMBIQUE
USAID/MALAWI

ASIA/NEAR EAST BUREAU:

USAID /INDONESIA
USAID/MANILA

LATIN AMERICA/CARIBBEAN BUREAU:

USAID/HAITI
USAID/GUATEMALA

Annex 7: Comments on Draft Evaluation Report

Organizations and individuals who reviewed the draft evaluation report were asked if they would like to include their formal comments in an annex to the report. This ensures that their views are clearly represented. The evaluation team has used these and other comments to make modifications to the draft report.

One organization, AIDSCAP, asked that their comments be included in this annex.

AIDSCAP COMMENTS ON ATSP EVALUATION REPORT,
March 28 draft

I. Broad overall comments

1. "Core package approach." The report suggests that ATSP/AIDSCAP was "inflexible", followed a "donor predetermined approach," and that programs were not community-based.

Comments: AIDSCAP does have a general technical approach to its programming -- i.e., the important synergistic advantages of access to condoms, STD treatment and behavior change communication (an approach which the evaluation team validates in the report). However, it is not accurate to assume, therefore, that all AIDSCAP-supported programs are identical. In fact, AIDSCAP programs differ significantly in the target populations they reach (e.g., people in workplaces, in-and out-of-school youth, STD patients, orphans, general population women, CSWs and their partners), in the focus of their efforts (e.g., prevention, care, capacity building), in terms of types of local implementors (governments, NGOs, community-based groups), and the extent of geographic focus (urban, rural, region-wide, community-based).

The differences among programs is based on country-specific needs assessments or, where applicable, the existence of a USAID Mission project design. AIDSCAP's needs assessment/strategic planning process is highly inclusive -- soliciting participation by and input from government, NGOs, community-based organizations, donors, and other influentials. Subprojects are designed by the NGOs and other organizations which are implementing them based on the needs of the constituency they represent. AIDSCAP's role is to provide technical assistance and financial support to these organizations as they implement their programs.

In addition to its regular programming, in 13 countries AIDSCAP supports a "Rapid Response Fund" grants program which to date has funded 174 small grants to community-based organizations reaching over 1 million women, men and youth at a total expenditure of \$536,720 since the program's inception in 1993. This program is purely community-based and community-initiated.

2. AIDSCAP not receptive to other CAs. The report states that AIDSCAP is perceived as being "impenetrable" (page 46), unaware of what other CAs are doing, and uninterested in the lessons/activities of other CAs, and unwilling to share information, a particular problem given "the original vision of AIDSCAP as a central clearinghouse and learning center within the umbrella project." (page 74)

Comments. We strongly disagree with these conclusions. AIDSCAP has numerous strong formal and informal linkages with other ATSP CAs. For example:

ATSP CAs are represented on AIDSCAP's Technical Advisory Group and technical working groups where their advice and input is sought, and AIDSCAP sits on a number of their TAGs and working groups.

AIDSCAP participates with other CAs on numerous USAID-supported task forces (e.g. adolescents, reproductive health, AIDS Economic Network) which provide rich opportunities for sharing information.

AIDSCAP is providing a \$220,000 grant to ICRW expressly designed to support the dissemination of ICRW research findings through materials development and distribution and the conduct of two regional conferences.

AIDSCAP has invited CAs to participate in interactive workshops coordinated by AIDSCAP to share lessons learned (e.g., the peer education workshop at the Kampala conference, the Women and AIDS workshop at the Beijing conference, the pre-conference workshop on AIDS in Africa at Kampala, the policy workshop at Marrakech).

PVOs are invited to briefings and debriefings of country program reviews.

PVOs are being invited to a lessons learned workshop planned for June 1996. AIDSCAP has invited CAs to submit articles to AIDSCaptions which is broadly disseminated (circulation averaging 8,000) and is a regular contributor to the NCIH newsletter.

AIDSCAP closely monitors the scientific literature and publications from these agencies to help identify trends; this literature is frequently cited in our work and their results incorporated.

The above examples do not include the numerous collaborative ventures with CAs including support to develop the AIDS module of the DHS, the information dissemination project with UNICEF, evaluation assistance to the Peace Corps in Cameroon, data sharing with BUCEN, joint sponsorship of a Peace Corps/NGO AIDS conference in Africa, information sharing with the HIV/AIDS Alliance, collaborative programming with ICRW, etc.

AIDSCAP is unaware of any problems experienced by smaller CAs in accessing AIDSCAP information since project databases, the library, and the regular publications of AIDSCAP are all accessed by CAs on a regular basis. Unless specific examples of these concerns exist and can be verified with us, we think unsubstantiated comments should be deleted.

The designation of AIDSCAP as a "central clearinghouse" for ATSP is not found in the AIDSCAP cooperative agreement or contract, nor has this ever been discussed with AIDSCAP as an expectation by USAID.

3. Women's programming. The report states (page 70) that the "at-risk groups" focus of ATSP effectively excluded general population women from most AIDSCAP projects.

Comments: We think this misses two important points. First, that as the epidemic has spread, more "general population" women are "at risk." Second, and most importantly, the AIDSCAP program has responded to this evolving situation by broadening its country-specific intervention and research programming on women, and establishing the AIDSCAP Women's Initiative which spearheads women's issues for the project. AWI areas of emphasis include: (1) the identification of women's issues and gender concerns as policy and programmatic issues, (2) the elevation of women's concerns regarding HIV/AIDS in international and regional fora (e.g., Cairo, Beijing, Vancouver and the Africa, Asia and Latin America/Caribbean meetings), (3) the increased capacity of organizations to incorporate gender considerations in the design of HIV/AIDS prevention projects, (4) the support of pilot activities which will help to inform future project design, (5) the mobilization of resources through organizational networks; and (6) the inclusion of women and HIV+ persons in the research, design and implementation of HIV/AIDS prevention policies and programs.

4. FHI capacity. The report states (p 37-38) that the "huge management burden of a very complex global program" was placed on "a non-profit entity which had never managed a program of comparable complexity or size" which "has struggled with this extremely large management burden and span of control." It also states that FHI came to AIDSCAP without institutional experience and capacity in behavioral change communications, behavioral research, evaluation and policy, and that subcontractor staff were used to fill the leadership roles for these technical specialties.

Comments: We disagree with the implication of the above that AIDSCAP was not prepared or equal to the challenge. We do not believe the evaluators provide any evidence that FHI has not risen to the challenge of managing this program, and in fact, the mid term evaluation of AIDSCAP said it ranked among the "best and most powerful HIV/AIDS prevention programs funded by any official development agency." While in 1991 it is clear that no organization had all of the resident skills to manage such a large project, FHI's AIDSTECH experience provided it with significant expertise in BCC, evaluation and behavioral research which was brought to AIDSCAP. A point of correction is that the leadership positions of the BCC and evaluation technical areas were FHI employees.

5. AIDSCAP slow to implement. The report states that AIDSCAP spent the first year setting up offices and hiring staff, the second year designing country program strategies, and "even in AIDSCAP's fastest-track countries" subproject implementation "rarely began before year 3." (page 47)

Comments: As the attached table shows, this analysis is inaccurate. AIDSCAP initiated strategic and implementation planning in 10 priority countries and had 26 active subprojects in 8 countries by the end of the first year. By the end of the second year an additional 70 subprojects were active.

II. Specific text comments/corrections

1. Page 18, paragraph 36. "AIDSCAP programs as somewhat autonomous and self-serving...designed to meet USAID needs rather than country (and especially government) needs."
Comment: AIDSCAP country programming is developed in response to comprehensive needs assessments at the country level involving governments, NGOs, donors, policy makers, and other community leaders. While it is true that most of AIDSCAP programming supports the NGO sector as implementors, AIDSCAP has built strong partnerships with governments primarily in the area of STD program improvement and policy. Also, in most cases the governments have implicitly or explicitly approved the country plans which included support to NGOs.
2. Page 21, second paragraph. "Comprehensive model was implemented in 18 priority countries."
Comment: AIDSCAP is operating in 15 priority countries and 3 major associate country programs, not 18 priority country programs.
3. Page 25, Section 7 concerning comparative advantage:
Comment: The U.S. also has considerable expertise in the prevention and treatment of STDs. It is assumed the evaluators' omission of this was an oversight, since the evaluators state on page 28 that diagnosis and treatment of STDs should be a priority in future work.
4. Page 27, Section 3, "Reduce women and girls' ..."
Comment: AIDSCAP evaluation data are all gender-specific.
5. Page 37, paragraph 5, "The unusual size and span of responsibility of AIDSCAP gave extraordinary visibility to the program, a visibility that AIDSCAP itself has taken pains to maximize."
Comment: It is not clear what the evaluators mean by this statement, however, the apparent suggestion that AIDSCAP has focused inordinately on self-promotion is inaccurate. This comment should be supported with factual examples or deleted. (It would be useful to know which bilateral donors are "astounded with this uniquely American creation.")
6. Page 48, paragraph 3, "The last scheduled [program] to close __ months before the AIDSCAP contract expires."
Comment: In fact, some country programs will extend beyond the life of AIDSCAP and thus are planned to run at full implementation through the life of AIDSCAP.

7. Page 53, 1st full paragraph, "...bilateral projects which do not utilize AIDSCAP"
Comment: Report incorrectly states that India and Indonesia are implementing AIDS programs outside of AIDSCAP -- in fact, both of these are AIDSCAP priority countries. Also, AIDSCAP has been asked to assist with a major component of the Zambia program and has provided on-going technical assistance to the Uganda program which was developed prior to AIDSCAP.

8. Page 54, para 4: "UNDP and UNICEF HIV/AIDS units, whose very existence UNICEF's HIV/AIDS units has depended upon ATSP..."
Comment: This statement can hardly be accurate. Both are well-funded organizations with extensive core funds for HIV/AIDS outside the USAID contribution.

9. Page 69, 1st full paragraph, "The dialogue regarding ...contextual approaches"
Comment: Initial design process adapted strategies to each country and subsequent shifts usually occurred at the request of the Mission. Shifts in programming have been difficult for two reasons: first, shifts would require a change in the Mission bilateral project (which can be difficult) and second, changing the program would require a modification to the country program delivery order, a time-consuming process.

Nonetheless, AIDSCAP has attempted to address contextual issues through studies and technical assistance provided by the AIDSCAP policy unit which seeks "to identify and change the social, economic and political factors that support individual and collective vulnerability to HIV transmission." This work provides an invaluable basis for developing contextual interventions.

10. Page 72, "Supporting community-organizing..."
Comment: AIDSCAP has expended tremendous energy building the capacity of organizations in all countries to help them define the AIDS problem in their community and develop a response which is constituent-based. AIDSCAP has strongly supported the "community-organizing" approach suggested by the evaluators -- for example, in Thailand where AIDSCAP has particularly fostered mechanisms for collaboration between CBOs and the municipal government under the "Bangkok Fight AIDS" campaign theme; in Tanzania, where AIDSCAP has facilitated formal networking among NGOs and joint program planning and implementation; and in Ethiopia, where unique public and private sector partnerships have formed into free-standing "intervention teams." Also see comments above re the Rapid Response Fund.

11. Page 73, paragraph 3, HIV/AIDS community mobilization approach.
Comment: The approach attributed to the HIV/AIDS Alliance is comparable to AIDSCAP's. AIDSCAP assisted the Alliance early in its life by providing training materials in community proposal development.

12. Page 75, E: "it does not appear that social science research..has contributed significantly.."

Comment: Research to understand risk taking behavior has been a critical component of the AIDSCAP project, whether it is the formative research used in baseline assessments to design interventions and later evaluate them, research used to determine behavior trends (such as the Targeted Intervention Research for STDs or the Behavior Surveillance Survey), policy research or strictly defined behavioral research. Taken in the context of the whole AIDSCAP project, these social science research findings were/are used continually to provide the understanding needed to design interventions for a wide range of populations in a variety of cultures and contexts.

Some specific examples that directly used knowledge gained on the determinants of behavior to modify risk behavior include research which explores resistance to condom use among disadvantaged young women in the Dominican Republic; examines risk taking among CSWS, their clients, brothel owners and men who have sex with men in Nicaragua; assesses the dynamics of risk taking among Thai military recruits; and explores the determinants of risk behavior among night school students and port workers in Brazil.

13. Page 100, "duality of responsibility of beh. research", para.4:

Comment: AIDSCAP has made a unique contribution to the field of behavioral research through the development of conceptual papers and publications, and through several "first of their kind" studies e.g. the Bali study with CSWs, the Thai military study, C&T, and the female condom study.

14. Page 101, para 1, "Staffing to Achieve the Objective":

Comment: CAPS works "under the direction of AIDSCAP's Behavioral Research Unit" only in terms of the CAPS projects which are funded by AIDSCAP in CAPS' capacity as an AIDSCAP subcontractor. CAPS is an autonomous organization which works through the University of California, San Francisco. Para 2: AIDSCAP's long-term objectives have not changed, but AIDSCAP has recognized for the past couple years that shorter, more program-focused research is more effective and yields more timely and relevant results than more expensive, longer-term research. At the same time, attention to longer term objectives has not waned. The Counseling and Testing study is an example of a multiyear, multicountry, multipartner study addressing a global issue on which AIDSCAP has been in a unique position to take the lead.

15. Page 102, para 2, "Conclusion":

Comment: AIDSCAP has not implicitly demoted behavioral research as a priority. In addition to several important headquarters' initiated, core-funded behavioral research activities, USAID missions continue to request AIDSCAP's assistance in initiating country-relevant research. Recent examples include Egypt (study of adolescents) and the Dominican Republic (study of 100% condom use in brothels program).

Behavioral research has improved the scientific rigor of AIDSCAP's interventions and has also helped to develop the capacity of local researchers. It is unusual to find this research capability in a service project such as AIDSCAP.

16. P. 103, 1st paragraph, AIDSTECH policy work:
Comment: During Phase 1, AIDSTECH conducted policy activities that included cost analysis of interventions, economic impact of AIDS projections, in addition to modeling projections which are noted in the report.
17. p. 103, last paragraph, second sentence:
Comment: The idea would be better expressed as: "Less time is now devoted to using stand-alone epidemiology-based models to sensitize leaders of the need for action. Rather, there is much more interest among leaders in understanding the implications of the socio-economic consequences of HIV/AIDS and in having practical and feasible means to reduce those consequences.
18. p. 104, first line -- "relatively few regulations have been identified which seriously inhibit the AIDSCAP core interventions."
Comment: While the statement is true in the narrow sense, AIDSCAP and collaborating agencies have identified a large number of policy issues, policy gaps, and legal constraints that impact on HIV/AIDS prevention interventions.
19. p. 104, first full paragraph, "problem countries."
Comment: It would be useful add a final sentence to the paragraph: "Development by AIDSCAP of the Private Sector AIDS Policy Presentation, a set of reference and training materials designed to assist business managers to adopt appropriate HIV/AIDS prevention policies and programs in the workplace, is both technically focused and illustrative of model programs.
20. p. 104, under "Coordination"
Comment: The title is the AIDS and Economics Network, not AIDS and Economic Development Working Group.
21. p. 105, first paragraph under "Sustainability"
Comment: In addition to the three categories noted, AIDSCAP in Kenya, Indonesia and to a lesser extent in Honduras, Brazil, and Senegal has promoted processes which are affecting the policy climate in positive ways.

22. Page 109, para 2: 'feeding behavioral research results'
Comment: Many results of AIDSCAP-funded behavioral research have already fed into other AIDSCAP program designs including (but not limited to behavior change communication interventions). Examples include, but are not limited to the CSW and brothel interventions in Bali, Indonesia, the interventions with the Thai military recruits in northern Thailand, the interventions with night school students and port workers in Brazil. In addition to these separate BR studies, all the formative research that is used in initial assessments in many AIDSCAP sub-agreements feeds directly into project design, and is used again for evaluation.
23. Page 101, "Levels and Proportions of Funding"
Comment: Core funding expenditures under the behavior research program have totalled \$5.4 million as of February 1996, not \$2.5 million as stated in the report. This does not include targeted intervention research studies which would be charged against the STD component, or formative research for subproject interventions. It is important to note that the core-funded behavior research grants program was made available to each Mission -- many Missions elected not to participate in this component.
24. Page 108, Section 7, AIDS module.
Comment: Unfortunately, the AIDS module is not uniformly applied, and the data collection and availability of analysis are rarely appropriate to the AIDSCAP program.



AIDSCAP DESIGN AND IMPLEMENTATION

BEST AVAILABLE COPY

		FY 1992	FY 1993	FY 1994	FY 1995*	FY 1996*
A F R I C A	Cameroon	[Solid black bar]				
	Ethiopia	SP	\$ IP			[Hatched bar]
	Kenya	[Solid black bar]				
	Malawi	[Solid black bar]				
	Nigeria	SIP\$	[Solid black bar]			
	Rwanda		SP	IP\$		
	Senegal	SP	IP			
	Tanzania	[Solid black bar]		IP		
Zambia	\$					
A S I A	Thailand	[Solid black bar]				
	India	\$ SP	[Hatched bar]			
	Indonesia		[Hatched bar]			
L A C	Brazil	SP \$ IP				
	Dominican Republic	[Solid black bar]				
	Haiti	[Solid black bar]				
	Honduras				[Hatched bar]	
	Jamaica	SP \$	IP			

SIP = Strategic and Implementation Plan

*Projected Activity for FY95 and FY96

SP = Strategic Planning IP = Implementation Plan \$ = Initial Mission Funds Transferred to AIDSCAP

Transitional Program or Minimal TA
 Interruption
 Program Implementation
 Anticipated Implementation