

**AIDS COMMUNICATIONS AND TECHNICAL SERVICES
(ACTS)
PROJECT**

**EVALUATION
OF PHASE ONE
&
PLAN OF ACTIVITIES
FOR PHASE TWO**

**LAC Health & Nutrition
Sustainability
Project**

**URC Contract
LAC-0657-C-00-0051-00**

February 16 1991

PREFACE

This report is a summary of findings from an evaluation of the USAID funded Eastern Caribbean ACTS project (Phase One) performed January 16 - February 15, 1991. The report also includes a suggested Plan of Activities - Phase Two to be incorporated into the Project Paper Supplement - the USAID document authorizing second phase funding. The evaluation team consisted of:

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- * Larry Forgy, PHD, economist; and
- * Sam Dowding, MPH, designated USAID project manager

The team found the evaluation an enriching experience. Discussions with USAID contractors, AED, FHI, USAID officials in Washington and Barbados, PAHO staff, Ministry of Health personnel in Trinidad, St. Lucia, St. Vincent, and Antigua, CAREC staff and other interested parties listed in Appendix 1, stimulating, constructive and thoughtful. We thank you for your expert advise and patience.

The purpose of the evaluation was fourfold:

- * to assess the state of implementation of project activities and identify actual versus planned achievements;
- * to determine the strengths and weaknesses of the current course of the project and the effectiveness of the implementation mechanisms;
- * to recommend modifications in the direction, scope, and implementation of project activities, as necessary; and
- * to draft an activities plan, including a timetable and an assessment of technical, material, and financial needs for the implementation of Phase Two activities. The findings and recommendations of the evaluation team will form the basis of the design for Phase Two.

Evaluation services were provided by University Research Corporation, International Science and Technology Institute under the LAC Health and Nutrition Sustainability Project.

The team wishes project personnel all the best in this important endeavor.

ACRONYMS

ACTS	AIDS Communications and Technical Services
AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSCOM	AIDS Communications Program
AIDSTECH	AIDS Technical Services Program
CAREC	Caribbean Epidemiology Centre
CSTD	Conventional Sexually Transmitted Diseases
EOPS	End-Of-Project Status
FHI	Family Health International
GPA	Global Program on AIDS
HIV	Human Immunodeficiency Virus
KABP	Knowledge, Attitudes, Beliefs and Practices
MIS	Management Information System
MTP	Medium Term Plan
NGOs	Non-Governmental Organization
NPA	National Program on AIDS
OECS	Organisation of Eastern Caribbean States
PIO/T	Project Implementation Order/Technical
RDO/C	Regional Development Office/Caribbean
SBR	Social Behavioral Research Unit
SPSTD	Special Program on Sexually Transmitted Diseases
STD	Sexually Transmitted Diseases (includes HIV/AIDS)
UWI	University of the West Indies
WHO	World Health Organization

EXECUTIVE SUMMARY

The AIDS Communications and Technical Services (ACTS) project is a USAID funded seven year AIDS prevention and control effort in the Caribbean. The purpose of the project is

- * to establish a capacity to develop and implement cost-effective surveillance, information, education, and intervention strategies in support of projecting future trends in and reducing the transmission of HIV infection and AIDS.

Project strategy is appropriately focused on improving surveillance and management capabilities and implementing activities to reduce sexual transmission of HIV (and implied in the project paper) other major STDs.

Project Management

The management structure of the project is complex. Its many implementing agents and layers of involvement are deliberate in an attempt to utilize technical assistance from two US contractors and to benefit from coordination and oversight from the PAHO sub-regional institute, CAREC; to meet the regional goals of the Eastern Caribbean and country-specific needs of the Ministries of Health. The technical assistance strategy is a particularly challenging one in that both regional disease prevention and control capacity is to be strengthened at CAREC's level as well as at the Ministry level. All parties are commended on their attempts to make this arrangement effective.

CAREC's current expertise in epidemiology and diligence in increasing its managerial staff to coordinate project activities has succeeded in performing many achievements since the USAID agreement was signed. The team strongly feels additional staffing is needed in the areas of communications/social marketing and psycho-social sciences. This will then provide the institute, the professional expertise to lead efforts in a more comprehensive direction; principles of epidemiology equally complemented by behavioral sciences. Such a mix of disciplines is crucial in STD prevention and control.

Training and Technical Assistance

More than thirty workshops were held during the first phase involving an estimated 600 persons. Most of these were regional in nature, which appears to have been appropriate for the first phase. In numbers of workshops and training activities, the project objectives were far exceeded. The quality of technical assistance

appears sound.

For understandable reasons, the provision of technical support has often been carried out in a more bilateral fashion than was envisioned in the project paper and related documents. Having resolved most staffing issues this last year, CAREC has more actively led in the organization of training and technical support activities. This trend should continue with CAREC taking a more definitive leadership role. Additionally, technical assistance should be increasingly directed at priority islands, rather than at the regional level.

The team assumes all priority countries will have designated by the end of this year, PAHO funded STD/AIDS National Program Coordinators as well as an STD/AIDS Regional Program Officer. It is preferable this latter position is assigned to CAREC. These positions are instrumental to creating an effective managerial foundation.

Conventional Sexually Transmitted Diseases (CSTDs)

The USAID project paper recognized the importance of CSTD in reflecting disease transmission patterns and in facilitating HIV transmission. Although references to "upgrading" these CSTD activities in project documents underestimated the attention and follow-up such efforts require. Separating prevention and control efforts of HIV from those of CSTD is not only conceptually a contradiction, but discourages the synergistic effect prevention and control activities have on prevention of sexual transmission of disease and on individual disease morbidity and mortality. This is especially true for a project that is committed to prevention measures. It has been noted that a few CAREC regional workshops have included CSTD subjects and AIDSTECH has assessed and provided limited assistance to STD clinics in ST Lucia and Antigua.

A review of both public and private provision of STD services, national plans of action and consistent comprehensive technical assistance in improving surveillance, laboratory/clinical services, counseling, health education and contact management should receive major project support in the second phase.

Surveillance Activities

Development of surveillance systems for HIV and AIDS cases has progressed well regionally, with direction provided by CAREC and AIDSTECH in standardizing reporting forms, developing guides and sponsoring informative workshops. Working with nationals at the country level to improve accuracy and timeliness of not only HIV/AIDS reporting but also the CSTDs is the next step towards development of a comprehensive and reliable surveillance system.

Completion of AIDS-related knowledge, attitudes, beliefs, and practices (KABP) surveys have been delayed for several reasons, most notably; lack of enthusiasm among some nationals, confusion over the survey's purpose, and delays in contracting services. Presently St. Vincent and St. Lucia have collected data, Dominica and Grenada are ready to begin the survey and plans within Antigua and St. Kitts are unclear.

Communications

Communication efforts during the first phase have concentrated on an impressive number of workshops and training to improve skills among professionals. It is not clear however, if these regional efforts have led to "trained trainers" carrying out additional training in their respective countries.

A transition is now required from building resources to reaching out to those at risk of contracting STDs. Planned, comprehensive campaigns would form an integrated approach on a larger scale to changing the behaviors of greater numbers of people.

Management Improvements and Costing

Activities in program management improvements have been linked to one regional management workshop in 1989 and the specific AIDSTECH training of the Technical Services Specialist working at CAREC. Three activities dealing with cost issues have been conducted: cost recovery of blood transfusions, screening pooled blood and establishment of an alternative treatment facility. Information stemming from these studies clearly have potential utility.

Overall, the project has not incorporated management improvements or cost analysis as an integral part of its other two strategies, (surveillance and prevention of sexual transmission). Thus, major activity plans in the future should explicitly state alternative ways of achieving the intended outcome with cost considerations applied.

Plan of Activities - Phase Two

It is proposed that the ACTS project contain the same strategy, a slightly modified purpose and be implemented under the current management structure, with the additional personnel discussed above. Significant emphasis will be placed on providing technical assistance in all three strategies at the country level, strengthening effectiveness of STD prevention and control efforts in public and private sectors, and directing outreach to large numbers of at risk individuals, especially young adults. The following major recommendations from the evaluation reflect this

emphasis and are incorporated into the Plan of Activities.

Recommendations

Project Strategy and Management

- * USAID fund and CAREC recruit two additional professionals, one in communications/social marketing and one in psycho-social sciences to provide additional support to STD prevention activities within CAREC. The professionals selected should have extensive experience and proven leadership in these fields and have demonstrated the capacity to direct prevention strategies. USAID and the appropriate US institution identify and assign resident advisors to provide technical guidance and extensive consultation to the two new CAREC employees for the first year.
- * USAID and CAREC develop a standardized MIS for ACTS project monitoring, that is simple to complete but comprehensive in its inclusion of objectives, indicators and status categories. The MIS should incorporate the proposed CAREC evaluation strategy.
- * CAREC, renew efforts to obtain greater involvement of NGOs and the private sector via the "Innovative Community Approaches" grant program.
- * PAHO/CAREC and Ministries of Health facilitate the systematic review of progress achieved in country MTPs.

Technical Assistance and Training

- * CAREC increase focus of technical assistance at the country level. Minimize the frequency of visits by lengthening visit durations and performing more comprehensive scopes of work. Increased involvement of CAREC personnel is expected.
- * CAREC develop a register and "network" of qualified professionals from the sub-region to facilitate increased use of these resources as consultants and the sharing of lessons learned. Circulate within this network: newsletters, literature, etc.; and encourage contributions.
- * CAREC increase the emphasis given to practical training to health educators, with particular focus on behavioral analysis and message planning.

KABP Studies

- * CAREC complete KABP studies in the four countries that have already collected data or agreed to start the activity. In the two countries that seem unlikely to agree to the KABP as originally planned, take steps to explore the possibility of doing a more flexible, at least partially qualitative investigation, to gather data for planning a national communication campaign.

Communications Strategies

- * CAREC shift ACTS emphasis from the current preparatory efforts in training, counseling, and measurement to a strong emphasis on behavioral oriented health communication for prevention of sexual transmission. Put priority on beginning national communication campaigns:
 - the content and messages should have clear behavioral objectives;
 - the target audience should for the most part be the young adult for which a common message is appropriate.

Continue the use of important face-to-face communication for the small high risk groups.

- * CAREC develop generic campaigns for specific objectives or target audiences (preferably young adults) for use in several countries. "Package" the campaign strategies, materials, and messages, with opportunity for local adaptation where appropriate.
- * CAREC investigate opportunities to develop a more general service hotline. This may be easier to promote and may be a way to successfully integrate STD concerns with other concerns related to sexual and reproductive health.

STD Program Services

- * CAREC assist countries in reviewing their complete STD paradigm of public and private services; from laboratory testing to contract tracing. Identify weaknesses and strengths, develop plans of action and implement. It is imperative that the private sector be involved. Consider the implications of reporting and contact management of non-gonococcal infections, use of a rapid syphilis serology test and improve the availability of CSTD information and education pamphlets.

Psycho-social Science and Behavior Intervention Programs

- * CAREC create a pool of consultants and investigators with psycho-social expertise, preferably familiar with the Caribbean culture.
- * CAREC develop a psycho-science research agenda in support of STD/HIV prevention with practical implications for country programs.
- * CAREC substitute case studies, small ethnographic studies, focus group methods, and expert consultation for KABP studies that experience continued delays. Increase focus on adolescents and young adults; consider other groups such as tourists and native foreign travellers.
- * CAREC develop short guidelines for outreach workers, to assist MOH training of their own outreach personnel.

Management Improvements and Costing Alternatives

- * CAREC strengthen managerial expertise in national programs. Determine need of either generic techniques in management or specific STD program issues. Convene regional courses in program management or on-the-job training.
- * CAREC undertake operations research activities to provide managers and others with information on optimal ways to deliver the project services. Such studies should focus on practical applications of the projects' major activities. Management of contacts and variations in provision of clinical services are suggested starts.
- * CAREC apply costing analyses to selective project interventions. Estimate and compare costs of alternative methods in achieving major objectives and various mixes of activities. Actual costs of hotlines and contact management (passive verses active) services deserve special attention.

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1. PROJECT RATIONALE, STRATEGY AND MANAGEMENT STRUCTURE

1.1. Rationale

USAID's decision in 1988 to develop an AIDS project in the Eastern Caribbean is easily justified. The rates of AIDS cases reported in the Organisation of Caribbean States (OCS) by the end of 1988 had reached levels as high as 32.0 per 100,000. Incidence of CSTDs had in the majority of Caribbean countries, increased significantly as well. WHO and the international community were working with countries to mobilize resources under the framework of the MTP. Traditional intervention strategies to effectively prevent and control STDs were being enhanced and broadened with the advent of the AIDS pandemic in countries throughout the world.

The ACTS project initiative reflected the Agency's recognition that 1) the devastating effect of the AIDS pandemic was beginning to reach the Caribbean region and of equal importance, 2) there existed prevention and control measures worth promoting.

1.2. Strategy

The ACTS project strategy formulated in the project paper is comprehensive and appropriately focused on improving surveillance capabilities (strategy 1), on implementing activities to reduce sexual transmission of the virus (strategy 2) and on improving management (strategy 3). Although not specifically stated, it is apparent from the context of the document that this improved surveillance and reduction included CSTDs of local importance.

Determining the magnitude of STDs via surveillance as well as the profile of those infected, and concentrating efforts on the sexual route of transmission is crucial in the initial stages of program development. Such an approach is supported by evidence that 90% of AIDS cases in the Caribbean are transmitted sexually, the knowledge that other donors are funding blood transmission interventions, and the inherent challenge posed in changing sexual behavior.

1.3. Purpose

The project's purpose,

" to establish a capacity to develop and implement cost-effective surveillance, information, education and intervention strategies"

would be complete with the additional function of monitoring. "Develop, implement and monitor" make-up the management cycle in most programs. The lack of a CAREC evaluation strategy as of this date (although one is planned) and the repeated concern by project and national personnel regarding the need for improved management

skills suggests a need in the future to stress monitoring and management. It should be mentioned that the activities presented in the project paper do specify management training and improvements; and a few have been carried out to date.

In reference to the laudable attempt by USAID to include "cost-effective" as a qualifier in the project's purpose, this concern is not apparent in the decision making process used for selecting certain intervention activities over others. There is no documentation on a comparison of costs of one approach variation verses another, aside from screening blood. This issue is discussed in further detail, later in report.

1.4. Working Through WHO/GPA Medium Term Plans (MTP)

In recognition of the international consensus to look to WHO as the primary international agency for AIDS strategy development, it is important for the project to work through the medium term plan (MTP) system. MTPs in theory not only represent the intentions of national ministries of health, but are also the means of coordinating donor assistance. Such an approach is based on the assumption that a review of MTPs are conducted routinely to ensure their valid reflection of program direction and implementation. The review team found MTPs to be on the whole, lengthy general guidance documents with limited genuine information or thought. This is not to say their compilation did not require a lot of work. At best, these documents are currently being used as reference for funding responsibilities, rather than as a specific guide for planning program activities. An attempt by all appropriate parties to modify the MTPs into shorter, more action-specific plans is encouraged by the team.

1.5. Supporting National MTPs Through CAREC

CAREC was selected in December 1988 by USAID as the most appropriate vehicle for supporting the implementation of the country MTPs.

CAREC's role in the health sector in the Commonwealth Caribbean is outlined in its mandate, and was refined most recently in a multilateral agreement dated February 1990. With regard to communicable disease control, CAREC's functions include serving as a specialized technical resource to assist, advise and cooperate with participating governments in surveillance, prevention, control and program development, and evaluating performance.

CAREC therefore has a central coordinating and leadership role in the control of STD infection which is consistent with the role ascribed to it under the ACTS project. CAREC has been involved directly and indirectly (through PAHO) in the preparation of the MTPs for Caribbean countries and convened in 1988, the last AIDS Donors meeting. The ACTS project strategies match three of the six

strategies put forth in CAREC's own sub-regional MTP.

USAID's choice of CAREC as facilitator and coordinator of ACTS efforts appears to have been a sound one, given the critical epidemiologic role CAREC plays in the Caribbean and the assumption that CAREC's capacity in communications and psycho-social sciences will be augmented in the process. In the long term, the regional and sustained support which CAREC can provide, the respect and goodwill which it has accrued among caribbean countries, and the experience it has gained in the AIDS prevention and control area in the last three years, make it a logical choice to fullfil the ACTS project management and coordination requirements.

1.6. Participation of NGOs

The project paper recognized the special impact which non-governmental organizations (NGOs) could have on both individuals and society, regarding AIDS and those infected with HIV and AIDS, and in support of Resolution WHA 42.34 of the 42nd World Health Assembly. The project paper planned that the potential role of NGOs would be fully explored by each country in all the activities of the project.

It appears from this review, that during this first phase of the project, the potential of NGOs in the process of AIDS education and counselling was not fully exploited. The workshop on "Effective Management of National AIDS Programmes in the Caribbean" held in July 1989 made a bold, and what is evident from the report, an impressive first step to encouraging AIDS Program Managers to initiate greater private sector and NGO involvement. Regrettably, there is no record of follow up in this area at the CAREC level. Country level efforts have been fragmented and not representative of activities conducted in the framework of a coherent and cohesive plan to utilize the comparative advantages which the private sector and NGO community offer. An analysis of potential NGO activities is provided in the Plan of Activities - Phase Two, where the ACTS grant program to support "Innovated Community Approaches" is discussed.

1.7. Management Structure

1.7.1. Overall

There exist more expeditious and direct means of providing technical assistance to ministries of health than under the current management arrangement. As mentioned in the executive summary, this structure is complex for understandable reasons pertaining to USAID's intent to capitalize on the technical and managerial expertise available from three sources, the two US based contractors, AED and FHI and the caribbean based CAREC.

The team has three areas of concern regarding such an arrangement. The first deals with the number of levels and actors; project ideas, coordination and funding must involve before implementation can occur. The project management chart (Attachment 1) illustrates this complexity. Delays and confusion are to be expected with such an arrangement. The team was specifically affected by this in our attempt to monitor activities planned verses those performed because each partner has its own management information system (MIS) for monitoring.

The second concern is that while CAREC has notable expertise and leadership capacity in epidemiology, their experience in communications, health education and psycho-social sciences appears limited. Asking CAREC to lead as well as to coordinate the US contractors' technical assistance in these areas is a difficult situation for all concerned. Additionally, the US contractors are asked to strengthen the very institution selected to oversee their work.

The third and most important issue is that of ensuring project initiatives "filter" down to the country level towards changing behavior and reducing morbidity and mortality.

After considerable discussions with all parties involved at all levels, the team acknowledges the importance of regional capacity strengthening and its potential as a sustained presence in the Caribbean, the limited capacity in Ministries to institutionally support all the professional expertise required to implement an effective program and the past two years' investment in making this arrangement work.

Consequently, the team suggests the current management structure remain during the second phase, but that USAID fund and CAREC recruit an additional communications/social marketing specialist and one psycho-social scientist before 1992. Advisors for each would be identified from the appropriate contractors to provide technical consultation for the first year.

Collaboration among partners has been a challenging task. The project paper envisions a division of technical assistance activities among the contractors along substantive lines, with each performing the activities where they have comparative advantage. These lines may have been clear in the design process but where communications, behavior intervention and epidemiology begin and end in implementation is not as apparent when carrying out the activities.

This overlapping subsequently led the project to adopt a geographical division of implementation, with AIDSTECH working in some countries and AIDSTECH in others. While the two contractors regard this as an improvement in working conditions, it could limit the pool of technical assistance from which each country can draw.

Collaboration exists among AIDSTECH and AIDSCOM on regional activities, such as on KABP surveys and workshops.

1.7.2. CAREC Institutional Capacity

One of the end-of-project status (EOPS) outputs in the project paper is for CAREC to develop an institutionalized capability in social/behavioral sciences and health education/communications. In the period since the grant was made to PAHO for activities under the ACTS project, CAREC has moved to strengthen its capability, by adding the following grant-funded positions:

- * Project Coordinator
- * Accountant
- * Communications Specialist
- * Secretary
- * Technical Services Specialist

The persons in these positions initially comprised an AIDS unit at CAREC. In mid-1990, CAREC formally revised its organizational structure and the project staff are now included in the Special Program on Sexually Transmitted Diseases (SP/STD). In addition to the above, the SP/STD staff now includes the following:

- * an Information Officer,
- * Evaluation Specialist
- * Laboratory Advisor,
- * Research Associate
- * Program Analyst/Statistician,
- * Medical Epidemiologist

A new position of Health Educator is to be established soon. The expanded orientation and staffing of the unit is reflective of CAREC's wider responsibilities to its member countries who are not covered by the ACTS project, as well as the logical placement of AIDS as an STD.

All positions in the revised structure have not yet been filled by permanent staff. Even those currently filled have generally been in place for just over one year, with the exception of the Communications Specialist and the Information Officer. Given the recency of the reorganization and filling of positions, it appears that CAREC is now at the "take-off" stage for increased activity in the STD/AIDS control area. The critical position in this matrix seems to be the Medical Epidemiologist/Head of the SP/STD. This position will need to provide the direct support and supervision of the Project Coordinator whose role must become more active in the next four years, especially in the promotion and monitoring of the activities included in country and CAREC MTPs.

CAREC has established a management structure to facilitate coordination of all activities in STD/AIDS in the Commonwealth Caribbean. These include the Annual AIDS Donors Review, (which has

not been conducted on an annual basis to date), an AIDS Project Management Committee, and a STD Policy Committee. Through these mechanisms, policies and progress are reviewed and revised. One mechanism conspicuously absent is a review of country MTP performance individually and as a group, on a regular basis, outside of the biennial meeting with Ministers of Health. This may be a role to be filled by the Head of the SP/STD unit in CAREC, taking a pro-active stand in getting country MTP implementation expedited, on an individual basis. The SP/STD Head efforts could be supplemented by a sub-regional review which may be conducted on the two or three days immediately preceding the Annual Donors review.

There is undoubtedly great respect by Caribbean Ministries of Health for the role and capability which CAREC has accomplished since its inception. By and large, these have been most visibly and concretely expressed in the epidemiological surveillance and laboratory diagnosis of communicable and non-communicable diseases area. There appeared to be consensus among the Ministries of Health visited by the team, that CAREC is essential to supporting the health infrastructure of those countries. CAREC has brought a degree and level of skill in epidemiological study and surveillance to the Caribbean health sector, which no country's economy could have attained or sustained on its own.

2. PROJECT IMPLEMENTATION

2.1. Technical Assistance and Training

2.1.1. General Overview

The activities of the first phase of the project have been sufficiently successful to expect that continuation of activities, with modifications such as those recommended in this evaluation, will lead to overall achievement of training and technical assistance outcomes.

More than thirty workshops were held involving approximately more than 600 persons and thus, the objectives were far exceeded. These training activities do not include the training and skill-building that is a by-product of carrying out the action projects in-country. The quality of assistance appears generally satisfactory. In addition to workshops and direct assistance, island personnel have been supported to attend training programs in Jamaica and Trinidad, and support has been offered by FHI for training two nurses in the U.S., although the latter has not yet been utilized. AED and FHI personnel have provided extensive and for the most part, accessible telephone consultation.

The sheer numbers of persons who have been involved in training activities or other technical assistance relationships have likely contributed to a generally increased comfort level with STD-related

work and has promoted networking relationships. Possibly this has contributed to a greater national awareness and intra-national dialogue. There is some feeling that more follow-up activities or communications following participation in training would be helpful. The CAREC newsletter could be mailed to trained participants with contributions encouraged.

2.1.2. **Challenges in Technical Assistance and Training**

Training and technical assistance were provided in areas pertaining to epidemiological surveillance, KABP survey, prevention of sexual transmission, and management. Where the actual activities in these areas fell short of original plans or yielded disappointing outcomes, it is unclear to what extent such deficiencies may reflect insufficient training and technical support functions. It was thought helpful to review some general characteristics of the social structural patterns of the training and assistance activities. Because training and technical assistance is a major component of the project, some of this discussion pertains to issues concerning the general structure and approach of the ACTS project.

2.1.2.1. **Bilateral AED and FHI Technical Assistance**

For generally understandable reasons, the provision of technical support often has been carried out in a more bilateral fashion than was envisioned in the project paper and related documents; that is, assistance has been provided directly to national institutions by the U.S. partners, with less direct role or collaboration by CAREC personnel. And, in reverse, assistance was sought by NPA personnel without involving CAREC. This bilateral tendency was primarily caused by the difficulties encountered by CAREC in opening and filling project staff positions.

Having resolved most staffing issues in the last year, CAREC has more actively played a part in the organization of training and technical support activities. However, CAREC project staff, who have overall responsibility for the project and its coordination, tend to have their own leadership and technical assistance roles subordinated to the tasks of monitoring AED and FHI activities. The bilateral tendencies and imbalance of initiative are less predominant in areas related to epidemiology and surveillance, where CAREC more easily and readily provides inherent leadership skills. But as mentioned previously, in the areas of communications and psycho-social leadership, the existing staff positions are not enough to direct technical strategies.

AED and FHI are commended for their initiatives in the national environments; however, the pattern is no longer compatible with the institution-building goals for CAREC and the ACTS project

generally.

2.1.2.2. Intensity and duration of technical assistance visits

The U.S. partners' responses to requests for assistance appear to have led to a pattern characterized by short visits. It appears short term visits by technical assistance personnel are more often for purposes of monitoring and provide little technical support. Thus there is a redundancy of monitoring activities by visitors to the national programs and redundancy in related communications. The sheer number of short-term visitors from AED/FHI, together with similar visits from other donor nations and agencies, burden the time of local program leadership. NPA leadership is bogged down in designing and reporting; and, more importantly, being focused on numerous small projects. The pattern of redundant monitoring derives partly from the bilateralism discussed above; it is also a function of USAID's expectations of AED/FHI in their PIO/Ts, which specify monitoring functions by these implementing agents for several activities. Fewer and longer assistance contacts may have been more appropriate in some areas and should increasingly be the pattern in the future.

2.1.2.3. National expertise, initiative, and emphasis

Each of the nations visited is acquiring greater scientific, organizational, and managerial capacity to lead a national AIDS program; and this development will enhance use of outside support. Of particular interest is the development of a coordinator role in St. Vincent and the emergence of a strong program director in St. Lucia.

All of the nations visited have various personnel who have quite strong technical preparation and skills in their professional areas and are highly motivated in applying their skills to the AIDS challenge. It is clear that in some professional areas, some of the national personnel are potential regional resources. A few are already acting as regional resources, but this is a direction which could be enhanced. Various personnel expressed interest in having more opportunity for technical, professional collaboration with colleagues from other islands on a one-to-one or small group basis.

Many of the program developments assisted by the U.S. ACTS project collaborators were initiated by island organizations. Yet the source of this initiative is not always clear in the project reporting. On the other hand, some nationals explicitly stated that many of their activities would never have been done without the assisting roles of the ACTS partners.

As local personnel have acquired greater skills, confidence, and

understanding of their own emerging national plans, some have noted a need for more advanced technical training and collaboration and fewer introductory level workshops at a regional level. As national programs develop, it can be expected that they will make more specific demands for technical support, at higher levels of sophistication.

2.1.3. Strengthening CAREC's Capability in Health Education

2.1.3.1. Background

During the first phase of the ACTS project, USAID has pursued an explicit strategy of developing an institutional capability within CAREC to pursue new activities in health education for AIDS. Prior to USAID's support for this sector, the discipline lay outside of CAREC's perception of its role as a regional technical support institution. At the start of ACTS, CAREC embraced the proposition that one of the types of support it could provide to member countries was in the area of health education. The perception of the services that would be useful include; 1) a passive educational role as a repository for information; 2) information sharing through newsletters and other forms of networking; and, 3) an active support role of creating materials for regional use, helping to set the educational agenda, and providing leadership in demonstrating innovative educational activities.

Under the ACTS project, USAID's objectives cover the strengthening of the institutional capability for the provision of such services only in the area of STD, and primarily only to the six OECS countries. This creates some structural difficulties for CAREC:

- * CAREC is used to serving all of its members equally, and has had some difficulty in adjusting to the notion that one group should be singled out.
- * In the past, CAREC's information and communication services have consisted only of the library and the print shop, both of which serve the full range of CAREC objectives. The provision of a health education unit specifically devoted to AIDS education is a different managerial structure for CAREC, and gives them some difficulty in deciding how to locate it organizationally.

2.1.3.2. Efforts to date

In implementing the ACTS program, CAREC has eventually settled on a structure that locates the AIDS-related efforts within the section handling sexually transmitted diseases. They have staffed the direct, AIDS-related communication and education position with a CAREC employee on a one year contract using ACTS funds, and

designated her the AIDSCOM counterpart. She has a background in commercial marketing, and is conversant with the social marketing approach promulgated by the AIDSCOM group.

Other related activities not under ACTS project funding include the creation of an information dissemination post under PAHO funding. This position has taken on the role of networking and providing information, through such tasks as a newsletter, a clipping service, and training workshops for journalists.

2.1.3.3. Prognosis and future needs

On the whole, the efforts have made partial progress toward the objectives set forth in the original plan. Most of the specific activities have at least been started, although many are behind schedule or behind reasonable expectations for the current time. Many of the delays relate to the complex organizational structure of the ACTS project. The overall sense of the status of the effort to strengthen CAREC is that it is making progress but that it faces two fundamental issues.

The first issue (discussed previously) is the degree to which CAREC is, in the long run, willing to commit to the role that is necessary for the support to the AIDS communication and health education efforts that are required. CAREC has operated with a self-image of being an organization that responds to requests from the member countries, rather than providing a bolder type of leadership that anticipates needs that the countries do not yet perceive. The urgency of the AIDS epidemic requires a more proactive type of relationship that sets a potential agenda for the countries and pulls them forward, rather than merely awaiting requests for technical assistance.

The second fundamental issue concerns whether the priorities among activities within CAREC and the ACTS project are the correct ones. The reviews of the activities taking place at CAREC and within the countries has revealed them to be heavily dominated by a concern for health education within the context of delivery of services. Thus, the majority of activities have to do with training of health educators or clinical staff in AIDS education or supportive and/or preventive counseling. The efforts at prevention education directly targeting a defined audience are relatively rare and generally haphazard. Most of the countries have managed only some modest, intermittent use of broadcast and print media offering basic information to an undifferentiated general audience. A small body of print materials for regional use has been produced, but little that will help support countries in a systematic analysis of their constraints and a deliberate plan for how to use interpersonal and mediated communication to enhance prevention of sexual transmission.

The focus on training and KABP measurement was an appropriate

perspective for the early phases of the project. The groundwork has been laid for ensuring that the medical community is enlisted and prepared to play its role. Despite the delays, much progress has been made in specific narrow areas, particularly in beginning to set up service delivery and some educational efforts for high risk groups. The planned efforts should be carried through to their logical completion, but the project activities oriented to preparing the countries to respond should be considered sufficient, and project priorities should be shifted to the later phase objectives of outreach to defined groups in the larger population.

The current need is to begin aggressive efforts to reach out, both to high risk groups and other audience segments engaging in risky behaviors. The second phase of the ACTS project should dramatically increase the emphasis on accomplishing direct health education.

2.1.4. Strengthening CAREC's Capabilities . . . Social Science

Our discussions with CAREC personnel provide evidence of progress, institutionally, in the direction of greater capacity to utilize psycho-social professional skills. CAREC is extensively involved in scientific research pertaining to health and disease where behavioral factors are critically important (i.e. tobacco use in the Caribbean, motor vehicle accidents, and chronic diseases). Additionally, CAREC is developing a new organizational plan to permit the expanding areas of work to find an appropriate institutional home. One strategy under consideration envisions three divisions - 1) psycho-social studies, 2) health education and communications, and 3) epidemiology and biostatistics. Psycho-social sciences are now viewed as necessary to provide support to the entire institution, not just the STD program.

It should also be mentioned that CAREC has added staff who have relevant training. The ACTS project coordinator is a behavioral psychologist; other personnel of the CAREC Special Program on STDs include persons with training in public health, health education, and media. The Caribbean Information and Education Center (CIEC), which aims to develop public health journalism, accessible to everyday practitioners.

CAREC appears prepared to develop relationships with psycho-social scientists in the Caribbean, such as at the University of the West Indies in Jamaica which is well-known for its strong departments in the areas here concerned. They may want to initiate contact with the Population Council's INOPAL project, which has conducted numerous studies in the Caribbean, as well.

The centre and specifically the ACTS project is in need of psycho-social leadership in order to appropriately direct their prevention

efforts. Thus, as discussed earlier, a position for such expertise should be created. This effort should be complemented by a pool of potential consultants or investigators who have conducted studies in the region (if possible) and have some cultural familiarity. There is a need for highly qualified scientists who will develop studies around a problem focus rather than around theoretical concerns exclusively. This would include social work.

Thus, an applied research agenda will need to be developed in support of AIDS prevention which conforms to the problems confronting the work of the NPAs of the region. Such research might include investigations of the private practice sector, factors influencing stigma in STD/HIV, factors influencing the decision to have an HIV antibody test, reproductive health behavior of youth, men's sexual health behavior, multiple sexual partner behavior, factors affecting condom use, experiments to promote condoms, socio-legal concerns, and social mobilization around health. A conference for this purpose, may be the appropriate forum.

We suggest CAREC utilize the resources of the US contractors to assist development of this institutional strategy; for example, consulting with FHI personnel who direct the AID/NIH program in Behavioral Science in Support of AIDS Prevention.

2.2. Surveillance of HIV Infection and STDs; Ethnographic Studies and Knowledge, Attitudes and Practice Surveys

2.2.1. Development of Standardized Surveillance Systems

2.2.1.1. Reporting of AIDS cases

CAREC has been monitoring AIDS infections since 1985. Routine reporting is received quarterly and periodically published in the CAREC Surveillance Report and PAHO bulletin. As planned in both the USAID project paper and the CAREC sub-regional MTP, a workshop was co-sponsored with AIDSTECH, in November of 1989 to review the status of present surveillance systems in effect and to introduce improvements. Additional workshops on HIV/AIDS surveillance related subjects (such as availability and use of emergency HIV antibody assays and monitoring activities for AIDS programs) have also been convened by CAREC.

Since the signing of the grant agreement with USAID, CAREC has coordinated the development and circulation of the following items that are required for thorough AIDS surveillance: standardized reporting forms, an algorithm on HIV testing, a revised AIDS case definition, and a new individual AIDS case investigation form providing more detailed clinical and epidemiological data.

Aside from continuous efforts to improve timeliness and accuracy of

AIDS reporting at the national level, it appears that national governments and CAREC are in an overall sound direction regarding the reporting of AIDS cases.

2.2.1.2. Reporting of CSTDs

Countries have been notifying CAREC of syphilis and gonorrhea cases since the late 70's based on public facility and laboratory reporting systems. Reliability of this reporting for the public sector varies from country to country. Reports from the private sector are rare. Cases of herpes, chlamydia and other major CSTDs are not reported for justified reasons concerning lack of appropriate laboratory techniques and limited personnel time. Cases of non-gonococcal infections are not reported, but should be, due to their major role in causing STD morbidity.

Data on cases of syphilis and gonorrhea cases provide a more immediate picture of the frequency and distribution of diseases transmitted sexually than data on AIDS cases. Since incubation periods are relatively short, symptoms often present (which allows many of those infected to seek treatment), laboratory testing quick and at low cost; an assessment of disease transmission and population behavior can be readily made, assuming adequate services and reporting systems for both private and public sectors are in existence. At the present, these systems are not in place in the six priority countries. This subject will be discussed in more detail in the following sections on STD program services and Planned Activities - Phase Two.

In summary, reporting of syphilis and gonorrhea (and non-gonococcal urethritis/cervicitis) will require much more attention at the local level in the next phase if STD/HIV program objectives are to be measured.

2.2.1.3. Surveillance of HIV and Syphilis Seroprevalence

The incidence of AIDS, syphilis and gonorrhea cases (discussed above) provide one perspective of the epidemiologic scenario. Prevalence of HIV and syphilis among the population or among certain core groups provides the other. CAREC has revised its standardized reporting form to include HIV surveillance of blood donors, antenatal attendees, STD patients and other groups and surveys as well as syphilis surveillance for antenatal and other groups. These forms have yet to be widely incorporated. Similarly, Ministries of Health have been encouraged to perform HIV and syphilis surveillance, sentinel surveillance and/or special surveys in several population groups such as: STD patients, commercial sex workers, gay males, prisoners, antenatal attendees, family planning participants, young adults and disciplined service members.

Sentinel surveillance of HIV seroprevalence will have to suffice

for the immediate future in most of the populations stated above due to cost and time constraints. Although it should be expected that in the near future, all antenatal women and STD patients should be screened routinely for both HIV and syphilis. Sentinel surveillance and frequency of surveys of the other groups will depend on previous seroprevalence data and population group accessibility.

The workshop in Jamaica identified several weaknesses of current CSTD surveillance systems (poor private participation, lack of STD services etc.) and made thorough recommendations regarding use of syndromes for diagnosis and reporting, identification of population groups, special etiological investigations, service delivery improvements and use of population based CSTD surveillance of antenatal women and men under 30. This last recommendation could be extremely important in predicting future HIV prevalence among the general population by using STDs (particularly positive syphilis serologies) as surrogate markers. This is based on the assumption that transmission of syphilis mimics closely that of HIV, thus a young population with a syphilis seroprevalence of 5-10 percent, could theoretically achieve the same rates of HIV. Consequently, monitoring the syphilis seroprevalence of young populations could reflect progress of (or lack thereof) program interventions.

Additional recommendations regarding STD/HIV surveillance were presented in the multi-donor review of the CAREC MTP. These recommendations are similar to the above issues discussed and basically re-emphasizes the need for strengthened STD surveillance systems and CAREC's leadership role in assisting local governments in these efforts.

2.2.2. Implementation of Epidemiologic Research

The CAREC/AIDSTECH Small Grants for Epidemiologic and STD/HIV Research Projects was introduced during the above mentioned 1989 workshop. As outlined in the project paper, research priorities were identified and proposals of up to two years funding encouraged at levels from \$5,000 - \$15,000. Research priorities consisted of several pertinent subjects still requiring investigation:

- * "rapid" assessment of CSTD
- * mass treatment of commercial sex workers
- * pharmacists role in STD control

Subsequent to this announcement, six proposals were received with four warranting acceptance subject to modifications.

Under the same program, a regional study was performed in 1990 in four countries, Antigua, Dominica, St. Lucia and St. Vincent to

estimate point prevalence for gonorrhea and chlamydia. (Chlamydia is often the cause of non-gonococcal infections.) This was a cross-sectional survey among 1) men complaining of urethritis and women with suspected cervical infections attending STD clinics and 2) women enrolled in their first visit from antenatal clinics and from private physicians' offices.

Chlamydia was present in an average of 10% of all groups and among both groups of women, chlamydia was much more common than gonorrhea. Resistance to penicillin was variable in the four countries.

Such a study provides an indication of specific disease frequency among patients seeking STD care and women seeking antenatal services. This information allowed local officials to establish treatment regimens for syndromes based on expected etiology and prevalence of resistance to penicillin and set standards for testing antenatal women for prevalent diseases. Additionally, this study suggests an unacceptable prevalence of chlamydia infection in women of child-bearing age.

Until the other five proposals are completed, it is too early to determine the utility of the small grants program. Although this first study was performed as a regional effort, it is a good sign of appropriate direction from CAREC and AIDSTECH in identifying research needs, in choosing studies that provide useful information and use of data in decision making.

2.2.3. **KABP and Other Behavior Studies**

2.2.3.1. **KABP surveys**

The ACTS project calls for the completion of surveys of AIDS-related knowledge, attitudes, beliefs, and practices in the priority countries. This portion of the project has been slow to develop, for a variety of reasons:

Countries have not been enthusiastic about hosting the survey, because:

- * the content and format have been modeled closely after the survey materials developed by the former Social and Behavioral Research (SBR) Unit of the Global Programme on AIDS (GPA). In order to maintain comparability across nations, and to take advantage of the investment made by WHO in the careful development of the questionnaire, CAREC and the AIDSCOM and AIDSTECH contractors have resisted the countries' desires to modify the questions. They have argued that the countries should keep the standard format or simply exclude those sections which they feel are irrelevant or too sensitive. This stance, which is methodologically sound, has generated country

resistance;

- * there is little or no social research capability available in the Ministries of Health, and the unfamiliarity of the task breeds anxiety;
- * the effort involved in a moderately sized survey of this type is substantial, and competes with other objectives; and
- * thoughtful non-researchers have expressed serious concerns about the reliability and validity of answers that members of their population are likely to give to many of the explicit questions concerning sexual behavior.

Countries seem confused about the purpose of the activity, a problem which is compounded by confusions embedded in the SBR instruments. The most logical motivations for a country to do a KABP survey are to gather information about the situation in their country so they can plan an intervention (a diagnostic function) or to establish a baseline so they can detect change over time in the things they are trying to affect (a baseline function):

- * the instruments do not serve the diagnostic function well. They reflect the orientation of an international comparative study that is basically descriptive, trading off depth for breadth. It provides global descriptions of behavior in standard parameters that permit one to compare one country to another. It does not, however, have sufficient detail to provide a good data base for planning a national intervention;
- * the instruments may or may not serve as a useful baseline for subsequent comparison of behavior change over time. The behaviors measured are stated in general terms, and will therefore be relatively insensitive measures of the effect of any specific activity undertaken by the country. The use of a representative sample permits description of the country as a whole, but will make it impossible to generalize about any specific high risk group.

The process of contracting out the survey and the use of multiple contractors has prolonged and complicated the effort. The delays in implementation of the activity resulted in missing the vacation period during which teachers could have been contracted to do data collection. As a result, much younger and less experienced persons had to be hired for the data collection, and the countries related that the youth of the interviewers caused awkwardness in the interview and concern for the validity of the data.

The delays have caused programmatic problems. The logic of the program development process calls for the gathering of data on which to base the design of national, comprehensive communication efforts. The planning of these efforts has been held in abeyance pending the completion of the KABPs. This has resulted in unnecessarily delaying most communication efforts, many of which could have done some constructive work even in the absence of a solid information base for planning.

The current status is that the data have been collected in St. Lucia and St. Vincent, and a workshop is planned for the end of February, as soon as the data are available, to work through how to develop a strategic communications plan from the research results. This activity is valid, and will be of benefit to all the islands, even if they have not yet undertaken a KABP survey. It should go forward as planned. The question of how to proceed in the other islands breaks down as follows:

- * Two islands (Dominica and Grenada) appear to be about ready to undertake the KABP data collection. Given the commitment of professional resources and extensive negotiation that has taken place to bring the situation to this point, it seems wisest to proceed as planned, and as quickly as possible.
- * The situation with the remaining countries (Antigua and St. Kitts) makes it appear unlikely that the KABP will take place in the near future. It seems counterproductive to hold work on the larger communication efforts hostage to the completion of a national survey. Some process must be found for pushing forward the effort despite the reluctance to participate in a national survey. A reasonable path to follow would be to approach the countries about substituting a more qualitative investigation oriented toward gathering planning data rather than baseline data.

2.2.3.2. Other behavior studies

The project has been somewhat more successful in implementing small KABP studies in special populations, for example, among brothel workers in Antigua, prisoners in St. Vincent and in St. Lucia, and STD clinic patients in St. Lucia and in Trinidad. Focus group methods have been used to assist some materials development. In St. Vincent, a survey of youth used multiple focus groups as a method of getting information. Similar methodology will be applied in Grenada and Dominica. These studies have provided potentially useful information, and other studies have been planned but are delayed for various reasons that are difficult to evaluate.

It is difficult to assess the quality of these efforts, from a scientific perspective. Their test is whether they provide

information for their purpose given the resources available. The application of ethnographic skills to understand commercial sex workers is quite appropriate, since it appears that these practices are not well understood by health personnel in the countries considered. KABP studies of small populations present some of the difficulties of large KABP surveys, in that they sometimes involve delays in implementation which slows development of intervention. They also suffer from problems in scientific supervision, responsibility, and accountability. It is sometimes not clear who the scientist is or whether a scientist is involved. Such conditions necessarily create concerns for protection of subjects and for the general credibility of the surveys.

Small KABP studies, like large ones, require a clear role of a scientist in charge. This does not have to be a Ph.D., but someone capable, and clearly accountable, adequately trained and in charge. There is some confusion over ownership of the data which should similarly be resolved, namely such that the scientist may confirm protection of confidentiality and the integrity of analysis. CAREC should monitor the adequacy of clear scientific/professional supervision of KABP studies. It would be very appropriate for CAREC to provide the principal investigator, with a co-investigator/project administrator in the nation, and with the data processing and analysis performed at CAREC.

Scientific direction should adapt itself to the applied purposes of each survey. The applied purpose should be respected over alternative interests, such as preparation of publishable papers. A working paper series should be considered by CAREC for the purpose of describing and presenting studies, separate from or at least different from the objective of scientific publication.

2.3. Prevention of Sexually Transmitted HIV Infection

2.3.1. Communication and Education Programs

2.3.1.1. Communication strategies development and implementation

The overall ACTS project strategy presupposes a phased effort, in which the initial work is oriented toward preparing the infrastructure that will be required when demand is stimulated, and the subsequent work is oriented toward stimulating that demand. Thus the initial communication efforts have concentrated very heavily on workshops and training, in order to create a pool of trained professionals who are well informed and equipped to respond appropriately when the need arises.

The range and number of training events conducted is quite impressive. The general impression one has is that these events have been successful at their immediate objectives of training the attendees. Much of the training was done with the intent that

those receiving the inputs would return to their countries and carry out additional training of their peers (a training of trainers strategy). There is less evidence that this secondary objective has been met.

The ACTS project has now reached the stage at which it must make the transition from building these resources to reaching out to those at risk of contracting AIDS. The transition will entail a substantial change in the way the communication efforts have been organized and executed. To date, the communication efforts and products have either been very narrow (e.g., the condom use pamphlet) or very broad (e.g., the "Unite Against AIDS" poster). They have not been part of a larger scale, integrated approach to changing the behaviors of large numbers of people. Similarly, the use of media in countries has tended to be haphazard -- the random radio spot for awareness, rather than, for instance, a coordinated series of spots supporting efforts through multiple channels to accomplish some specific set of objectives.

There is too little evidence of the elements of planned, comprehensive campaigns in the education efforts observed in countries. More thought needs to be given to both audience segmentation or behavioral analysis:

- * the notion of audience segmentation is expressed largely in the fact that different groups have been trained in the expectation that they will address the needs of different audience segments. The upcoming communication campaigns will need to consider segmentation much more seriously. Probable audience segments containing significant numbers of people at risk include in-school youth, out-of-school youth, women, single young adults, etc.;
- * despite the rhetoric of social marketing, there is to date little evidence of behavioral analysis and the crafting of messages or objectives to overcome the constraints and specific attitudes of the audiences. The content of communication for general or large audiences has primarily been information or exhortation -- it has not typically reflected an analysis of exactly what circumstances people face, what constrains their behavior, and what appropriate behaviors should be modeled. The step into integrated campaigns must include a much heavier emphasis on this approach;
- * there is only casual setting of priorities among audiences by level of risk of transmission. This leads, for example, to an unanalyzed investment of lots of energy in low volume efforts such as hotlines and prison interventions, and proportionately less investment in the much larger, but lower risk groups. This may or may not

be a serious misallocation of effort; the point is that it is not driven by a consideration of how best to use the limited resources available.

Implementation of the communication efforts has been documented extensively in the background materials prepared by CAREC, AIDSTECH and AIDSCOM. The field investigation indicated that the contractor reports were accurate, but that several general observations are in order:

- * Most of the communication work to date has been done as part of a discrete small activities. The communication components of these small activities reflect the management structure of the first phase of the contract, which generated a number of independent actions managed by different organizations.

This fragmentation produces an environment in which countries do little strategic thinking about nature of the AIDS problem they face and how they should organize to attack it. The minimal health education resources in the country are already heavily taxed, and these additional demands for small activities impede their ability to step back, take a wider view, and do systematic planning.

The ACTS project must structure a way to work that incorporates and supports a more strategic approach. Much of the burden for this emphasis will fall on CAREC and the AIDSCOM and AIDSTECH staff.

- * The scale of these efforts is small; not only are the countries themselves very small, but the ACTS project process has been one of identifying a limited set of objectives (such as a research project) and creating materials specific to that task. This scale of activity creates a situation in which the effort required for systematic materials development approaches (use of focus groups and pretesting) may seem disproportionate to the total effort, since so few people will ultimately be exposed to the communication. It is vital to recognize the importance of continuing to employ these methods of proven effectiveness. Hence the ACTS project should seek ways to aggregate the effort into larger scales of operation, by focusing on larger groups within the general population, and by producing materials for use in more than one country.
- * There has been a heavy emphasis on interpersonal communication channels in many of the planned activities. This refers not only to counseling programs, but also the intent to use medical personnel for education during patient encounters and to use of Ministry of Health non-

medical personnel (such as Family Life Educators) to do face-to-face instruction in the communities. There are undeniable strengths to interpersonal communication, but it is not realistic to try to meet large scale needs through that channel.

- * The content of messages is concentrated in the informational end of the spectrum. The level of detail is often good, with specific practices named as risk factors, etc. However, all the indications from the available data and anecdotal reporting are that the information dissemination phase has been successfully completed -- that most of the population already knows most of the basic facts about AIDS and how it spreads. This argues for a shift in focus to messages designed to give skills about how to accomplish a less risky lifestyle. Rather than simply telling people they must use condoms, the messages must start doing things like showing how people can negotiate with each other about condom use and sexual practices, or show plausible, attractive role models adopting the promoted behaviors (such as keeping to one partner). This is not to say that informational objectives should be abandoned, but that it is now time to develop and use messages that transfer skills and enable people to respond.

2.3.2. Training Health and Educational Professionals, Community Leaders and Influential

A review of training in this area has demonstrated progress, with possibly less seen in reaching educational professionals. It is important to highlight the internal national needs to reach teachers and other educators, and, secondly, a need to reach front-line health care and social service personnel. These strategies are best developed in the national context. In some settings, a speakers bureau service has been valuable in reaching community groups and influential. Some progress has been made in securing cooperative roles, as well as independent involvement by religious leaders. The position of AIDS Program Coordinator should assist in this way. Resources should be made available to assist the coordinator in formulating national training plans with the appropriate ministries. Plans to focus on youth can be expected to require strategies for educating and involving health and education personnel, community leaders, and influential.

CAREC may take a leading role, with assistance of partners, in reviewing innovative approaches (and there are several in the region) to classroom curriculum, community theatre, school clubs as well as other forms of education sector involvement in STD/AIDS prevention. Educators would likely respond well to sound but innovative approaches.

2.3.2.1. Skill building training for health educators

The project emphasis on training has included skill building training for health educators. AIDSCOM reports that it has held five training activities for health education skill building, aside from training that has covered counseling skills. Most of the skill building efforts have served only one or two people. The training has been on health promotion, AIDS communication, focus group techniques, social marketing methods, and advanced communication training.

The content of the skill building must recognize that the health education units are unlikely to have access to significant operational budgets. The priority areas for training should include behavioral analysis and message planning, since these are areas in which the existing staffs are deficient and in which the effectiveness of health education can be improved considerably for little cost.

Generally the efforts envisioned for Phase One have been implemented, even exceeded, as noted in review of training, above. "Train-the-trainer" workshops for health care workers and others reached impressive numbers of persons and have resulted in the production of the training manual specified.

Training in pre-test and post-test counseling and for counseling of HIV+ persons and families with AIDS has been very useful to national personnel who previously had little or no familiarity with counseling concepts or with the specifics of applying counseling concepts in the context of HIV and AIDS concerns. This kind of training has represented a large part of the training provided. The workshop approach provided important networking and motivating effects that likely have enduring importance for many participants. The next phase may carry these influences into nationally based training activities.

Training in patient counseling has also been supported by other international programs, such that one may conclude that this area has been adequately supported.

2.3.2.2. AIDS information hotline programs

A hotline approach was very successfully assisted in Trinidad. It is notable for its development as a non-profit organization with its own fund-raising activities. It, like the effort in St. Lucia, is led by a very competent social worker, who has skills in volunteer recruitment and in teaching good telephone listening/counseling skills. Both hotlines are located with health services which make possible access to supportive professional consultation. Both services, especially the Trinidad service, use a range of persons as volunteers; but primary representation it

appears, is from nursing personnel.

The hotline experience in Trinidad contributed to work elsewhere, using the Trinidad director as a regional workshop resource.

Hotlines provide a valuable bottom line of access to information and support. However, they are very resource intensive, especially in small communities and especially where their advertisement is not integrated into ongoing media and daily activities of many sectors. Thus, the call rate in St. Lucia has dropped from the first experience at the time of initiation a few months ago. While hot lines are sometimes initiated for single purposes, such services may be combined with others or broadened in scope. A nurse volunteer in St. Lucia expressed some enthusiasm for serving also as a hotline for other reproductive health concerns, birth control and CSTDs. This would not be possible under present arrangements without greater training or more professional volunteers.

2.3.3. STD Program Services

2.3.3.1. Overall

Original project documents and MTPs mention the importance CSTDs play in reflecting disease transmission patterns and in facilitating HIV transmission. This acknowledgement for the most part, fails to translate into a recognition of the day to day operational efforts CSTD programs require. Current work plans and budgets appear to underestimate the time and costs of establishing or "upgrading" effective services for CSTDs. Additionally, by treating this endeavor (STD program upgrading) as a separate entity, from that of developing "AIDS control and prevention programs", CSTD surveillance, CSTD clinic services, CSTD education materials and CSTD partner tracing become afterthoughts, leaving the "AIDS program" inadequate in its ability to achieve its objectives. CAREC is commended on its formation of a Special Program on "Sexually Transmitted Diseases" which includes HIV/AIDS; thus accentuating the shared major route of transmission and numerous program similarities of these diseases and overall synergistic affect of the interventions in changing behavior and reducing morbidity and mortality.

PAHO is currently exploring ways to fund a regional STD program officer who would be able to provide constant in-country assistance to ministries on CSTD management. The appropriate place for this person to be assigned, would appear to be CAREC. If PAHO is unsuccessful in this endeavor, AID and CAREC should pursue this idea by creating an STD program manager position and recruiting an experienced professional.

AIDSTECH has performed STD clinic assessments (funded from non-ACTS project funds) in Antigua and St. Lucia, has sponsored training of

health personnel, provided minor clinical equipment and assisted CAREC and nationals in performing etiological studies to determine treatment protocols. CAREC has not had a chance to focus on CSTD program upgrading in a minimum of four countries, as stipulated in its grant with AID. Both partners have encouraged CSTD-related research under the small research grants program and have distributed CSTD instructional aids for health personnel.

As mentioned previously, CSTD surveillance can be considered unreliable at this time in the six priority countries due to the meager and variable CSTD services and poor private sector participation. If reports from Jamaica and Trinidad/Tobago (non-priority countries) can be interpreted to reflect trends in the Caribbean, rates of syphilis have increased since the mid-1980's.

2.3.3.2. STD Facility Services

Clinics providing STD services were visited in the capitals of Trinidad, Antigua and St. Lucia. A description of available integrated services was given by the AIDS Coordinator in St. Vincent. The quality of services in the facilities ranged from poor to good although personnel motivation and competency appeared consistently high. Rapid serologic tests for syphilis are not available, thus personnel and patients must wait one to three weeks for test results. Counseling and partner referral occurs, but again varies in degrees of quality. Trinidad counselors have received sophisticated overseas training and have private counseling rooms, whereas counselors in Antigua must whisper to patients because no private room for counseling exists. It was not clear if partner referral is encouraged for patients with non-gonococcal infections, even though chlamydia was found to be prevalent in 10% of the select population surveyed, can cause pelvic inflammatory disease in women and has been suggested to play a facilitating role in HIV transmission. Educational materials on CSTD were scarce and waiting rooms too cramped except for Trinidad, where the room is sufficient and a TV provides educational videos. Condoms were available and the penis model was visible and apparently used often in condom demonstrations in St. Lucia.

Partner referral by the patient is promoted in all the facilities, although active provider follow-up varies in degrees among the countries. Some places are weak in documentation and monitoring of contacts tested, treated and counseled. Stressing of confidentiality could stand reinforcement in St. Lucia and Antigua. In St. Lucia, the team was told that a sexual contact could be told who "named him/her" if the original patient failed to notify the contact as instructed. Clinics and staff could lose credibility in the community if such disclosure of names occurs widely.

Referral of contacts can potentially be time intensive if the original patient fails to refer his/her sexual partner(s) to the clinic leaving this follow-up to health personnel. Thus, training

of personnel in patient counseling and motivation is well worth the investment. This applies equally in preventing repeated infections.

2.3.3.3. STD Program Outreach

The outreach activities initiated from these facilities look promising. The health and social work professionals in all four countries visited, have worked hard with certain core groups such as commercial sex workers and migrants to increase their STD knowledge and use of condoms. Gaining trust and building up the STD programs' reputation will take time. These programs are discussed in further detail later in the report.

If this region is like most, a sizable portion of the people seeking CSTD care are going to private physicians (or other types of providers). Little has yet been done in improving private and public collaboration. Networking with the medical and pharmaceutical association is the first step. Determining who in the private sector is seeing patients with STDs is the second. This is followed by workshops in diagnosis, treatment, reporting, counseling and partner notification, including both the physician, nurses and other appropriate providers. Liaisons with the identified physicians will need to work out agreements on how notifications of major STDs will be made and who will take the responsibility of partner follow-up. These activities with the private sector are workload enough for one person, but would be worth the time in improved patient care, disease case management and partner follow-up in the private sector.

2.3.4. Behavior Intervention Programs

All activities associated with the strategy of reducing the sexual transmission of AIDS should be considered behavioral intervention studies. Media and communication efforts provide an environment which can be assumed to increase the acceptability of direct, interpersonal efforts and provide some element of reinforcement. All methods contribute to emergence of new norms and expectations for behavior. Thus the project paper envisioned a wide range of activities. These activities are valuable separately, but greater value could be expected if there were a greater mix of activities, especially with increased mass media materials. The latter could be enhanced by regional approaches, as discussed elsewhere. Note is made here, however, to underscore the need for greater balance of activities and possibly for greater integration. This will be facilitated, we believe, by strengthening of the NPA generally, and especially through the emerging role of a NPA Coordinator.

2.3.4.1. Behavioral Interventions With High Risk Groups

Intervention in high risk populations is a priority of the ACTS project and substantial effort has been applied to this goal. The PIO/Ts and project paper were, however, not highly specific in setting expectations, except to support behavior intervention by FHI in four countries, Trinidad, Antigua, St. Lucia, and Barbados and to support behavior intervention by AIDSCOM in unspecified nations.

Behavioral interventions were generally designed in a research mode, that is, in populations where KABP surveys were also planned, sometimes with a before and after intervention measurement plan. In some cases the intervention plan was also accompanied by seroprevalence survey. Efforts were planned to be aimed at commercial sex workers, men and women with multiple partners, migrant workers, prisoners, and STD clinic patients.

Activities to improve the functioning of STD clinics were discussed earlier in this document.

Commercial sex workers. The most advanced project has been conducted in Antigua where a team of consultants from Mexico and the Dominican Republic conducted training sessions with the sex workers and trained peer educators who have been hired to do outreach to the brothels and bars in St. Johns. The KABP found high prevalence of vaseline use, but no mention is made of identifying this as a target behavior to change. A study long in preparation is reported near beginning stage in Barbados, aiming to train outreach workers to work with commercial sex workers and women with multiple partners; additionally the project will conduct an ethnographic study aimed at estimating the characteristics and distribution of such activity. All of these projects have been led by FHI.

Efforts to reach these populations appear to have been initially stalled by political resistance. However, it also appears that, with the exception of the brothels in Antigua, the sex worker population is not easily targeted; for example, there are women who have multiple male friends and receive some economic support in this way but do not acquire the definition of prostitute.

Women and men with multiple partners. The primary intervention developed has been the support of outreach workers who visit bars and social clubs in Trinidad and Antigua. There have been some difficulties in reaching the women at their places of work due to lack of quiet appropriate space for discussions. The outreach workers are attempting to solve this problem with alternative sites.

Migrant workers. Serology testing has been obtained for some 700 St. Lucians who applied for migrant work contracts in the U.S. Educational programs have been developed for this population, and

pilot survey of KABP for has been performed. The educational program plans to utilize peer educators, but the migrant program is temporarily in suspension until new arrangements are made with the U.S.

Prisoners. Prison populations have been KABP surveyed in St. Vincent and in St. Lucia and educational efforts are in planning stages, apparently waiting for analysis of the survey findings. In each country, there is only one prison which apparently serves also as a short-term jail and as a holding place for persons awaiting trial. There is substantial turnover and recidivism. There is support from prison administration on education activities, but condom "distribution." is not acceptable. Interestingly, it appeared in conversations in St. Lucia, that provision of condoms by a physician to persons specifically identified at risk would be acceptable. Perhaps the manner of promoting condom distribution needs rethinking. Instead of proposing anything like "handing out condoms," discrete provision methods may be acceptable. There has been no serological survey to accompany the study, although this was planned initially in St. Vincent.

In discussions with the interim evaluation team, prison and NPA personnel voiced interest in designing interventions for prisoners in the immediate pre-release period. In St. Vincent, the Red Cross was suggested as a nearby site where counseling could take place and follow-up counseling could be developed.

Other populations have been suggested as target groups, but no specific projects have been undertaken, except for adolescents, where educational seminars have been provided to Youth Guidance Councils in St. Vincent. Carnival outreach programs should also be included; there are instances of attention to carnival in Trinidad and in St. Vincent, for example.

It is disappointing to find that interventions in high risk populations have been delayed by slow progress in conducting KABP surveys. Considering the priority which is verbalized in this area of effort, the actual delivery of services has been slow developing. It seems also that the strategy of developing segmented, intensive efforts for high risk groups must be moderated where these populations are difficult to find or differentiate poorly from many others in the community.

2.4. Program Management Improvements and Costing Alternatives

An explicit goal of the project paper was to "improve management skills of the human resource base charged with implementing AIDS programs and to design intervention programs that are cost-effective and sustainable." It stipulated that cost data will be used to measure the cost-effectiveness of each behavior intervention against other possible strategies. However, this component of the project was allocated less than \$175,000 out of

the \$3.5 million in project funds for phase One. The result has been modest efforts at program management improvements through a workshop and three specific activities dealing with cost issues. The project has not incorporated management improvements or cost analysis as an integral part of its other two strategies.

2.4.1. Program Management Improvements

The project paper recognizes the need for improved program management and directs both AIDSCOM and AIDSTECH to work on increasing capacity. This is to be done through regional and national program management workshops and intensive technical assistance.

One workshop, entitled "Effective Management of National AIDS Programs in the Caribbean" was held in July 1989. However, the broad format and apparent substance of the workshop does not match the specific management skills content listed in the project paper. There seems to have been little follow up from this workshop.

In addition, AIDSTECH has trained CARAC's Technical Services Specialist in program management. Both AIDSCOM and AIDSTECH comment that they have worked with Ministries of Health and AIDS action committees on program management, but as the AIDSCOM program report states: "This is an area that continues to need attention by all members of the ACTS Project."

WHO is currently in the process of developing an AIDS Managers Course. Until this program is available, the project will need to find alternative sources. Many private companies and universities specialize in such training. Additionally, the US Centers for Disease Control (CDC) has provided formal instruction in management of STD programs. Additionally, public health advisors with STD management experience are numerous in the US government and PAHO may also have such resources. Short-term public health advisor consultancies with specific tasks delineated for on-the-job training could be requested of CDC or PAHO.

Strengthening management can focus on generic management skills and techniques and/or specific management of STD/AIDS programs. The project will need to determine which of the two (or both) are needed at this stage.

2.4.2. Program Costing Alternatives

Although the original project paper discusses costing alternatives and cost effectiveness, attention to these issues has been limited. Cost issues were addressed in the three programs for which cost information is the major component, but for other programs, there has been virtually no cost analysis. Collecting cost data requires defining measurable outputs and the quantity and cost of inputs

used. Rather than going through these steps, most programs have simply monitored expenditures against their budget. Some programs do have the capacity to make very simple cost calculations. The various hotlines, for example, would be able to determine the cost per contact, but appear not to have done so. KABP surveys, surveillance activities, and counseling are other activities where it may be straightforward to determine cost per unit of service.

The absence of good information on costs has two major implications on operation of the project. There is little ability to understand and implement efficiency measures, and it is not possible to determine cost effectiveness. More efficient service delivery is often as simple as determining high cost components of operations and identifying lower cost substitutes. More sophisticated cost analyses will determine the marginal contribution to output of each input. By comparing this contribution to the cost of the input, project participants could determine ways to minimize cost. For most of the project activities, there has been only some simple qualitative efforts at efficiency. For example, there has been cursory analysis of the optimal hours of operation for hotlines. However, there has been no systematic incorporation of efficiency measures.

The lack of real cost analysis means that cost-effectiveness analysis is virtually impossible. Cost effectiveness is a comparison of alternative ways of achieving a stated goal to identify the one that achieves the most for the least cost. Beyond the project's three explicit cost studies, programs have not been required to justify their approach as being cost effective. There is virtually no discussion of alternative methods, or of the cost of those alternatives.

In fairness to project implementers, it should be noted that, the project paper de-emphasizes economic analysis. It states that it is "impractical to perform conventional financial or economic analysis on the types of interventions proposed in this project. Moreover, the decision to participate in a project of this nature clearly does not have its foundation in economic analysis of a specific set of interventions." This statement would appear to absolve project participants of the necessity of serious economic analysis.

The economic performance of the project might be improved if project activities were required to explicitly state alternative ways of achieving the intended outcome, and to provide at least a qualitative discussion of the cost effectiveness of each alternative, including the proposed one. For the proposed activity, there should be a more detailed discussion of the expected costs per achieved outcome, and the major efficiency problems associated with the intervention. To do this with each activity would help to institutionalize critical thinking about the economic aspects of this project.

The three small projects discussed below have the most detailed cost analysis of the project. However, there has been no institutionalization of the cost-effectiveness analysis within either the conceptualization or implementation of project activities. What has been examined has dealt mainly with blood supply issues. There has been no careful examination of the relative cost effectiveness of the KABP surveys, AIDS hotlines, STD clinic interventions, work in prisons, or other interventions.

2.4.2.1. Cost recovery of blood transfusions

This activity is being conducted in Trinidad.

The stated rationale for this study is the prospect that CAREC, which currently provides all HIV blood testing, will not be able to continue to provide these services free of charge. As a result, this project examines the possibility of instituting a cost recovery scheme for blood services.

Currently, the National Blood Transfusion Service (NBTS) has completed a costing exercise to determine the cost of providing blood services. They intend to use this information to develop a fee schedule aimed at 100 % cost recovery from private hospitals. The intention is to apply the fees to public hospitals in the future.

The NBTS is very eager to begin charging private hospitals, in part because they believe the private sector is charging exorbitant fees for transfusions. They also plan to be aggressive in competing with private blood suppliers.

While it may be easier to begin charging the private sector before doing the same for the public sector, this is exactly the practice to avoid if one wishes to encourage private sector participation in supply of health services. In addition, there has been no effort to determine if the fees currently being charged in the private sector are higher than reasonable costs.

One of the stated objectives of the project was to assess the demand for transfusion services and the elasticity of demand. The study has not attempted this, and is proceeding on the assumptions that private hospitals will not raise their fees when cost recovery begins.

The team did not have an opportunity for close analysis of the study and was not able to determine how the cost of blood services was determined. The staff did explain that some overhead costs had not been attributed to the cost of services. It may be that even at 100 % cost recovery, the NBTS fee schedule puts private suppliers at a disadvantage.

2.4.2.2. Screening pooled blood

This study was conducted in Trinidad.

Because HIV testing is expensive for developing countries, a method of pooling sera for testing has been studied in several countries. This study cites results from Zaire, where it was recommended that sera be pooled in sizes from 5 to 15, depending on the seroprevalence rates in the population. This study tested the possibility of pooling 5 sera together for testing.

It is unclear what this study added to sera pooling knowledge already extant, but it did point out some deficiencies in the current testing practices of the Trinidad and Tobago Ministry of Health.

This project required an investment of \$65,000 to determine that such pooling was feasible in Trinidad and Tobago. The results are presumed to be generalizable to the rest of the Caribbean, so that the study will not need to be repeated.

2.4.2.3. Alternative treatment facility

This is a study of the possibility of using hospice care for AIDS patients in Barbados as an alternative to hospitalization. The study estimated that hospitalization of AIDS patients costs \$160 per day, and that hospice care could be provided for about \$50 per day. About 40% of hospital stays were judged to be candidates for hospice care. There are plans for a workshop to develop detailed plans for hospice services. This study apparently was the result of response to local initiative in Barbados. The MOH has plans for development of a hospice and asked for a study of the relative costs.

3. CONCLUSIONS

The following Plan of Activities For Phase Two provides a summary of the evaluation and suggests modifications in project focus and implementation for the future years. The format follows that of a USAID Project Paper Supplement, the document used for authorizing additional funding.

I.. PROJECT SUMMARY DESCRIPTION

By the end of 1991, the ACTS project will have completed three years of project life. This First Phase has succeeded in initiating efforts among a wide range of activities to better monitor disease trends and prevent sexual transmission of HIV. Two US contractors, FHI and AED and the PAHO sub-regional center, CAREC have jointly strengthened the Caribbean capacity to advise Ministries of Health on effective STD prevention and control measures.

During the First Phase, regional activities focused on training of personnel, developing standardized surveillance forms and generic KABP study questionnaires for country use, determining point prevalence of two CSTDs, promoting condom use, and developing educational materials. These activities benefited all countries at once and was an effective use of early project funds.

Country-specific efforts consisted of initiating behavioral interventions among high risk groups, establishing hotlines, upgrading two STD facilities and performing three cost alternative initiatives.

An interim evaluation in early 1991 found overall project performance quite satisfactory and recommended the project management arrangement to continue with CAREC playing a more active role in project coordination and technical direction. Strategies in surveillance and prevention of sexual transmission were to be in the future, focused at the national level towards achieving greater impact. Management skills and techniques were to be strengthened through regional workshops or if appropriate, in the form of on-the-job training. Major intervention efforts were to include costing analyses on implementation variations to determine most effective use of project monies.

The evaluation team stressed the importance of focusing IEC activities and interventions at the largest target core group, that of the young urban adult (approximate age range 15 - 35). Communication and education "packages" reaching this target group would be developed by CAREC and the US contractors during the second phase on proposals for local research, printed materials, media plans, training aids and monitoring techniques for use by health education units. Youth would also be reached through behavior intervention efforts in the form of peer counseling and condom distribution. STD services would control disease transmission through improved youth counseling and more effective contact management.

These approaches would supplement the ongoing intervention efforts directed at high risk sub-groups (prostitutes, migrants, etc.) who are themselves part of this larger core group, and thus

reach a larger population. Investigation and research will need to be performed in order to determine places of access and what messages are most likely to encourage youth to practice safe sexual behavior and when infected with STDs, referral of sexual partners. CFPA's experience and collaboration in working with project partners would be sought through a grant from USAID.

This Project Paper Supplement incorporates the findings of the evaluation team into the Project Description by summarizing project direction for the Second Phase, 1992 - 1995, discussing major issues of importance in preventing STDs and providing a financial breakdown of activities.

II.. PROJECT RATIONALE AND DESCRIPTION

A.. Rationale

1.. Problem Description

Since the writing of the original project paper in 1989, AIDS has continued to be the most critical world health crisis in recent times. The cumulative global total of officially reported AIDS cases as of November 30, 1990 is 307,379 compared to 129,385 reported the same month two years ago. This represents an average increase of 7,416 cases per month. More countries (156) are now reporting AIDS cases than to the 138 countries in 1988.

WHO estimated in a Delphi survey in 1989, that by the year 2000, annual adult AIDS cases would rise from the present level of less than 100,000 per year to over 800,000 per year. The same survey suggests worldwide adult HIV infections will increase to 13 million by the year 2000.

Modes of transmission have remained the same, with sexual transmission remaining the most dominant. Risk factors for AIDS and other STDs are directly related to patterns of sexual behavior. A history of STDs, numerous sex partners, being young, being single and urban residence are the factors of risk most often identified. Highest incidence of STDs are found in urban women and men between the 15 and 35 year age range. Up to 80% of male patients mention commercial sex workers as the source of infection in some parts of the third world and are considered an important reservoir of disease (Piot and Over, 1990).

STDs are priority health problems in view of both the mortality and morbidity which result directly from them and their impact on reproductive health. AIDS has added a new dimension to STD risks. It has characteristics that make the risks more threatening to individuals and society: it is new; there are aspects of its threat that are unknown; and it is perceived to be fatal.

Experience gained and lessons learned earlier from national CSTD prevention and control programs are being applied to the extensive efforts to prevent sexual transmission of HIV. The new heightened concern and influx of resources brought about in response to AIDS during the past few years has enhanced the promotion of STD prevention measures against sexual transmission of disease and can also be used to strengthen CSTD clinical services.

a.. Regional Outlook

AIDS cases reported to CAREC in the region show a male to female ratio of 2.3:1. Ages 20 - 44 make-up 73.4% of the cases. Case fatality rate is approximately 62.4%. The following cumulative cases of AIDS were reported by OECS countries to GPA/WHO as of December 1 1990:

COUNTRY	1979-87 Cases	1988 Cases Rate	1989 Cases Rate	1990 Cases To Date	LAST Official	CUMUL Cases
Antigua/ Barbuda	3	0	0.0	0	0.0	0
Dominica	6	1	1.1	3	3.4	2
Grenada	8	3	2.9	5	4.8	3
St.Kitts/ Nevis	1	17	3.7	0	0.0	0
St.Lucia	10	2	1.4	4	2.8	2
St.Vincent/ Grenadines	8	8	7.1	6	5.4	4
Montserrat	0	0	0.0	1	10.0	0
Barbados	56	15	5.7	40	15.3	34
Trinidad\ Tobago	236	160	12.5	167	13.0	85
TOTALS	328	206		226		130
						887

Thus cases reported have increased by 559 (a relative increase of 170 %). At the present, data on gonorrhoea and syphilis cases reported to CAREC are questionable due to variability of services and lack of private participation. However, it appears CSTDs in the region have increased in the last decade, especially, these last four years. Trinidad syphilis cases bear this out with 131/100,000 cases reported in 1987 compared to 37/100,000 in 1984. This increase was also seen in positive syphilis serologies among antenatal attendees, a more representative group of the total population.

2.. Relationship to Countries' Development Strategies

All countries developed MTP's in 1988, and a review of these plans has just recently been initiated by PAHO. The majority of the country efforts have focussed on organizational and monetary issues in an attempt to respond with adequate resources. It is anticipated that the review process will concentrate on more technical and operational issues dealing with the six strategies reflected in the CAREC sub-regional MTP:

1. Epidemiological Surveillance and Research
2. Prevention of Sexual Transmission
3. Prevention of Transmission Through Blood
4. Prevention of Perinatal Transmission
5. Reduction of the Impact of HIV on Individual Groups and Societies
6. Promotion of Effective Management of National Programs

The ACTS project addresses three of the six strategies in the CAREC/Country MTPs: numbers 1,2 and 6. The three other strategies are being supported by other donors, under the CAREC umbrella.

Donors and WHO/PAHO have mobilized financial and technical assistance with contributions for the region in late 1989 consisting of approximately \$14,621,000 for a three year time period:

CIDA	\$ 4,200,000 (approximation)
EEC	\$ 3,750,000 (in equipment and technical assistance)
ODA	\$ 455,000 (support to CAREC)
GPA	\$ 2,162,000 (monetary and technical assistance)
USAID	\$ 4,054,000 (monetary and technical assistance)

TOTAL	\$14,621,000

A re-organization of the SF/STD unit in CAREC was an outcome of an August 1990 "donors" review of the CAREC MTP. The re-organization allows CAREC a more appropriate management structure for carrying out its STD mandate.

Both the August 1990 review and the recent ACTS interim evaluation recommended a greater emphasis on improving management of the programs at the country levels. This is not inconsistent with objectives of sustainability and efficiency, which the beneficiary countries share.

3.. Relationship to Regional Development Strategy Statement

USAID will continue to support the WHO/GPA initiatives in the control and prevention of AIDS/HIV transmission. These initiatives continue to be coordinated and implemented through

the WHO regional offices, of which CAREC is the Commonwealth Caribbean representative. Strengthening of regional institutions is similarly a feature of the RDO/C strategy for development of the Caribbean. Focussing this effort through CAREC, with technical and institutional development assistance is therefore consistent with the regional development strategy.

The project has determined three categories of beneficiaries: primary, limited and pilot study. The primary beneficiaries are all Eastern Caribbean countries which are the focus of the development efforts of RDO/C. The institutional development aims, and the health and economic consequences of this project's success are all consistent with the development assistance goals which RDO/C has for its target countries.

B.. Goal, Purpose and End-of-Project Status

1.. Goal and Purpose

The goal of the ACTS project remains the same; "to prevent and control the spread of AIDS in the Eastern Caribbean." The purpose;

to establish a capacity to develop, implement and monitor cost-effective surveillance, information, education and intervention strategies in support of projecting trends in and reducing the transmission of STDs, with special attention to HIV/AIDS,

has been modified from the first phase in that "monitoring" and "STDs" have been included to accentuate their importance.

Attention during the second phase will continue to be paid to assisting governments and NGO's through regional channels with strategies 1 and 2;

- * establishing and strengthening epidemiological surveillance and research programs to gather information on the extent and characteristics of STD transmissions and AIDS cases, and
- * introducing, improving and evaluating programs which will reduce the likelihood of sexual transmission of HIV infection.

Having received less attention in the first phase, an attempt will be made to increase efforts under the additional strategy 6 (in the CAREC MTP);

- * improving the management skills of the human resource base charged with implementing AIDS programs and to

design intervention programs that are cost-effective and sustainable.

2. End-Of-Project-Status

The two quantifiable objectives identified at project initiation will remain the same although more can be said about possible methods of verification.

- To reduce the annual rate of new sexually transmitted disease cases by 25% from the current or projected level in select target countries.

Fortunately, the numbers of AIDS cases are too small in most of these countries to demonstrate a 25% decrease annually. More importantly, since AIDS cases represent infections received an average of eight years ago, one can not expect to see an impact from intervention activities until (at the earliest) the mid-90's. And yet this is the period the expected "peak" is to occur. Numbers of cases in syphilis and gonorrhea are large enough, but their reporting system (based on public services) fail to represent the whole picture and can be indicative of other factors (such as variation in availability of drugs) rather than disease transmission patterns or changed behavior. Assuming facilities that provide STD care are functioning well in a select number of sentinel sites in the near future, and private sector involvement in reporting is improved, STD clinic cases might be feasible as validation data.

Sentinel surveillance of gonorrhea and syphilis among antenatal women in several different urban sites appears the most likely population for verification of this objective. Monitoring syphilis seroprevalence among young women in the under 19 year age group will provide a reflection of relatively "new" disease or incidence. Other methods currently being tested may be available in the near future, such as surveys of reported symptoms of urethral discharge and genital ulcers (FHI's QuISTD Index).

-To prevent HIV infection from exceeding 1 percent prevalence in 7 years in countries which have little or no infection today as measured in groups representative of the general population.

As mentioned in the project paper, this objective will be measured in antenatal attendees. Again, sentinel surveillance will need to be established in several urban clinics.

CAREC will introduce to countries a sentinel surveillance matrix that will suggest what sentinel surveillance activities are to be

developed for monitoring the above. This matrix is discussed later in the document.

Five conditions are to exist after seven years. These will be retained for the second phase with some modification, to highlight the importance of using syphilis rates to reflect disease transmission. These are repeated here for clarity and emphasis:

- (1) Eastern Caribbean governments will have an adequate data base and information system for tracking changes in the HIV+, AIDS and syphilis prevalence in their countries.
- (2) A majority (75%) of the adult population in the region will have an accurate assessment of their own perceived risk and appropriate concern, motivation, skills and support to adopt behavior change.
- (3) Governmental ministries and departments, and non-governmental, community-based organizations in the region will have the enhanced technical, professional, and social science skills to effectively plan, implement, and evaluate AIDS prevention, counselling and treatment programs for AIDS patients and their families.
- (4) A 50 percent increase will be effected among targeted at-risk population groups in at least four countries in practicing improved safe sexual behavior as a result of information, education, and promotion of condoms.
- (5) The Caribbean Epidemiology Centre will have strengthened its institutional capabilities in social/behavioral sciences and health education/communications to enhance its ability to effectively plan, coordinate and evaluate responses in these areas to chronic disease problems arising in the Caribbean.

The process indicators and outputs listed in the logframe will remain intact. Progress on their achievement is discussed in the sections below, with suggested additional monitoring indicators.

C.. Project Description

ACTS assists primarily six priority countries (Antigua, St. Vincent and the Grenadines, St. Lucia, St. Kitts and Nevis, and Dominica) in addressing the challenge of AIDS by improving surveillance of the disease and preventing its sexual transmission. The ACTS project expands this goal to assisting

the priority nations in addressing the challenge of AIDS and CSTDs, aiming to achieve coordination and, as appropriate, integration among activities and resources in both areas of concern. This expansion of focus is consistent with viewpoints of the Global Program on AIDS, the Declaration of Kingston, and the conclusions of the interim evaluation. While some use of a combined focus was begun in Phase One, the potential usefulness of this approach should be more fully realized in Phase Two.

Strategy 1, surveillance of AIDS, HIV and CSTDs will assist countries in establishing sentinel surveillance systems that reflect an estimation of disease frequency and distribution, and provide an indication of program effectiveness in reducing transmission. Assessing and monitoring knowledge, attitudes, beliefs and practices will be performed using a variety of methods, including KABP studies.

Prevention of sexual transmission (Strategy 2) is recognized to rest primarily on IEC promotion of safe sexual practices. The target population is the young adult core group with its higher risk sub-groups; prostitutes, clients of prostitutes, STD patients and migrant workers. Behavioral research, IEC and behavior intervention activities will be directed towards reaching this target core group at the country level. Prevention of disease transmission will be augmented through promotion and distribution of condoms and effective treatment and management of sexual partners of STD patients.

Strategy 6 is devoted to improving management and developing costing alternatives. Regional management courses and/or on-the-job training will be available to national managers. Costing of major intervention activities with emphasis on comparing several approaches will become part of the planning process.

For those activities from Phase I which are not discussed below, efforts will proceed without change. The activities highlighted below include several from Phase I which, based on the evaluation, have been revised, augmented, or are highlighted for emphasis.

1.. Overview of Project Management Structure

The overall management structure for the project will continue to involve USAID/RDO/C, CAREC and the US institutional contractors, working in close collaboration with the National AIDS Coordinators in each of the six priority countries. Based on the experiences during the first phase in trying to develop a workable arrangement, and the findings of the recent project evaluation, the management structure will remain the same during the Second Phase with a slight modification in CAREC's role.

Giving recognition to CAREC's standing as a Caribbean technical resource, CAREC will play a strong coordinating role in project implementation. Two positions funded by USAID, in psycho-social science and communications/social marketing strategies will be added to the existing CAREC staff responsible for STD efforts; to be retained once the project is over by CAREC for broader health promotion efforts.

CAREC will direct project efforts in all project strategies, identify and coordinate technical assistance and small grant resources and monitor country and regional program implementation and the circumstances affecting progress.

U.S. institutional contractors will strengthen CAREC's capabilities to deliver its responsibilities under the project and generally to its members. The technical assistance will be provided directly to CAREC and under the terms of the country and regional MTPs, to countries directly. The purpose of the technical assistance will be two-fold; to assist CAREC to develop expertise in the planning, management and evaluation of AIDS prevention and control programs; and to fill technical resource gaps in the implementation of field programs. Both long and short term assistance will be required, although the primary mode of assistance will continue to be short term. Experienced advisors identified by the institutional contractors will be assigned to the new CAREC personnel mentioned above, to provide technical guidance and consultation for the first year.

While contracting of the US technical assistance firms will be done by USAID, they will be responsible both to CAREC and to USAID for the performance of their scope of work. CAREC will however have a corresponding responsibility to ensure that the scopes of work of the contractors are effectively carried out, and that as far as possible, obstacles to smooth implementation, such as poor communications with cooperating countries, are minimized.

At the country level, the national AIDS programs will be managed by a National AIDS Coordinator. This position has already been filled in St. Vincent, with the promise of PAHO financial assistance. A similar arrangement is being pursued by St. Lucia, and PAHO is encouraging the other countries to follow suit. PAHO is also planning to assign a STD program officer to the region to assist ministries in STD program management. Such expertise would be best served at CAREC. These new positions are critical to the effective implementation of plans made by the NAPCs.

2.. **STD Surveillance and Knowledge, Attitudes, Beliefs and Practices Studies**

a.. **Development of Standardized Surveillance Systems**

(1). **Regional Level**

CAREC will continue to strengthen STD surveillance systems in the region by convening an additional workshop on STD surveillance (co-sponsored by the appropriate US contractor) to re-enforce the content of the 1989 surveillance workshop. The objectives of the workshop are twofold:

- To again summarize use of new reporting forms and to discuss any problems or issues regarding completion, accuracy and timeliness; and more importantly
- To recommend a suggested STD surveillance plan for countries to follow. The plan will be simple in its listing of diseases to be monitored and populations surveyed:

SUGGESTED IN-COUNTRY SENTINEL SURVEILLANCE MATRIX

Disease	Routine Reporting	(Prev/Incid)	Special Surveys	(Prev/Incid)
HIV	blood donors STD patients	X X	prostitutes prisoners migrants cohorts	X X X X
AIDS	H.C. facility patients			X
Syphilis	antenatals STD patients family plan.	X X X	X X	X X X
Gonorrhoea	STD patients antenatal	X X	X X	X X
Urethritis	STD patients	X	males	X

(Prev = Prevalence and Incid = Incidence)

Countries will be encouraged to work towards the establishment of routine sentinel surveillance and reporting in the groups listed for each disease or syndrome. The special surveys will be dependent upon individual country environments, assessment of

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risk for each group and available resources. These surveys will not be performed at the expense of the routine sentinel surveillance activities.

CAREC and countries will include these data reported from above, as indicators within their respective STD evaluation strategies. It will be assumed that these data will be gathered from both public and the private sector; and that priority will be accorded to urban sites versus rural. Linked and unlinked testing of HIV will be determined at the local level.

Three sources of data in existence could provide additional STD trend information at the regional level. HIV testing is (or was) performed as a requirement for US visas and thus could be analyzed. Several employment-insurance programs are also requiring HIV testing for new enrollments. Lastly, positive syphilis serology data on antenatal women performed over the recent years should be analyzed by age group and year. Rates of seroprevalence among the youngest women would provide a close approximation to new syphilis (incidence) and thus, potential HIV rates. Significant change in rates of syphilis would reflect impact from intervention programs, assuming availability of antenatal services stays the same.

In June 1991, CAREC will convene a workshop on STD laboratory diagnostics for all 19 countries. Information from a survey questionnaire show countries in need of chlamydia and herpes testing and confirmatory testing for syphilis. CAREC will need to develop STD guidance on basic laboratory needs. MTPs may need to reprogram funds for these relatively small costs. At the present time CAREC is in the process of defining its own role in serving as a regional laboratory in the area of CSTDs. Their role is probably that of performing regional studies that require antibiotic sensitivity and confirmatory serology testing.

(2). Country Level

Aside from developing their sentinel surveillance strategy (based on CAREC's matrix) countries will be "polishing" their reporting systems in ensuring forms are completed on a timely basis, improving the inclusion of biographical data (age, marital status {or number of steady partners} address, etc. on reporting forms and ensuring facilities and laboratories are complementary in reporting procedures.

Much effort will be needed in assessing private sector reporting potential.

This particular effort will be one part of a larger effort to work with the physicians and pharmacists in overall STD management. This is discussed later in the document.

Since standardized reporting forms have yet to be incorporated into the local surveillance system, CAREC will assist the priority countries at the local level to implement their surveillance systems for monitoring and estimating trends in AIDS, gonorrhea, and infectious syphilis cases, and HIV and syphilis seroprevalence. The feasibility of reporting non-gonococcal infections will be investigated. Several weeks of technical assistance in each country will address the existing epidemiologic situation, defining the objectives of the surveillance, determining general survey methods, sampling methods, laboratory services and training/briefing personnel and identifying equipment needs. Supervision and feedback will be accentuated with a supervisory checklist and the CAREC Communicable Disease Review will provide important feedback to personnel.

The following indicators may be selected to assist in the monitoring progress:

- * percentage of sentinel sites with regular reporting during the preceding 12 months;
- * proportion of responsible officers trained;
- * proportion of sentinel laboratories receiving an uninterrupted supply of materials and equipment;
- * proportion of STD clinic patients who are first attenders by age group;

(3). STD Small Grants Research program

CAREC and AIDSTECH will provide close oversight to the principal investigators of the small grant research proposals funded during the last year and will promote additional proposals centered on CSTD. Proposals could look into the feasibility of:

- * performing the special surveys among certain population groups listed in the sentinel surveillance matrix and ;
- * performing a pilot study to determine significance of pelvic inflammatory disease (PID) in health care facilities caused by STDs. Interviewing female patients recently diagnosed with PID and determining percentage of source contacts who are asymptomatic.

(4). STD Symposia

Since specific STD symposia were not convened during the last phase, these forums are planned again during the second phase. CAREC with the assistance of the appropriate US contractor will convene a technical symposium on STD/HIV infections in late 1991.

The objective of this regional symposium will be to review available data on HIV infection and CSTD in the Caribbean and to identify areas of research and control strategies. The small grants research program for CSTD will be re-introduced. A follow-up symposium will be held in 1993 to report results of this targeted research program. Survey data collected by CAREC in 1990/91 will assist organizers in determining status of country diagnostic capabilities. Participants will be asked to bring certain information on their STD programs to augment further CAREC knowledge of regional weaknesses and strengths.

(5). KABP Studies

Completion of KABP surveys during the First Phase have been delayed for several reasons, most notably; lack of enthusiasm among nationals, confusion over the survey's purpose, and delays in contracting services. Presently St. Vincent and St. Lucia have collected data, Dominica and Grenada are ready to begin the survey and plans within Antigua and St. Kitts are unclear.

During this Second Phase, the KABPs will be completed in 1991 in four countries where activity has already begun or is planned. In Antigua and St. Kitts, steps will be taken to explore more flexible, at least partially qualitative investigation, and to gather data for planning a national communication campaign. These latter activities will be completed by 1991 as well.

3.. Strategy 2: Prevention of Sexually Transmitted HIV Infection

a.. Strengthened Capacity in Psycho-Social Sciences

Limited additions of personnel and substantial efforts to develop resource networks and collaboration will be pursued by CAREC towards strengthening the region's capabilities in psycho-social sciences. Such efforts will improve the conduct of surveillance-related activities, improve the design and implementation of activities aimed at reducing the risk of sexual transmission, and enhance the overall development of NPAs. The limited additions of personnel will include a resident psycho-social scientist at CAREC, provided under the appropriate US institutional contractor, for approximately nine months to a year. A new position at CAREC, to be financed under the ACTS grant, will be created as liaison/counterpart to the resident scientist. This position will continue the program developed in collaboration with the scientist, who will pay periodic visits to the project and field sites after completion of the resident tour. In order to complement the role of the psychologist who presently serves as ACTS Project Coordinator, recruitment of the regional liaison/counterpart to the resident scientist should be limited to persons qualified and skilled in sociology or anthropology.

The US institution will give active consideration, in filling the position of the resident advisor, to recruiting a qualified non-US national, and preferably a Caribbean social scientist.

(1). Activities

Another aspect of strengthening the region's capabilities in the psycho-social area will involve identifying sub-regional, regional, and U.S. networks of psycho-social scientists who are familiar with the Caribbean or have particular strategic skills and availability.

The work of the resident scientist during Phase II will include planning and conducting at least one seminar on psycho-social research in support of AIDS prevention and developing a strategy of behavioral surveillance to serve the Priority Nation NPAs; and research services and consultation to the Priority Nation NPAs in developing applied KABP and ethnographic research to support surveillance, intervention planning, or intervention implementation.

b.. Behavior Intervention Programs

(1). Focus on Youth

Youth constitute the largest target group for STD infection in the Caribbean. The incidence of AIDS and CSTDs in this population point to their vulnerability, and evidence from focus group surveys in St. Vincent, and from key informants elsewhere indicate that their level of awareness on STDs needs to be improved. There is widespread enthusiasm for efforts to reach this population, and a variety of efforts has emerged. These efforts will be supported during Phase II, with higher visibility to reflect the priority which this group should be accorded.

(2). Activities

Efforts during this phase targeted to youth will include:

- * continuation of the research, using focus groups and other qualitative and quantitative methods to determine the needs of youth;
- * development of campaign "packages" with aids in education and communications to be used by Health Education Units
- * review of effective youth programs, such as the peer counselling program in St. Lucia, and adolescent health centers in St. Vincent and Antigua, so that replication to other countries could be assessed and applied;

- * strategy development to reach youth in various settings: in and out of school, and the young adult who has completed schooling.
- * collaboration with CFPA under a grant from USAID to augment the work they have done in reaching young adults and in promoting sexual health.

(3). Special Male and Female Targeting

As part of a "Lifestyles" campaign to be implemented regionally, a special effort will be made to target Caribbean males. The male role in social, economic, and cultural contexts in the region is obviously a critical factor in maintaining healthy sexual relationships. Evidence from outside the region suggests that men will respond positively to supportive interventions which promote healthier sexual lifestyles and cooperation with partners in sharing health and (in heterosexual relationships) contraceptive concerns.

This special concern for effecting lifestyle changes in Caribbean males is warranted in spite of the fact that other education efforts will also reach this group. The Caribbean appears to have a considerable incidence of "serial monogamous relationships", and long term extra-marital relationships.

CFPA appears to have the skills and inclination to mount such a lifestyles campaign aimed at males. This has already been fairly successful in the family planning area, and building on this narrower effort should be effective from a holistic, lifestyle-type perspective.

CFPA is also the likely regional resource for targeting young women. Due to the devastating effect HIV and CSTDs have on children and the reproductive health of women, combined reproductive and sexual health counseling should be implemented. When choosing among contraceptive methods, women should be advised of the assumed benefits of barrier methods against disease transmission.

Discussions with CFPA regarding possible means of collaboration will be initiated by RDO/C with the assistance of CAREC this year.

c.. Information, Education and Communication Efforts

(1). Strategy

An analysis of the situation in the region and the first phase of the ACTS project revealed during the interim evaluation that:

- * The resources (both financial and human) in individual countries are too thin to plan local generation of significant amounts of effective interventions.
- * The potential size of the target audiences is small and makes it difficult to amortize the investment in developing effective messages over a large population base. The logic of aggregating the potential audiences in different countries to achieve economies of scale is compelling.
- * The initial efforts have generally been of two types -- building capability to respond by training and service development, and prevention efforts directed at small, high-risk groups. The second phase of ACTS will need to move from preparation and research to larger scale action.
 - The preparation cycle has laid the necessary groundwork for the larger scale programs -- many people have been trained, counseling capabilities have been created, the medical community has been educated, and many essential policy issues have been raised. The effort to foster an appropriate infrastructure for responding should continue, but should receive a much lower proportion of ACTS resources.
 - It is now appropriate to direct outreach to young adults with behavioral oriented campaigns for prevention of sexual transmission. The smaller high risk group activities will continue, supplemented with beginning new activities focused on this larger target group.

The strategy proposed for the second phase is to continue in the same basic approaches, but to use the techniques of social marketing much more extensively to develop communication campaigns to reach a larger segment of the population. The limited resources within the Ministries of Health suggest that substantial external support (both technical and financial) will be required to accomplish the goal. The urgency of the situation with the epidemic leads one to put a higher initial priority on getting effective preventive health education in place than on developing the local capability to create it. Although, the two go hand-in-hand, the crisis nature of AIDS does not offer the option of waiting to build up indigenous ability to respond before beginning intense efforts. Thus a strategy will be developed to supplement the local resources with assistance that

provides a level of response that is both more intensive and more effective than they might normally generate.

(2). Methods

The objective for Phase II of ACTS is to enhance the abilities of the small countries to undertake well planned campaigns addressing sexual transmission among young adults and significant at-risk portions of that population. The methods for doing this include strengthening CAREC's capabilities in communication and developing interventions that the countries can adopt and adapt, rather than create from scratch.

The main new technique the project will use is to develop generic packages of materials reflecting integrated campaigns targeted on a defined youth audience that can be utilized in several countries.

- * A campaign "package" would include suggestions for local research or focus group topics, pretested print materials, scripts or taped messages for radio, training manuals for people working on the campaign, video programs or spots if appropriate, media plans, monitoring techniques for assessing coverage and progress, background information on the specific AIDS issues, suggestions for coordination with activities of other organizations, suggested lists of ancillary activities, events, or messages, etc.
- * This will allow the health education unit of the Ministry of Health or for an NGO to undertake a comprehensive, effective activity without having the resources or the skilled personnel to create the campaign themselves. Therefore the packages themselves would be promoted to countries, perhaps with a workshop or seminar. The handling of the hotline training during Phase I may provide a useful model.
- * The packages will presumably be developed in a particular country, perhaps but not necessarily in the model countries selected for intensive communications work, and then prepared for "export" by revising them with an eye to generality and expanding them if appropriate to include additional activities not undertaken in the initial site.
- * To the extent possible, the flexibility for adaptation will be preserved, so that, for example, local audio tracks can be dubbed onto video, or furnished radio scripts can be recorded with local talent in the correct accent.

* The high risk group interventions initiated during the first phase (that address smaller audiences) are themselves candidate interventions for "packaging," if it appears that they would be useful in multiple sites.

It is anticipated that between five and ten such packages might be required during the second phase of ACTS.

(3). Management

In order to help establish the communications capability at CAREC, a resident advisor in communication/social marketing will be funded by USAID for a period of at least one year. CAREC will recruit a counterpart professional (also funded by USAID through the duration of the project) to be retained by CAREC after the project ends. The immediate objective of these position is to work with the countries and CAREC staff to produce the intervention packages and facilitate their adoption among the countries. The secondary objective is to transfer a fuller understanding of the methodology and build the institutional capability within CAREC to generate this type of activity autonomously.

The most important skills for the candidates are those having to do with planning and design of communication interventions. These are more important qualifications than research, media production, or commercial advertising experience.

In addition to the long-term technical assistance, short-term TA will be necessary, both to complement the professional skills of the long term staff and to augment the manpower applied to specific tasks.

(4). Indicators

Indicators of the impact of the project funded activity will remain as listed in the initial project logical framework. For tracking overall changes in the general population, the KABP survey on comparable samples will be repeated near the end of the project.

CAREC will consider the development of specific behavioral objectives of a campaign that would give a more immediate measure of how well a particular campaign is going. These measures would then be incorporated into the planned USAID/CAREC MIS and evaluation strategy.

d.. Disease Prevention - STD Program Services

The main goals of CSTD prevention and control are the same as those for AIDS infections with an additional focus on "preventing the development of complications and their consequences" of CSTD

that can be cured; mainly syphilis, gonorrhea and non-gonococcal infections. This specific goal is accomplished by

- * detecting and curing disease by implementing disease detection activities, providing effective and efficient diagnostic and treatment facilities, and promoting health-seeking behavior.
- * limiting complications of infection by providing early and appropriate treatment for both symptomatic and asymptomatic infected patients and their contacts.

Disease detection will be accomplished by 1) screening certain identified populations in the community 2) case finding using clinical and/or laboratory tests to detect infections in individuals seeking health care for other reasons (antenatal and STD patients for syphilis, gonorrhea and non-gonococcal infections); and 3) diagnosis by application of clinical and laboratory procedures to detect the cause of the above mentioned CSTDs.

Program activities will emphasize prevention and control of three major CSTDs: gonorrhea, syphilis and non-gonococcal infections. Although there are more than fifty STDs, concentration on these diseases would appear most cost effective for the time being, due to reasons of high prevalence, risk of complications, available low-cost treatments and laboratory tests for diagnosis. Additionally, the above diseases can be diagnosed by syndrome, (genital ulcer disease, urethritis, cervicitis) which precludes the need for laboratory support.

Choice of drugs for treatment and other interventions for cure will follow WHO guidelines which address drug efficacy, acceptability, convenience, cost, and availability. Funding for drugs and minor laboratory support will be covered by national budgets or other donors.

Management of sexual contacts and health education are the main components of patient counseling. As with AIDS, health education for CSTDs consists of 1) activities which increase individual and community awareness and knowledge of STD, and 2) efforts to produce positive changes in their attitudes and behaviors. Management of sexual contacts will be a direct result of patient counseling which may include motivating the patient to assume an active role in bringing contacts for evaluation and treatment or it will be implemented as an active search for STD contacts by health personnel. Motivating the patient to refer contacts is the most cost-effective means of contact management. Appropriate management of STD patients will include the application of prophylaxis treatment regimens to selected contacts.

STD services in the Eastern Caribbean are provided at clinics, private offices, hospitals, pharmacies and other facilities which ensure some privacy for patient-clinician encounters. Where exactly people do seek and find care for STDs will need to be investigated in each priority country.

Proper CSTD management will require 1) frequent professional and technical training of public and private health personnel, 2) minimal laboratory support and 3) information systems (surveillance, reporting, analysis and feedback).

(1). Activities

--CAREC will review complete CSTD program elements with the six priority countries. The reviews will encompass an examination of the public CSTD information system, laboratory support (which has been initiated via survey questionnaire), diagnosis and treatment procedures, counseling services, health education activities and contact management.

--The above will be done for the private sector as well, although this effort will require a survey of providers to determine who is providing STD care and careful initiation of dialogue regarding reporting and contact management. The Caribbean College of Family Practitioners may be the first contact.

--As already mentioned, CAREC may find it appropriate to ask country participants to bring some of the above information to the previously mentioned STD symposium.

--Plans of actions will be developed in country, designating technical assistance and equipment needs.

--Technical assistance for the above will require several months duration in each country in order to perform a thorough analysis and advise personnel on day-to-day operational elements. Technical assistance will also be needed to assist CAREC in facilitating at the training forums for public and private physicians in clinical care, interpersonal and counseling skills, contact management and reporting.

(2). Indicators

Indicators for monitoring progress can be the following:

- * number of new STD service centers (or sessions) existing
- * number of existing STD service centers which have been assessed for needs and strengthened

- * proportion of STD services with adequate and continuous supply of STD drugs and condoms
- * percentage of STD services with improved contact management indices (# of contacts examined per index patient)
- * number of repeat infections per year

e.. **Skill Building Training for National Health Educators**

The evaluation identified the over-concentration of resources at the person-to-person level as a weakness in the health education/communications strategy. Since fewer contacts are made via this route than by the more mass media related interventions, Phase II will concentrate more efforts at mass media strategizing, and building up capacity at the regional level. Correspondingly, skill building in the same area will proceed for national health education staff, through workshops on research methodology, planning mass media campaigns, and assessing impact. The workshop activities will be supplemented by follow up visits made to the priority countries by CAREC and contractor personnel.

The resources in health education at the country levels are limited. Most of the countries have only one or two officers who are responsible for the entire range of health education needs. The evaluation of Phase I determined that there was a need to build the skills of the health education personnel in ministries of health. To this end, the project will arrange several workshops aimed at upgrading the health education skills of the staff in HE units in the priority countries, specifically addressing the interventions being implemented under this project.

f.. **Training Professionals, Community Leaders, and Influentials**

Several workshops conducted during Phase I addressed the improvement of the HIV/AIDS knowledge base in health and education personnel. Except for the trainer of trainers (TOT) workshops, which have not been translated into follow on actions at country level, there were no actions taken which addressed the problems of reaching community leaders and influentials.

During Phase II, greater attention will be given by the National AIDS coordinators to reach and involve community leaders and influentials, particularly educators, politicians, sports personalities, and entertainers. These efforts at country level will be supported by follow up regional TOT workshops, and technical assistance visits from project personnel located at CAREC.

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The AIDS Impact Model (AIMS) will be promoted in all countries if possible in order to persuade decision makers to move forward more quickly on AIDS interventions.

g.. **Hotlines**

AIDS hotlines have been established during Phase I in Trinidad and Tobago and St. Lucia. Continuing support will be provided to the St. Lucia hotline which has been in operation for less than six months. This hotline may be made accessible to callers from St. Vincent on a toll-free basis in 1991, and as this experiment goes forward it will be monitored closely, particularly for its cost effectiveness.

As planned in the original project paper, consideration will be given during this phase to establishing a single hotline for the priority countries, given the small population sizes, and therefore potential contact demand. The review of the St. Lucia hotline, after inclusion of St. Vincent, will assist in evaluating volunteer morale, cost per contact, and ease of referral of callers to health facilities in their own country.

Concern has been expressed in the region for the stigmatization of the hotlines as being only for AIDS infected persons or those who fear they may have contracted HIV/AIDS. It has been recommended, and the project will explore the possibility of expanding the focus of the hotline to a broader one of "personal health": including a range of topics from sexual functioning, reproductive health, CSTDs, relationships, pregnancy and family planning.

h.. **Innovative Community Approaches**

The original project paper outlined strong arguments for involving the non-governmental, and community-based organizations in each priority country in the HIV/AIDS prevention program. Except to a limited extent in St. Vincent and St. Lucia, the involvement of NGOs has been marginal to date. The Project Paper proposed a motivational tool of small grants, not to exceed US\$ 5,000, for which NGOs could apply to support, or start their AIDS prevention activities. This program was not concretely instituted, but remains one of the important features of the plan to increase NGO and private sector involvement. Efforts will be redoubled in Phase II to institute the small grants program, and to encourage greater community participation in AIDS prevention and control. A workshop or similar type of forum will probably need to be convened, inviting potential grant recipients.

4.. **Strategy 6: Promotion of Effective Management of National Programs**

a.. **Program Management Improvements and Costing Alternatives**

The specific goal of this activity is to "improve the management skills of the human resource base charged with implementing AIDS programs and to design intervention programs that are cost-effective and sustainable." Greater attention on this effort will be provided during Phase II in the form of management training. Costing alternatives will be incorporated in the design of interventions under Strategies I and II so that the most cost-effective measures are adopted.

(1). **Training in Management**

The original project paper outlined several areas which should be addressed by the management intervention. These were inter alia development of goals, objectives, and work plans, time management, task management, supervisory skills, group dynamics, skills for conducting meetings and practical cost-effectiveness methodologies. With technical assistance provided through the appropriate institutional contractor, the project will identify the weaknesses in the AIDS program management structures in each country, especially at the service delivery level, and design a training program which addresses these needs. Recommendations from the previous workshop of July 1989, will also be addressed.

An important effort under this activity will be to assist the countries to "disaggregate" MTPs for more effective implementation. The intention of this effort is to transfer skills in the planning process, and encourage greater participation by all the agencies involved in implementing AIDS prevention programs.

The project staff will also work closely with the AIDS Coordinators from each of the priority countries, assessing their level of management skill, to determine the best way of addressing their management assistance needs. From this assessment, workshops or specific, individualized technical assistance interventions will be designed and implemented.

Where computer skills and availability exist in the countries, the project will assist the coordinators to build on these skills using the same management software as the Project Coordinator does. These interventions will be reinforced by the sharing of copies of management articles and publications when available.

(2). Program Costing Alternatives

Operations Research - Within selected program interventions, operations research activities will be undertaken to provide managers with information on optimal ways of implementing these interventions. It must be stressed that these research activities must have practical application in improving project implementation or management; for example, optimal methods of contact tracing, diagnosing CSTD by syndrome versus laboratory confirmation and feasibility of extending or changing STD clinic hours.

Alternative Financing and Demand Analyses - The project will apply alternative financing and demand analyses to selected interventions, whether implemented through this project or supported by another donor. The objective of these analyses will be to assist the National AIDS Committees and the Governments to make more informed decisions on the allocation of activities for implementation. Decisions on the involvement and extent thereof of the NGO community in implementing AIDS activities would be assisted by the results of these studies.

In order to obtain a measure of the sustainability of the AIDS hotlines, a study will be made of the two which have been developed to date. This study will examine demand for the services and estimate costs of serving that demand, as well as assessing alternative financing prospects. This study will provide information critical to the decisions on whether hotlines should be regional or country specific (and whether they should be AIDS specific or more generic).

It should be mentioned here that USAID/RDO/C anticipates that cost-effectiveness analyses will be promoted at the country level through a Health Care Financing initiative to be developed in US fiscal year 1992.

III.. IMPLEMENTATION PLAN

The implementation plan discussed in the original Project Paper remains unchanged except for the previously mentioned stronger coordinating role performed by CAREC during the Second Phase and the additional two positions in psycho-social sciences and communications/social marketing.

The following suggested Plan of Activities is listed below for the remainder of the First Phase (1991) and the Second Phase:

SUGGESTED PLAN OF ACTIVITIES

ACTIVITY	RESPONSIBLE PARTY	YEAR	TECHNICAL ASSISTANCE
<u>Surveillance</u>			
1. Regional			
--STD Surveillance Workshop	CAREC	1991	1 mos
--STD Laboratory Diagnostics	CAREC	1991	0
2. In-country			
--Review of STD sentinel systems	CAREC	1992/3	6 mos.
3. Epidemiologic Research			
--Small Grants Program (15)	CAREC	1992/4	7 mos.

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4. STD Symposia

--First symposium	CAREC	1992	.5 mos
--Second symposium	CAREC	1993	.5 mos

5. KABP

--Complete data analysis (2)	CAREC	1991	1 mos
--Perform survey (2)	CAREC	1991	3 mos
--Alternative studies (2)	CAREC	1991	2 mos

Psycho-Social Sciences

--Recruit Sociologist/Anthro.	CAREC	1992	0
--Assign Science Advisor	USAID	1992	12 mos
--Seminar	CAREC	1993	1 mos
--Negotiate CIPA agreement	USAID/CAREC	1993	

Communications

--Recruit Communications Spec.	CAREC	1991	0
--Assign Communications Advisor	USAID	1991	0
--Campaign Packages (10)	CAREC	1991/4	10 mos
--Workshop	CAREC	1992/3	1 mos

STD Program Services

--In-country reviews	CAREC	1992/5	18 mos
--In-country workshops	CAREC	1993/5	3 mos

NGO Small Grants

--Proposals (15)	CAREC	1991/4	2 mos
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Training

1. National

--Prof/Comm. Leaders/Influen. (6)	CAREC	1992/5	2 mos
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2. Regional

--Health Educators Workshop	CAREC	1993	.5mos
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Hotlines

--Continuation-St. Vincent/Lucia	CAREC	1991	0
--Initiation in other countries	CAREC	1992	2 mos

Management Training

--Regional Workshop (1)	CAREC	1993	1 mos
--On-the-Job Training	CAREC	1992/4	3 mos

Costing Alternatives

--Operations Research (7)	CAREC	1993/5	7 mos
--Financing/Demand Studies (4)	CAREC	1992/4	6 mos

<u>Management Information System</u>	USAID/CAREC	1991/5	0
<u>Internal Review</u>	CAREC	1993	0
<u>External Evaluation</u>	USAID	1995	4 mos

IV.. MONITORING AND EVALUATION

A.. Management Information Systems

A standardized MIS format will be developed by USAID with CAREC's assistance before mid-June of this year. This format will be followed by CAREC, and the two US institutions. The format will be simple but complete in its inclusion of the project activities, logframe objectives and indicators. STD data from the countries' surveillance systems and the suggested STD program process indicators should be available to be included in these reports by 1993. CAREC and the two institutions will complete this three times a year, incorporated within their quarterly progress reports.

B.. Internal Review and External Evaluation

An informal internal review will be performed by the three implementing agents and country nationals at the end of 1993. The components of the review will be identified by the implementers and country AIDS Coordinators. This will allow project personnel to identify problems and issues, recommend solutions and their resolution over a one year period, in preparation for and before the external end-of-project evaluation in 1995. The purpose of the external evaluation will be to determine if all objectives have been achieved. USAID will identify the size, makeup and specific terms of reference of the external evaluation.

V.. COST ESTIMATES AND FINANCIAL PLAN

Annex 1

PERSON MET AND PLACES VISITED BY EVALUATION TEAM

Washington D.C. - Agency for International Development

Mr. N. Studzinski
Dr. J. Harris
Dr. T. Meyer
Ms. L. Bradshaw
Mr. E. Soto

- Pan-American Health Organization/American
Regional Office

Ms. L. Bond
Dr. A. Brandling Bennett
Dr. F. Zacarias
Ms. A. Kimball

- Academy for Educational Development

Dr. W. Smith	Mr. G. Margo
Mr. J. Novak	Ms. S. Middlestat
Mr. M. Helquist	Ms. P. Chenais
Mr. M. Ramah	

North Carolina - Family Health International

Ms. J. Lewis	Dr. P. Lamptey
Ms. L. Cole	Ms. C. Brokenshire
Mr. M. Ostfield	Ms. A. Martin
Ms. N. Brenden	Mr. M. Welsh
Dr. S. Hassig	Mr. S. Forsythe
Mr. E. Archbold	Ms. P. Sketo

Barbados - AID Regional Development Office

Dr. C. Becker	Dr. J. Cashion
Ms. A. Yu	Mr. D. Clarke
Mr. J. Wooten	Mr. E. Harewood
Mr. N. Selman	

Trinidad

- Caribbean Epidemiology Centre

Dr. F. White	Dr. J. Hospedales
Dr. B. Theodore-Gandhi	Dr. B. Hull
Ms. E. de Gourville	Mr. C. Cholmondeley
Ms. C. Francis	Ms. A. Reid
Ms. J. Chandler	Ms. C. O'Neil
Mr. L. Fitzpatrick	Ms. H. Joseph
Ms. A. Rocke	Ms. D. Renaud
Ms. N. Taylor	Ms. C. Drakes
Ms. A. Camejo	Mr. J. Boisson

- National Blood Transfusion Service

Dr. K. Gomez-Adams Dr. W. Charles

- QPCC STD Clinic

Ms. L. Nurse

Antigua

- Ministry of Health

Dr. L. Simon
Dr. Locker
Ms. P. Reynolds
Ms. Wallace
Ms. Kelsick

- U.S. Embassy

Mr. B. Salters

- Caribbean Family Planning Affiliation

Dr. T. Jagdeo

St. Vincent

- Ministry of Health

Ms. A. Anderson	Dr. A. Eustace
Mr. C. Brown	Ms. V. Beache-Murphy
Dr. F. Rampersaud	

- Prisons

Mr. Marksman

St. Lucia

- Ministry of Health

Dr. M. Ooms	Mr. P. McDonald
Dr. J. St. Catherine	Mr. J. Medard
Dr. M. Grandison-Didier	Ms. Henry
Ms. Burnett	Dr. S. King
Dr. F. Glover	Ms. R. Dalphenis
Ms. E. Auguste	Mr. G. Emmanuel
Ms. P. Etienne	Mr. E. Emmanuel

- Correction Institute

Mr. Melchoir

- Labour Department

Mr. S. Vincent

Annex 2

BACKGROUND DOCUMENTS

AID Project Paper, 19 June 1989

AIDS, HIV and STD Surveillance in the Caribbean, Proceedings of a Workshop held in Jamaica, 21-24 November, 1989, CAREC in Collaboration with AIDSTECH and USAID

AIDSCOM Program Report, January 1988 - December 1990, Evaluation ACTS Project Eastern Caribbean, The Academy for Educational Development

AIDSTECH, Eastern Caribbean Acts Project Evaluation, Family Health International, January 1991

AIDSTECH, Easter Caribbean, ACTS Project Evaluation, January 1991 Family Health International

Caribbean Subregional Medium Term Programme for the Prevention and Control of AIDS, 1989 - 1991, Caribbean Epidemiology Centre (CAREC), September 1988

Caribbean Epidemiology Centre, ACTS Project Review, June 1989 - December 1990
Development of a Strategy for Cost Recovery for Blood Transfusion Services in Trinidad and Tobago, Subagreement, Family Health International, October 1, 1989

Effective Management of National AIDS Programming in the Caribbean, CAREC, PAHO/WHO, 1990 Interventions with High Risk Behavior Groups, Antigua, Subagreement, Family Health International

Kingston Declaration on Behavioral Interventions for the Prevention of STD and HIV/AIDS

Multilateral Agreement for the Operation of the Caribbean Epidemiology Centre, Final Draft, 28, February 1990

Saint Lucia National AIDS Prevention and Control Programme, Short and Medium Term Plans, 1988 - 1991, Ministry of Health, Housing, Labour, Information and Broadcasting, May 1988

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Semi-Annual Report 1 April - September 1990, Cooperative Agreement, AID/DPE-5972-1-00-7057-00, AIDSTECH

Trip Report by Gail A. Goodridge on multi-donor team review of CAREC MTP, 130-17, August 1990