

Agency for International Development
Washington, D.C. 20523

FD-ABC-582
70001

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR
FOR SCIENCE AND TECHNOLOGY

FROM: S&T/H, Ann Van Dusen (Acting)

SUBJECT: Authorization of Amendment Number 2 to the AIDS
Technical Support Project (936-5972)

Problem: Your approval is required to amend the AIDS Technical Support project. The purpose of the amendment is to increase the life of project funding, extend the life of project and redesign the project. The life of project authorization would be increased from \$38 million to \$179 million. The life of project ceiling would be increased from \$69 million to \$319 million. The life of project period would be extended from FY 1995 to FY 1997. The Project Assistance Completion Date would be September 21, 1997. The redesign focuses the AIDS prevention and control strategy.

Discussion: A.I.D. approved the AIDS Technical Support Project in 1987, authorizing it for \$38 million through 9/30/95. The project was designed to strengthen the capacity of developing countries, and particularly their health delivery systems, to undertake AIDS prevention and control programs through technical assistance, applied research and procurement.

The rationale behind requesting an increase in the life of project ceiling from \$69 million to \$319 million is based on extending the life of the project by five years which requires a commensurate increase in core funding and allows for a steady increase in levels of Mission add-ons to the project. Recent requests to raise the funding levels for both the ongoing AIDSCOM and AIDSTECH agreements reflect the substantial underestimation of Mission demand. As indicated in the Project Paper Amendment illustrative budget, the level of future S&T core funding is projected to increase by approximately \$5 million in FY 1992 and then remain relatively constant throughout the life of the project. Current proposed appropriations language for the FY 1992 Agency budget indicates a Congressional intention to increase the level of funding for AIDS activities in FY 1992 and again in FY 1993. Historically, the AIDS Technical Support Project has received an increasing share of the Agency AIDS bilateral (non-DFA) funds -- reaching nearly 70 percent in FY 1991. We assume that the AIDS Technical Support Project will continue to receive a substantial proportion of Agency AIDS funds.

Based on previous Mission and Regional Bureau add-on trends, and estimates of FY 1991 and 1992 Mission add-ons (in response to recent worldwide AIDS Technical Support Project Amendment cables) the level of add-ons is expected to steadily increase over the life of the project. In FY 1991, we estimate an add-on level of

\$10.3 million; to date, the Missions have committed \$9.3 million. In FY 1992 we estimate an add-on level of \$12.4 million. Missions have already indicated a level of \$12.8 million.

AIDS Technical Support has eight major subprojects. The two largest include AIDSCOM, a \$17 million contract, and AIDSTECH, a \$28 million cooperative agreement.

In the spring and summer of 1990, the AIDS Cluster reviewed the entire S&T AIDS portfolio. Prompted in part by concern that: (a) both AIDSCOM and AIDSTECH were rapidly approaching their ceilings; (b) a number of gaps had been identified, during the portfolio review, in the A.I.D. response to the AIDS crisis; and (c) under the project strategy resources were spread too thin to have a measurable impact on HIV incidence upon project completion, the AIDS Cluster recommended that the project be extended to 9/21/97 and redesigned.

Project redesign incorporates major lessons learned during the three years of implementation of the AIDS Technical Support project. These lessons reflect what has been learned concerning ways to design and implement AIDS interventions to achieve greater impact on HIV prevalence. Based upon these lessons, the redesigned project will focus on four proven interventions: increasing demand for condoms, increasing access to condoms, partner reduction and diagnosis and treatment of sexually transmitted diseases. The redesign will also include country-specific communications strategies aimed at influencing behavior change, especially among at risk groups.

To enhance the potential for impact, the redesigned project strategy will involve: (a) concentration of resources and the development of a targeted "AIDS strategic plan" in 10-15 priority countries based upon the proven interventions; and (b) short-term technical assistance in non-priority countries. The redesigned project strategy aims at creating full scale, national programs in the priority countries and effective support activities in the non-priority countries. A major objective of this project is to have a measurable impact on HIV incidence in the priority countries upon project completion.

On February 20, 1991 the Agency AIDS Working Group approved the redesign.

Recommendation: That you approve the increase to the life of project funding, the extension of the project period and the redesign by signing the attached project authorization amendment No. 2.

- Attachments: (1) Project Authorization
- (2) Project Paper

Clearances:

S&T/H/AIDS/JHarris gmk you Date 3-27-91
S&T/H:GPettigrew GP Date 3-27-91
S&T/H:NPielmeier NP Date 3-27-91
S&T/PO:DSheldon _____ Date _____
GC/S&T:GWinter (draft) to 3-22-91 Date 3/22/91
DAA/S&T:BLangmaid _____ Date _____

Drafted by: S&T/H: gmk Harris:es:3/4/91:5-4494:auth3

PROJECT AUTHORIZATION AMENDMENT NO. 2

NAME OF PROJECT: AIDS Technical Support
NUMBER OF PROJECT: 936-5972
COUNTRY: Worldwide

1. Pursuant to Section 104 and Section 105 of the Foreign Assistance Act of 1961, as amended, A.I.D. authorized the AIDS Technical Support Project on May 5, 1987. The project involved centrally-funded planned obligations of \$13,000,000 in grant funding and up to \$6,000,000 of additional funding contributed by A.I.D. missions and Regional Bureaus. That authorization was amended on May 5, 1987 to increase the amount of centrally-funded planned obligations to \$38,000,000 while the amount of additional funding provided by A.I.D. missions and Regional Bureaus was increased to \$31,000,000. The authorization is hereby further amended as follows:

(a) The amount of centrally-funded planned obligations is increased to \$179,000,000 and the amount of additional funding which may be provided by A.I.D. missions and Regional Bureaus is increased to approximately \$140,000,000.

(b) The project has been redesigned to focus on four proven interventions: increasing demand for condoms, increasing access to condoms, partner reduction and diagnosis and treatment of sexually transmitted diseases. The redesign will include country-specific communications strategies aimed at influencing behavior change, especially among at-risk groups. The redesign will also concentrate resources in 10-15 priority countries to achieve impact on HIV prevalence and provide short-term technical assistance in non-priority countries.

(c) The project assistance completion date is extended from September 30, 1995 to September 21, 1997. The extended year of obligation is changed from 1994 to 1997.

2. The authorization cited above remains in effect except as hereby amended.

3. Three components of the AIDS Technical Support project which will contribute to the overall objective of having a measurable impact on HIV incidence in priority countries are the existing agreements with federal agencies. Findings that support the continuation of the FAA Section 621 (a) Determination for (1) a PASA with the Centers for Disease Control (CDC); (2) a PASA with the National Institutes of Health (NIH); and (3) a RSSA with the

the National Institutes of Health (NIH); and (3) a RSSA with the Department of Commerce, Bureau of the Census (BuCen) include predominant capabilities such that these services would not be competitive in the private sector. The CDC has technical expertise in service delivery related to sexually transmitted diseases not found in the private sector. The agreement with the NIH affords our program access to federal scientists not available in the private sector for specialized training and research evaluation. BuCen provides a unique method of collecting HIV seroprevalence data and maintains a worldwide database not available in the private sector.

It should be noted that these services do not deprive the CDC, the NIH nor BuCen of the capability to do their own work. These organizations have established separate international service divisions for the express purpose of continued involvement in international programs. I hereby determine that the aforementioned agreements qualify for continued exemption from the provisions of OMB circular A-76 under section 621 (a) of the Foreign Assistance Act because (1) they are for the provision of technical assistance; (2) the facilities and resources of each agency are particularly and uniquely suitable for the assistance to be provided; (3) the services are not competitive with the private sector; and (4) it will not interfere unduly with normal agency work.

Signature: _____
Assistant Administrator for S&T

Date: _____

Clearances:

S&T/H:GPettigrew: GP Date: 3/27/91
S&T/H:NPielmeier NP Date: 3/27/91
S&T/FO: DSheldon _____ Date: _____
GC/S&T:GWinter (draft) 12/3/22/91 Date: 3/22/91
AA/S&T: BLangmaid _____ Date: _____

d

PROJECT DATA SHEET

1. TRANSACTION CODE PD-ABC-58

A - Add
 C - Change
 D - Delete

Amendment Number 2

DOCUMENT CODE 13

2. COUNTRY/ENTITY

Worldwide

3. PROJECT NUMBER

936-5972

4. BUREAU/OFFICE

S&T/H/AIDS

5. PROJECT TITLE (maximum 40 characters)

AIDS Technical Support Project

6. PROJECT ASSISTANCE COMPLETION DATE (FACD)

MM DD YY
09/21/97

7. ESTIMATED DATE OF OBLIGATION

(Under "B" below, enter 1, 2, 3, or 4)

A. Initial FY 87

B. Quarter 4

C. Final FY 97

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	1,000		1,000	179,000		179,000
(Grant)	(1,000)	()	(1,000)	(179,000)	()	(179,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. Add-ons	500		500	140,000		140,000
2.						
Host Country						
Other Donor(s)						
TOTALS	1,500		1,500	319,000		319,000

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) AIDS				26,301		95,000		164,000	
(2) HE/PN	530			4,310		9,500		9,500	
(3) EHR	600			0		500		500	
(4) DFA				0		5,000		5,000	
(5)									
(6)									
TOTAL				30,611		110,000		179,000	

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To expand access to HIV prevention and control programs in developing countries.

14. SCHEDULED EVALUATIONS

Interim MM YY 09/93 Final MM YY 09/96

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

The purpose of the amendment is to increase the life of project funding from \$38 million to \$179 million and to extend the project assistance completion date from 9/30/95 to 9/21/97.

17. APPROVED BY

Signature: Nancy R. Pielmeier
Title: Ann Van Dusen
Acting Director, S&T/H

Date Signed MM DD YY 09/18/97

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

****PROCUREMENT SENSITIVE MATERIAL****

AIDS PROJECT PAPER AMENDMENT

I. **INTRODUCTION.** This paper amends the AIDS Technical Support project (936-5972). The AIDS Technical Support project is a broad-based, umbrella project under which a wide range of activities and subprojects are undertaken to prevent and control HIV infection worldwide. Most of these activities will continue under this amendment. However, they will be implemented as part of a new, more focused strategy that concentrates resources in priority countries. The new project strategy will involve: 1) development of a targeted "AIDS strategic plan" in ten to fifteen priority countries based upon proven interventions; and 2) provisions of short-term technical assistance in non-priority countries. LOP funding will be increased from \$69 million to \$319 million. The new overall project strategy aims at creating full-scale, national programs in the priority countries and effective support activities in non-priority countries. A major objective of this project is to have a measurable impact on HIV incidence in priority countries upon project completion.

II. **RATIONALE.** AIDS represents a world health crisis of unprecedented proportions. It is spreading rapidly and threatens to undermine social and economic development worldwide. By the end of October 1990, 288,337 cases of AIDS had been reported to the World Health Organization (WHO) by 157 countries (85 percent of the world's nations). Thus the rationale for this project is as follows.

The Actual Scope of the Problem is Greater Than AIDS Case Data Indicate. The AIDS case data cited above considerably understate the actual scope of the global pandemic. Due to time lags between diagnosis and reporting, and underreporting due to a lack of recognition of AIDS, limited surveillance activities and, in some countries, a limited willingness to report, WHO has estimated that the actual number of AIDS cases was closer to 1.2 million by the end of 1990. However, these statistics on current AIDS cases reflect infections from the human immunodeficiency virus (HIV) from many years earlier, not current levels of HIV infection. To gain an accurate picture of the current scope of the problem, one must examine HIV seroprevalence levels, that is, the percentage of people who have HIV antibodies in their blood. WHO estimates that approximately eight to ten million people were infected with HIV by the end of 1990. More than 50 percent of these people will probably develop AIDS within eight to ten years of their being infected. In the 1990s, WHO estimates that there

will be at least twice as many HIV infections as occurred in the 1980s.

AIDS Undermines Development Progress. AIDS is not simply a tragic disease for individuals and society, it threatens to undermine social and economic development in several key areas.

- o Economic Development. AIDS and HIV infection occur principally in the 14-45 year age group -- the bulk of a country's labor force. AIDS deaths could severely reduce a country's labor force and have subsequent adverse consequences on a country's gross domestic product. In the U.S., for example, AIDS is expected to cost U.S. businesses \$55 billion in productivity losses and \$8.5 billion in health care costs in 1991 (Population Reports, 1989). Moreover, public sector funds for catastrophic health care are extremely limited in the developing world. In some countries of Africa, per-person government health-care expenditures currently range from one to six dollars per year (AID, 1990). World Bank estimates of the cost of inpatient and outpatient care for AIDS patients (including drugs) ranged between \$104 and \$631 per case in Tanzania and between \$132 and \$1,585 per case in Zaire (AID, 1990). Multiplying even the lower number by the projected number of AIDS cases suggests staggering health-care costs for both the public and private sectors. The World Bank has estimated that the share of government health expenditures required to treat AIDS will be, for example, 55 percent in Uganda and 5-10 percent in Burundi, Malawi and Rwanda. These costs do not include monitoring or prevention programs.
- o Child Survival. The significant advances made in the last decade in the area of child survival will, in all probability, be reversed due to AIDS. A.I.D.'s Office of Health has estimated the potential overall increase in infant and child mortality rates due to HIV infection in three African and two Caribbean countries. Current projections suggest that the virus could increase infant mortality in Uganda by approximately 23 percent over current levels. Similar projections for Zambia and Haiti are approximately ten and seven percentage points, respectively. The death rate for children in Uganda between one and four years of age could increase by 55 percent (Child Survival Report to Congress, 1990). One analysis conducted in Uganda estimated that by 1992, between one-tenth and one-third of all deaths among children under five in Kampala will be AIDS-related (AID, 1990).

The problem of children orphaned by the death of both parents will also have to be addressed. UNICEF estimates that, by the year 2000, in ten countries in East and Central

Africa there will be five million children whose mothers died from AIDS (Child Survival Report to Congress, 1990).

- o There is No Vaccine or Cure for AIDS at the Present Time. Despite intensive efforts during the past decade and some advances in the early phases of vaccine development, it is unlikely that either a vaccine or a curative treatment will become available to assist in controlling the AIDS epidemic prior to the late 1990s.

In summary, given that: (1) HIV infection is growing rapidly; (2) HIV infection may have a potentially devastating impact on development worldwide; and (3) HIV infection has no cure, it is of paramount importance that A.I.D. take measures to prevent and control the spread of this disease. This project amendment proposes a strategy to accomplish this objective.

III. BACKGROUND ON THE AIDS TECHNICAL SUPPORT PROJECT. The AIDS Technical Support project is designed to strengthen the capacity of developing countries, and their health delivery systems in particular, in AIDS prevention and control through technical assistance, applied research and procurement. The project currently has a \$69 million ceiling: \$38 million of S&T core (55 percent) and \$31 million of "buy-in" funds (45 percent). The buy-in level for the first four years of the project has increased from 31 percent in the first year to 54 percent in fiscal year (FY) 1990. That trend is expected to continue and is reflected in this project amendment.

Authorized through 9/30/95, the current project has eight major subprojects. The two largest include AIDSCOM, a \$17 million contract and AIDSTECH, a \$28 million cooperative agreement. Both were awarded in 1987 as five year programs. By early FY 1992, AIDSCOM will have reached an increased ceiling. AIDSTECH is very close to its current ceiling.

A. AIDSTECH. AIDSTECH's mandate is to develop and implement programs to slow the spread of HIV infection in developing countries. It provides technical assistance and program support in areas such as program design/administration, epidemiology, HIV screening, health-care financing, applied research, training, provision of equipment and commodities and information dissemination.

Since the award of the cooperative agreement, AIDSTECH has developed extensive, multifaceted programs in 16 countries. It has also worked on 151 subprojects and specific technical assistance programs in a total of 38 countries. Forty subprojects and technical assistance programs have been

completed: nine in the area of sexual transmission; seventeen in blood transmission; six in surveillance; four in health care finance; three in training health-care providers in disease control procedures and one in prevention of intravenous drug use transmission.

More than 50 percent of AIDSTECH's efforts are focused on the prevention of sexual transmission of HIV. Accomplishments in this area include:

- o Influencing Policy. AIDSTECH has educated policy-makers who were initially reluctant to approve intervention programs targeted toward high-risk groups.
- o Program Implementation. AIDSTECH has assisted with the design, implementation and support of 59 sexual transmission interventions and activities since 1987. An additional 21 are beginning to get underway.
- o Capacity Building. AIDSTECH has focused on capacity building by providing technical assistance in the areas of information, education, communication (IEC), condom distribution and sexually transmitted disease (STD) diagnosis and treatment. In addition, AIDSTECH has upgraded 12 STD clinics and provided equipment and supplies for selected programs.
- o Training. AIDSTECH trained 285 health-care professionals in the treatment of STDs in the Philippines and 20 health-care professionals in STD counseling in the Eastern Caribbean.
- o Social Marketing. AIDSTECH expanded the condom social marketing project in Burkina Faso and continued the social marketing programs in Zaire and Cameroon.

As of September 30, 1990, AIDSTECH's obligations totalled approximately \$24.5 million. The regional breakdown was approximately \$11.3 million for Africa, \$9.5 million for Latin America and \$3.7 million for Asia/Near East. Of these totals, approximately \$3.5 million, \$3.4 million and \$1.0 million were provided by Africa, Latin America and Asia/Near East missions, respectively, through buy-ins.

B. AIDSCOM. The purpose of the AIDSCOM contract is to develop, test and refine the Public Health Communications Framework (PHCF) for AIDS prevention and control. This framework draws upon and integrates A.I.D.'s successful experiences in the fields of development communication and social marketing.

Since 1987, AIDSCOM has conducted assessments of HIV prevention programs in 67 countries and has implemented extensive technical

assistance in 42 of these countries. AIDSCOM is currently providing technical assistance to 26 countries in addition to developing longer-term interventions in 12 emphasis sites. AIDSCOM has learned to adapt the PHCF to the special needs of AIDS communication and education in each country. Project accomplishments include the following:

- o Training. AIDSCOM published an extensive AIDS Prevention Counseling Training Guide for the Caribbean. More than 600 copies have been distributed throughout the region. The guide is being translated into Spanish for use throughout Latin America.
- o Materials Development. AIDSCOM has developed numerous materials in support of prevention campaigns. These have included technical support items used by trainers and educators in their work, condom-use training guides, prevention counseling manuals and country-specific educational materials designed to inform, entertain and motivate audiences, such as prevention videos, films, television and radio spots and brochures. The project completed filming for a drama about AIDS in a Ugandan workplace. The AIDS prevention student handbook and teacher's guide for both public and private schools is in process. The AIDSCOM video of the successful AIDS drama "One of Our Sons is Missing" has been broadcast in countries throughout the Caribbean.
- o Sixth International AIDS Conference. AIDSCOM played a major role in the 1990 International AIDS Conference held in San Francisco in June. Conference organizers invited AIDSCOM staff to give ten presentations on lessons learned with social marketing in Tanzania, media programs in the Eastern Caribbean, behavioral research in Mexico and Jamaica and community-based prevention programs in Peru.

As of September 1990, total AIDSCOM obligations since September 1987 were approximately \$17.1 million.

IV. BACKGROUND ON THE CURRENT AMENDMENT. In the spring and summer of 1990, the AIDS Cluster, created by AA/S&T in May 1990 to address issues related to managing an intersectoral activity, reviewed the entire S&T AIDS portfolio. Prompted in part by concern that: a) the AIDSCOM and AIDSTECH subprojects were rapidly approaching their budget ceilings; b) a number of technical and program gaps had been identified, during the portfolio review, in the A.I.D. response to the AIDS crisis; and c) AIDS Technical Support resources were spread too thinly to have a measurable impact upon project completion, the AIDS Cluster recommended that the project assistance completion date

be extended to 9/30/97 and that the project be redesigned. The AIDS Working Group approved the concept and recommended that a project committee begin work on the redesign.

Some of the gaps identified during the AIDS Cluster review included relative lack of in-depth, intervention-oriented behavioral research and STD prevention and control efforts. The Cluster also recognized the need for A.I.D. to make more comprehensive plans to respond to the increasing demand for condom social marketing programs.

V. INTEGRATION WITH S&T PROJECTS AND MISSION STRATEGIES. AIDS activities have been integrated with many other S&T/Health and S&T/Population activities in order to avoid duplication of effort and take advantage of infrastructures and service delivery approaches developed to date. This project will continue to integrate its activities with other S&T projects as appropriate. Current AIDS Division efforts to integrate AIDS activities with other S&T/Health and S&T/Population projects include: a \$2.5 million buy-in to the Family Planning Logistics Management project over five years; a \$150 thousand per year buy-in to the Centers for Disease Control (CDC) Resource Support Services Agreement (RSSA) for condom logistics; a \$167 thousand buy-in to the SOMARC project for data collection and marketing; and a \$150 thousand per year buy-in to the NCIH PVO Coordination project.

In addition, there exist other specific S&T/Health and S&T/Population and FVA/PVC Bureau projects which are relevant to the priority components identified in this project, as follows (an illustrative list):

- o Technologies for Child Health (HEALTHTECH), No. 936-5968
- o Maternal and Neonatal Health Nutrition (MOTHER CARE), No. 936-5966
- o Contraceptive Procurement, No. 936-3018

Many of these projects have developed data and information systems and provide additional support services which are complementary to those proposed under this project. The intent is not to duplicate but rather to extract elements of those activities which improve the effectiveness and impact of the AIDS program.

Project staff will also attempt to integrate AIDS Technical Support project activities with mission strategies and bilateral health and family planning programs. Regional Bureau and Mission staff will be invited to participate in the identification of

priority countries, the development of the AIDS strategic plan and the design of country subprojects. The selected cooperating agency will work collaboratively with mission staff to monitor and implement all subprojects. Project staff will attempt to provide assistance to all mission requests for help in any aspect of HIV prevention and control.

VI. PROJECT DESCRIPTION

A. PROJECT GOAL. The goal of the project is to prevent and control the spread of HIV infection in developing countries.

B. PROJECT PURPOSE. The purpose of the project is to expand access to HIV prevention and control programs in developing countries.

C. PROPOSED APPROACH AND AREAS OF EMPHASIS. While AIDS represents a global health crisis, the health community knows relatively little about ways to design effective interventions to control and prevent this disease. Thus, any strategy which aims to accomplish this objective must, by definition, have a built-in learning process, both in project design and implementation, which documents and applies lessons learned, as well as an extremely effective communications system. This type of approach is even more imperative than in other health projects because of the relative lack of existing research and data upon which project staff can draw. Thus, the design of this project will be based on seven major lessons that the development community has learned in recent years. These lessons are:

- 1) We can prevent HIV infection on a limited basis.
- 2) Increasing demand for and access to condoms has been a key part of success to date.
- 3) We have had the greatest success with NGOs and PVOs, which have been able to mobilize rapidly and respond to the current crisis.
- 4) Treatment and diagnosis of STDs play a major role in prevention and control of HIV infection.
- 5) We have not had an impact on HIV infection at the national level, in part, because of lack of concentration of resources.

- 6) We need to learn more about communications for behavioral change and sexual behavior, especially in Africa, in order to prevent and control HIV infection.
- 7) We have learned about the critical importance of multiple reinforcing channels of communication aimed at changing knowledge and attitudes of individuals and societies toward sexual behavior, as a prelude to behavior change. Multiple reinforcing channels of communication refer to using a diverse array of communications approaches such as mass broadcast and print media, community organizations, clinical counseling, peer group counseling, and entertainment, among others, to bring about behavior change.

Applying Lessons 1, 2 and 4, the project will:

- o Focus on what works. This project will focus on several proven interventions, i.e., those interventions which research has shown to be the most effective in preventing and controlling AIDS: increasing demand for and access to condoms, partner reduction and treatment and control of STDs.

Applying Lesson 3, this project will:

- o Work with the private sector. First, it will establish an NGO/PVO AIDS Federation. The federation will be an international organization, somewhat like the International Planned Parenthood Federation. It will be the locus of technical assistance, research and other activities designed to prevent and control HIV infection. It will also leverage other donor funds. Second, the project will actively seek public-private commercial sector partnerships to increase access to and demand for condoms. Third, the project will involve the private sector in STD diagnosis and treatment and in counseling on partner reduction.

Applying Lesson 6, this project will:

- o Contain a communications for behavior change research component to study the sexual behavior of the target population. Lessons from this research, as well as from the study of other ongoing project interventions, will be synthesized and fed back into the project to improve effectiveness of communication efforts. Specific approaches to establish dissemination and feedback mechanisms are cited below.

Applying Lesson 5, this project will:

- o Scale-up resources and focus on ten to fifteen priority countries (discussed below). This would be done to avoid spreading resources too thinly and help ensure a positive and documented impact on HIV prevalence.

Applying Lesson 7, this project will:

- o Support the strategic integration of a wide variety of communications approaches (broadcast and print mass media, community organizations, women's groups, individual counseling, peer counseling, entertainment etc.) to bring about behavior change.

Applying lessons from the project evaluation (October, 1989) concerning weaknesses in the project's evaluation effort, this project will:

- o Begin measuring effectiveness and potential for impact right from the start. Most projects develop strategies for evaluation at the end of the project, if at all. This results in the common refrain of almost all evaluation teams, "There were no data." In this situation, systematic assessment of effectiveness and impact is exceedingly difficult and frequently impossible. Approaches to ensure the development of evaluation plans early in the project and ongoing implementation of these plans are discussed below.

Applying lessons from the 1989 evaluation and the 1989 management review concerning monitoring and management weaknesses, this project will:

- o Use advanced communications technology to improve project monitoring and management. The technology is described below. The purpose in using this technology would be to reduce unnecessary travel between the central office and subproject sites thereby allowing more time for actual communication and planning. Moreover, the technology should permit the central staff to provide more technical assistance and guidance, more frequently, at lower costs to subproject staff than is possible in most global projects of this nature.

In addition, this paper will state many of the other, more specific lessons and recommendations from the evaluation (1989) and the management review (1989), as well as lessons from health and population projects generally, throughout the text below and will indicate how these lessons will be applied in the design of this amendment.

D. PROJECT OUTPUTS. The project will have four outputs:
 1) improved design, implementation and evaluation of HIV prevention and control programs; 2) improved knowledge of sexual behavior and application of this knowledge to communications strategies for behavior change; 3) an international PVO/NGO federation; and 4) policy reform.

1. OUTPUT ONE: IMPROVED DESIGN, IMPLEMENTATION AND EVALUATION OF HIV PREVENTION AND CONTROL PROGRAMS.

a) Introduction.

Major activities in this category would include three types of proven interventions (subprojects):

- 1) Training staff and providing counseling in partner reduction (and increase condom demand);
- 2) Training staff in and providing diagnosis and treatment of STDs; and
- 3) Increasing access to condoms.

These activities will be undertaken to contribute to the creation of "full-scale" programs in ten to fifteen priority countries, for which there will be developed a detailed "AIDS strategic plan" and to support HIV prevention and control programs in non-priority countries.

Before proceeding, a definition of "full-scale" is required. The definition of full-scale which will be used in this project is based upon a similar definition used in family planning. In family planning, a full-scale program includes the entire range of program components (such as IEC, counseling, commodities provision, training, research/evaluation, logistics, monitoring and supervision) required to provide effective service delivery nationwide to increase contraceptive prevalence. Thus, for this project, full-scale will refer to the entire range of program components (such as provision of commodities [e.g., drugs, medical equipment], counseling, training, IEC, research/evaluation and monitoring/supervision) that are required nationwide to provide effective services to prevent and control HIV infection. All of these program components are included in this project to establish full-scale programs in priority countries and to support HIV programs in non-priority countries, as requested, and are discussed in more detail below.

There are probably no countries, with the possible exception of Zaire, that are ready to implement a full-scale program. We do not know how long it will take to develop full-scale programs: demand creation is a slow and laborious process. Thus it is

estimated that only six full-scale programs would be developed during the first year of implementation and four would be developed during the second year. The decision to develop an additional five full-scale programs will be made after approximately 18 months of implementation of this amendment.

The decision to focus the overall project strategy on the creation of full-scale programs in priority countries reflects a major lesson learned in family planning programs over the years. The lesson is that multidimensional programs are the most effective and, to have impact, a family planning program must do many things well. This finding is based on a major study conducted in 100 countries (Mauldin and Lapham, 1984) by two of the most highly respected family planning experts in this country. The authors concluded that, to succeed, the "program effort" must include a wide range of subprojects and subprograms and requires many different kinds of inputs. Thus, in attempting to establish full-scale AIDS prevention and control programs in priority countries, this project will attempt to avoid the characteristics of ineffective family planning service delivery programs of the past: fragmentation, inadequate inputs, and absence of coordination and strategic planning, basically, lack of a "full-court press." It will emphasize including a wide range of inputs, interventions and multisectoral approaches in priority countries to bring about an effective "program effort." It will also strive for the creation of public-private sector partnerships and will thus not be limited to working solely with the public sector (e.g., the Ministry of Health).

b) Subproject/Activities.

Substantial assistance under this project will be directed toward planning and subproject planning and funding new AIDS prevention and control subprojects in order to develop full-scale programs in the priority countries, as well as provide support in non-priority countries. Project staff will make efforts to develop subprojects that emphasize the following three proven interventions:

- 1) increasing the demand for condoms and reducing numbers of sexual partners;
- 2) training staff in and providing diagnosis and treatment of STDs; and
- 3) increasing access to condoms.

Other types of subprojects may be undertaken, but these three approaches will be the main elements of any country strategy. Subproject design will pay close attention to the need for capacity building in these areas. The three subprojects are discussed below.

- 1) **Subprojects that increase demand for condoms and train staff and provide counseling in partner reduction.** This approach is based on a lesson that scientists and researchers have learned in recent years: **Condoms prevent HIV infection.** Increasing evidence from the U.S., Europe and Africa shows that condom use protects against HIV infection. The more consistently condoms are used, the more protection they provide. For example, a study in Kenya showed that those prostitutes who **always** used condoms were **not infected**, compared with 56 percent of those using condoms less than half the time and 72 percent of nonusers. Similar results have been reported among prostitutes in Zaire and the U.S. (Population Reports, 1989). These results confirm what numerous laboratory tests have shown: latex condoms block HIV transmission even in concentrations much higher than usually found in semen. Subprojects designed to increase demand for condoms will rely heavily on a wide array of communications strategies described in detail below.

With respect to partner reduction, research shows that 75 percent of all HIV transmission occurs through sexual intercourse with an infected person. The chances of becoming infected through sexual intercourse significantly increase with an increased number of sexual partners, due simply to the greater probability of having sexual intercourse with an infected person.

Two types of partner reduction programs are needed: (a) activities aimed at partner reduction for those who are already sexually active; and (b) activities aimed at encouraging postponed sexual intercourse (i.e., fewer and later partners) for those who are not yet sexually active. Both types require an understanding of cultural and societal norms and intensive efforts to change those norms through mass media, individual and group counseling, especially by peers, and community involvement.

Communications for Behavior Change. A communications element aimed at influencing people to change their behavior will be an integral element of both types of subprojects described above. As a recent report noted, **"Against AIDS, education is the only vaccine"** (Population Reports, 1989). Influencing people to change their behavior is extremely difficult under any circumstances but is even more challenging due to the nature of the HIV infection: the behavior to be changed is sexual; the actions sought are preventive; risky behavior sometimes but not always leads to

disease transmission; and adverse effects become apparent only many years after exposure (Population Reports, 1989).

This project will use a wide array of communications approaches to convey and reinforce information aimed at changing behaviors, approaches such as broadcast and print mass media, individual clinic counseling, peer counseling, hotlines and entertainment. It will also work with and through community organizations, local political groups, women's groups, and religious groups, among others. The importance of conveying information through many different channels stems from the inordinate difficulty of changing sexual behavior: while information campaigns and other educational efforts may **increase knowledge**, they have not always been successful in **changing behavior**. For example, a 1988 survey in Zaire indicated that over 90 percent of the respondents knew how the AIDS virus was transmitted but only 25 percent of unmarried men said that they had used condoms with their partners (Population Reports, 1989). Thus this project will work with many diverse groups and organizations to develop effective communications approaches that not only aim to increase knowledge but also change behavior. The operational effort to change behavior will be closely linked to the research on behavioral change, undertaken as part of this project and described below.

- 2) **Subprojects that Train Staff in and Provide Diagnosis and Treatment of Sexually Transmitted Diseases (STDs).** The justification for this focus is based on lessons from recent scientific research. **STDs can increase the chance of HIV transmission.** Five major studies reported in 1988 (in the Journal of the American Medical Association, the New England Journal of Medicine and the Journal of Infectious Diseases) indicated that STDs -- specifically genital ulcer diseases such as chancroid, syphilis and genital herpes -- can increase the chance of HIV transmission through sexual intercourse by as much as sevenfold. Other research has shown that virtually all STDs increase risk, not just genital ulcer disease.

Because the capacity to diagnose and treat STDs is poorly developed or nonexistent in many developing countries, particularly in Africa, improvement or creation of this capacity will require a broad range of goods and services provided flexibly through both the public and private sectors. In countries where public-sector STD services are nonexistent, the most effective approach to providing services may well be to focus on

altering both provider and client practices and behaviors, improve diagnostic treatment practices of private-sector providers and to increase treatment-seeking and compliance behaviors of clients with STDs.

Alternatively, in countries where public sector services do exist or require improvement, support may focus on upgrading of equipment, provision of drugs and diagnostic reagents or technical assistance for training and guidelines development. Priority countries will likely require assistance to both the public and the private sectors.

To implement the types of subprojects described above (condom demand/partner reduction and STD diagnosis and treatment), the project will train both public and private service providers, as well as appropriate individuals and groups (e.g., traditional practitioners) who may be in a position to provide information and influence behavior. The training will assist these individuals in providing accurate information about HIV infection and counseling those with HIV infection (e.g., in STD treatment, proper use of a condom and its effectiveness in preventing AIDS, and the importance of partner reduction, among other topics). Thus the project will set up an internal capacity for training and retraining of service providers and others. The training will be provided only to achieve the goals of this project (i.e., there will be no long-term training). Training experts would be included on the staff of the Regional Offices and would provide the training required in each of the priority countries.

- 3) **Subprojects that Increase Access to Condoms.** Based on the assumption that there will not be enough condoms, especially for large countries like Tanzania, if the private sector is not involved, this project will employ two principal approaches to increase access to condoms: (1) contraceptive social marketing programs; and (2) public-private sector partnerships. Thus it is critical that the contractor for this project have condom marketing expertise and be able to speak the language of commercial condom suppliers. In developing the country strategy, project staff will also consider the need for a public-sector "safety-net" distribution system as well.

Contraceptive Social Marketing Programs (CSM). In some countries, this project might initiate entirely new CSM programs. In countries that already have contraceptive social marketing programs, this project should ensure

that the new programs that it proposes are integrated into ongoing plans.

Another approach might involve the continuation and expansion of a current effort. The Office of Health has already invested resources in S&T/Population's CSM programs in select countries. The purpose of their investment is to expand the programs' distribution of condoms to target groups that would not normally be the target population in a family planning program (e.g., commercial sex workers, intravenous drug users, homosexuals and bisexuals). Under this approach, the Office of Health will reach AIDS target groups without having to set up new, parallel programs and they will obtain the data they need to determine their effectiveness in reaching these groups. Thus, this effort might continue and expand under this project in those countries where the two offices have mutual interests.

Public-Private Sector Partnerships. This project must aggressively seek out various types of public-private sector partnerships. Examples of such collaborative commercial ventures could include but not be limited to the following.

- (a) A.I.D. might initiate CSM programs for one year in two or three geographically-linked countries where demand is low to build a regional market with the agreement that a private sector company would take over condom marketing after a certain level of sales were reached.
- (b) In countries where demand is already fairly high (i.e., Mexico, Brazil, the Dominican Republic), and where private sector condom suppliers are already active, A.I.D. might provide mass-media advertising, especially designed to reach the AIDS target groups, while the company would intensify its distribution effort and benefit from an enlarged market.
- (c) In other countries, A.I.D. might undertake market research on the target population, pricing studies or policy reform efforts to relax restrictions on condom distribution, while the private sector would agree to intensify further its distribution efforts.
- (d) Finally, this project might be able to work toward parallel objectives with projects like PROFIT (Promoting Financial Investments and Transfers).

PROFIT is designed to mobilize the resources of the for-profit sector for family planning services in innovative ways. Collaborative efforts in areas such as condom manufacturing, employee-based programs and/or AIDS awareness activities might be especially promising.

c) Design and Implementation of Subprojects.

The "core project staff", which will be based at headquarters and regional offices, will have the responsibility to provide the technical assistance required to identify, design, initiate and monitor new subprojects in priority countries only. In addition, the core project staff will establish country priorities, allocate resources and identify prospective contractors. The "short-term technical assistance staff", based at headquarters, will not work in priority countries but will identify the consultants and organizations required to respond to ad hoc requests from all Missions for assistance in non-priority countries.

During the design phase for all subprojects, the recipient will send a team from the headquarters or regional office to develop the detailed subproject documents. Each subproject document will:

- 1) specify the subproject purpose and explain how purpose achievement will contribute to the achievement of the goals of the AIDS strategic plan (the AIDS strategic plan is discussed below);
- 2) identify the strategy that will be used to achieve the subproject purpose and specify the target groups;
- 3) identify the institution that will be involved in subproject implementation and how the institution's training needs will be addressed under this project;
- 4) specify the subproject evaluation plan which identifies the indicators which will be used to measure purpose achievement, methodologies and approximate dates for data collection and analysis;
- 5) identify the sentinel surveillance activities that may be undertaken as part of the subproject; and
- 6) include a workplan and a multiyear financial plan.

In countries where it is feasible, the financial plan will include the institutions's contribution to the subproject (at least 25 percent and can include in-kind contributions) and a plan for cost-sharing which will show how the grantee plans to

assume increasing proportions of the costs of the program during and after the funding period. If relevant, the financial plan will identify all other donors (both domestic and expatriate) supporting the grantee. This plan is not intended to serve as a condition precedent to continued support but to set realistic targets so that recipients begin to share a manageable share of project costs. To the extent possible, the financial planning process should also consider and incorporate cost recovery schemes such as fee-for-service and revolving drug funds as a means of partially recovering costs. When relevant, the subproject plan will also specify commodity requirements.

The subprojects which are selected should meet the following general criteria. They should:

- o be linked to an institution which conducts health/and or family planning programs consistent with A.I.D. policies and have the means of sustaining the activity once project funds have terminated, thus contributing to institutional sustainability;
- o be consistent with the Mission's strategy and the government's medium term plan;
- o not involve an additional high recurrent cost burden which exceeds the capacity of the organization; and
- o ideally, have the potential to demonstrate broader feasibility for implementation in other countries.

2. OUTPUT TWO: IMPROVED KNOWLEDGE OF SEXUAL BEHAVIOR AND APPLICATION OF THIS KNOWLEDGE TO COMMUNICATIONS STRATEGIES FOR BEHAVIOR CHANGE.

a) Introduction.

Output Two involves undertaking research to understand sexual behavior in the priority countries and applying the results of this research to targeted communications strategies aimed at changing behavior. The effort is designed to: a) contribute to the impact of full-scale programs in priority countries; and b) support HIV prevention and control activities in non-priority countries.

Under this approach, the targeted communications for behavioral change interventions will become the major element or driving force of the AIDS strategic plan developed for each priority country. This approach is based on lessons and experience from the past. In many past programs, the A.I.D. communications for behavioral change element was frequently detached from the overall health or family planning program. Under this project,

each country's communications strategy will be linked closely to and shaped by the lessons learned from both the overall services program and the behavioral research undertaken in that country. There would be, for the first time, an effort to determine how effective communications strategies can be in bringing about the desired behavioral change if other program elements (condom distribution and supply, STD counseling and treatment, for example), as well as behavioral research, are linked to it closely. Lessons from the communications literature suggest that this approach may be extremely effective.

It is S&T Bureau policy that all research activities having a total cost of over \$100,000 (estimated cost for the behavioral research is approximately \$400,000/country/year) shall be subject to peer review. A Peer Review Plan will be developed (as specified in the September 20, 1990 Memo: "Peer Review Policy and Implementation Guidelines for the Bureau for Science and Technology) prior to initiation of any behavioral research as identified in this project.

b) Activities.

Six of the priority countries will be singled out as intensive learning sites regarding communications for behavior change. These will receive additional resources for impact evaluation and behavioral research related to communications interventions. While all priority countries will employ appropriate communications interventions and be evaluated, this additional support in six countries will increase the likelihood of rapid learning from program interventions.

While there is much that we have already learned about communications for behavior change and can begin to apply immediately in the priority countries, there is still much to learn. We need to learn how we can best apply promising behavioral research theories to the communications and behavior change process. Many of these promising theories have not been fully exploited for their potential to increase the impact of communications for behavior change interventions. Accordingly, this project will include sub-agreements (of the overall cooperative agreement) which will fund approximately six leading behavioral research scientists (or their institutions). Each researcher would represent a major behavioral science orientation that promises to have impact on behavior. Each researcher will conduct a special research project in one of the priority countries and will assist in planning and implementing the country's communications strategy which will be enhanced by his or her theoretical perspectives. Under this component, funding would also be provided to bring the researchers together to explore how their research and theories could have an impact on progress in all the priority countries.

3. **OUTPUT THREE: INTERNATIONAL PVO/NGO FEDERATION.**

a) **Introduction.**

This project will establish an international PVO/NGO federation. The rationale for working with PVOs through such a federation is as follows:

- o Most host government health infrastructures are weak. U.S. and indigenous health and family planning PVOs frequently have the only infrastructures that work. Thus the federation would provide an opportunity for PVOs to take on an AIDS service delivery function in countries where the government health infrastructure is lacking. Moreover, in most countries there currently is no delivery system for AIDS services and piggybacking AIDS service delivery onto weak health and family planning service delivery infrastructures is not an optimal approach.
- o Host government commitment to controlling and preventing the AIDS epidemic is weak. It is doubtful that donors can change low levels of host government commitment by working primarily with Ministries of Health. Strengthening the capacity of PVOs to perform an advocacy function may eventually bring about increased commitment on the part of some host governments.
- o Host governments are generally unwilling to deal with populations that are socially marginalized because of their risk behaviors. A better way to reach these groups is to allow them to work with PVOs so that they can put together community action programs for themselves.
- o PVOs can be a vehicle for leveraging other donor funding and private resources. At the present time there is no way to leverage such funding nor capture private donations for AIDS control and prevention. The S&T/Population Population and Family Planning Expansion project provides a model of a joint A.I.D.-CARE effort to leverage significant non-A.I.D. funding. Under the project, CARE, as a private agency, is able to make a sizeable contribution to both core institutional costs and direct pilot project costs. CARE will work to raise funding for family planning activities under the project and will be able to raise funds from the general public and corporate and foundation sources. It is anticipated that PVOs involved in the federation will seek out similar relationships.

b) Activities.

Accordingly, the principal functions of the federation would be as follows:

- o Advocacy and Fundraising: to mobilize the resources of other donors and private individuals and organizations for HIV control and prevention activities;
- o Technical Assistance: to energize, encourage and provide technical assistance to indigenous PVOs in developing countries so that they can increasingly perform an AIDS service delivery function. This could involve training in HIV counseling and screening; assistance in establishing condom distribution networks; help in establishing procedures for STD treatment and diagnosis; and/or guidance on undertaking operations research and evaluation, among other activities. The federation might also consider providing technical assistance in management, e.g., for groups having technical medical expertise but lacking capacity in accounting, logistics or budgeting, for example.
- o Educational and Guidance Materials: to prepare educational material and guidelines to assist PVOs in AIDS prevention and control activities. In this context, the federation will establish a medical advisory committee which will provide guidance in the preparation of these materials. The immediate tasks of the medical advisory committee might be to: a) establish treatment policies, norms and procedures; and b) develop a general training curriculum and training materials.
- o Rapid Information Dissemination: to disseminate quickly to member PVOs the latest information on, for example, AIDS treatment, successful interventions and approaches, findings from operations and behavioral research, and/or new opportunities for funding, among other topics. The federation might distribute a regular newsletter to members which addresses many of these topics while at the same time it must seek procedures for rapid dissemination of new and critical information concerning AIDS.
- o Provision of Subgrants: to provide subgrants to indigenous and other PVOs to encourage the expansion of AIDS service delivery and HIV prevention and control activities.

This type of federation would be especially important as AIDS interventions increase globally in number and scope and current, relatively small-scale urban programs become regional and national in character. The federation could complement and support these programs as they develop and mature. It should be headed by an individual who would be widely recognized as being

able to provide immediate legitimacy to the organization, as well as having administrative and fund-raising skills.

To establish this federation, A.I.D. envisions providing a grant to an international organization. The organization would be tasked with setting up an institution that would be a major implementor of AIDS prevention and control programs. The process of shaping this organization will be both a top-down and a bottom-up effort. It will involve numerous discussions with other donor agencies over the next eight to twelve months, as well as talking to indigenous PVOs to identify their needs and interests. Notionally, the new federation ought to be working toward a budget on the order of magnitude of the IPPF budget. In 1990, IPPF expended \$75 million.

4. OUTPUT FOUR: POLICY REFORM.

a) Introduction.

There is a critical need for materials and information that can be used to convince policymakers that AIDS is a serious problem that they must address. In addition, policymakers must have accurate information concerning the potential developmental impact of the epidemic and the effectiveness of proven interventions.

b) Activities.

To provide this information, the AIDSTECH project has developed three different modeling approaches, whose target audience includes policymakers, technical personnel and service providers, that provide information on these topics. The three different modeling approaches are as follows:

- 1) The Simple Projection Model. The projection model is based upon HIV seroprevalence estimates. The model can estimate the number of adult and childhood AIDS cases through the year 2000. It can help decision makers understand the implications of HIV's long incubation period.
- 2) The State Department's Interagency Working Group Model (iwgAIDS). This model provides information on the social, sexual and drug-using behaviors and relationships of different population groups. It permits the systematic study of alternate scenarios resulting from changes in initial conditions.
- 3) The AIDS Impact Model (AIM). AIM can take the results of the iwgAIDS model or the projection model and show the impact of the epidemic on a wide variety of sectors including child and adult mortality, health-care costs,

hospital bed utilization, population growth, the labor force, costs of prevention versus costs of care, among other topics.

These models can provide estimates for policymakers who ask questions such as:

- o How many AIDS cases will there be in the future?
- o Will AIDS have a greater impact than other diseases such as malaria or measles?
- o What are the relative costs of prevention programs compared with the future costs of treatment?
- o What are the relative effects of different intervention strategies?

The project and The Futures Group are collaborating closely in the field testing phases of these models in Haiti and Uganda. After these trials, and under this amendment, USAID missions will be offered the opportunity to request that a modeling team apply and customize the model for their country. This approach will require that the modeling team work with local counterparts to specify model inputs, develop descriptions of feasible interventions, conduct workshops and make presentations to policymakers and others to increase understanding of the models' results (AIDSTECH, 1990).

An additional element of the project's policy reform effort will involve reviewing each priority country's regulations. This effort will aim to synthesize existing S&T/Health and S&T/Population information on regulatory policy problems in order to understand and modify the current barriers to program implementation.

E. COUNTRY PRIORITIZATION. Evaluations of several S&T health and family planning projects have indicated that documentation of effectiveness and impact is exceedingly difficult, and performance is impaired, when centrally-funded projects operate in too many countries. Many of these reports have urged clear specification of country selection criteria and implementation of subprograms in a limited number of target countries only.

Accordingly, this project will select a limited number of countries for full-scale program development based upon clearly specified criteria. Core project staff will develop six full-scale country programs during the first year to 18 months of the project. During the second year, the core staff will develop, at a maximum, four additional full-scale programs, for a maximum of ten full-scale programs. After 18 months of implementation of

this amendment, A.I.D. and project staff will decide whether to develop full-scale programs in an additional five countries. The country prioritization criteria are as follows:

- o Mission commitment;
- o Potential for HIV transmission (HIV and STD levels);
- o Population size and distribution;
- o Country commitment;
- o Country capacity to respond;
- o Availability of bilateral funds;
- o Availability of other donor funds.

Based upon these criteria, A.I.D. and the core staff will develop a list of priority countries. The list will have three categories: 1) countries which will have full-scale programs developed during the first year to 18 months of project implementation; 2) countries which will have full-scale programs developed during the second year of project implementation; 3) countries which will be the recipients of periodic assistance as requested. The project will attempt to provide technical and other assistance to all non-priority countries requesting such help from all Regional Bureaus.

An illustrative list of countries which meet most of the criteria listed above includes the following:

AFRICA

Cameroon, Ghana, Malawi, South Africa, Uganda, Zaire, Zimbabwe

ASIA

India, Thailand

LATIN AMERICA/CARIBBEAN

Dominican Republic, Haiti, Jamaica, Mexico, RDO/C

EUROPE/NEAR EAST

Philippines

An illustrative list of countries which meet **many** of the above criteria includes the following:

AFRICA

Burkina Faso, Kenya, Mali, Niger, Nigeria, Rwanda, Tanzania, Zambia, Togo, Central African Republic, Cote d'Ivoire

ASIA

Indonesia, South Pacific

LATIN AMERICA/CARIBBEAN

Bolivia, Brazil, Honduras

EUROPE/NEAR EAST

Egypt, Morocco

F. SUSTAINABILITY. Because HIV prevention and control is a new area for international development practitioners, and much still needs to be learned about how to design and implement cost-effective interventions, this project will not aim to achieve overall project sustainability. It will make an effort to achieve institutional sustainability, especially through training, and will attempt to recover costs where possible. It will also require a financial plan for each subproject. This plan will analyze the source of and potential for resources which would enable the institution to continue the activity after A.I.D. assistance terminates. The institution's ability to do this, however, will not necessarily be a condition for funding.

VII. PROJECT INPUTS.

A. COOPERATING AGENCY - COOPERATIVE AGREEMENT.

1. **Technical Assistance to and Monitoring of Full-Scale Programs in Priority Countries.** The project's core staff of 36 staff at headquarters and a total of 48 staff in the three regional offices (16 persons in each office) would provide assistance to and monitoring of priority country programs. The total dollar amount of this input (staff salaries, benefits allowances, and travel) will be \$41.9 million. Of that total, Missions funded add-ons are estimated at \$8.4 million or 20 percent.
2. **Short-Term Technical Assistance for Non-Priority Countries.** This mechanism is designed to provide rapid response to ad hoc requests from missions for technical assistance in non-priority countries. Five staff persons employed by the contractor (the "technical assistance staff") would be

responsible for maintaining a consultant roster which would include individuals, organizations and institutions having the skills in areas that reflect the three priority concerns of this project (STDs, condom access and condom demand/partner reduction), as well as other areas that are frequently requested such as:

- o condom support: strategy formulation; forecasting; targeting; promotion and promotional materials and supply logistics;
- o blood transfusion: blood screening; improved transfusion practices; lab quality assurance;
- o counseling: training counselors; peer education; AIDS in the workplace;
- o IEC: health education; materials development;
- o financing: fee-for service; cost recovery;
- o evaluation: economic and social impact assessment;
- o surveillance and epidemiology.

The technical assistance staff would be responsible for responding in a timely fashion to all requests for assistance and identifying the highest quality professionals and organizations with the requisite skills and experience to fill the work requirements. This category includes salary, travel and per diem for 4,865 person-days/year of short-term technical assistance. This level of effort allows for 695 short (7 days) trips/year. The total dollar amount of this input (staff and consultant salaries, benefits and travel) will be \$20.7 million. Mission add-ons are estimated at 90 percent.

3. Resident Advisors. A key component is the placement of resident advisors in ten to fifteen countries. Selection and placement of advisors will occur at intervals during the first three years. During the first year six resident advisors, three locally hired, will begin work. In the second year, an additional four advisors will be placed: two of whom will be hired locally. Then in the third year of the cooperative agreement the final five advisors, three locally hired, will be placed in the field. This category includes salary, allowance and travel for each resident advisor and indicates an inflation factor of 6 percent. The total dollar amount of this input is \$8.8 million; it is anticipated that approximately 90 percent of the cost will be funded through Mission add-ons of \$7.9 million.

4. **Subprojects.** Over the life of the cooperative agreement approximately 262 subprojects will be carried out at an estimated \$200,000 per subproject as part of the effort to establish full-scale programs in priority countries. In the first year, it is anticipated that two subprojects in each of the initial six priority countries will begin. New subprojects will be implemented incrementally to a level of five subprojects in all fifteen of the priority countries. Also included in this category are eight subprojects per year to be carried out in non-priority countries. The total dollar amount of this input will be \$60.4 million. Mission add-ons are estimated at 90 percent or \$54.4 million.
5. **Behavioral Research.** The cooperative agreement will provide funding of research for behavior change in roughly six countries at approximately \$400,000 per activity per year. The total amount of this input will be \$10.8 million. Mission add-ons will supplement core funds by 50 percent or \$5.4 million.
6. **Information Dissemination.** Based on previous experience, \$2.3 million is required. No mission add-ons are anticipated.
7. **Contingency.** A contingency of 5 percent is included.
8. **Audit/Evaluation.** During the project there will be two combined audit/evaluations (a mid-project and a final), as required.

B. REMAINING ACTIVITIES.

1. **PVO/NGO Federation.** This activity will be funded for approximately \$34.3 million with Mission buy-ins (20 percent) of \$6.75 million.
2. **Ongoing Agreements.** Ongoing agreements (currently underway including both AIDSCOM and AIDSTECH among others) will be funded to completion. Of a total of \$16.6 million, approximately 30 percent will be Mission add-ons.

VIII. PROJECT IMPLEMENTATION.

A. RESPONSIBILITIES OF THE PRIMARY COOPERATING AGENCY. This project will be implemented by a U.S.-based Cooperating Agency (CA) selected through the competitive procurement process. It will be based upon a Cooperative Agreement between A.I.D. (Office of Health) and a Cooperating Agency. Once awarded, it will be

the responsibility of the Cooperating Agency to undertake the following:

1. **Hold a team planning meeting prior to the initiation of project activities.** The purpose of the meeting would be to facilitate team building and develop a shared commitment to and vision of the project. The CA must provide a copy of the amendment to all staff and consultants who are employed under the project and it will be a key topic during the team planning meeting.
2. **Establish regional offices.** To facilitate decentralized decision-making, the project should establish offices in designated regions (most probably two in Africa, possibly one in Asia, and the LAC Regional office based at the CA U.S. headquarters). Selection of regional office locations must be undertaken in close collaboration with USAID missions. Criteria for selection of locales for the regional offices will include: ease of communication and travel and likelihood of the locale being identified as a priority country. The CA will staff these offices with local and expatriate experts (approved by AID) and specified in their response to the RFA. Staff for each office would include a Director, a Deputy Director, a Program Officer and an Evaluation Officer, as well as administrative and other professional staff and others to be specified in the RFA. To the extent possible, the CA will select local expertise to staff these offices to contribute to an in-country capacity for AIDS prevention and control upon the termination of this project. (It obviously will not be possible for the CA to identify all local experts when responding to the RFA.)
3. **Undertake country planning visits in the priority countries.** The CA will undertake six such visits during the first year to 18 months of the project and four to eight such visits during the second year. The purpose of these visits would be to initiate contact with local organizations in the priority countries and identify possibilities for subproject development.

After completion of each country planning visit, it will be the responsibility of the CA to prepare a document called the "AIDS Strategic Plan". The strategic plan will identify the major goals of the full-scale program and will explain how the selected subprojects will contribute to goal achievement. It will also contain detailed evaluation, communications, and behavioral research plans. It will be designed to guide project implementation in each country in order to avoid a "target of opportunity" approach.

4. Establish subcontracts with local NGOs or business/management firms. This activity would be undertaken to support subproject implementation and financial and logistical needs.
5. Establish a core staff Evaluation Unit at the beginning of project activities. There is considerable emphasis on evaluation in this project and this approach is based upon an important lesson from the family planning literature. Programs that have effective monitoring and evaluation systems achieve significantly greater impact than those not having such systems. A comprehensive analysis conducted in 1982-83 in 24 countries (Ross et. al., 1989) showed that those countries that received the lowest score on the quality of their evaluation system achieved contraceptive prevalence levels of approximately 5 percent, while those countries that received the highest score on their evaluation system achieved contraceptive prevalence levels of approximately 43 percent.

The evaluation staff that will be employed under this project should be indicated in the CA's response to the RFA. The responsibilities of this staff would be as follows.

- a) To develop evaluation plans as integral elements of the AIDS strategic plans and to assist in the monitoring and implementation of these plans. The purpose of the country evaluation plan is to show how progress and impact (or, potential for impact) will be measured at intervals throughout project implementation. The plan must show: 1) how the appropriate process and outcome indicators will be monitored; and 2) how impact will be defined and assessed at regular intervals. The overall country strategy evaluation plan will basically entail plans for data collection and analysis during the implementation of the subprojects and the regular tracking of subproject performance.
- b) To establish sentinel surveillance programs. These programs are less expensive to conduct than surveillance programs among the general population. Sentinel surveillance refers to the systematic and regular testing of blood samples from selected groups of individuals in order to monitor the incidence and prevalence of HIV infection among the groups over time. Groups may be chosen because they are thought to be representative of the general population, such as women attending prenatal clinics and voluntary blood donors, or because they are believed to be at higher risk than the rest of the population, such as military personnel, STD clinic patients, commercial sex workers, patients at drug treatment centers and migrant workers. In

areas of high HIV prevalence, both high-risk and low-risk groups are monitored.

This particular approach might be selected because defining impact with respect to AIDS incidence may be difficult. While reduction in HIV infection and AIDS cases in the entire population might be the appropriate impact indicator for most HIV prevention and control programs, HIV infection in the national population might not be possible to measure or it might be prohibitively expensive. Moreover, the number of AIDS cases might not be a useful measure of impact because infection may have occurred years before the initiation of the program. Thus, each country evaluation plan will have to clearly state the impact (or outcome) indicators that will be used to assess effectiveness and impact and the plan obviously must be closely linked to the AIDS strategic plan. The Evaluation Unit should consider the following illustrative indicators in preparing the evaluation plan for the AIDS strategic plan and for subprojects (adapted from WHO, 1990).

Process Indicators:

- o number of clients (monthly, annually) by sex and age since the integration of AIDS education and counseling into family planning or health services;
- o the number of condoms sold or distributed free (monthly, annually);
- o the number of at-risk individuals reached (monthly, annually) with HIV and family planning information;
- o the number of STD clients treated (monthly, annually);
- o the number of blood banks using self-screening procedures;
- o the number of staff trained in risk assessment counseling (monthly, annually);
- o and/or the number of family planning facilities providing HIV education for their clients.

Outcome Indicators:

General: improved knowledge of the population or specific groups about HIV infection and AIDS

Other Outcome Indicators:

- o trends in safer sex behavior, such as condom use, number of sexual partners and changes in sexual practices, among at-risk individuals who are participating in prevention programs
- o incidence (monthly, annually) of STD among MCH/FP clients (if people are changing their behavior and reducing risks for HIV, new cases of STD should decline)
- o prevalence or incidence (annually) of HIV among different populations (family planning clients, women coming in for MCH services, participants in high-risk intervention programs)
- o prevalence (annually) of HIV infection among first time blood donors
- o percentage of delivering women who are infected (annually)
- o percentage of infants born who are infected (annually)

For HIV prevention programs, monitoring condom use will be especially important. Given the difficulty of obtaining accurate information on condom use, multiple measures would be desirable: reports of condoms sold or distributed; self-reported use; the availability of condom supplies; partner-reported use and problems encountered in use (breakage, slippage, partner resistance to use, etc.) (WHO, 1990).

The Evaluation Unit should consider using both quantitative and qualitative methods in developing the country evaluation plan. A project in Uganda, for example, is relying on tests for HIV infection, surveys of knowledge, attitudes and practices, STD service statistics before and after a health education program and focus group discussions conducted periodically throughout the project (Population Reports, 1989).

Other responsibilities of the Evaluation Unit will include:

- a) ensuring that all subproject objectives are clearly stated and measurable;
- b) preparing those sections of the Semi-Annual Reports (discussed below) that involve evaluation and lessons learned;
- c) meeting regularly with priority country staff using the advanced communication technology described in this paper to monitor and guide the implementation of each country evaluation plan.

- d) providing technical assistance in evaluation, when requested, only to priority country staff.
6. **Establish a Behavioral Research Unit.** The CA will establish a Behavioral Research Unit at the beginning of project implementation. The individuals who are to staff this unit should be identified in the response to the RFA. The goal is to set up a behavioral research unit that is organizationally separate (to ensure that the research gets done and is not lost in the demands of implementation of service delivery) but at the same time operationally relevant. The research will be designed to provide information on sexual behavior, especially in the priority countries. It would focus especially on ways to increase partner reduction, condom demand and treatment-seeking behavior for STDs. The principal responsibilities of the Behavioral Research Unit will be as follows:
- a) To prepare a coherent behavioral research agenda for each priority country. The research agenda should be closely linked to the AIDS strategic plan. The AIDS Technical Support project's lack of a coherent research agenda was one of the major concerns of the 1989 evaluation team. (As specified in the September 20, 1990 Memo: "Peer Review Policy and Implementation Guidelines for the Bureau for Science and Technology", a Peer Review Plan will be developed prior to initiation of any behavioral research).
 - b) To establish subagreements and professional linkages with researchers and institutions who will conduct the research.
 - c) To disseminate and feed back into this project's communications strategies and ongoing operations the lessons learned from the behavioral research. One person in the Behavioral Research Unit will have the responsibility for overseeing this effort and collaborating with the staff person in the Evaluation Unit who is similarly assigned.
 - d) To use the advanced communications technology to meet with and provide guidance to the staff of the research institutions and universities in the priority countries which are undertaking the behavioral research under this project.
7. **Develop a Plan and Establish Procedures for Documenting and Disseminating Evaluation and Research Findings and Lessons Learned.** As early as possible, the CA must prepare a plan, to be submitted to A.I.D. for approval, which specifies the procedures which will be used to document and disseminate

evaluation and research findings and lessons learned: to A.I.D., to regional and priority country staff, among core staff in the headquarters office and to other donors, PVOs and governments, as appropriate. The CA should identify one person from the Evaluation Unit and one person from the Behavioral Research Unit who would be responsible for working with the Training Division on information dissemination throughout the life of the project.

The purpose of the information dissemination plan would be to specify the procedures that will be used under the project to: 1) disseminate information on the lessons and findings of evaluations and behavioral research undertaken as part of the project, and other research findings, as relevant; and 2) the procedures that will be used to ensure that this information is used, i.e., applied during the design of new subprojects and programs.

A wide variety of approaches should be employed such as preparing and circulating executive summaries of findings and results from research and evaluative efforts, providing "targeted assistance" to subproject design teams to ensure that they consider "lessons learned" and preparing analytical syntheses on a particular topic, as well as using the advanced communications technology to discuss lessons and results.

8. Establish Procedures for Using Advanced Communications Technology for Monitoring and Managing the Project. A major lesson from the 1989 evaluation was that while the AIDS Technical Support project responded remarkably well to the enormous administrative and logistical challenges, A.I.D. needed to review the project's considerable coordination and communications burdens.

To streamline project management and communication in a global project of this nature, the CA will be required to investigate and set up state-of-the-art communications technology. One possibility might be the USIS World Net Interactive program. Some technologies of this nature would involve setting up "workstations" at A.I.D., CA headquarters and in the regional and priority country offices. These workstations (the cost of each workstation is approximately \$12,000) would allow a roomful of A.I.D. or headquarters staff to "meet" with a roomful of resident country staff for the cost of a phone call. There is a speaker/transmitter at each workstation that picks up and transmits the voices of those at each workstation. The speakers, however, do not talk into a telephone or a transmitter. They talk to each other just as they would at a regular meeting and they talk to the people overseas in the same way. In addition, there is a screen that has the

capability to project lotus spreadsheets and any other graphic information made from slides. Thus two groups could meet, and project onto the screen, budget information or graphic data from analyses and surveys. (This technology was used very successfully by a group of medical doctors in Massachusetts to train medical doctors in Beijing. Each one hour training session cost \$120 -- the cost of phoning Beijing.) Given its relatively low maintenance and transmission costs, this technology might offer considerable savings in terms of travel costs, not to mention time and energy. Some of the evaluation/management applications for a global project such as this one might include the following:

- o Subproject design. Given the technology's capacity to project Lotus spreadsheets and other graphs and data on the transmission screen, project budgets and proposals could be discussed between in-country staff and central staff, lessening the need for frequent travel.
 - o Subproject monitoring. Service delivery projects require intensive supervision. This technology would permit core staff to "meet" with in-country staff on a regular basis. Used at regular intervals, it would probably allow for more intensive supervision of subprojects.
 - o Dissemination of "Lessons Learned." Priority country staff could "meet" frequently not only with core staff at headquarters to discuss lessons and findings from behavioral research and ongoing interventions, but they could also meet with and learn from other emphasis country staff.
9. Organize annual workshops. Project staff would prepare papers that address project results and lessons learned. Participants would include representatives from subprojects in priority countries and core and priority country staff.
10. Maintain a database. The database would indicate not only the current status of project and subproject implementation, funding, commodity procurement and other technical information, but it would also provide information on all A.I.D. support to AIDS activities.

A CA will be sought that can provide expertise and demonstrated competence in the design, implementation, evaluation and management of diverse health and family planning service delivery projects. The CA must have demonstrated experience in working in sub-Saharan Africa, Asia, and the Caribbean. All staff proposed by the CA must have requisite language skills (French, Spanish). Since an

important component of this project will be subproject development, monitoring and evaluation, and communications strategies/behavioral research, the CA must have demonstrated competence in these areas. Individual staff members proposed by the CA will be evaluated on their technical expertise, language capabilities, previous field experience and management and evaluation backgrounds.

The CA should have a demonstrated record of having worked with developing country consulting firms, research institutes and/or universities. The CA should have a clearly conceived plan of action for establishing relationships with these types of organizations. The plan should indicate how the institution will assist in the implementation of the overall project and which staff of the institution will be assigned to work on the project.

B. PROJECT STAFFING.

- o U.S. BASED HEADQUARTERS. At U.S. headquarters in the Washington Metropolitan area, the headquarters staff would consist of a Project Director and a Deputy Project Director. They will supervise the work of staff in five major divisions, each headed by a Division Chief. The divisions will be: 1) Program Design and Implementation; 2) Behavioral Research; 3) Evaluation; 4) Training and Information Dissemination; and 5) Non-Priority Country Support. In addition, the Headquarters will have a Senior Finance Officer.
- o REGIONAL COUNTRY OFFICES. Each Regional Office will be headed by a Regional Director and Deputy Director. The Regional Office Divisions will have the same organizational units as the headquarters office and with three additional officers: STD Specialist, Private Sector Officer and Commodity Logistics Officer.
- o PRIORITY COUNTRIES. There will be a Resident Advisor in each of the estimated ten to fifteen priority countries.

C. PROJECT ORGANIZATION. The staffing pattern for this project is on the following page. The Project Director will have overall responsibility for project implementation and will be responsible for assuring timely and high-quality preparation of each AIDS country strategy, as well as subproject development, provision of technical assistance, timely delivery of commodities and all other tasks related to the implementation of this project. Each of the priority country resident advisors will have similar responsibilities for their respective countries.

STAFFING PATTERN**A. HEADQUARTERS STAFF**

- 1. Office of the Director**
 - o Project Director
 - o Deputy Director
 - o Senior Finance Officer
 - o Administrative Assistant
 - o Secretary

- 2. Evaluation Division**
 - o Evaluation Chief
 - o Deputy Evaluation Chief
 - o Evaluation Officer
 - o Administrative Assistant
 - o Secretary

- 3. Training and Information Dissemination Division**
 - o Training Chief
 - o Deputy Training Chief
 - o Training Officer
 - o Secretary

- 4. Behavioral Research Division**
 - o Behavioral Research Chief
 - o Deputy Behavioral Research Chief
 - o Behavioral Research Officer
 - o Secretary

- 5. Non-Priority Support Division**
 - o Non-Priority Support Division Chief
 - o Deputy Non-Priority Support Chief
 - o Non-Priority Support Officer
 - o Administrative Assistant
 - o Secretary

- 6. Program Design and Implementation Division**
 - o Program Office Chief
 - o Deputy Program Office Chief
 - o Program Officer
 - o Administrative Assistant
 - o Secretary
 - o IEC Officer
 - o STD Officer
 - o Private Sector Officer
 - o Commodity Logistics Officer

B. REGIONAL OFFICE STAFF

(Africa, Asia, and Latin America and the Caribbean - 4 offices)

1. **Office of the Director**
 - o Regional Office Director
 - o Deputy Regional Office Director
 - o Finance Officer
 - o Secretary

2. **Regional Staff Office**
 - o Program Officer
 - o Evaluation Officer
 - o Private Sector Officer
 - o Commodity Logistics Officer
 - o STD Officer
 - o Training Officer
 - o Non-Priority Country Officer x2
 - o Behavior Research Officer
 - o Administrative Assistant
 - o Secretary
 - o Secretary

C. Resident Advisors in each priority country

D. REPORTING REQUIREMENTS. The CA will be expected to prepare semi-annual reports to A.I.D. These reports will not follow the usual pattern of reports, which frequently involve a listing of planned and completed activities. This approach is useful at times, but the AIDS project requires a more focused type of reporting.

The AIDS project Semi-Annual Report will provide information on:

- a) progress in implementing each AIDS strategic plan;
- b) constraints to goal achievement; and
- c) the action that managers will take to solve problems and achieve strategic goals.

In the early stages of the project, the reports should set forth the key goals of each strategic plan, a discussion as to why that particular strategy was chosen, the challenges to be anticipated in implementing the strategy, as well as a description of the full-scale program and evaluation and communications/behavioral research strategies for each country. As the overall project progresses, the Semi-Annual Report should present the results from quantitative and qualitative data analyses, undertaken as part of the evaluative and behavioral research effort, which show progress toward goal achievement in each country. The Semi-

Annual Report should then discuss the problems and challenges to implementing the strategy and the implications of the research for fine-tuning the AIDS project. Finally, it should discuss the action that managers will take based on the data presented in the report. Each Semi-Annual Report should be prepared as a thoughtful, analytical piece which emphasizes problem-solving and evidence on results and progress rather than as a public relations document.

E. A.I.D. MANAGEMENT. Primary technical and administrative responsibility for the AIDS project will rest with S&T/Health. The A.I.D. Cognizant Technical Officer (CTO) will provide the CA with overall policy and technical guidance and will ensure that project implementation is consistent with A.I.D. AIDS policy and the design set forth in this paper. In managing the cooperative agreement, the CTO's responsibilities will include:

- o collaborative involvement in the development and approval of each AIDS strategic plan, including the evaluation and behavioral research plans and in all modifications of these plans;
- o written comments, requiring contractor actions if necessary, on each Semi-Annual Report;
- o collaborative involvement in and approval of the "lessons learned and dissemination plan";
- o monitoring project implementation and reviewing all regular and special reports;
- o approval of all activities carried out under this contract including subcontracts, subproject proposals, ad hoc consultancies for technical assistance and international travel;
- o participation in periodic management reviews and evaluations to review program progress and future strategy; and
- o approval of all key personnel and consultants.

The CTO, in conjunction with Regional Bureaus, USAID Missions and REDSOs, will define country and programmatic priorities during the life of the project. All subproject proposals, contractor travel to a particular country and the assignment of regional office staff and resident advisors will require approval from the appropriate Mission.

Throughout the life of the project, the CTO will ensure coordination with other S&T/Health, S&T/Population and other appropriate projects. The CTO will work closely with various

technical, administrative and other bureau personnel such as M/SER, PPC, Regional Bureau, GC and Missions to ensure that subcontracts and subprojects adhere to A.I.D. regulations and are consistent with A.I.D. strategies in a given country.

Finally, the CTO will prepare an initial cable to the field to describe this project. Missions will be asked to identify future needs and possible add-ons.

F. IMPLEMENTATION SCHEDULE. S&T/Health, S&T/Population, S&T/Education, and the AIDS project committee review of this amendment should be completed by the end of February 1991 and approval is expected to take place by early March 1991. Procurement for the cooperative agreement will begin in mid-April 1991.

Once the project has been awarded, subproject planning and design work will get underway with six AIDS strategic plans developed in FY 1992, and four in FY 1993. Project monitoring and the execution of subcontracts with local firms and institutions will take place continuously beginning in FY 1992 .

In-service training is scheduled continuously beginning in FY 1992 and workshops each year. Two external evaluations may be scheduled at the middle and end of the project. (Other evaluation procedures are described in Section D. and Section H.) Internal management reviews will also be scheduled periodically during project implementation.

G. AUDIT/EVALUATION. There are three types of evaluation included in this project: internal, external, and country program/subproject evaluation, and Non-Federal Audit.

1. **Internal/External Evaluation.** The internal evaluation process was described in section D., "Reporting Requirements." The internal evaluation process will provide A.I.D. and contract managers with information and empirical data, every six months, on the overall progress of the project toward purpose and goal achievement. The process of continual internal evaluation is an extremely important one for this project and the CA must designate well-qualified staff to be continually responsible for the overall effort.

If the CA produces high-quality semi-annual analyses that: (1) include both quantitative and qualitative data (developed through the evaluative and behavioral research efforts); and (2) analyze progress toward or the difficulties in reaching each country goal, a mid-term evaluation may be unnecessary. (We recognize that this type of analysis will not be possible in the first year of the

project. Nevertheless, the reports undertaken in the first year should describe what is being done, in terms of evaluative and behavioral research activities, to make the requisite data for these reports available in the next four years of the project). The CTO, in collaboration with the other appropriate A.I.D. staff, will determine whether a mid-term evaluation is required, at the appropriate time. Similarly, a final external evaluation may not be necessary if the CA's final report provides the necessary information on process, effectiveness and impact in each priority country (and/or analyzes the reasons for lack of progress in particular countries and supports the analysis with the requisite data). This decision too will be made by the CTO at the appropriate time prior to project termination in Year 5.

2. **Country Program/Subproject Evaluation.** Some of the main procedures for country program/subproject evaluation were discussed in Section III.A.5. These evaluation procedures are designed to provide A.I.D. and the CA with information and data on subproject effectiveness and impact which, presumably if aggregated, should provide effectiveness and impact information for each priority country program. The evaluation staff will have to be aware of other donor programs that may be contributing to HIV prevention and control and should discuss these programs' contribution to effectiveness and impact in their semi-annual analyses.

It will be the responsibility of the project evaluation staff to develop evaluation plans for each priority country subproject, during subproject development and design. Thus the evaluation staff will have to work closely with subproject design staff to ensure that subproject objectives are clear and measurable. The evaluation staff must include an evaluation plan for each subproject with the AIDS strategic plan that is submitted to the CTO for approval. Each subproject evaluation plan must specify the indicators and methodologies which will be used (possible indicators were identified in Section III.A.5) and explain how the data gathered will provide information on subproject and overall country program goals.

At the beginning of project implementation, the evaluation staff should familiarize themselves with the literature on rapid, low-cost evaluation methods for health and family planning projects. To the extent possible and appropriate, the evaluation staff should use these methods to evaluate subproject performance. In responding to the RFA, the CA should indicate the extent to which the proposed evaluation staff has expertise in these methods.

3. **Audit.** In addition to a mid-term and final evaluation, Project funds will be used to finance a Non-Federal Audit of the cooperative agreement, if required, near the end of the second year of the project. Recommendations from both the audit and the mid-term evaluation will be incorporated into readjustments, as appropriate.

H. BUDGET AND FINANCIAL PLAN. The total life of project funding for activities described in this amendment will be \$319 million in S&T and Mission funds over the next five years. This includes a projected \$168 million for the primary agreement with the CA, \$68.5 million of central \$99.2 million in add-ons. Also, the PVO/NGO federation is budgeted for \$27.5 million in S&T core and another \$6.7 million from add-ons. Under this umbrella project, on-going agreements will require \$16.4 million from FY 1992 through FY 1997. An illustrative budget is provided as an attachment.

Project redesign assumes that add-ons will finance approximately 90 percent of project categories such as subprojects, short-term technical assistance and resident advisors. This assumption is based upon the fact that in FY 1990 buy-ins totaled approximately 45 percent of S&T core funds, increasing steadily from a project inception level of 31 percent. Thus the assumption that there will be approximately a 55/45 percentage split in core/buy-ins follows the overall buy-in pattern to date.

Finally, it should be noted that cooperative agreement funds will not be used to purchase condoms. Beginning in fiscal year 1992, S&T/Health central AIDS funds will play a limited role in condom procurement and should be considered the "source of last resort." Commodities will be financed through subproject agreements and will include items such as STD diagnostic material, drugs and medical equipment.

LOGICAL FRAMEWORK**NARRATIVE SUMMARY****Goal:**

To prevent and control the spread of HIV infection in developing countries

Purpose:

To expand access to HIV prevention and control programs in developing countries

Outputs:

- 1) Improved design, implementation and evaluation of HIV prevention and control programs
- 2) Improved knowledge of sexual behavior and application of this knowledge to communications strategies for behavioral change
- 3) Creation of an international federation dedicated to global HIV prevention and control
- 4) Policy reform

OBJECTIVELY VERIFIABLE INDICATORS**Goal:**

Reduction in HIV incidence in given countries over time

Purpose:

Increase in the number, quality and coverage of HIV prevention and control programs

Outputs:

- 1) Ten to fifteen full-scale HIV prevention and control programs in priority countries and HIV prevention and control activities conducted in non-priority countries leading to documented changes in the indicators listed on page 29-30
- 2) Application of behavioral research findings to communications strategies in priority countries leading to documented changes in the indicators listed on page 29-30

- 3) Global federation contributing to development and expansion of HIV prevention and control activities in priority and non-priority countries
- 4) Improved policies, especially with respect to condom distribution and mass media communications, in priority and non-priority countries

MEANS OF VERIFICATION

Goal: Surveys

Purpose:

Semi-Annual Project Reports containing quantitative and qualitative data generated by subproject evaluations and behavioral research

Outputs:

- 1) Country evaluation reports, subproject evaluations
- 2) Semi-Annual Reports; research reports; published papers
- 3) The Federation's Semi-Annual Report (which should report on the same type of information called for in this project's semi-annual report)
- 4) Semi-Annual Reports, country evaluation reports

IMPORTANT ASSUMPTIONS

Goal:

Continued commitment of developing countries and donors to HIV prevention and control

Purpose:

Sufficient host country and donor resources remain available

Outputs:

- 1) Host governments are committed to developing full-scale programs and commit the requisite resources
- 2) Communications on behavioral change can have a significant impact on HIV prevalence
- 3) Other donors and private individuals and organizations will support an international federation for HIV prevention and control
- 4) Developing country governments will accept and implement policy reform recommendations

MAJOR PROJECT INPUTS

(Dollars in millions)

Core Staff	\$20.0
Resident Advisors	8.7
Short-Term TA (consultants)	20.7
Subprojects	60.4
NGO Federation	34.3
Behavioral Research	10.8
Other (Condoms, on-going agreements)	<u>24.1</u>
Total	\$179.0

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ILLUSTRATIVE BUDGET FOR THE AIDS TECHNICAL SUPPORT PROJECT REDESIGN

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	TOTAL
AIDSCOM BUY-INS	1,000,000 424,680	2,717,429 2,484,921	1,825,000 2,568,150	3,015,000 3,367,529	2,100,000 4,500,000	0	0	0	0	0	0	10,657,429 13,345,280
AIDSTECH BUY-INS	1,403,317 958,990	7,064,143 5,854,789	4,057,468 1,441,235	6,260,276 4,122,253	6,000,000 4,000,000	4,000,000	2,000,000 0	2,000,000 0	0	0	0	32,785,204 16,377,267
CDC PASA BUY-INS	0 0	250,000 0	500,000 350,000	2,011,260 461,300	700,000 300,000	300,000 500,000	300,000 500,000	300,000 500,000	300,000 200,000	200,000 300,000	0 200,000	4,861,260 3,311,300
ICRW BUY-INS	0 0	0 0	0 0	500,000 75,000	800,000 0	800,000 0	0	0	0	0	0	2,100,000 75,000
NCIN BUY-INS	0 0	0 0	200,000 235,000	118,192 14,527	150,000 0	150,000 0	0	0	0	0	0	618,192 249,527
IFAR WHO/STD	0	0	100,000	100,000	100,000	0	0	0	0	0	0	300,000
BUCEM RSSA	0	235,000	149,000	241,000	0	0	0	0	0	0	0	75,000
NIAD PASA	0	85,000	85,000	85,000	0	0	0	0	0	0	0	625,000
FPLH	0	0	0	500,000	500,000	500,000	65,000	65,000	65,000	65,000	65,000	665,000
SOMARC	0	0	0	167,710	500,000	500,000	500,000	500,000	0	0	0	2,500,000
PCP CDC	0	0	150,000	150,000	200,000	200,000	200,000	200,000	200,000	200,000	0	1,967,710
PATH	0	0	0	300,000	300,000	300,000	225,000	225,000	250,000	250,000	250,000	1,900,000
INT'L AIDS CONF SUPPORT	0	0	100,000	0	100,000	0	0	0	0	0	0	900,000
AAAS	55,000	65,000	120,000	65,000	80,000	80,000	85,000	85,000	90,000	90,000	90,000	200,000
CS FELLOW	0	0	0	0	80,000	80,000	80,000	85,000	85,000	90,000	90,000	905,000
CONDOMS	0	0	0	1,500,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	8,500,000
MOTHER CARE	0	0	0	0	250,000	250,000	250,000	0	0	0	0	750,000
EVALS/REVIEWS	0	0	75,000	0	50,000	50,000	125,000	0	0	142,000	0	442,000
OTHERS	600,000	0	7,845	44,000	154,000							805,845
NEW CA BUY-INS	0 0	0 0	0 0	0 0	6,000,000 1,500,000	11,049,397 10,915,948	12,966,781 17,223,578	13,922,263 21,622,779	14,879,136 24,589,989	9,717,573 23,373,232	0 0	68,535,150 99,225,525
NEW PVO/NGO FEDERATION BUY-INS	0 0	0 0	0 0	0 0	500,000 0	4,000,000 1,000,000	4,800,000 1,200,000	5,600,000 1,400,000	6,200,000 1,550,000	6,400,000 1,600,000	0 0	27,500,000 6,750,000
CONTINGENCY	0	0	0	0	0	2,000,000	2,120,000	2,247,200	2,382,032	2,531,556	0	11,280,788
Total BUY-INS	1,383,670	8,339,710	4,594,385	8,040,609	10,300,000	12,415,948	18,923,578	23,522,779	26,339,989	25,273,232	200,000	139,333,899
Total S&T CORE (incl OYB transfers)	3,058,317	10,416,572	7,369,313	15,132,438	19,564,600	25,344,397	24,716,781	26,229,463	25,451,168	20,686,129	1,495,000	179,463,578
GRAND TOTAL	4,441,987	18,756,282	11,963,698	23,173,047	29,864,000	37,760,345	43,640,359	49,752,242	51,791,157	45,959,361	1,695,000	318,797,477

ILLUSTRATIVE BUDGET FOR THE NEW COOPERATIVE AGREEMENT UNDER THE AIDS TECHNICAL SUPPORT PROJECT

	FY 91	FY 92 YEAR 1	FY 93 YEAR 2	FY 94 YEAR 3	FY 95 YEAR 4	FY 96 YEAR 5	TOTAL
STAFF (including benefits)	2,000,000	2,965,351	3,143,272	3,331,869	3,531,781	1,743,688	16,715,960
ALLOWANCES	2,000,000	3,226,855	3,429,467	3,625,695	3,843,236	2,073,830	18,190,083
INDIRECT COSTS	2,000,000	2,965,351	3,143,272	3,331,869	3,531,781	1,743,688	16,715,960
S & A & INDIRECT COST Buy-in @ 20%		2,289,389	2,426,753	2,572,358	2,726,699	2,890,301	12,905,501
SHORT TERM TA Core		414,375	414,375	414,375	414,375	414,375	2,071,875
SHORT TERM TA Buy-in @ 90%	1,500,000	3,729,375	3,729,275	3,729,275	3,729,275	2,229,275	18,646,475
RESIDENT ADVISORS Core		77,465	136,394	209,016	221,557	234,851	879,283
RESIDENT ADVISORS Buy-in @ 90%		697,183	1,227,550	1,881,146	1,994,015	2,113,656	7,913,550
			0				
SUBPROJECTS		400,000	960,000	1,360,000	1,660,000	1,660,000	6,040,000
SUBPROJECTS Buy-ins @ 90%		3,600,000	8,640,000	12,240,000	14,940,000	14,940,000	54,360,000
BEHAVIORAL RESEARCH Core		600,000	1,200,000	1,200,000	1,200,000	1,200,000	5,400,000
BEHAVIORAL RESEARCH Buy-in @ 50%		600,000	1,200,000	1,200,000	1,200,000	1,200,000	5,400,000
INFO DISSEMINATION		400,000	424,000	449,440	476,406	504,991	2,254,837
AUDIT AND EVALUATION		0	125,000	0	0	142,151	267,151
GRAND TOTAL	7,500,000	21,965,345	30,190,359	35,545,042	39,469,125	33,090,805	167,760,675
BUY-INS	1,500,000	10,915,948	17,223,578	21,622,779	24,589,989	23,373,232	99,225,525
S&A CORE (including OYB transfers)	6,000,000	11,049,397	12,966,781	13,922,263	14,879,136	9,717,573	68,535,150

AIOS TECHNICAL SUPPORT PROJECT NEW COOPERATIVE AGREEMENT BUDGET

PERSONNEL AT HEADQUARTERS Positions	GS Scale	GS Rate (\$)	Number of Positions	Allowances	Year 1 Salaries	Year 2 Salaries	Year 3 Salaries	Year 4 Salaries	Year 5 Salaries	Total Salaries
Project Director (12pm)	15/10	80,138	1	0	80,138	84,946	90,043	95,446	101,172	451,745
Deputy Director (12pm)	14/10	68,129	1	0	68,129	72,217	76,550	81,143	86,011	384,050
Behavioral Research Chief (12pm)	14/5	58,384	1	0	58,384	61,887	65,600	69,536	73,708	329,116
Evaluation Chief (12pm)	14/5	58,384	1	0	58,384	61,887	65,600	69,536	73,708	329,116
Training and Info Dissemination Chief (12pm)	14/5	58,384	1	0	58,384	61,887	65,600	69,536	73,708	329,116
Non-Priority Support Chief (12pm)	14/5	58,384	1	0	58,384	61,887	65,600	69,536	73,708	329,116
Program Design & Implementation Chief (12pm)	14/5	58,384	1	0	58,384	61,887	65,600	69,536	73,708	329,116
Senior Finance Officer (12pm)	14/5	58,384	1	0	58,384	61,887	65,600	69,536	73,708	329,116
Deputy Evaluation Chief (12pm)	13/7	53,216	1	0	53,216	56,409	59,793	63,581	67,184	299,984
Deputy Training Chief (12pm)	13/7	53,216	1	0	53,216	56,409	59,793	63,581	67,184	299,984
Deputy Non-Priority Support Chief (12pm)	13/7	53,216	1	0	53,216	56,409	59,793	63,581	67,184	299,984
Deputy Program Chief (12pm)	13/7	53,216	1	0	53,216	56,409	59,793	63,581	67,184	299,984
Deputy Behavioral Research Chief (12pm)	13/7	53,216	1	0	53,216	56,409	59,793	63,581	67,184	299,984
LAC Evaluation Officer (1x12pm)	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC Behavioral Research Officer (1x12pm)	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC Program Officer (1x12pm)	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC Training Officer (1x12pm)	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC Non-Priority Country Officer (1x12pm)	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC IEC Officer	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC STD Officer	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC Private Sector Officer	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC Commodity Logistics Officer	13/1	44,348	1	0	44,348	47,009	49,829	52,819	55,988	249,994
LAC Administrative Assistant	9/1	26,717	1	0	26,717	28,320	30,019	31,820	33,730	150,606
Administrative Assistant (4x12pm)	9/1	26,717	4	0	106,868	113,280	120,077	127,281	134,918	602,425
Secretaries (9x12pm)	6/1	18,919	9	0	170,271	180,487	191,316	202,795	214,963	959,833
Headquarters Salary Total					1,467,639	1,555,697	1,649,039	1,747,982	1,852,860	8,273,217
Fringe Benefits (22%)					322,881	342,253	362,789	384,356	407,629	1,820,108
Headquarter Personnel					1,790,520	1,897,951	2,011,828	2,132,537	2,260,490	10,093,325

PERSONNEL AT REGIONAL OFFICES Positions	GS Scale	GS Rate(\$)	Number of Positions	Allowance Only	Year 1 S & A	Year 2 S & A	Year 3 S & A	Year 4 S & A	Year 5 S & A
Regional Director (12pm)	14/10	68,129	1	121,871	190,000	201,400	213,484	226,293	239,871
Deputy Regional Director (12pm)	13/7	53,216	1	136,784	190,000	201,400	213,484	226,293	239,871
Program Design & Implementation Offr (12pm)	13/1	44,348	1	120,652	165,000	174,900	185,394	196,518	208,309
Private Sector Officer (12pm)	13/1	44,348	1	120,652	165,000	174,900	185,394	196,518	208,309
STD Officer (12pm)	13/1	44,348	1	120,652	165,000	174,900	185,394	196,518	208,309
Training Officer (12pm)	13/1	44,348	1	120,652	165,000	174,900	185,394	196,518	208,309
Evaluation Officer (12pm)	13/1	44,348	1	120,652	165,000	174,900	185,394	196,518	208,309
IEC Officer (12 pm)	13/1	44,348	1	120,652	165,000	174,900	185,394	196,518	208,309
Non-Priority Country Officer (2x12pm)	13/1	44,348	2	241,304	330,000	349,800	370,788	393,035	416,617
Behavioral Research Advisor (12pm)	13/1	44,348	1	120,652	165,000	174,900	185,394	196,518	208,309
Commodity Logistics Officer (12pm)	11/1	31,116	1	0	31,116	32,983	34,962	37,060	39,283
Finance Officer (12pm)	11/1	31,116	1	0	31,116	32,983	34,962	37,060	39,283
Administrative Assistant (12pm)	6/1	18,919	1	0	18,919	20,054	21,257	22,533	23,885
Secretaries (3x12pm)	2/1	12,365	3	0	37,095	39,321	41,680	44,181	46,832
One Regional Office S & A Total					1,983,246	2,102,241	2,228,375	2,362,078	2,503,802
One Regional Office Salary Only					638,723	677,046	717,669	760,729	806,373
Total S & A for 3 Regional Offices					5,949,738	6,306,722	6,685,126	7,086,233	7,511,407
Total Salary Cost for 3 Regional Offices					1,916,169	2,031,139	2,153,007	2,282,188	2,419,119
Total Allowance Cost for 3 Regional Offices					4,033,569	4,275,583	4,532,118	4,804,045	5,092,288
PERSONNEL AT HEADQUARTERS (SALARIES)					1,790,520	1,897,951	2,011,828	2,132,538	2,260,490
PERSONNEL AT REGIONAL OFFICES (SALARIES)					1,916,169	2,031,139	2,153,007	2,282,188	2,419,119
TOTAL PERSONNEL (SALARIES)					3,706,689	3,929,090	4,164,836	4,414,726	4,679,609
INDIRECT COSTS					3,706,689	3,929,090	4,164,836	4,414,726	4,679,609
TOTAL					7,413,378	7,858,180	8,329,672	8,829,452	9,359,218

LONG TERM RESIDENT ADVISORS	GS	GS Rate	Positions	Only	S & A	S & A	S & A	S & A	S & A	S & A
FY 92 3 Resident Advisors (3@12pm)	13/7	53,216	3	410,352	570,000	604,200	640,452	678,879	719,612	3,213,143
FY 92 3 Resident Advisors (3@12pm)	13/7	53,216	3	0	204,648	216,927	229,942	243,739	258,363	1,153,620
FY 93 2 Resident Advisors (2@12pm)	13/7	53,216	2 †	293,568		400,000	424,000	449,440	476,406	1,749,846
FY 93 2 Resident Advisors (2@12pm)	13/7	53,216	2 †	0		142,818	151,387	160,470	170,098	624,774
FY 94 2 Resident Advisors (2@12pm)	13/7	53,216	2 †	313,568			420,000	445,200	471,912	1,337,112
FY 94 2 Resident Advisors (3@12pm)	13/7	53,216	3 †	0			224,381	237,843	252,114	714,338
Total					774,648	1,363,945	2,090,162	2,215,572	2,348,506	8,792,833
† incrementally field resident advisors (6 in year 1; 4 in year 2; 5 in year 3)										

SHORT TERM TECHNICAL ASSISTANCE

Salary (250/day @ 4,865 days/year)	1,216,250
Travel & Transportation	
Africa - 300 trips @ \$5000/trip	1,500,000
Asia - 100 trips @ \$5000/trip	500,000
Latin America - 125 trips @ \$2000/trip	250,000
Near East & Europe - 20 trips @ 3,000/trip	60,000
Interregional - 50 trips @ \$1000/trip	50,000
Domestic - 100 trips @ \$600/trip	60,000
Per diem (average trip = 7 days)	
Africa - 300 trips x \$100/day	210,000
Asia - 100 trips x \$100/day	70,000
Latin America - 125 trips x \$100/day	87,500
Near East & Europe - 20 trips x \$100/day	14,000
Interregional - 50 trips x \$100/day	35,000
Domestic - 100 trips x \$130/day	91,000
Total for Short term consultants	4,143,750
Total Short term TA for 5 years	20,718,750