PD-AAZ-861

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number ______

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Regional Development Office/Caribbean

3. PROJECT NUMBER: 538-0161

4. BUREAU/OFFICE: LAC 05

5. PROJECT TITLE (maximum 40 characters): AID Communications and Technical Services

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 95

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 88 B. Quarter 4 C. Final FY 92

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

A. FUNDING SOURCE	FIRST FY ____ B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant) RDO/C	(524)	(-)	(-)	(7,000)	(-)	(7,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1. AID/S&T/Health				554		554
Other U.S. 2.						
Host Country						
Other Donor(s) WHO/GPA	524			300		300
TOTALS	524			7,854		7,854

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. 2. Loan	D. OBLIGATIONS TO DATE 1. Grant	D. 2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	E. 2. Loan	F. LIFE OF PROJECT 1. Grant	F. 2. Loan
(1) HE	582	530		224				3,592	
(2) DG	512	590		300				3,408	
(3)									
(4)									
TOTALS				524				7,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 520 | 550

11. SECONDARY PURPOSE CODE: 519

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

A. Code	R/H	TNG
B. Amount		

13. PROJECT PURPOSE (maximum 480 characters)

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

14. SCHEDULED EVALUATIONS: Interim MM 03 YY 91 | MM __ YY __ | Final MM 06 YY 94

15. SOURCE/ORIGIN OF GOODS AND SERVICES: [ ] 000 [X] 941 [ ] Local [ ] Other (Specify) ______

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

Methods of Finance/Implementation

Thomas F. Fallon, CONT

17. APPROVED BY

Signature: [signature]

Title: Acting Director, RDO/C

Date Signed: MM __ DD __ YY __

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM __ DD __ YY __

AID 1330-4 (8-79)

PROJECT AUTHORIZATION

Name of Country: Caribbean Regional

Name of Project: AIDS Communications and Technical Services (ACTS)

Number of Project: 598-0161

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AIDS Communications and Technical Services Project for participating countries of the Commonwealth Caribbean, including, as primary recipients, Antigua and Barbuda, Dominica, Grenada, Montserrat, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and, as limited participants, Anguilla, Barbados, Cayman Islands, Bermuda, Bahamas, Belize, the British Virgin Islands, Jamaica, Suriname, Trinidad and Tobago and Turks and Caicos, involving planned obligations of not to exceed Seven Million United States Dollars (U.S. $7 million) in grant funds ("Grant"), subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is seven years from the date of initial obligation, consisting of Phase I of three years and Phase II of four years.

2. The Project will assist the above listed countries to establish a capacity to develop and implement cost-effective surveillance, information, education and intervention strategies in support of projecting future trends in and reducing the transmission of HIV infection and AIDS.

3. The Project Agreement may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority.

Thomas Fallon

~~Larry~~ Armstrong, Acting Director
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6/19/89
DATE

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AIDS COMMUNICATIONS AND TECHNICAL SERVICES PROJECT (538-0161)

PROJECT PAPER

TABLE OF CONTENTS

	Page
Project Data Sheet	
Project Authorization	
Table of Contents	i
List of Tables	iii
List of Acronyms	iv
I. SUMMARY AND CONCLUSIONS	1
A. Recommendations	1
B. Project Summary Description	2
C. Project Paper Design Team	3
II. PROJECT RATIONALE AND DESCRIPTION	3
A. Rationale	3
1. Problem Description	3
2. Relationship to Countries' Development Strategies	8
3. Relationship to Regional Development Strategy Statement	9
B. Goal, Purpose, and End of Project Status	11
C. Project Description	15
1. HIV Infection, STDs and Knowledge, Attitudes and Practices Surveys	15
2. Prevention of Sexually Transmitted HIV Infection	18
3. Program Management Improvements and Alternatives	26
4. Phase II Overview	28
III. COST ESTIMATES AND FINANCIAL PLAN	29
A. Component Cost Summary	29
B. Methods of Implementation and Financing	34

		Page
IV.	IMPLEMENTATION PLAN	36
	A. Institutional Arrangements	37
	1. Caribbean Epidemiology Centre	37
	2. Academy for Educational Development	39
	3. Family Health International	40
	B. Mission Responsibilities	41
	C. Governments' Responsibilities	41
	D. Training Plan	42
	1. Regional and In-country Training	42
	2. Overseas Training	43
	E. Procurement Plan	43
	1. Technical Services	43
V.	MONITORING AND EVALUATION PLAN	44
	A. Project Monitoring	44
	B. Project Evaluation	45
	1. Process Evaluation	45
	2 Impact Evaluation	46
	3. External Evaluation	48
VI.	PROJECT ANALYSES	49
	A. Technical Analysis	49
	B. Economic Analysis	54
	C. Social Soundness Analysis	56
	D. Administrative Analysis	61

ANNEXES

A. Initial Environmental Examination Cable
B. Logical Framework
C. Project Checklist
D. Detailed Budget
E. Request for Assistance (PAHO/CAREC) (pending)
F. Executive Summary: CAREC Medium Term Plan
G. Implementation Plan
H. World Health Assembly Resolution WHA42.34 "Nongovernmental Organizations and the Global AIDS Strategy

LIST OF TABLES

TABLES			PAGE
Table 1	-	AIDS in the Caribbean, December 1988	6
Table 2	-	Component Cost Summary	30
Table 3	-	Summary Budget: Phase I	31
Table 4	-	USAID Summary Budget by Program Area for Phase I	32
Table 5	-	Summary Budget: Phase I By Component and Cost Element	33
Table 6	-	Summary Budget: Phase II By fiscal Year and MTP Program Area	33
Table 7	-	Obligation Plan and Funding Sources	34
Table 8	-	Methods of Implementation and Financing: Phase I	35

ACRONYMS

ACTS	AIDS Communications and Technical Services
AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSCOM	AIDS Communications Program
AIDSCOM CPC	AIDSCOM Caribbean Program Coordinator
AIDSTECH	AIDS Technical Services Program
AIDSTECH CPC	AIDSTECH Caribbean Program Coordinator
ASOs	AIDS Service Organizations
CAREC	Caribbean Epidemiology Centre
CIDA	Canadian International Development Administration
EEC	European Economic Community
EPI	Expanded Program on Immunization
EPI-INFO	Epidemiological Information (software package)
FHI	Family Health International
GPA	Global Program on AIDS (of the World Health Organization)
HIV	Human Immunodeficiency Virus
HIV+	Human Immunodeficiency Virus seropositive
KAP	Knowledge, Attitudes and Practices
MOH	Ministry of Health
MTP	Medium Term Plan
NGOs	Non-Governmental Organizations
ODA	Overseas Development Administration
OECS	Organisation of Eastern Caribbean States
PIO/T	Project Implementation Order/Technical
PSC	Personal Services Contractor
RDO/C	Regional Development Office/Caribbean
RDSS	Regional Development Strategy Statement
SAC	Scientific Advisory Council
ST/H	Science and Technology Bureau/Health Office
STD	Sexually Transmitted Disease
UNICEF	United Nations Children's Fund
UWI	University of the West Indies
WHO/GPA	World Health Organization's Global Program on AIDS

I. SUMMARY AND CONCLUSIONS

A. Recommendations

1. Funding

In the 1988 AAP Cable the Mission was given approval to undertake a four-year $3.5 million AIDS prevention program through buy-ins to two AID/ST/H programs, AIDSCOM and AIDSTECH. Following the December 1988 Donors' Meeting on the WHO/GPA-assisted Medium Term Plans (MTPs) for the Caribbean, the Mission decided to expand the Project design to include more direct support to the region's MTPs via a grant to the Pan American Health Organization and its regional representative, the Caribbean Epidemiology Centre (CAREC). Since a majority of the activities planned for the first fiscal year of the project (FY 1988) were held in abeyance by the WHO/GPA planning process, it was also decided to expand the life-of-project by three additional years for a total of seven years. Based on these decisions, it was determined that a full Project Paper should be prepared to outline the expanded activity. RDO/C therefore recommends that a DA Project of $7.0 million be authorized for the AIDS Communications and Technical Services Project (538-0161). A total of $523,800 was obligated by Mission buy-ins to the Public Health Communications Component [AIDSCOM] and Broad Public Health Support Component [AIDSTECH] of the ST/H AIDS Technical Support Project (936-5972) in FY 1988. The remaining balance of RDO/C funds will be obligated over the FY 89-92 period for activities to be undertaken by AIDSCOM, AIDSTECH, and PAHO.

Participating countries of the Commonwealth Caribbean include, as primary recipients, Antigua and Barbuda, Dominica, Grenada, Montserrat, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Barbados and Trinidad and Tobago; and, as limited participants, Anguilla, Cayman Islands, Bermuda, Bahamas, Belize, the British Virgin Islands, Jamaica, Suriname and Turks and Caicos. With the exception of participation at regional training workshops, technical assistance to Barbados and Trinidad and Tobago will be limited to pilot project activities where there is clear justification for testing programs in these countries prior to diffusion to primary OECS project countries. Limited participation countries will be eligible only to send representatives to regional training workshops; no other technical assistance is anticipated in these countries without prior RDO/C approval. RDO/C is prohibited from providing assistance to Guyana at this time.

2. Geographic Code

The Project Authorization will specify that, except as AID may otherwise agree in writing, goods and services financed by AID under this Project shall have their source and origin in countries included in AID Geographic Code 941.

B. Project Summary Description

The purpose of the project is to establish a capacity to develop and implement cost-effective surveillance, information, education and intervention strategies in support of projecting future trends in and reducing the transmission of HIV infection and AIDS. Under Phase I (September 30, 1988 - September 29, 1991), the Project will assist participating governments and non-governmental organizations primarily with two strategies identified in the national and sub-regional Medium Term Plans for AIDS Prevention and Control: strengthening epidemiological surveillance and control systems and reducing HIV infection through sexual transmission. Assistance under the first strategy will allow governments to get a firm understanding of the current extent of the problem as well as to establish a system to track the characteristics of HIV transmission and AIDS cases in the Caribbean as a first step to designing prevention programs. Assistance to reduce sexual transmission of the virus will focus on the design and implementation of activities with both governments and non-governmental organizations (NGOs) regarding public education strategies, training of health care workers, and the establishment of counselling programs to encourage behavior change to reduce the risk of infection.

Assistance to governments and NGOs will be provided over seven years primarily for implementation of the Sub-regional Medium Term Plan of the Caribbean Epidemiology Centre with technical support by AIDSCOM and AIDSTECH. Under Phase I (September 30, 1988 - September 29, 1991), the Project will introduce new interventions which will become available with the changes in the epidemiology and treatment of AIDS. The project will endeavor to institutionalize the most effective strategies piloted during the first Phase and foster sustainability of AIDS prevention. In implementing this Project special emphasis will be placed in supporting the World Health Assembly Resolution WHA42.34 "Nongovernmental Organizations and the Global AIDS Strategy" adopted at the 42nd and World Health Assembly which promotes the role of NGOs in the implementation of the national plans for AIDS prevention and control.

It is expected that by the end of the Project governments will have adequate surveillance systems for tracking the virus and that governments and NGOs will be able to develop, implement and sustain effective communications and counselling programs for both general and higher risk populations. A majority of the adult population should have a basic knowledge of how HIV is transmitted and what behaviors they should adopt or avoid to reduce their risk of contracting the virus.

C. Project Paper Design Team

The following individuals contributed to the development of this Project Paper:

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II. PROJECT RATIONALE AND DESCRIPTION

A. Rationale

1. Problem Description

a. General Overview

The tragic epidemic of acquired immune

deficiency syndrome (AIDS), is, without a doubt, the most critical world health crisis in recent times. Over 138 countries have reported cases including nearly every Caribbean country. Reticence to report as well as under-recognition of AIDS cases has meant that the reported number of AIDS cases falls significantly below the actual number. As of November 30, 1988, the official number of AIDS cases worldwide was reported to be 129,385. The World Health Organization estimates the actual figure could be higher by 200 percent or more. Additionally, because of the latency period which can occur between infection by the human immumodeficiency virus (HIV) and the presentation of AIDS, the number of reported cases represents only a fraction of the number of persons who are infected with this disease. Worldwide, WHO estimates that between 5 and 10 million persons or more are infected with HIV. By 1991 WHO estimates that between 50 and 100 million persons may be infected.

HIV is transmitted by exposure to the body fluids of an infected person. Transmission may be via sexual contact; contaminated blood and blood products (through injections with infected needles and by use of improperly sterilized skin-piercing equipment); and from the mother to her newborn (during pregnancy, at birth or shortly after birth). This combination of transmission modes indicates that virtually all segments of the world's population have some degree of risk of HIV infection. By far the most dominant mode of transmission is through sexual contact (almost 90 percent of all cases), followed by blood (about 10 percent) and fewer than 1 percent by other means.

AIDS threatens individuals, families and societies in innumerable ways. It not only takes the lives of people who are breadwinners, homemakers, and often the most productive cohort from society; it also shakes the foundations of social interaction, causing those at low risk to needlessly and inhumanely reject those who are infected with the virus. Groups of individuals who are correctly or incorrectly associated with high-risk behavior have faced discrimination, resulting in the loss of jobs, housing, medical care, insurance, and families.

In addition to this human side of what U.S. Surgeon General has called a global "pandemic," the financial implications of the problem are equally staggering: the cost of designing and implementing public education programs; the introduction of blood screening programs to safeguard blood supplies; the exponentially growing demand by panicked

individuals for HIV tests; the mushrooming requirements for testing supplies, protective equipment such as plastic gloves, and disposable syringes; as well as the growing demand for tertiary level services to care for AIDS patients, all severely challenge the capacity of public health services in developed and developing countries alike. The demands of AIDS-related activities have stretched the human and financial resources of Ministries of Health like no other public health crisis.

b. Regional Outlook

The first confirmed case of AIDS in the Caribbean was reported in Jamaica in 1982. In 1983, Trinidad and Tobago reported 8 cases, all of whom were male homosexuals or bisexuals. The first cases in the Eastern Caribbean were reported in Barbados (2 cases) in 1984 and St. Vincent (1 case) the same year. Since then, the number of cases in Barbados has risen to 70, and in St. Vincent to 16.

As of December, 1988, the 19 CAREC member countries* reported a total of 1,013 cases, nearly 40 percent of which have occurred in Trinidad and Tobago. The country with the second highest number of cases is the Bahamas with nearly 200 cases. Barbados, with a similar population size as the Bahamas has approximately 70 cases ranking it seventh place in the world for the rate of reported AIDS occurrance in its population. Among the OECS countries, St. Kitts and St. Vincent have the highest number of reported cases at 14 and 16 cases respectively. Dominica has reported six-cases and Antigua has reported three AIDS cases. No AIDS cases have been reported yet in Montserrat. The following table illustrates the number of reported AIDS cases as well as the incidence of the disease per 100,000 population.

* CAREC Member Countries include: Anguilla, Cayman Islands, Bermuda, Bahamas, Antigua and Barbuda, Barbados, Belize, the British Virgin Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Suriname, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago, and Turks and Caicos.

TABLE 1
AIDS in the Caribbean, December 1988

	AIDS Cases	Population	Cases per 100,000
OECS Countries			
Antigua/Barbuda	3	80,000	3.8
Dominica	6	87,700	6.8
Grenada	11	100,677	10.9
St. Kitts/Nevis	14	43,700	32.0
St. Lucia	13	136,152	9.5
St. Vincent/ Grenadines	16	111,419	14.4
Montserrat	0	12,000	-NA-
Barbados	70	253,838	27.6
Trinidad/Tobago	380	1,079,971	35.2

Source: Caribbean Epidemiology Centre and Medium Term Plans

Of the adult cases reported up to December 1988, approximately 70 percent were male although the number of females with AIDS has been dramatically increasing (from zero cases in 1984 to 23.5 percent of total cases as of June 1988 and 25.4 percent in December 1988). Over 40 percent of the AIDS cases during the period 1982 - 1988 have been homosexual or bisexual males, however the rate of increase in the number of AIDS cases is greater among heterosexuals than homosexual/bisexuals in recent years. This is a problematic statistic for the Caribbean where early onset of sexual activity and multiple partnering are widespread, if not culturally acceptable. Blood transfusion recipients represent 1 percent of the cases, and haemophiliacs less than 0.5 percent. Intravenous drug use in the Eastern Caribbean is very rare. Since 1985 approximately 90 cases of pediatric AIDS cases have been reported.

Due to the lag time of 5, 10, or more years before infection can present itself as AIDS, perhaps a more important forecasting statistic is the prevalence of HIV infection in the population. Limited seroprevalence studies have been undertaken mostly in the more developed Caribbean countries (Trinidad, Guyana and Jamaica). A 1983 study of 100 homosexuals attending sexually-transmitted disease (STD) clinics in Trinidad showed that fully 40 percent were HIV seropositive (HIV+); a 1985-86 study of 125 homosexuals in Jamaica found 15 percent to be HIV+. According to CAREC,

surveys of a small number of prostitutes in four countries (Trinidad, Guyana, Antigua and the Bahamas) showed seropositivity ranging from zero to 13 percent.

The CAREC MTP notes that the first reported cases of AIDS in some Caribbean countries occurred among farmworkers who work in North America for 3-5 month periods each year. Of farmworkers tested in 1985 and 1986 fewer than one percent in St. Vincent and St. Lucia were found to be HIV+. Various blood donor samples were tested in 1986 in several OECS countries with the following results: 1 HIV+ of 379 tested in St. Vincent, 1 HIV+ of 50 tested in Grenada, and 1 HIV+ of 177 tested in St. Kitts. Each of the OECS countries have asked for assistance in testing various high-risk behavior populations in their MTPs.

Epidemiologists also track the increasing rates of STDs in the Caribbean since the presence of STDs not only increases the risk potential for HIV infection but is in some populations the single most important predictor of seropositivity. STDs are often associated with multiple partners, and thus provide some indication of the potential for spread of AIDS. In the Caribbean, the incidence of reported STDs has increased significantly in practically all countries, most notably in Trinidad and Tobago, St. Vincent and Antigua. Similar increases, particularly in syphilis, have been noted in many parts of the U.S. and around the world where cocaine addiction is leading to prostitution.

What does the future hold for HIV infection and AIDS case development? Presently there is no effective basis for estimating the eventual magnitude of the AIDS pandemic, its duration as the most critical global health crisis, or the resources which will ultimately be required to manage it. In the near term, however, further spread of HIV infection and the chaos it brings is certain to occur for several reasons:

1) Persons infected with HIV can be presumed to be infected for life; most will not develop any symptoms or evidence of illness for at least several years, during which time they may transmit HIV to others;

(2) The various modes of transmission means that virtually all segments of the global population are to

some degree at risk of exposure to HIV so that spread is inevitable; and

(3) Despite 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 pandemic of HIV infection prior to the mid-1990s.

Since there is no cure or effective treatment for AIDS, the most important strategy for fighting the disease is through prevention. This project focuses on improving the prevention capabilities of governments, non-governmental organizations, individuals and societies.

2. Relationship to Countries' Development Strategies

In November 1987 the Caribbean countries attended the first AIDS Planning and Funding Workshop at the Caribbean Epidemiology Centre (CAREC) in Trinidad. The purpose of the meeting was to introduce the World Health Organization's Global Program on AIDS (WHO/GPA) and to review and further develop short term implementation plans developed by Caribbean countries for AIDS prevention. At this meeting RDO/C and others pledged continued commitment to supporting the WHO/GPA and agreed that any assistance provided would be in response to country and sub-regional plans for the medium term (1989-1991). In 1988 using guidance provided by WHO/GPA and with assistance from CAREC/PAHO/WHO, each country developed an MTP; CAREC developed its own sub-regional plan. These plans were approved at the December 1988 Donors' Pledging Meeting for AIDS Control in the Caribbean held in Barbados. Each of the plans address the following five AIDS prevention strategies:

I. Epidemiological Surveillance and Research
II. Prevention of Sexual Transmission
III. Prevention of Transmission through Blood
IV. Prevention of Perinatal Transmission
V. Reduction of the Impact of HIV on Individuals, Groups and Societies

The CAREC plan includes each of the above five strategies and adds a sixth:

IV. Promotion of Effective Management of National Programs.

At the December Donors' Meeting, the Mission determined that the most effective way of supporting the country plans would be through the sub-regional CAREC plan. In particular, the Project will target its efforts on two of the six MTP areas: (1) epidemiological surveillance and research, and (2) prevention of sexual transmission. Other donors (.g., CIDA and the ODA) will provide support for the other program strategies: prevention of transmission by blood and blood products; prevention of perinatal transmission, reduction of the impact of HIV on individuals, groups, and societies; and promotion of effective management of the national programs. Both CIDA and ODA are financing their CAREC AIDS contribution through he WHO/GPA; the former at a level of CAN$1.5 million (US$1.26 million) for three years and the latter at a level of British Pounds 450,000 (US$751,500). The CIDA contribution will be used to finance strategies IV. through VI and will be allocated to specific identifiable activities. The ODA funds will support strategy III and will support core costs such as duty travel, laboratory and computer equipment. These funds are anticipated to be available to CAREC in time for Project startup. In addition to these funds, a total of $300,000 of AID-earmarked GPA funds have been made available to CAREC for the AIDS Communications and Technical Services Project.

At the 13th Plenary Meeting of the 42 and World Health Assembly, governments adopted Resolution WHA42.34 "Non-governmental Organizations and the Global AIDS Strategy" which urges member states and the WHO to promote the participation of NGOs in the implementation of national plans and the global program on AIDS. (See Annex H for complete resolution.) Every effort will be made in this project involve NGOs and thereby facilitate AIDS programming and support this resolution. Our efforts as well as those of the other donors will be coordinated by CAREC through regular planning meetings and the adoption of a "master workplan" for the CAREC MTP. This workplan will be finalized before September 1989. Each activity to be undertaken through this project will be in direct response to the needs identified in the MTPs and will be approved specifically by the participating governments or, where appropriate, non-governmental organizations.

3. <u>Relationship to Regional Development Strategy Statement</u>

The A.I.D. policy on AIDS was first

enunciated by the Administrator in April 1987. For this reason the AIDS epidemic, which was already presenting itself as an important public health problem in the Caribbean during this time, was not addressed in the 1985-1989 RDSS.

The Agency's AIDS Policy declares its support of the WHO/GPA as the key player in global AIDS prevention and control activities, however, it also clearly provides a mandate for action by A.I.D. missions around the world in concert with the WHO/GPA. This dual multi- and bilateral approach is manifested in the significant portion of the Agency's AIDS budget which is provided directly to the WHO/GPA as well as the commitment to the ST/Health worldwide AIDS Technical Support Project with its two major components--AIDS Communications (AIDSCOM) through a contract to the Academy for Educational Development, and AIDS Technical Services (AIDSTECH), through a cooperative agreement to Family Health International, as well as through bilateral funding. Through a buy-in arrangement, RDO/C used FY 88 funding to secure start-up services (country needs assessments, sub-project designs, and initial program implementation) from AIDSCOM and AIDSTECH.

The 1990-1994 RDSS acknowledges the severe strain which AIDS prevention and control programs place on fragile public health care systems. The document recognizes both the need to target Mission resources to gain maximum potential benefit, and to coordinate our activities closely with those of other donors. The RDSS outlines the following activities for Mission support:

(1) Assessing both the level of HIV seropositivity and the knowledge, attitudes and practices (KAP) of select high risk groups and the general population;

(2) Developing effective communications strategies for reaching these populations;

(3) Training health care workers, counsellors, and others in AIDS surveillance, counselling and education strategies; and

(4) Testing and replicating effective and innovative models for increasing knowledge, changing high risk behavior, and reducing the financial burden on health care systems.

The RDSS calls for the strategy to be implemented by the Caribbean Epidemiology Centre with technical assistance from AIDSCOM and AIDSTECH.

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

1. Goal and Purpose

The Goal of the AIDS Communications and Technical Services (ACTS) project is to prevent and control the spread of AIDS in the Eastern Caribbean. The Purpose of the project is to establish a capacity to develop and implement cost-effective surveillance, information, education and intervention strategies in support of projecting trends in and reducing the transmission of HIV infection and AIDS. Specifically, the project will assist and support the implementation of the MTPs for AIDS Prevention and Control Programs developed under the guidance of the CAREC/PAHO/WHO and approved by donors including U.S.A.I.D.

The Project will be implemented in two phases. Phase I will include activities currently identified in the MTPs over the period FY 1988 through the end of the MTP (1991). Phase II (FY 1992 through FY 1995) will include activities to be designed prior to the end of Phase I based on careful evaluation of Phase I activities, new strategies and the changing epidemiological picture. Under Phase I special attention will be paid to assisting governments and NGOs through regional channels with Strategies 1 and 2 of the national and sub-regional Medium Term Plans: (1) establishing and strengthening epidemiological surveillance and research programs to gather information on the extent and characteristics of HIV transmission and AIDS cases; and (2) introducing, improving, and evaluating programs which will reduce the likelihood of sexual transmission of HIV infection. Other strategies from the plans being supported by other donors include the reduction of transmission by blood and perinatally, reducing the impact of AIDS on societies and individuals, and improving management skills in AIDS.

It is essential to understand that all interventions will have to be conducted against a backdrop of visibly rising numbers of HIV disease and AIDS cases. Therefore, perceived success in this program may be quite different in the eyes of the general public than in formal evaluations. Quantifiable goals are difficult to set because they depend on projecting what the prevalence of HIV infection would have been in the absence of interventions. In the case

of immunization or family planning, death rates or birth rates can be projected reasonably in the absence of the intervention. This is not the case with AIDS, where there is inadequate experience with the disease to predict its future course. This project will seek:

a. To reduce the annual rate of new sexually transmitted disease cases by 25 percent from the current or projected level in select target countries (e.g., Antigua, St. Vincent and the Grenadines, Trinidad and Tobago or the Bahamas) and

b. To prevent HIV infection from exceeding 1 percent prevalence in 7 years in countries which have little or no infection today (e.g., St. Lucia, Montserrat) as measured in groups representative of the general population (e.g., antenatal clinic attendees).

Although it is useful to attempt to quantify overall goals in terms of impact measures, quantifying process or intermediate indicators may be more practical. In setting quantifiable indicators, an effort has been made to select criteria that bridge the gap between what is necessary to have an impact on the spread of the disease and what is likely to be achieved. By the end of the project, however, it is expected that the following conditions should exist:

(1) Eastern Caribbean governments will have an adequate data base and information system for tracking changes in the HIV+ and AIDS prevalence in their countries.

(2) A majority (75 percent) of the adult population in the region will have an accurate assessment of their own perceived risk and appropriate concern, motivation, skills and support to adopt behavior change.

(3) Governmental and non-governmental, community-based organizations in the region will have the enhanced technical, professional, and social science skills to effectively implement AIDS prevention, counselling and treatment programs for AIDS patients and their families.

(4) A 50 percent increase will be effected among targetted at-risk population groups in at least four countries in practicing improved safe sexual behavior as a result of information, education and promotion of condoms.

(5) The Caribbean Epidemiology Centre will have strengthened its institutional capabilities in social/behavioral sciences and health education/communications to enhance its ability to effectively respond to the chronic disease picture in the Caribbean into the future.

During the last year of Phase I the Mission will undertake a comprehensive evaluation of project activities in concert with the WHO/GPA evaluation program as well as identify successful programs worldwide. The Project will assist CAREC and participating countries in developing MTP follow-on strategies and will incorporate the most cost-effective of these into a workplan for Phase II.

2. Illustrative Outputs and Accomplishments

The AIDS Communications and Technical Services Project will focus its efforts on those areas where A.I.D. has the comparative advantage among donor agencies including operations research, economic analysis, development of surveillance methdologies, communications, training, information dissemination, technical and program support, coordination with non-governmental and community organizations, and health care financing.

Expected outputs will include:

a. Improved epidemiological sentinel and periodic seroprevalence surveillance and reporting systems for tracking the prevalence of HIV, AIDS and sexually transmitted disease (STD) cases as well as changes in the knowledge, attitudes, characteristics and behaviors of the general population and those practicing high risk behaviors in eight countries.

b. Improved management, prevention and treatment of STDs through STD clinic staff upgrading and technical assistance in a minimum of four project countries.

c. Cost-effective strategies for testing pooled blood, the potential for cost recovery for blood screening, and cost containment in select program countries.

d. Pilot tested operations research intervention studies to reduce the sexual transmission of HIV in a minimum of four countries among groups practicing high-risk behaviors.

e. Complete economic analyses of the comparative costs of and guidance for governments and NGOs on various intervention strategies, various case management procedures, and various public education campaigns in each of the participating countries.

f. Communications materials (print, audio and video media) designed, tested, disseminated and evaluated for efficacy and cultural relevance in changing knowledge, attitudes and behavior among high risk behavior groups and the general population.

g. Counselling/communications centers in up to six program countries based at the community level which can provide information, enabling/motivational skills, and counselling such as AIDS "hotlines" organized and staffs trained.

h. A cadre of up to 400 trained health care workers, counsellors, and communicators in the Eastern Caribbean as well as specially designed, tested, and integrated training curricula to facilitate continued intensive, in-service training beyond the project

in the region.

i. Institutionalized capabilities in social/behavioral sciences and health education/communications in the Caribbean Epidemiology Centre.

C. Project Description

This project is part of a larger strategy that seeks to strengthen national and institutional capabilities to confront the AIDS crisis. Phase I of the Project has three major strategic thrusts:

1. Surveillance of HIV Infection, STDs and Knowledge, Attitude and Practice Surveys

2. Strategies for Prevention of HIV Infection through Sexual Transmission

3. Program Management Improvement and Alternatives

The activities to be supported in each of these areas in Phase I of the project are described below:

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

This component of the project will ensure that the information needed to develop AIDS strategies, to design intervention programs, and to evaluate their effectiveness is available. During Phase I of the project baseline and periodic data will be collected to monitor the prevalence rate of HIV infections within project countries, to identify those groups which have the highest rates and risk of infection, to design appropriate interventions, and to evaluate the impact of intervention programs through the following activities:

a. Development of Standardized Surveillance Systems

Because of the long incubation period and other diagnosis and reporting problems with AIDS, the number of reported AIDS cases under-represents the extent

of the problem. HIV serosurveillance data provide a more accurate assessment.

Many Eastern Caribbean countries are planning to test for HIV in selected population groups in 1989 and 1990. CAREC will coordinate these efforts, standardize data collection procedures and provide regular feedback to the countries. Surveillance will be undertaken of sentinel groups at increased risk of exposure to HIV such as STD clinic attendees and persons with multiple partners. Groups representative of the general population such as antenatal clinic attendees and blood donors also will be tested.

As a first step to developing the HIV/AIDS surveillance systems, protocols will be developed which propose standardized data collection instruments and data analysis procedures for region-wide adoption. These protocols, data collection procedures, and implementation plans for conducting sentinel surveillance will be finalized at a workshop of epidemiologists from each of the CAREC countries. Data will be collected from each of the member countries on a quarterly basis, analyzed by CAREC staff and reported in CAREC's quarterly AIDS Newsletter and the monthly CAREC Surveillance Report. Annual workshops for national epidemiologists and laboratory directors will be convened to discuss and improve the HIV/AIDS surveillance systems, to train health care workers and laboratory technicians in surveillance work, and to present results. HIV/AIDS surveillance is only an extension to the disease surveillance programs already instituted by CAREC with its member countries. As the reference lab for the region, CAREC already conducts confirmatory tests by Western Blot and immunoflourescence of suspected HIV+ individuals.

b. Implementation of Epidemiologic Research

CAREC will conduct a workshop with input from AIDSTECH in late 1989 or early 1990 to establish epidemiological research priorities and to promote research initiatives. Potential research topics include identification of risk factors among various groups; analyses of the cultural, social, and economic environment of HIV and/or STD infection; and comparisons over time of incidence rates among specific high risk groups.

Participants at this workshop will include national epidemiologists, UWI researchers, laboratory directors, hospital/health clinic medical staff and family

planning clinicians. As part of this workshop, participants will develop actual study proposals which following the workshop will be reviewed by CAREC and AIDSTECH, and the best ones funded. A limit of $15,000 per subgrant study will be allowed with a maximum study length of two years. AIDSTECH will assist CAREC in the follow-up and monitoring of these subgrant studies.

c. Sexually Transmitted Diseases Symposia

There is evidence that STDs, particularly genital ulcers, are a risk factor for contracting HIV infection. In view of the rising incidence of STDs in many of the Caribbean countries, CAREC with the assistance of AIDSTECH will convene a technical symposium on HIV infection and STDs early in 1990. The objective of this regional symposium will be to review available data on HIV infection and STDs (in particular Syphilis) in the Caribbean and to identify areas of research and control strategies. A small grants research program similar to b. above but specifically targetted to STDs will be open to the Caribbean research and program implementation community. This program will be managed by AIDSTECH in collaboration with CAREC. A follow-up symposium will be held in 1991 to report the results of this targetted research program.

d. Knowledge, Attitudes and Practices (KAP) Surveys and Other Behavior Studies

KAP surveys are used to obtain baseline information on general knowledge, personal attitudes and behaviour regarding AIDS which can be used to design educational messages, to identify high risk behaviour groups and to evaluate the impact of educational messages and intervention programs. With the exception of Trinidad/Tobago and Montserrat which have already conducted baseline KAP surveys of their general populations, each of the Project countries have requested assistance from CAREC in their MTPs for implementing baseline KAP research.

AIDSCOM and AIDSTECH are prepared to assist CAREC in responding to these requests during FY 1989 and 1990. Specific activities include developing a KAP protocol, data collection instruments and data analysis procedures to standardize survey efforts and to facilitate cross-country comparisons of the data. Proposed model questionnaires will be introduced to countries at a regional workshop convened to introduce country personnel to KAP survey and other

psychosocial, ethnographic or consumer-based research methodologies. AIDSCOM will assist governments in assessing the costs and benefits of the Ministries of Health running the KAP surveys versus employing a professional Caribbean research firm(s). Whether the research is contracted out or performed by the MOH, AIDSCOM will provide technical assistance with sampling, interviewing, and data collection procedures. At least one follow-up KAP survey of the general population in each of the participating countries will be conducted prior to the end of Phase I of the Project to serve as both an evaluation and planning tool.

In addition to the general population surveys, KAP surveys will also be conducted with select high-risk and other groups. Data will be reported as they become available and collected by CAREC to allow for cross-national analysis and reporting of results through workshops and meetings.

To facilitate follow-up general and sub-group KAP surveys, AIDSTECH will provide technical assistance to CAREC in the design and testing of a "Rapid KAP" survey methodology. This methodology is based on an integrative, user friendly computer program (such as EPI-INFO) which allows questionnaire design, data collection data entering and analysis in a matter of days, thereby saving months of delay generally required while data are assessed and available for interpretation.

AIDSCOM will provide technical assistance to CAREC and participating countries to increase skills in the design and implementation of various other research approaches and techniques, including (a) explorative qualitative research (focus group discussions and in-depth interviews, ethnographic studies); (b) background qualitative research (small scale KAP surveys); (c) message testing; and (d) tracking and feedback. Particular attention will be paid to designing interventions that can be evaluated and that will yield information to guide further program development.

2. <u>Prevention of Sexually-Transmitted HIV Infection</u>

This component of the project comprises the heart of the Mission's contribution to the reduction of HIV infection through sexual transmission. Sexual contact is the primary way that the HIV infection is transmitted. In the Caribbean as a whole, sexual transmission accounts for over 89

percent of the total number of AIDS cases. Sexual transmission of HIV can occur from any infected person to his or her sexual partner. The risk of transmission increases with the number of high-risk partners, if there is a history of sexually transmitted diseases, and for anal rather than vaginal intercourse. Education is needed to encourage people to reduce the number of their sexual partners and to abstain from high-risk sexual behaviour. For those who persist in known patterns of high-risk behaviour, this project will promote the use of condoms.

Project efforts will be targetted in three specific areas: (1) developing communications and education programs for the general and select sub-populations, (2) training health and education professionals as well as community leaders and influentials to help them reach out to the various publics more effectively, and (3) undertaking specific behavior intervention programs with select sub-populations to test specific strategies for reducing HIV infection among these groups.

As noted in the World Health Assembly's Resolution 42.34, "in view of their contacts with and access to individuals and communities, their commitment and versatility, and their knowledge and experience, nongovernmental organizations can make a special impact on individuals and society regarding AIDS and the needs of HIV-infected people and those with AIDS." NGOs, including AIDS Service Organizations (ASOs), can often provide more rapid responses particularly to politically sensitive issues than can the best-intentioned public sector officials. Worldwide experience to date by the WHO/GPA has led it to actively promote NGOs, ASOs, and the private sector as critical partners for effective MTP implementation. USAID will join governments in support of the WHA Resolution by encouraging consideration of the potential role of these organizations in all activities to be financed under the AIDS Communications and Technical Services Project.

a. Communication and Education Programs

(1) Communications Strategies Development and Implementation

The potential for motivating behavior change will depend greatly on the ability of countries to design and deliver communications messages which raise awareness, target the concerns, motivate and teach skills required by the various populations in their countries. Under

this component the project will finance a series of activities designed to improve these capabilities including conducting regional, sub-regional and national workshops for government, NGO, and private sector health and education personnel as well as providing on-site follow-up technical assistance to the countries to implement a specific country-level program. Examples of such country-level programs might include developing the national AIDS Communications Strategy for 1990, undertaking an "AIDS and You" strategy for carnival season, preparing an education program for hotel workers on "AIDS in the Workplace," etc.

(2) Innovative Community Approaches

To be effective, communications programs cannot be limited to mass media-based programming designed by health educators. To increase the potential for significant impact, AIDS education should also be taken to the community by the community. Under this component CAREC, AIDSCOM and AIDSTECH will provide support for local community-based (non-governmental) organizations (e.g., the local Red Cross Society, youth councils, student associations, Parent-Teachers Associations, and community councils) throughout the Eastern Caribbean region to undertake small-scale, innovative AIDS education and prevention programs. A small grants program totalling $135,000 over three years regionwide administered by CAREC will be available to such groups on the basis of brief concept proposals submitted to and reviewed by CAREC, AIDSCOM and AIDSTECH as appropriate. Activities might include co-financing a community fair on AIDS prevention, producing the winning play of a school-wide competition, etc. Grants may also be used to provide seed money to community organizations wishing to introduce an AIDS prevention component to their current services portfolio. Concept proposals will include objectives, workplan, activities timeline and budget and will be considered on the appropriateness of proposal, geographical priorities and budgeting limitation. Funding will be limited to $5,000 per sub-project. CAREC, AIDSCOM and AIDSTECH will provide limited technical assistance and monitoring of the activities as needed and will ensure that the activities sponsored under this grants program are adequately reported and disseminated for review by other community groups.

b. Training Health and Education Professionals, Community Leaders and Influentials

(1) Skill-Building Training for Health Educators

Most of the OECS countries noted an identical problem as the most glaring obstacle to successful implementation of their medium term plans for AIDS prevention and control: the lack of trained manpower in their health education units. The Grenada and St. Kitts health education units employ only two health educators who are responsible for AIDS prevention education as well as the entire national health education program; Dominica has one health educator.

To maximize the efforts of these individuals, AIDSCOM and CAREC will convene a series of regional and national workshops for health educators, health care providers and community-group leaders. These workshops will focus on basic skills needed for health promotion and AIDS prevention: research strategies, focus groups, message testing and materials development, monitoring and evaluation. Special attention will be paid to developing motivational and group organizational skills in an effort to strengthen the ability of these limited personnel to draw upon the services of the health and general community. Scheduling of these skills-building workshops will be carefully arranged to minimize the time required in conferences and workshops.

(2) Prevention Counselling Training

AIDSCOM in association with CAREC has already conducted two train-the-trainer workshops for health care workers which have resulted in over 5,000 persons being contacted at the country level through training or lecture programs. A model training program in prevention counselling is already underway and will result in the development of a region-specific counselling manual for the English-speaking Caribbean by AIDSCOM with input from Caribbean-regional experts and produced and disseminated by CAREC. The training curricula will use a "train the trainers" approach and will include specialized modules on pre- and post-HIV test counselling, risk-reduction counselling and family counselling. Additional workshops updating counsellors will be held during Phase I.

(3) AIDS Information Hotline Programs

AIDS information hotlines have proven to be an invaluable means of providing information to hard-to-reach populations at risk for AIDS as well as the

general public in the United States and Western Europe. By tracking the kind of questions and issues raised by callers (or by proactively asking them questions, hotlines are also an excellent means for obtaining feedback on program success. Several countries in the Caribbean have made the establishment of national hotlines a priority in their AIDS control plans.

AIDSCOM has taken the lead in providing technical assistance with development of hotlines programs. In collaboration with CAREC and the National AIDS Committee of Trinidad and Tobago, AIDSCOM has assisted with the operation of the pilot AIDS information hotline in Port-of-Spain to test methods, structures, and research strategies that will have relevance in other countries in the region. AIDSCOM and CAREC will collaborate to conduct a regional workshop on hotline development, fo'' 'ed up by national workshops if appropriate and follow-on technical assistance to governments wishing to set up this anonymous counselling methodology. Due to the small population sizes in some of the target countries the possibility of establishing a regional toll-free hotline will be explored.

(4) Regional Media Collaboration

Accurate and sensitive reporting on the incidence of HIV infection and AIDS in small island communities is not only beneficial to the overall public education strategy for AIDS prevention and control; it is critical. The broadcast or otherwise wide dissemination of false information or sensationalistic journalism can undermine months of responsible, systematic, and meticulous public education. Opportunistic front-page stories on "AIDS Babies" and exaggerated risks faced by hospital staff nurses are clearly designed to sell newspapers rather than to educate readers. However even when journalists seek to be responsible in discharging their duties to inform the public, a lack of accurate, up-to-date information or an innocent lack of sensitivity about the issue can have equally devastating effects on the AIDS health promotion strategy.

A comprehensive program of activities will be implemented for and with Caribbean media houses aimed at minimizing the attractiveness of sensationalistic reporting and maximizing the opportunity for fruitful collaboration between AIDS program managers and media representatives. This program, implemented primarily by AIDSCOM with the assistance of the CAREC Media Officer, will include the design and dissemination of regular media packets

with information suitable for inclusion in national newspapers and broadcast programs. Audio and video materials will be produced by CAREC with AIDSCOM technical assistance for broadcast on Caribbean radio and television stations. Liaison efforts should be aimed at institutionalizing a working relationship among CAREC, the National AIDS Committees and the region's news agencies. To facilitate this relationship, annual media conferences will be convened to update journalists on HIV and AIDS trends, to solicit their cooperation in designing and supporting the AIDS Communications Strategies at the national level, and to recognize outstanding contributions by the media in responsible broadcasting and reporting for the previous year.

A "clipping service" of articles on AIDS will be introduced at CAREC with assistance by AIDSCOM to allow content analysis of information provided in local newspapers.

(5) STD Program Upgrading

Unlike some countries which have specially-dedicated facilities for clients with sexually transmitted diseases (e.g., the Queens Park East Counselling Centre and Clinic in Trinidad), most Ministries in the region do not have single-use facilities but schedule treatment programs at regular periods in select health clinics. The relative success or failure of these services in reaching the community depends in large part on the attitudes, commitment and interest of the clinic staff.

Untreated STDs appear to be a major co-factor facilitating the transmission of HIV, and may account for the higher risk of heterosexual transmission in some countries compared to the United States. Improving the diagnosis and treatment of STDs, especially of genital ulcers, may prove to be an effective and important intervention approach to reduce HIV infection. AIDSTECH will provide technical assistance in upgrading equipment, minor facility renovation and training personnel at STD clinics in select countries, e.g., Antigua and St. Lucia. CAREC will assist in making STD training courses available to clinic personnel.

(6) Model Country Programs

The Project will support "model country" intensive technical assistance to two Eastern Caribbean countries over the course of 12 months to test market

specific prevention messages and interventions, and to develop interventions that can be applied throughout the region.

Assisted by a resident fulltime AIDSCOM "Communications Specialist" who will be recruited for the 12 month assignment, AIDSCOM can provide the following types of assistance to governments in implementing their MTPs: (1) assisting with implementation of the baseline KAP survey, (2) planning communications strategies from KAP survey results, (3) developing and implementing a training program for health care providers, teachers and community leaders in counselling and prevention control, (4) mobilizing and organizing community-based NGOs to develop and implement a community information and counselling center, and (5) developing and training staff to initiate an AIDS Hotline.

The AIDSCOM Communications Specialist will be counterparted to a designated representative of the National AIDS Committee and will be assisted by AIDSCOM technical experts over the course of the 12 month model program period. The position will be recruited locally if possible in the hopes of finding a citizen or resident to take advantage of cultural sensitivity and familiarity with community resources.

c. Behavior Intervention Programs

The most efficient way to reduce the spread of HIV infection is to modify the behavior of those individuals at greatest risk through targeted interventions. Therefore, in addition to assisting with broadly-focused communications and training activities, AIDSCOM and AIDSTECH with assistance of CAREC will support the implementation of several self-contained, country-specific sub-projects designed to test strategies for behavior change among various sub-populations. High-risk behavior group interventions will be evaluated, modified, and, in some instances, expanded as experience is gained in working with these groups. The sub-projects will include pre- and post-intervention evaluation components to allow accurate measuring of the cost-effectiveness of the intervention and its success in achieving targetted objectives. In all cases the targetted groups will participate in pre-and post-intervention mini-KAP surveys to measure changes in their awareness and behavior as a result of the program. In some cases, as appropriate, periodic seroprevalence testing will be included to measure changes in HIV infection rates. In all cases, data collected will be carefully stored and analyzed to ensure confidentiality and to protect sub-project participants. Examples of behavior

intervention activities include:

(1) Condom use studies

AIDSCOM in association with CAREC will conduct studies in a minimum of three countries to assess the level of correct condom use; to obtain information about clients' knowledge, attitudes, and practices related to condom use; and to train clients how to correctly use and properly dispose of condoms.

AIDSCOM is developing a special training curriculum on teaching correct condom use for health care workers who work with clients at risk for HIV infection. The module will present an innovative approach for health care providers to use when discussing AIDS risk reduction measures with their clients. The curriculum was pilot tested in March 1989 with 22 Trinidadian health care workers including STD contact investigators, substance abuse counsellors and mental health professionals. The training curriculum will be designed to serve both as a separate, stand-alone training unit or as a specialized addition to a larger, more extensive counselling workshop.

(2) Behavior Interventions with High Risk Groups

High-risk groups vary across and within countries. For this project, high risk behavior groups will be confirmed by serological surveys combined with survey research questions that confidentially obtain information on knowledge, attitudes and behavior. On the basis of current AIDS and HIV reporting in the Caribbean, worldwide trends, and discussions with medical authorities, it is hypothesized that high risk behavior groups in the Eastern Caribbean may include migrant farm-workers, prisoners, male homosexuals, bisexuals, males and females with multiple partners, and STD clinic attendees.

The typical intervention to be supported under this project will included two major objectives: (1) assessing and increasing knowledge of high-risk behavior groups about their perceived risk of contracting HIV infection, and (2) reducing risk through teaching skills and activities for positive behavior change, establishing external and internal support systems, and promoting increased use of condoms. The results of these activities will be disseminated at a research workshop convened

by AIDSTECH, AIDSCOM and CAREC. Based on the interest by governments and the results of the sub-projects, successful interventions may be expanded or introduced in other islands.

3. Program Management Improvements and Costing Alternatives

The Project will seek to both improve the management skills of the human resource base charged with implementing AIDS programs and to design intervention programs that are cost-effective and sustainable. Cost data will be gathered for each behavior intervention implemented under the Project to measure its cost-effectiveness against other possible intervention strategies. In addition, however, this Project will support two specific efforts related to strategic and financial planning for HIV blood screening programs and one related to treatment alternatives. These health care financing activities will be undertaken by AIDSTECH with technical support as necessary by CAREC. Given the increased size and higher number of AIDS cases in Trinidad and Barbados, the activities will be piloted in these countries and expanded into the OECS countries as appropriate.

a. Program Management Improvements

With several sources of funding and with various interventions and research studies being conducted, effective program management for regional and national AIDS coordinators will be essential. AIDSCOM and AIDSTECH will assist with increasing capacity in this area by conducting regional and national program management workshops and providing intensive technical assistance to selected country programs (e.g., the model country approaches undertaken by AIDSCOM). Specific content areas for the workshops and the individual technical assistance include: development of goals and objectives; development of yearly, quarterly and monthly workplans; time management; personnel management and supervisory skills; developing effective hierarchies of responsibilities; task management; group dynamics; listening skills; and skills for conducting meetings.

b. Program Costing Alternatives

(1) Cost Recovery Program for Blood Transfusion Services

A study will be conducted in

Trinidad with the National Blood Transfusion Service (NBTS) of the Ministry of Health for developing a cost recovery program for blood transfusion services including HIV screening. AIDSTECH will evaluate the current NBTS system and assess the possibility for developing a user fee system for blood screening for the private sector and a sliding scale structure for the public sector. In addition, AIDSTECH will provide assistance to the Government of Trinidad in establishing a management information system for tracking blood transfusion services and related costs.

(2) Screening Pooled Blood

Transmission of HIV through blood transfusions can be almost completely eliminated with the development of a sensitive HIV detection methodology. This can be very expensive, however, in low prevalence countries such as those in the Eastern Caribbean. Under this project AIDSTECH with assistance from CAREC will evaluate the sensitivity of the results obtained from screening each blood sample individually compared with the pooling of five samples and testing the pooled serum. Where pooled sera tests reveal HIV antibodies, the samples will be individually tested to determine the infected supply. This methodology can not only be used by transfusion services or blood banks, but in other HIV screening (e.g., sentinel surveillance) systems.

(3) Alternative Treatment Facility

There has been a growing demand on facilities for AIDS treatment in the Caribbean including inappropriate hospitalization of patients for routine diagnostic tests. Examples exist of patients abandoned at hospitals by relatives thus extending the patients' stay even though acute nursing care was not needed. In one country a young HIV+ child has been living in a hospital ward for two years due to a lack of alternative housing.

An analysis of treatment costs is proposed in Barbados with the Ministry of Health to develop more efficient, humane care for HIV+ persons. AIDSTECH will provide assistance to the Ministry of Health in developing the feasibility study and operational plan for an AIDS hostel. The project is important to the AIDSTECH and Mission strategy of defining for governments the opportunity costs of hospital treatment and to assist them in redirecting resources in more cost effective ways.

4. Phase II Overview

Given the rapidly changing epidemiological picture on AIDS around the world, the experimental nature of the program activities, and the timeframe of the Medium Term Plans, Phase II (FY 1992 through 1995) activities will be firmly designed in early FY 1991. Three primary sources will be used to guide the development of activities for this phase: (1) an evaluation of project activities conducted early in FY 1991, (2) the results of evaluations of AIDS projects in other parts of the world and of the broader AIDS MTPs in the Caribbean, and (3) epidemiological and clinical realities of the AIDS epidemic at that time. Phase I activities will be timed to facilitate a smooth transition into the $3.5 million Phase II follow-on activities. Activities which at this time seem logical sensible next steps from the current project design are highlighted below.

(a) Surveillance/survey systems strengthening

By 1992, the HIV surveillance and KAP survey systems should be well introduced although continued support will be needed by CAREC for implementation and refinement of the surveillance system. HIV testing of sentinel groups will be conducted on at least an annual basis. KAP surveys, although less frequent than in Phase I, will continue to be used in evaluating messages and programs. It is estimated that $750,000 will be allocated to continuation of Strategy I activities, $525,000 to HIV surveillance and epidemiological research, and $225,000 to KAP surveys.

(b) Expansion of education/intervention activities

At the end of Phase I an evaluation of education and intervention programs will be conducted. Successful and cost-effective programs and approaches will be expanded and replicated throughout the Caribbean with modifications as appropriate. Additionally, new technologies can be expected to be introduced during Phase I which might hold promise for the Caribbean. An estimated $1,000,000 will be allocated in Phase II for continuation and expansion of successful Strategy II activities and the introduction of innovative approaches.

During the second phase, steps must be taken to institutionalize successful programs. Infrastructures

will be strengthened and innovations in methods of sustainability will be explored. Recurrent cost information obtained in Phase I will be used to project resources needed to sustain project activities. As a part of the effort to make programs more self-sufficient, the existing Eastern Caribbean contraceptive social marketing program will be approached to expand into the AIDS area. Condoms could be specially packaged as "AIDS Prevention Methods" and distributed through non-family planning outlets such as bars/social centers, peer distributors, etc. An estimated $300,000 will be programmed to evaluate creative methods for sustaining AIDS prevention programs.

(c) Follow-on training

The need for continuing education in the rapidly changing AIDS field is clear. Regular updates of the latest AIDS findings and their significance for health educators, counsellors and policymakers will be provided through a series of regional workshops to be conducted in Phase II. An estimated $850,000 will be allocated for this activity. The remaining $600,000 will be used for program support and to fund relevant initiatives not covered in the above descriptions.

The actual design of Phase II activities will be undertaken following a comprehensive evaluation of Phase I activities. A Project Paper Supplement/Amendment will be prepared to outline the exact project description, outputs, EOPS indicators and budget for Phase II. Assuming the Project implementation design (using CAREC as the regional base and main implementation agency with technical assistance from AIDSCOM and AIDSTECH) proves to be successful in the FY 1991 evaluation and assuming both AIDSCOM and AIDSTECH continue to be a part of the ST/H AIDS Technical Support Project, this same strategy will be carried forward for Phase II. If not, the required revised project analyses will be included in the Supplement/Amendment.

III. COST ESTIMATES AND FINANCIAL PLAN

A. Component Cost Summary

The ACTS Project, which was initiated in late FY 88 as a buy-in to the S&T/Health AIDS Technical Support Project (936-5972) is a discrete part of a much broader, multi-donor regional program on AIDS implemented by the CAREC in

conjunction with the Medium Term Plans for AIDS Prevention and Control developed by individual Caribbean countries. The total estimated cost of the ACTS Project is $7.854 million over a 7 year period, including contributions (in millions of dollars) from:

TABLE 2
Component Cost Summary

AID of which:		$7.554 million
RDO/C: Phase I & II @ $3.5 mil.	(7.000)	
AIDSTECH Core Funding *	(0.172)	
AIDSCOM Core Funding *	(0.382)	
WHO/Global Program on AIDS		$0.300
TOTAL		$7.854 million

* S&T/Health project funding

To the above amounts, participating governments will contribute internally funded operational staff plus a portion of the funding which they are receiving from WHO/GPA bilateral allocations in support of the CAREC regional and country-specific initiatives (See Section II.A.2). The specific amounts of country contributions to activities included in ACTS will be determined as country-level sub-activities are designed and negotiated (with RDO/C approval) during project implementation.

The project will be implemented in two phases of three and four years, respectively, which have three implementation mechanisms for direct RDO/C support: (1) a Handbook 13 grant to PAHO for implementation by CAREC ($1.59 million), (2) two buy-ins to the S&T/Health AIDS Technical Support Project ($1.65 million) for participation in the AIDSTECH and AIDSCOM activities, and (3) limited direct procurements for commodities, project evaluation, and project management services ($260,000). Table 2 presents a summary of the budget for Phase I by fiscal year and element.

TABLE 2
Summary Budget: Phase I
(by Fiscal Year and Element)

COMPONENT	FY 88-89	FY 90	FY 91	TOTAL
CAREC	340	636	614	1,590
AIDSCOM	263	382	155	800
AIDSTECH	476	276	98	850
PSC/EVAL/COMMODITIES	80	75	75	260
TOTAL	1,159	1,369	972	3,500

Other implementation mechanisms may be developed for Phase II based on insights gained during early implementation experience.

The project will provide support to the regional program on AIDS in three key areas: (1) design and implementation of appropriate surveillance strategies, (2) development of communications and education programs to reduce sexual transmission of the virus, and (3) institutionalization and strengthening of management capabilities. Table 3 presents the illustrative summary budget by program area.

Table 4
USAID Summary Budget by Program Area for Phase I
(US$)

	FY 1988-89	FY 1990	FY 1991	TOTAL
SURVEILLANCE OF HIV and KAP SURVEYS				
HIV Surveillance	121,452	166,000	133,830	421,282
Epidemiological Research	62,000	134,875	115,875	312,750
KAP Surveys	93,269	37,929	16,041	147,239
PREVENTION OF SEXUAL TRANSMISSION				
Communication/Education Programs	111,442	192,751	171,893	476,086
Training Health Educators and Community Leaders	110,664	319,060	148,036	577,760
Behavior Interventions	255,711	160,994	28,582	445,287
MANAGEMENT IMPROVEMENTS/ALTERNATIVES				
Cost-effective Care	57,476			57,476
Cost Recovery/Containment for Blood	116,165			116,165
EVALUATION			30,000	30,000
MANAGEMENT SUPPORT				
CAREC	49,968	132,705	141,625	324,298
AIDSCOM	40,255	50,767	28,914	119,936
AIDSTECH	21,700	25,200	11,900	58,800
PAHO	39,120	73,152	70,649	182,921
PSC/Commodities	80,000	75,000	75,000	230,000
TOTAL	1,159,222	1,368,433	972,345	3,500,000

Funds will be used to cover the costs of (1) salaries, travel and overhead costs of personnel and consultants from CAREC, AIDSCOM and AIDSTECH, (2) training activities, including workshops, conferences and and seminars, (3) small sub-grants to non-profit groups in participating countries to undertake HIV/AIDS research or to assist in the execution of country specific activities, (4) other direct costs, including media programs and materials development, and (5) limited direct procurement of commodities (condoms), RDO/C project management services through a personal services contract and evaluation services. The following table distributes the costs by component and implementing organization.

Table 5
Summary Budget: Phase I
By Component and Cost Element
($000)

COST ELEMENT	CAREC	AIDSTECH	AIDSCOM	TOTAL
Salaries	204	195	100	499
Consultants	-	34	89	123
Equipment	-	9	-	9
Travel	110	159	98	367
Sub-grants	160	231	75	466
Other Directs	933	-	280	1,213
Overhead	183	222	158	563
SUBTOTAL	1,590	850	800	3,240
EVAL/PSC/Commodities				260
TOTAL				3,500

Detailed funding and implementation arrangements for Phase II are dependent upon the successful implementation and evaluation of activities during Phase I. However a summary of the budget for RDO/C funding in Phase II is presented below in Table 5. This budget is based on a continuation of USAID support to Strategies 1 and 2 of the regional plan for combatting AIDS.

Table 6
Summary Budget: Phase II
By Fiscal Year and MTP Program Area
($000)

	FY 92	FY 93	FY 94	FY 95	TOTAL
STRATEGY 1					
HIV Testing	145	145	125	110	525
KAP Surveys	40	55	60	45	200
STRATEGY 2					
Project Expansion	300	300	300	100	1,000
Institutionalization	100	100	50	50	300
Training of Trainers	250	250	225	150	875
Program Support	150	150	150	150	600
TOTAL	985	1,000	910	605	3,500

Annex D presents the detailed budgets for the life of the project, including contributions from RDO/C, WHO/GPA and core funding from AIDSTECH and AIDSCOM.

It is anticipated that the Project will be incrementally funded from both Health and AIDS Program Accounts each fiscal year during Phase I. During Phase II, however, it is intended that the balance of funding required is provided in one tranche from both of these Accounts. The obligation plan is as follows for RDO/C funding:

Table 7
Obligation Plan and Funding Sources
($000)

ACCOUNT	FY 88	FY 89	FY 90	FY 91	FY 92	TOTAL
Health	223.8	930.0	830.0	800.0	800.0	3,591.8
AIDS	300.0	700.0	800.0	800.0	801.2	3,408.2
TOTAL	523.8	1,645.0	1,630.0	1,600.0	1,601.2	7,000.0

B. Method of Implementation and Financing

1. Assessment of Methods of Financing

Table 8 indicates the methods of financing proposed to secure technical services and commodities under this Project for Phase I. Funds will be disbursed to PAHO, an international organization, and through it to CAREC by an LOC. Sub-grants will be provided from PAHO/CAREC to various small, non-profit, community organizations and managed within the accounting guidelines established in PAHO. Family Health International (FHI--AIDSTECH) and the Academy for Educational Development (AED--AIDSCOM) are US-based non-profit and private corporations, respectively. Funds to these organizations will be disbursed via a Federal Letter of Credit.

Table 8
Methods of Implementation and Financing: Phase I

Project Activity	Method of Financing	Amount ($000)
PAHO/CAREC Handbook 13 Grant	Letter of Credit	1,590
AIDSTECH/FHI (Buy-in) Handbook 13 Coop Agr.	Letter of Credit by AID/W	850
AIDSCOM/AED (Buy-in) Handbook 14 Contract	Direct Payment by AID/W	800
Commodities Direct PIO/C	Direct Payment by AID/W	20
Management/Evaluation Handbook 14 PSC	Direct Payment by RDO/C RAMC Check	240
	TOTAL	3,500

2. Financial Management Capability Assessment

CAREC, part of PAHO/WHO, was established in 1975 under the aegis of regional governments who also provide some of the funding to support its operations. Its primary functions are research and monitoring of diseases, training and laboratory services. CAREC has considerable experience in implementing donor-funded regional and sub-regional activities in disease control and research. Included among these is the USAID-funded Epidemiological Surveillance and Training Project (538-0027) between 1980 and 1987. According to Mission records, there were no major implementation problems on this activity and funds were successfully channelled to CAREC through PAHO as is planned for under this project. PAHO will retain fiduciary responsibility for all USAID funds which it receives and disburses to CAREC and participating community organizations.

In accordance with USAID policy, international organizations which receive USAID grants in support of multi-lateral programs are responsible for applying their regular accounting procedures to management of those funds. Accordingly, a pre-implementation financial management capability assessment is not required for PAHO.

3. Audits

PAHO, as a public international organization implementing a multi-donor project such as this one, is not subject to audit by the AID/IG and is assumed to have financial management controls and audit capabilities upon which USG agencies can rely for adequate accountability of funds.

Given the involvement of FHI and AED in the Agency's worldwide AIDS activity under the S&T/Health AIDS Technical Support Project, these agencies will be managing substantial amounts of AID financial resources and will, therefore, be subject to audit by the AID/IG under the ST/Health Project. No provision, therefore, is being made in the ACTS Project for audit of these agencies.

IV. IMPLEMENTATION PLAN

The life of this Project will be seven years (1988-1995). Developmental and early implementational activities undertaken by AIDSCOM and AIDSTECH prior to the first obligation of funds were financed by core funds of the ST/H AIDS Technical Support Project components AIDSTECH and AIDSCOM. The pace of developmental design activities during early FY 1988 was limited by the decision of governments to defer planning major AIDS activities until their medium term AIDS plans had been prepared, reviewed and adopted at a regional donors' forum. In general, the plans provide for the equipment, supplies and other local direct costs of implementing AIDS programming. Most of the plans also note a concern by governments that implementation of the plans may be hampered by human resource constraints in the health education divisions of the Ministries of Health.

Given A.I.D.'s policy of collaborating with the WHO/GPA mechanism and the concern of governments regarding resource constraints, RDO/C determined that the most effective means of assisting governments in AIDS programming would be to provide technical assistance and training to the governments via the CAREC sub-regional plan in collaboration with the ST/Health Projects AIDSCOM and AIDSTECH. During Phase I the Mission will strengthen its links with AIDSCOM and AIDSTECH through additional buy-ins while more carefully integrating their work with that of the Caribbean Epidemiology Centre (CAREC) and participating governments.

The implementation schedule in Annex G presents an illustrative plan for activities outlined in Section II.C. A comprehensive workplan detailing activities of the major implementing agencies over the first 18 months of the grant period will be prepared by CAREC, AIDSTECH and AIDSCOM within one month of grant agreement signature.

Activities for Phase II are briefly highlighted in the plan. While based on sound hypotheses about project planning in the out years, these activities should nonetheless be seen as illustrative since Project activities in Phase II will be contingent upon the relative success of surveillance and prevention activities undertaken during the earlier Project years, as well as on changes in the worldwide AIDS epidemic and technologies available to address it.

B. Institutional Arrangements

1. Caribbean Epidemiology Centre

To support specific activities from the national and regional plans, the Mission will enter into a Handbook 13 Project Agreement with the Pan American Health Organization through its regional representative and collaborating centre, CAREC. As the principal implementing agency, CAREC will be the primary vehicle through which the Mission will provide support to the participating countries. CAREC will be responsible for technically integrating Project-financed activities in Strategies I and II with the overall Caribbean Sub-Regional Plan for AIDS Prevention and Control. It will be responsible, therefore, for ensuring that activities are carefully scheduled to minimize duplication and overload at the country level and that all inputs are in place to carry out project components.

CAREC's scope of work requires it to provide services in training, technical direction, developing and coordinating regionally-adopted AIDS protocols and procedures, and, in conjunction with AIDSTECH, AIDSCOM and the countries, logistics conference/workshop planning. CAREC will receive limited technical assistance from AIDSTECH in epidemiological surveillance; it will receive more assistance from AIDSCOM and AIDSTECH in KAP survey design and analysis, counselling, and behavioral science upgrading.

CAREC plans to staff a seven-person AIDS Unit in its Special Program on STDs to undertake its sub-regional MTP. According to the MTP and subsequent discussions, this

team will consist of a medical epidemiologist, CAREC program officer, media officer, laboratory advisor, research assistant, biostatistician and an evaluation officer. All of these posts are financed by the GPA through the MTP with the exception of the evaluation officer who will be financed by CIDA. All, with the exception of the evaluation specialist, biostatistician and administrative officer are currently on staff. These individuals are complemented by additional CAREC staff who provide back-up technical support to the AIDS Unit, i.e., the heads of the epidemiology and laboratory units, the materials production staff, and, as available, the Director of CAREC. The AIDS Unit at CAREC is managed by an in-house policy committee comprised of the AIDS epidemiologist; the heads of CAREC's epidemiology unit, laboratory, and GPA Education and Information Center; and the CAREC Director who chairs the committee.

The AIDS Unit will also be strengthened by five fulltime posts to be financed directly through the project--a Project Coordinator, a Communications Specialist, a Technical Services Specialist, and two support staff (an accountant and secretary). The Communications Specialist will be financed initially through the $300,000 earmarked GPA funds and afterwards directly through the CAREC grant.

<u>Project Coordinator</u>. The Project Coordinator will be locally hired by CAREC and will play the critical management role in the implementation of the Project Grant Agreement. This individual will be responsible for (1) ensuring that the Project Agreement workplan stays on schedule and remains consistent and harmonious with the broader CAREC AIDS workplan, (2) coordinating/overseeing the activities of the AIDSCOM communications and AIDSTECH Technical Services Specialist, and (3) assisting in project implementation in areas such as conference designing, logistics planning, and sub-activity coordinating. The Project Coordinator will also be responsible for managing reporting requirements of the Project Grant Agreement. He or she will collaborate closely with the technical inputs provided by CAREC, AIDSCOM and AIDSTECH as well as other CAREC staff including the evaluation specialist and the chairman of the CAREC AIDS policy committee.

<u>Communications Specialist</u>. This CAREC staff position will be locally hired. His/Her primary function will be to assist in the implementation of AIDSCOM activities by providing both technical and administrative management of sub-projects. The person will be responsible for (1) liaising with governments and AIDSCOM to ensure technical assistance

activities are designed and implemented on schedule, (2) coordinating the provision of short term technical assistance from AIDSCOM staff or consultants, (3) preparing, reviewing, and disseminating reports and other project documentation related to AIDSCOM technical assistance in the region, and (4) assisting with the technical design and logistics management of regional and national workshops at which AIDSCOM will participate. As a CAREC employee, the Communications Specialist will also be responsible for assisting the CAREC AIDS Unit with activities which go beyond AIDSCOM involvement although his/her primary responsibility will be to facilitate AIDSCOM efforts. In return, AIDSCOM will be responsible for developing the technical expertise of this person so that her skills will be even more useful to CAREC in the future.

Technical Services Specialist. This CAREC staff position will also be hired locally. This person will have an identical mandate as the Communications Specialist except that he/she will be assigned responsibility for AIDSTECH activities in the region.

It is intended that these posts will be absorbed by CAREC during the life of the project so that the new skills which they will bring to the institution can remain there into the future. They will report to the head of the CAREC AIDS Unit through the Project Coordinator.

Secretary and Accountant. These two posts will be filled by Trinidadian residents and funded by the Grant Agreement for the life of the Project in support of the implementation of the Agreement Scope of Work. The Accountant will be responsible to the Chief Administrator at CAREC; the Secretary will be supervised by the Project Coordinator and through her/him, the head of the CAREC AIDS Team.

2. Academy for Educational Development

The Academy for Educational Development (AED) manages the AIDS Communications (AIDSCOM) Project of the AID/ST/H office. Via buy-ins to this worldwide contract, AIDSCOM will primarily be active in Strategy II activities -- developing communications and education programs with the countries, training health care workers and community leaders, and conducting behavior intervention activities with groups at higher risk of contracting the virus through sexual behavior. Additionally, AIDSCOM will collaborate with CAREC and AIDSTECH in the implementation of KAP surveys at the country level.

The Mission's buy-in will finance the

part-time services of a technical expert who will serve as the AIDSCOM Caribbean Program Manager (AIDSCOM CPM) from Washington with overall management responsibility for AIDSCOM activities in the region. This individual will be supported by short-term technical experts from AIDSCOM staff and consultants and will serve as the primary contact point for CAREC and RDO/C on matters pertaining workplan activities. All project-funded travel to and within the region will be approved in advance by RDO/C. The AIDSCOM CPM will coordinate activities of the CAREC-resident Communications Specialist with the CAREC Project Coordinator and the head of the CAREC AIDS Unit.

In addition, it is anticipated that AED will hire one or two longer-term advisors to assist with the model country programs. These advisors will be hired locally if possible to ensure that the skills developed over the course of the programs remain in the participating country. These two posts will be financed for one year directly through the AIDSCOM buy-in. Their work will be coordinated by the Communications Specialist and the AIDSCOM CPM. In some instances sub-agreements may be required for country level activities, e.g., graphics artists or radio announcers. All sub-agreements required for country level activities will be developed by AIDSCOM staff. They will also have responsibility for obtaining approvals by RDO/C, CAREC, and participating country-level organizations.

3. Family Health International

Family Health International manages the worldwide AIDSTECH Cooperative Agreement from AID/ST/H. Their primary areas of responsibility will be in Strategy 1 -- HIV surveillance, epidemiological research, and KAP surveys, however they will also collaborate with governments on sub-projects with high risk behavior groups. An additional special focus will be sub-projects to improve the cost-effectiveness of HIV surveillance and AIDS case management programs.

The implementation structure will be similar to AIDSCOM's, relying primarily on two persons: the North Carolina-based AIDSTECH Caribbean Program Manager (AIDSTECH CPM) and the CAREC-based Technical Services Specialist. Working with the CAREC Project Coordinator, the head of the CAREC AIDS Unit, and the Technical Servvices Specialist, the AIDSTECH CPM will ensure the timely provision of technical assistance from AIDSTECH staff and consultants and will serve as the primary contact point for CAREC and RDO/C on workplan implementation matters. As with the AIDSCOM technical

assistance, all trips to the region by staff and consultants will be approved by RDO/C in advance and any sub-agreements required for activities at the country level will be developed by AIDSTECH staff who will also have responsibility for obtaining approvals by RDO/C, CAREC, and participating country-level organizations.

B. Mission Responsibilities

The Health, Population and Education Office will be responsible for managing the Project. The health staff currently consists of one US Direct Hire and one USPSC who will serve as Project Advisor. The USAID Project Advisor will be responsible for close oversight and monitoring project implementation, preparing all earmarking and committing documentation, drafting all Project-related correspondence, preparing in-house quarterly and semi-annual reports, and approving all travel to and within the region by U.S.-based technical assistance and training expertise. RDO/C will review and approve all contracts and sub-grant proposals submitted for funding.

While significant Mission management oversight will be required, particularly in the start-up phases of this project, it should be noted that the project design has been formulated with Mission resource constraints in mind. The decision to base the project at CAREC is a reflection of this thinking as it will reduce the Mission management burdens which usually accompany "long distance" management by U.S.-based home offices. Additionally, the placement of a fulltime Project Coordinator at CAREC will facilitate the coordination of the various technical inputs which otherwise often unavoidably fall on Mission staffing.

C. Governments' Responsibilities

Given the overriding objective of this Project -- to assist governments in implementing AIDS prevention and control efforts which they have themselves designed and for which they have received national and donor approval--active participation by participating Caribbean governments will be critical. Governments will be responsible for (1) ensuring that their health care workers, health educators and other relevant staff are available and will fully participate in the training programs, and (2) arranging for the timely release of GPA funding to finance the country level activities which Project-funded technical assistance and regional training will technically support. In addition and in keeping with

Resolution WHA42.34 of the World Health Assembly, governments will be urged:

"(1) to include representatives of nongovernmental organizations, as appropriate, on national AIDS committees and in other bodies engaged in combating AIDS;

"(2) to recognize the important contribution nongovernmental organizations can make in the design, implementation and review of national AIDS plans;

"(3) to avoid legal provisions which may impede the implementation of the global strategy and national programmes on AIDS and to work in collaboration with nongovernmental organizations to overcome discriminatory attitudes;

"(4) to provide support for relevant nongovernmental organizations in the light of their financial and technical resources, and to seek solutions to structural impediments that constrain their operations."

D. Training Plan

As the preliminary implementation plan illustrates, in-country, third-country and to a limited extent overseas training of public (e.g., health care workers) and private sector (e.g., media) personnel will be a mainstay of the Project.

1. Regional and In-country Training

Several training opportunities are planned over the course of the Project. Regional or sub-regional (i.e., OECS and Barbados) workshops will have three interrelated purposes: (1) to help National AIDS Committee coordinators to schedule and implement workplan activities (e.g., conducting baseline KAP survey research or establishing hotline information systems) which could benefit from advance training and technical assistance, (2) skill-development for counsellors, epidemiologists, laboratory technicians, educators and other health care workers, and (3) information dissemination. Some workshops may address all three purposes, others only one or two. Workshop formats will be interactive, product-oriented, and use Caribbean-specific AIDSTECH and/or AIDSCOM-designed training materials. Where appropriate, the modules will take a "training-of-trainer" focus so they can be re-used and revised as necessary with minimal expatriate

technical assistance. All workshops will be evaluated for effectiveness and usefulness. The Project will finance travel, per diem, and incidental expenditures associated with convening regional and sub-regional training workshops. The Project will also finance AIDSCOM, AIDSTECH and CAREC resource persons to participate in national level workshops although the local costs for most of these workshops will be covered by the countries' MTP budgets.

2. Overseas Training

Overseas training through short courses or seminars will be available to a limited extent to provide opportunities for technical skills upgrading unavailable within the region. These training opportunities will primarily be for CAREC staff although some funding will be available for sending country level personnel to international conferences and workshops as may be deemed appropriate. CAREC, in collaboration with AIDSCOM and AIDSTECH advisors will coordinate with the National AIDS Committees in identifying candidates for such overseas training. RDO/C will have final approval of all candidates considered for overseas training.

E. Procurement Plan

1. Technical Services

As noted above, most of the technical services required for implementation of the Project will be provided through buy-ins to AIDSCOM and AIDSTECH. AIDSTECH and AIDSCOM may be required to locally procure technical or professional services for research assistance, data collection, or communications expertise. In such instances where sub-agreement arrangements are required, AIDSCOM or AIDSTECH will be responsible for preparing agreements and receiving approvals of RDO/C and other relevant organizations in advance of securing such services. A small portion of Project funding will provide for continuing the services of a USPSC in RDO/C to manage the project.

2. Commodities

Because the MTP budgets provide for the procurement of equipment and supplies, the Project budget does not include significant levels of funding for major procurements of equipment, vehicles or other commodities. Limited renovations (e.g., air conditioning, security safeguards) to the condom storage facilities at CAREC or to STD

clinics may be required and a small number of microcomputers may be purchased under the AIDSTECH behavior intervention sub-agreements to assist in country-level data collection and analysis.

Materials and supplies required for workshops, training programs and behavior intervention activities at the local level are provided for within the relevant activity line items of the Project financial plan. Additionally, the project will finance the costs of producing some communications and educational materials at CAREC in both print and electronic media for regional use.

Since ACTS is a multi-donor activity, procurements financed under the PAHO/CAREC grant will follow the established procurement procedures for PAHO, an international organization. Procurements under the AIDSTECH or AIDSCOM buy-ins will follow the AID procurement guidelines stipulated in their cooperative agreement or contract, respectively.

Condoms scheduled to be provided through this project will be supplied by the ST/H/AIDS, however a minimal amount of funding has been included in the Project to provide a safeguard if Mission financing is later required.

V. MONITORING AND EVALUATION PLAN

The critical and controversial nature of the AIDS epidemic makes it imperative that the Project be closely and continually monitored and that a comprehensive evaluation strategy be an integral component of Project activities.

A. Project Monitoring

Project monitoring will be an on-going function of the CAREC Project Coordinator, the AIDSCOM and AIDSTECH CPMs and the RDO/C Project Officer. Together they will ensure that the inputs are being provided in a timely manner, track the extent to which planned outputs are being achieved, and facilitate timely corrective action when necessary. The Administrative Analysis (Section VI.D of this Project Paper) details the management systems which are currently or will be put into place to secure continual monitoring of program efforts. These include regularly scheduled meetings with donors, top level CAREC managers, AIDS program administrators at CAREC and the country levels, and RDO/C. Quarterly financial and programmatic progress reports will be required

from CAREC, AIDSCOM and AIDSTECH to chronicle Project activities and the extent to which objectives are being met.

B. Project Evaluation

The evaluation strategy provides for multi-faceted and on-going measurement of the effect of Project activities taken individually and together towards achieving the purpose of the project. The degree to which the Project purpose is being met will be measured in two ways -- by process evaluation and impact evaluation. Process evaluation will measure the extent to which inputs have been provided and outputs are being produced; impact evaluation will measure the extent to which the outputs actually result in achieving the Project purpose and impacting on the Project goal: preventing and controlling the spread of AIDS. To this extent, a critical function of evaluation will be to help the Mission identify progress toward achieving logframe indicators and to determine whether those indicators are adequate measures of Project success or should be revised, supplemented, or abandoned given potential changes in epidemiology of AIDS and technologies available to prevent or treat it.

The evaluation strategy comprises both efforts which will be integral parts of Project implementation (e.g., pre- and post-testing of workshop participants to measure changes in knowledge as a result of the training opportunity), as well as interim and final project evaluations conducted by external evaluators.

1. Process Evaluation

Process evaluation, provides the simplest measure of Project success. It consists of comparing actual with expected outputs as provided in the Project logframe, e.g., numbers of health care workers trained, numbers of workshops held, number of sentinel surveillance systems established. Other process indicators will be examined over time to measure changing levels of activities, e.g., reactions by target audiences to AIDS programs or changes in those programs, the number of condoms provided through intervention programs, the number of high-risk individuals counselled in clinics versus through telephone hotlines, and public response to an AIDS education pamphlet. These measures may be further refined to emphasize program efficiency such as the number of persons counselled per day by health workers or the number of individuals accepting condoms per person counselled.

Special attention will be paid to data collection possibilities for each activity undertaken under the Project. Mechanisms will be established at the initiation of each activity and a prescribed points along the way to ensure that these data will be carefully and correctly collected both for ongoing analysis and review during formal evaluation efforts.

2. Impact evaluation

Evaluating program impact and determining the most effective program components will be essential to sustaining and expanding intervention activities. Impact measures will vary depending on the particular activity, but should include at least one of the following indicators: improving public knowledge of AIDS and changing personal behaviors to reduce risks of contracting the virus, decreasing the prevalence of STDs, and decreasing the prevalence of HIV infection.

a. Knowledge and behavior change

Knowledge and behavior change must go hand in hand to achieve reductions in HIV transmission. Changes in knowledge and attitudes are an important first step but must be accompanied by changes in behavior if the program is to have the desired impact. On the other hand, measuring the impact of behavior change interventions requires that one first obtain information on the prevalence of high-risk behaviors in the target populations. Survey research methodology can identify the level of awareness and prevalence of such behaviors and provide a baseline against which to assess project impact. For example, if baseline surveys reveal the prevalence of high risk behavior but those practicing such behavior do not correctly perceive their risk status, the first step of any intervention must be to help those individuals assess their risk status.

Follow-up surveys will measure any changes in knowledge or attitudes as a result of the Project. Survey responses will be verified where possible by independent data sources, e.g., reports of increased condom use will be verified by against condom sales and distribution where possible.

Baseline KAPs will be conducted of the general population in each of the participating countries before early 1990; follow-up surveys will be conducted in 1992. Survey populations will include groups of higher risk as

well as sub-populations which can serve as surrogates for the general population (i.e., antenatal clinic attendees).

b. HIV Surveillance

The truest indication of success of an HIV intervention program is an attributable reduction in the incidence of infection. Repeated serological surveys can yield a measure of the incidence of HIV seroconversion and such surveys in sentinel populations are an integral part of this project. However, it is not always be practicable or desirable to rely on the measurement of HIV infection, particularly in low prevalence countries since such large samples are needed to show rate changes. In addition, increases in HIV rates are not easy to interpret: a seroprevalence increase from 5 to 10 percent could mean education prc rams are not working or could mean the prevention program averted a more dramatic increase to 20 percent. The prevalence of HIV in the population also factors into the level of risk. Because the likelihood that an individual will seroconvert is dependent on both the number of partners he or she has and prevalence of HIV infection in those partners, behavior modification does not necessarily reduce the risk of seroconversion if prevalence has simultaneously increased. Thus, while the Project will measure HIV seroprevalence among groups at higher risk, additional, more practical measures of project impact will also be undertaken.

c. STD Surveillance

Surveillance of STDs has many advantages over HIV surveillance and, therefore, is proposed to be the basic measure of clinical program evaluation. Its advantages are that (1) it is less controversial; (2) since STDs are treatable it allows one to measure behavior changes by a single individual; (3) the incidence of common STDs is much higher than HIV and therefore decreases in incidence rates can be more easily demonstrated; and (4) the ethical issues concerning anonymity and confidentiality are less serious. STD surveillance will not be possible in all countries, however, as some countries have very weak STD programs, making accurate tracking difficult. Limited assistance will be available to upgrade the weakest STD programs and a small grants program will promote country attention to enhancing STD surveillance systems.

d. Cost-Effectiveness and Sustainability

All sub-project activities will be

analyzed for cost-effectiveness, sustainability, and the potential for replicability in other country settings. Some of these activities, e.g., the potential for screening pooled blood and for instituting user fees for blood screening, will by their very nature, examine these issues. In other cases, costs will be carefully tracked and inputs will be compared to outputs achieved to determine whether program interventions are cost-effective and worth replicating.

3. External Evaluations

In addition to these on-going program evaluation procedures, an interim evaluation in early 1991 and final evaluation of the project in 1995 will be conducted. The interim evaluation in 1991 will examine (1) the role and interrelationships of the three Project implementing agencies and their contribution to the implementation of the MTPs, (2) the degree to which the implementing agencies are on schedule in completing the scopes of work in the workplan, (3) the viability of the Project management/implementation structures, and (4) the degree of coordination among the various organizations and funding sources especially with reference to availability of GPA funding at the country level and the incidence of unnecessary duplication of efforts. In addition, the evaluation will serve to assess the continuing validity of the Project rationale and strategy, will identify problems and constraints, and will make recommendations for changes in strategy as necessary to facilitate achievement of Project objectives within the remaining Project timeframe.

The interim evaluation should serve as a valuable tool to governments and RDO/C in assessing the progress made in Strategies I and II during the MTP period 1989 - 1991 as they prepare to plan for the next phase of AIDS prevention and control programming. This Project evaluation will obviously be more narrowly focused than the broader WHO/GPA evaluation of the entire MTPs scheduled for the same year. It should, however, be able to provide illumination for the broader GPA effort and verify its conclusions.

Funding for the interim and final evaluations will be available for direct RDO/C contracting. The evaluations will be conducted by independent evaluation teams whose members shall be selected collaboratively by CAREC, AIDSCOM, AIDSTECH and RDO/C.

VI. PROJECT ANALYSES

A. Technical Analysis

The objective of this technical analysis, pursuant to Handbook 3, is to ascertain whether the design of the project is consistent with the body of knowledge about possible solutions within the cognizant professional community with regard to AIDS transmission, and whether the proposed component activities are technically the most suitable and cost-effective.

As AIDS is currently incurable, the only way to contain the epidemic is to identify and then modify those behaviors which (1) increase one's risk of acquiring HIV infection and (2) are open to control. This solution is not as clear or simple as it first might seem, however, for several reasons. First, the body of knowledge available is replete with numerous, critical gaps. For example, the risk of contracting the disease at one exposure has not been quantified, and it is not known if infectiousness varies with the duration of infection or with other factors. Additional risk factors for the transmission of HIV infection are still inadequately defined. These gaps complicate the design of practical behavior change recommendations. Epidemiologists have identified three patterns of infection in differing parts of the world but require more effective and accurate reporting systems in each country before they can more fully understand or hope to prevent the spread of the pandemic.

The second problem relates to the enormous difficulty in building a bridge from what can be achieved in the near term to alter human behavior to what is needed in epidemiological terms to control the spread of HIV infection. In many Eastern Caribbean countries condoms are still irregularly used (if used at all) and it is still uncertain whether the fear of AIDS will motivate people strongly enough to reduce their number of sexual partners or practice "safe sex" at the level necessary to contain the disease. Epidemiological knowledge about this disease is still so incomplete that the protective role of barrier methods possibly is being oversold; at the same time it is also possible that if the basic reproductive rate of the virus itself is low, then even modest compliance with safe sex practices would significantly slow the spread. Present generation models of the spread of infection seem to demonstrate that a few people with many sexual partners disseminate a sexual infection more rapidly than many people with relatively few partners each. Worldwide, AIDS specialists are operating on the assumption

that providing some degree of protection in AIDS prevention is important even if the first programs are not perfect.

Given the current epidemiological status of this disease, the most prudent course of action must be for each country to (1) develop an effective surveillance system to monitor the course of the virus within their own borders and (2) to develop prevention and control programs including public and targeted education, with clear messages regarding transmission of the disease and the need for individual action to reduce the risk of transmission. The fact that sexual transmission accounts for well over 95 percent of all cases of HIV infection or AIDS in the Caribbean clearly justifies the focus of Project activities on this area. As clearly demonstrated in the Project Description (Section II.C) of this paper, a diversity of activities and approaches will be undertaken during Phase I of the Project to address the course of action aimed at sexual transmission.

While motivating behavior change is an extremely difficult objective in any health area, it is particularly difficult when it is directly interrelated with cultural norms and basic human drives. Through its population programming, A.I.D. has developed decades of expertise in and an appreciation for the difficulties inherent in this area. It is known, for example, that no single strategy can be effective in motivating every segment of the target population and no perfect communications medium exists to reach each person who needs to hear and accept the message being delivered. It is also known that the process leading to behavior change is accumulative requiring multiple steps from initial awareness to consideration to decision-making to adoption. Finally, family planning programming has demonstrated that even the most highly-skilled health professionals will not be effective at reaching certain segments of the population who are embarrassed or otherwise dissuaded from seeking professional consultation. Therefore, motivating behavior change demands a comprehensive program of events and activities which, taken as a whole, will bring forth the desired results.

The strategy laid out in this paper both reflects this knowledge and expertise and demonstrates how it can be best used to increase the probability for eliciting necessary behavior change. Proactive promotion of mass communications strategies will be coupled with more passive opportunities (e.g., telephone hotlines, information centers) to increase accessibility to correct information. Selected high-risk group peers as well as health care workers will receive training and be recruited to reach the more difficult but higher-risk

segments of the population. One-time outreach efforts (e.g., community presentations) as well as more comprehensive behavior intervention programs will be undertaken to foster the accumulation of information leading to behavior change. The following exemplifies the holistic approach which will be the hallmark of this Project.

The following steps will comprise the typical intervention study:

Step 1. Collecting baseline sero-prevalence and KAP survey data. Under this component potential participants will be tested for HIV seroprevalence and their knowledge, attitudes and practices regarding AIDS and sexual behavior. Participants will receive pre- and post-test counselling to obtain their informed consent and to reduce any psychological stress or anxiety which may result from this initial testing. The initial HIV testing will in most cases be undertaken on STD patients within country with confirmatory tests being undertaken at CAREC. Sero+s will receive additional counselling and assistance. Information will be collected on the sex, age, sexual behavior, knowledge of AIDS, and condom use. All information will be protected to ensure confidentiality and prevent tracing by others than study managers. The KAP surveys will be designed by AIDSTECH and CAREC to ensure comparability across countries. Data will be analyzed by CAREC and AIDSTECH staff.

Step 2. Identification and training of peer and health AIDS educators. Several years of experience with the use of peer counsellors in family planning programs have suggested that motivated and trained peers can be immensely effective means of reaching groups which traditional health personnel have difficulty in reaching. Peers will be selected from the target group based on leadership ability, communication skills, ability to learn and desire to participate in the sub-project. Peer and participating health educators will receive training to facilitate their participation in the sub-project.

Step 3. Developing/adapting educational materials. An educational program consisting of messages for individual and group counselling on

AIDS will be developed to (1) inform high risk behavior individuals about AIDS and safe sex practices, (2) motivate them to reduce high risk behavior and to use condoms consistently, (3) teach them how to obtain, store, use and dispose of condoms properly, and (4) provide strategies to cope with partners who are reluctant to use condoms. The slant of these materials will be determined from KAP survey results and focus group discussions with target groups. All messages will be pre-tested with the targetted groups.

Step 4. Intervention activities. During this step, the particular outreach strategy for the sub-project will be undertaken. In general, however, it is during this step that target groups will receive education on HIV transmission and the means of reducing the risk of infection and be provided with condoms. The intervention period may last from 9 to 12 months during which time seroprevalence data will continue to be collected as appropriate. Project costs will also be carefully tracked to facilitate the cost-effectiveness assessment of the project.

Step 5. Evaluation. The impact of the sub-project will be evaluated by measuring the change in knowledge and behavior as well as seropositivity as appropriate. Records of condom distribution will be kept and analyzed and the costs of implementing the program will be evaluated to determine the potential for sustainability and replicability in other countries.

The technical capacity of governments and the private sector to prevent transmission of the virus is essentially limited to their competence in adopting this course of action. As noted earlier in this paper, the ability of governments both to reasonably assess and track the presence of the virus and to develop effective strategies for preventing its spread through the sexual transmission is seriously hampered by three major deficiencies: (1) inadequate surveillance systems, (2) health manpower deficiencies, and (3) the lack of adequate supplies and equipment. Section II.C, Project Description, illustrates in detail the types of programs and activities which will be undertaken to ameliorate these deficiencies through the provision of technical assistance, training and limited levels of equipment and supplies.

Of particular concern to RDO/C and the governments themselves is the burden on MOH human resources: most Eastern Caribbean countries have only two health educators who are responsible for the entire gamut of health education in their countries. While the Project will provide some relief through technical assistance in the short term and in select countries on a longer term to fortify Health Education Offices, the Project cannot provide indefinite staff support to the Ministries. Two specific strategies will be implemented to help governments stretch their human resources: (1) the convening of short, intensive practical workshops geared to assist governments in planning and implementing critical activities (e.g., baseline data collection, developing communications strategies) which should reduce the burden and help maximize the benefits from these critical activities; and (2) involving other government ministries as well as the private voluntary sector and others in the provision of health education strategies. Examples of the latter include staffing AIDS hotlines with trained volunteers rather than scarce MOH personnel, enlisting support of the media in AIDS education, and training peer educators to reach out to high risk populations.

A typical sequence of activities for helping governments stretch manpower in developing an AIDS Carnival Education Program might consist of the following steps:

<u>Step 1. Convene a regional workshop sponsored by CAREC and AIDSCOM for national delegations</u> consisting of the chief health educator, a member of the government information service, a local newspaper journalist, PVO representations and the family planning health promoter. The purpose of the workshop would be to assist countries in determining themes for AIDS prevention and to examine the types of activities a country might include in designing a comprehensive, multi-media AIDS prevention strategy tied to Carnival celebrations. The workshop would also assist delegations in preparing workplans, media strategies and budgets for such a program, train participants in the development and testing of communications messages, and provide the opportunity for countries to exchange ideas which they may have successfully implemented the previous year.

<u>Step 2. Convene follow-up country-level workshops.</u> In select participating countries.

AIDSCOM and CAREC would serve as facilitators and resource persons to the country delegation which attended the regional workshop and were now taking primary responsibility for conducting the national Carnival Strategy workshop. Participants at this workshop might include select teachers, newspaper editors, youth council presidents, district nurses, and National AIDS Committee members who would gather over three or four days for the purpose of devising and refining the multi-sectoral, multi-media Carnival education plan, developing a condoms-distribution component, developing the evaluation methodology for the strategy, programming financial and in-kind counterpart support, and electing a steering committee to manage the implementation of the strategy.

Step 3. Follow-on technical assistance would be provided by the AIDSCOM and/or CAREC staff to support the implementation of the strategy as required including directing the pre-testing of draft Carnival posters, coordinating and assessing the evaluation procedures, etc.

With expertise provided by CAREC, AIDSCOM and AIDSTECH, the governments will be assured access to the most timely epidemiological information as well as the benefits from field tested intervention models from other parts of the world. Every effort will be made to ensure that AIDSCOM and AIDSTECH technical experts used in the Project continue to be available to it so that their understanding of the Caribbean, and effective contribution to it, can be maximized over time. The pairing of two CAREC staff members to an AIDSTECH and AIDSCOM CPM through the Project Coordinator also demonstrates the importance of establishing and strengthening relationships between these organizations for the benefit of Caribbean countries.

B. Economic Analysis

The ACTS Project is the USAID contribution to a regional, multi-donor, parallel-financed program aimed at reducing the spread of AIDS in the Caribbean. RDO/C has determined that its funds would be best suited for activities in which the Agency has had considerable relevant expertise and success at executing. These include provision of technical assistance and training in (a) the research and development of

cost-effective interventions to improve surveillance capabilities and (b) behavior modification through multi-media communications interventions.

AIDS is a relatively new disease whose epidemiological profile is rapidly evolving. To date, there is no cure for AIDS. This, combined with the absence of reliable data on the costs and benefits of treatment of infected persons, particularly since currently death of infected persons is inevitable, renders it impractical to perform conventional financial or economic analysis on the types of interventions proposed in this project. Moreover, the decision to participate in a project of this nature clearly does not have its foundation in economic analysis of a specific set of interventions.

It is prudent, however, to examine whether the interventions to be carried-out represent the least-cost methodologies given the currently available and socially acceptable technical approaches to survey and track changes in infection rates and to encourage modification of behavior towards more safe sexual practices.

Through support to the WHO/Global Program on AIDS, the centrally funded AIDSTECH and AIDSCOM activities as well as numerous bilateral projects, the Agency is currently conducting and supporting extensive and intensive research into prevention and treatment methodologies. At this point, no one can unequivocally say what is and what is not cost-effective. Given this, ACTS will essentially be a research and development project to examine what is technically feasible, socially acceptable and financially sustainable in the context of the small island economies of the Caribbean which include countries with some of the highest incidence rates of AIDS in the world. The project has carefully integrated cooperation with AIDSTECH, AIDSCOM and the WHO/GPA to increase the likelihood of benefitting from as well as contributing to research being conducted worldwide.

The project proposes the following activities methods:

- o Design, implementation and analysis of baseline and follow-up infection surveillance and behavior surveys
- o Training of trainers in a wide range of activities
- o Development and distribution of communications materials

- Development and implementation of workshops, symposia and conferences
- Testing of measures for screening pooled blood
- Development of multi-media advertising spots
- Limited condom distribution
- Establishment of telephone hotlines
- Data collection and analysis and program evaluation

Each intervention will be pre- and post-tested to determine the effectiveness and efficiency in achieving its specific objective. Successive iterations will incorporate lessons learned. An evaluation will be conducted of the overall effectiveness of the various delivery mechanisms pilot tested in Phase I and will provide the basis for design of activities to be institutionalized in Phase II. Data collected and analyzed during Phase I will provide the basis for a more conventional economic analysis of activities in preparation for designing Phase II of the Project.

No matter what the outcome of Phase I, however, it is clear that the AIDS pandemic will have dramatic negative impacts on the economies and national health care budgets of the Caribbean countries. Governments are already seeing the costs of their AIDS-related supplies (disposable syringes, latex gloves) expanding exponentially. The hospital costs of treating the opportunistic diseases are also rapidly increasing while treatment with Zidovudine at $7,500 per patient per year is beyond the scope of most governments. Although it is crucial to help these countries to determine how best to deploy their scarce health resources in the battle against AIDS, continued external assistance will obviously be required for the indefinite future. In light of this, a key concern of cost-effectiveness will continue to be how to best integrate the expenditure of external resources available to the Caribbean into the broader worldwide network of AIDS research and development work. ACTS is designed in two phases in recognition that, as with the epidemiological profile of AIDS, this too is an evolving situation. The design of Phase II will provide the opportunity to re-examine the institutional arrangements for achieving this integration.

C. Social Soundness Analysis

This project will help build the capacity of Eastern Caribbean countries to prevent the spread of HIV infection and AIDS. The medical and socio-cultural complexity

of AIDS makes it exceedingly difficult to design effective AIDS prevention efforts. Resource constraints compound the problem in Caribbean countries.

AIDS will kill thousands of people in the prime of life within the next few years in the Eastern Caribbean. Public health workers are at war against the disease and time is critical. Knowledge which assesses both the extent of the disease in the Caribbean as well as what those at risk do or do not know about the modes of transmission are essential. Trained personnel to collect this information as well as to develop and carry out prevention programs based on these data are desparately needed. If interventions are unduly delayed, more people will die and the possibility of controlling the epidemic will become significantly more difficult. Policymakers and the public must understand that although the epidemic may be brought in check, enormous numbers of people already infected with the virus will develop the disease. For these reasons, there are essentially two "primary target" groups: the health care workers and other professionals who are fighting the epidemic as well as sexually-active individuals who are at highest risk. Secondary target groups include those who are currently HIV+ or who have AIDS and those who will become sexually active in the future.

The Social Soundness Analysis has two distinct but related aspects: (1) the compatability of the project with the socio-cultural environment in which it is to be introduced (its socio-cultural feasibility); and (2) the social impact or distribution of benefits and burdens among different groups and the secondary or spread effects of the Project beyond the primary target group.

1. Socio-cultural and Political Setting

The design and implementation of an appropriate and acceptable technical assistance plan for AIDS prevention and control in the Caribbean presents a unique development challenge. The challenge is to develop a program in an area of great public interest, which governments want to and can effectively promote, but promote cautiously, and which must attempt to insure ironclad confidentiality in societies where often very little remains confidential.

To design and be able to effectively measure the impact of AIDS public education and health campaigns, it is critical first to understand both the extent and epidemiological characteristics of HIV and AIDS infection in

participating countries. Politically, economically and socially-motivated fears, however, often result in a reticence (if not outright refusal) by governments to allow experts to examine this individually and societally-threatening problem. Tourism-dependent countries are understandably concerned about the potential effects on national economic welfare should they allow foreign researchers access to data on the sexual mores and private lives of its citizens and the attendant HIV infection rates. Despite these concerns, governments cannot disregard the current and projected costs of dealing with their HIV infected and AIDS patients. In Grenada, for example, the cost of surgical gloves has quadrupled in the past four years, critically straining MOH supplies budgets. At an annual cost of US$7,500 per AIDS patient, treatment with Zidovudine (formerly called AZT), is outside of financial capability of developing countries.

Health ministers and other policymakers responsible for allocating resources to various programs must be convinced of the need to deal with the problem of HIV prevention or little will be accomplished by the health sector. This project will collect and distribute up-to-date information on a regular basis about AIDS and HIV infection in the Eastern Caribbean and organize conferences and workshops to provide more information to decision-makers and program managers to enable them to better confront the problem.

Accessibility to critical data, the extent of circulation of project-generated reports, and the qualifications of technical experts are common concerns of hyper-sensitive public officials. Throughout this project all individual test and questionnaire results will be kept strictly confidential. Only highly placed, authorized personnel will have access to test results. Questionnaires and laboratory forms will be identified by code numbers rather than names.

The Caribbean culture, particularly in Barbados and the Catholic Eastern Caribbean countries is dominated by conservative ethics and the moral imperatives of the Church. Public officials and the general public strongly would wish to avoid addressing such difficult issues as homosexuality (the extent of which is vigorously underestimated) and prostitution (the existence of which is illegal). Evidence is emerging in many countries of the importance of the cocaine abuse/prostitution linkages with higher syphillis rates and ultimately HIV infection. Project activities will stress the need for protecting the confidentiality of information, ensuring free and open consent

on the part of participants in behavior intervention operations research activities, and insuring that the project does not result in attracting or increasing discrimination against high risk behavior individuals as a result of the attention that the project will give them. KAP surveys and educational materials will be developed in close collaboration with CAREC, the Ministries of Health and National AIDS Committees and will be pre-tested with targetted populations to ensure that they are culturally appropriate.

Socio-cultural taboos concerning homosexuals and prostitutes affect the degree to which countries will be willing to develop effective programs targetted directly to these higher risk groups. They also affect the degree to which such individuals will be receptive to prevention messages and will trust the health system sufficiently to maintain confidentiality. RDO/C's extensive experience in MOH family planning programs in the Caribbean suggest that sensitivity training of health care providers, including dealing with deep-seated religiously-based attitudes by health care personnel towards their patients' perceived promiscuity and sexual orientation, will need to be an integral component of counselling training programs.

A related and certainly more political issue concerns the area of counselling infected women about the risks of perinatal transmission with pregnancy and about the option of pregnancy termination for infected pregnant women. While noting the importance of such counselling for infected women, Agency guidance is clear in proscribing involvement in any activities that include abortion.

Also from RDO/C's family planning experience comes the knowledge of the primarily male socio-cultural bias against the use of condoms, a proven effective method of reducing AIDS and STD transmission. In addition to the usual aesthetic objections surrounding condom use (which seem particularly strong in this region) and despite contraceptive advertising trying to dispel this image, there appears to be the additional connotation that using a condom is not masculine. Women in general find it difficult to convince men to use condoms, however, in the Caribbean where many relationships are "common law," where it is generally acknowledged that men have multiple partners, and where women still tend to be more economically dependent, women find it more difficult to assert their desires. The other target group of women with whom the Project will be working (commercial sex workers) are often not Caribbean nationals. If these women do not work in organized houses or if the houses do not strictly

enforce condom use, these Spanish-speaking women face language barriers which compound the difficulty in changing client behavior.

Where the reluctance to use condoms is symptomatic of religious aversion to birth control, the prophylactic use of condoms -- as a means of disease protection rather than preventing births -- will be helpful. Where the problem is primarily cultural, a different strategy for dealing with the reluctance will be required. Educational messages for sexually active women will be developed in English and Spanish to help women work with their partners.

2. Direct Beneficiaries and Spread Effects

a. Direct Beneficiaries

Although the primary public beneficiaries of the ACTS Project will be sexually-active individuals, the project will target both the general population and groups which can be defined as most-at-risk. These high risk behavior groups include STD clinic attendees, men and women with multiple partners, migrant farm workers and prisoners. Both the general population as well as those at higher risk will be the recipients of education programming, improved counselling services, and in some cases, special behavior intervention sub-projects to reduce their risk of contracting HIV. Individuals who are currently HIV+ or who have AIDS will also benefit from this Project as a result of the improved capabilities of the health delivery sector and a more enlightened general population. In addition, other direct beneficiaries of the project will include epidemiologists and public health officers who will be trained in AIDS and HIV surveillance, and health care and other personnel who will be trained in AIDS and STD prevention and counselling and public education programming.

Assuming that the Project is successful in safeguarding confidentiality of participants, that participation in targetted project activities is based on free choice, and that none of the project activities are implemented in such a manner as to violate basic bioethical principles (including those concerned with the conduct of research on human subject), there are no categories of people or groups which are likely to be adversely affected by project.

b. Spread Effects

Project activities will be

developed mindful of the need not only to provide initial technical assistance or to train those immediately involved in HIV/AIDS prevention, but with an emphasis on the need to institutionalize improved health delivery systems and training capabilities. Thus training programs will be accompanied by full training manuals so that the modules can be conducted by health personnel at regular intervals.

Health personnel will be trained in a number of new skills that will make them better educators and counsellors not only in HIV and AIDS but in other sensitive health areas as well such as sexually transmitted diseases, family planning, and sexual abuse. The advanced methodologies for developing effective health communications strategies will be useful for other health promotion areas particularly where behavior changes are required to reduce the incidence of "lifestyle" chronic diseases. Technical assistance and training focused on improving surveillance systems will be useful not only for HIV, AIDS and STD infections, but also for hepatitis B and immunization programs.

Intervention activities will also be implemented in such a way as to facilitate expansion to larger numbers and replication in other settings beyond the life of the particular sub-project activity. The peer counselling methodology which trains a core of committed individuals who then reach out into their communities has proven to be an effective and lasting method of contacting individuals often unreachable through the traditional health care system. Peer educators used in the targeted interventions will be selected for (1) leadership ability, (2) communications skills, (3) ability to learn, and (4) desire to participate in the program. Management and financial information will be collected, recorded and analyzed on each of the behavior intervention activities to provide other interested communities sufficient information to judge whether the particular intervention could be successfully replicated in their settings for HIV prevention or for other health issues (e.g., anti-smoking, family planning, improved nutrition).

D. Institutional and Administrative Analysis

Despite the singular objective of the Project goal, the Project purpose would suggest that a fair measure of institution-building at CAREC and the country level will be required. This analysis reviews each of the three major implementing agencies then describes administrative management

systems which are or will be put in place to promote effective management of the Project.

1. <u>The Caribbean Epidemiology Centre (CAREC)</u>

a. <u>Background</u>

The Caribbean Epidemiology Centre (CAREC) was established in 1975 by the CARICOM Ministers Responsible for Health in the belief that regional cooperation provided the most effective and efficient means for obtaining epidemiological surveillance and control services. CAREC is administered under a Multilateral Agreement between the governments and the Pan American Health Organization (CAREC's parent institution) adopted at the 1975 Health Ministers Conference. A new agreement approving the Centre's operations through 1995 will be reviewed at the upcoming Health Ministers Conference. CAREC is directed by an 11-member Council composed of a representative of its host government (Trinidad and Tobago), two other Health Ministers, one representative from the University of the West Indies, the Commonwealth Caribbean Medical Research Council, PAHO, the Overseas Development Administration and the Scientific Advisory Committee, and two other discretionary members. The Council meets annually to review the CAREC Directors Report and to review and make recommendations on the proposed program and budget of the Centre. The Scientific Advisory Committee is composed of three UWI Faculty of Medicine members, one UWI Faculty of Agriculture member, two representatives from the Caribbean Health Ministers, and five members designated by PAHO. The purpose of SAC is to advise PAHO/WHO and the Council on the planning and management of the Centre.

The four basic objectives of CAREC can be summarized as follows:

(1) To establish and consolidate communicable and non-communicable disease surveillance in the Caribbean,

(2) To assume primary responsibility for some types of laboratory work (e.g., virology including confirmatory HIV testing, for example) and to provide referral services for national

laboratories in other areas (e.g., bacteriology and parasitology),

(3) To provide laboratory and surveillance training for Caribbean health personnel, and

(4) To conduct research relevant to communicable (and in the future non-communicable) disease surveillance and laboratory work.

CAREC serves 19 Caribbean countries from the Cayman Islands to Suriname and is financed from three broad sources: (1) quota contributions from member countries, (2) support from PAHO and ODA, and (3) extra-budgetary support from donors. The first two sources cover core program services, the third applies to specialized activities (e.g., AIDS prevention). Of the planned 1989 CAREC budget of US$5,105,740, nearly 30 percent ($1,511,400) is theoretically expected to come from quota contributions, 8 percent ($422,200) will be provided by PAHO, 3 percent ($140,000) from ODA and the remaining 59 percent is anticipated from extra-budgetary support.

Two financial issues involving CAREC are worth noting. First, like other regional institutions, over the past few years CAREC has begun to experience significant financial difficulties as a result of late or non-payment of quota contributions by some governments. For example, of the approximately $1 million received in quota contributions in 1988 (of $1.5 million due), only 8 percent represented collections against the 1988 assessment; the remaining collections were against <u>previous years</u>. The financial strain in 1988 resulted in such stringent cost containment measures that their actual core program expenditures for 1988 were only $867,208 against a planned $1,472,148 and CAREC's Scientific Advisory Council (SAC) issued a warning that their ability to fulfill their mandate was severely jeopardized. The second point is that extra-budgetary support represents a larger proportion of their budget than does core program support. To the extent that these monies support special activities which are additional to CAREC's basic mandate, they could represent "the tail wagging the dog" and come increasingly at the expense of providing core services. CAREC staff and the SAC recognize and have expressed concerns about the effect of this extra-budgetary support, but

feel that the funds and expertise developed in these areas can be used for institution building and in the long run make CAREC a stronger institution.

Given that the immediate staff, equipment and supplies costs required for CAREC's AIDS program are funded from extra-budgetary rather than core support, the financial uncertainties related to core contributions should not pose critical dangers to project implementation. Given the secondary objectives of this Project to strengthen this institution as it moves into the chronic disease areas, however, RDO/C will monitor at a distance CAREC's core financing difficulties to ensure that project implementation is not jeopardized and to facilitate institutionalization of the most cost effective HIV/AIDS prevention programs at CAREC.

b. The CAREC-RDO/C Relationship

RDO/C has developed a strong relationship with CAREC which began a decade ago with the signing of a project grant agreement with PAHO, CAREC's parent institution, for implementation of the Epidemiological Surveillance and Training Project (538-0027). Under that $2.5 million project (which was completed after 8 years and several expansions to the original scope of work), CAREC was able to develop as a first-class epidemiological surveillance and control institution. Some of their more notable successes under that project include: (1) establishing a Disease Surveillance System at international standards which relies on national surveillance skills with back-up CAREC support, (2) developing a capacity in each of its member countries for primary disease investigation and control using national and deputy epidemiologists and laboratory directors trained through in-country or CAREC-based workshops and training attachments, (3) creating a surveillance communication system which includes quarterly or annual publications such as the CAREC Surveillance Report, EPI (immunization) Notes, and the Caribbean Zoonoses Newsletter, and (4) the production of the first-ever Epidemiology Manual for the Caribbean, a Sexually-Transmitted Disease Manual, Laboratory Safety Manual, and numerous other training and investigation guides.

c. CAREC's AIDS Program

CAREC's activities in the area of AIDS can be seen as providing a bridge from the institution's sole focus on infectious, communicable diseases to its future expansion into chronic, non-communicable diseases. Over the

past few years the institution as well as the SAC have noted the need for CAREC to expand its existing capacities to "develop targetted plans to address priorities in non-communicable diseases." The AIDS epidemic, while still an infectious disease, must be addressed through public education, counselling and developing communications strategies. Those same skills will be essential if the Caribbean is to reduce the prevalence of other "lifestyle" diseases such as hypertension, diabetes, and obesity. Thus a deliberate spinoff of this Project will be assistance to CAREC in developing the expertise in the social and behavioral sciences to help it meet the changing disease patterns of the Caribbean. The AIDS Program allows CAREC the opportunity to develop its social science skills in anticipation of this broader mandate. Making this transition from a strictly "hard science" institution to one which also includes behavioral and social science skills, will require some institutional adjustments and accommodations.

While CAREC will need to develop its social and behavioral expertise, their recognized leadership in surveillance, training, and research will provide critical skills to fighting the AIDS epidemic. CAREC played a critical role in developing the medium term plans and continues to take the lead in tracking the infection through the Caribbean. It has an even more critical role to play in helping Caribbean countries to prevent and control further spread of AIDS in the region.

As the principal implementing agency of the ACTS Project, CAREC will be responsible for technically integrating the human resources available from AIDSCOM and AIDSTECH, and managing the warehousing and distribution of condoms which will be provided to the region through this project.

d. Administrative Management

In attempting to identify the various options available for administration of the AIDS Project grant, two options were explored. The first option considered was direct granting of funds to the Caribbean Epidemiology Centre who would be the direct grant implementor. The second option considered was the use of the Pan American Health Organization (PAHO), the parent organization of which CAREC is a subregional center. Discussions with the staff of CAREC and PAHO determined that by limitation of charter, CAREC cannot enter into grant agreements on its own; only the Director of PAHO (or his designee) has authority to enter into such agreements. While delegating authority for technical

implementation to CAREC, PAHO, which earns a 13 percent overhead, maintains fiduciary responsibility for the Grant. (A portion of this 13 percent program support overhead is often returned to CAREC to support core operations or special activities.)

2. Family Health International/AIDSTECH

a. Background

Family Health International was incorporated in North Carolina in July, 1971 as an independent non-profit corporation. FHI is located in Research Triangle Park, North Carolina, and has well-established working relationships with the University of North Carolina at Chapel Hill, Duke University, and North Carolina State University which provide FHI with a broad range of medical, scientific and technical skills. Several FHI staff hold academic appointments at the University of North Carolina at Chapel Hill.

Since 1971, FHI has worked in 80 countries carrying out joint projects to help solve problems identified by governments, clinical researchers, and health care providers. FHI works closely with international health and development organizations, including the World Health Organization, the United States Agency for International Development, the Centers for Disease Control, the National Institutes for Health, the International Development Research Center of Canada, UNICEF, and a host of other agencies working in related areas.

FHI has become the major international organization evaluating the safety, efficacy and acceptability of contraceptives. FHI programs and studies are carried out in partnership with collaborating investigators and institutions. FHI's currently active network involves investigators in more than 50 countries in Africa, Asia, Latin America, Australia, North America and Europe. FHI works with government ministries and institutions, private sector organizations, clinical researchers in universities and hospitals, and family planning organizations.

FHI's staff of 175 includes experienced physicians, public health researchers, experts in pharmacology and reproductive biology, biostatisticians, epidemiologists, systems analysis and social scientists. Many FHI staff have extensive professional experience in the developing world. FHI is governed by a Board of Directors composed of distinguished reproductive scientists, leaders in

international family planning business leaders experienced and knowledgeable in all aspects of drug development, physicians experienced with the practice of contraception and the delivery of health and family planning services, and businessmen concerned about efficient management and the timely, cost-effective meeting of corporate commitments.

b. FHI and AIDS

AID awarded the Cooperative Agreement AID/DPE-5972-A-00-7057-00 to FHI on September 16, 1987, as a five year, $28 million program for technical assistance to prevent HIV transmission.

The AIDSTECH Project consists of an integrated and internationally mobile team with multidisciplinary technical and managerial skills. The program has an office in Washington, D.C. and a core of technical experts located at FHI's North Carolina headquarters. The AIDSTECH team consists of a Director, six technical specialists who are experts in the areas of epidemiology, operations research, laboratory sciences, public health, health care financing and training; geographic area managers; administrative staff and a host of short term consultants. AIDSTECH has recently identified an area coordinator for the Caribbean to direct the technical resources provided to the region to assist in implementing the ACTS Project.

The program was designed by AID to provide rapid technical assistance services and to work in conjunction with the AIDSCOM Communication Project, implemented by the Academy for Educational Development (AED) in Washington. AIDSTECH provides for epidmiological and applied research to design and evaluate various intervention strategies and assess their costs and impact to prevent HIV infection. The project focuses intervention actions on policymakers and service providers, and both professional and traditional practitioners.

3. Academy for Educational Development/AIDSCOM

a. Background

The Academy for Educational Development (AED) is one of the largest U.S. private sector agencies concentrating on education, training and manpower development in international development. The total value of programs in progress exceeds $88 million. Throughout the

history of AED more than 300 projects in more than 100 countries have been successfully conducted.

The Academy employs over 250 fulltime staff of whom nearly 25 percent are resident overseas. Its Washington, D.C. office includes full services for management and administration of large developing country and AID contracts. The Academy has developed corporate-style leadership comprising officers, senior and junior staff, and central services facilities. Current projects address needs in development sectors including training, administration and management, manpower development, business, education, agriculture, engineering, communications, health and nutrition and population.

b. AED and AIDS

In 1987 AID/ST/H approved a five year AIDS Public Health Communications (AIDSCOM) contract with AED for technical assistance to AID offices and National AIDS Committees worldwide to help them develop health promotion programs for AIDS prevention. AIDSCOM builds on A.I.D.'s successful experience with social marketing and health communication to create modules uniquely suited to the needs of AIDS prevention.

AIDSCOM comprises three major components, two of which will be employed in the ACTS Project implementation. The communications support component is designed to help answer questions about how best to apply communication to the control of AIDS. It is anticipated that over the five years of the project resident advisors will be placed in a minimum of 15 countries to assist public and private institution in testing and developing new prevention strategies. The second component, short-term technical assistance, will provide specialists in such areas as AIDS communications planning, behavioral marketing research, counselling and support services, media planning, medical and mental health provider training, condom marketing, and project evaluation. The third component, dissemination efforts, will ensure that results, lessons, and materials developed under the project are made available worldwide. To help build an international network of AIDS prevention specialists, AIDSCOM has identified educators, counsellors, behavioral change experts, advertising and marketing professionals, and AIDS communications experts.

The AIDSCOM Project staff consist

of specialists in health promotion and education, development communications, social marketing, cross-cultural communications, media planning and organizing, and reproductive health. AIDSCOM staff have been involved extensively in AIDS prevention work for the last eight years in both more developed and developing countries. AIDSCOM staff have pursued an agenda that offers both education and communications prevention programs to address immediate needs and requests for assistance with planning and implementation of qualitative and quantitative research to guide the further development of prevention activities. AED subcontractors include The Johns Hopkins University which provides specialized assistance in medical anthropology, health education, health provider training and linkages to family planning programs; Porter Novelli and their advertising network which brings state-of-the-art assistance in commercial marketing, advertising and mass media; the University of Pennsylvania Annenberg School of Communication which specializes in project evaluation, and the PRISM Corporation which brings video production and conference organizing skills to the Project. AIDSCOM also relies on a number of international health consultants.

AIDSCOM has already undertaken an number of activities in the region including among other things conducting two regional train-the-trainer counselling workshops, developing the first AIDS hotline in the region (in Trinidad), developing a Caribbean AIDS Prevention Counselling manual, and conducting a condom use survey with STD clinic attendees.

4. Institutional Coordination

A number of institutional arrangements will be put in place to facilitate successful management of this Project. Project implementation and management review committees are proposed at macro and micro levels to meet the specific needs of donors, implementing agencies, and the countries.

a. AIDS Donors' Reviews

Given the placement of this Project within the larger context of the Medium Term Plans for AIDS Prevention and Control, the RDO/C Project represents only a portion of the activities which will be undertaken at the sub-regional (i.e., CAREC) and country levels. A number of donor agencies are financially contributing to this larger

program including CIDA, ODA, EEC and others. It was proposed at the December 1988 Donors Meeting that CAREC host an annual donors' review of MTP implementation possibly in conjunction with their annual Scientific Advisory Committee and CAREC Council meetings since these two meetings generally serve the function of reviewing activities under the previous operational year and setting out the broad workplan for the coming year. Additionally, the major donor agencies are generally represented as observers at these meetings. This meeting will afford the donors an opportunity to review the status of project implementation at a macro-level and to identify any problems in coordinating activities under the various MTP strategies.

b. CAREC AIDS Policy Committee

As noted earlier in this section, CAREC has established an in-house policy committee to review the institution's response to and programming for AIDS prevention and control in relation to the work of the various CAREC divisions. As such, the committee has a broader interest than strictly AIDS programming although the members of the committee both approve the activities of the AIDS Unit and can provide management guidance to the Unit. The committee generally meets monthly or bi-monthly.

c. Caribbean AIDS Program Managers Meetings

Annual meetings of country level AIDS Program Coordinators will be convened by CAREC to coordinate country level activity workplans, to review activities undertaken during the year, and to share program experiences. The first such meeting will be convened in July 1989 and will cover such topics as coordinating country-level first year MTP activities (e.g., baseline KAP surveys, epidemiological surveillance systems), apprising Program Coordinators of the WHO/GPA financing system and reporting procedures, and introducing the ACTS Project. Training sessions on developing management skills will also be included as time permits. Subsequent meetings of this group may be convened as single purpose workshops or may be convened in conjunction with other technical workshops. AIDSTECH, AIDSCOM will be represented at these meetings.

d. CAREC MTP Management Unit

On a day-to-day basis

implementation of the ACTS Project will require intimate collaboration and cooperation by CAREC, AIDSCOM and AIDSTECH project staff. The first formal project implementation step, i.e., developing the 18 month workplan, will be a critical one to ensuring that the CAREC, AED and FHI components are well orchestrated for the start up of the program. Developing and monitoring the implementation of this plan will be a collaborative effort of CAREC, AIDSCOM and AIDSTECH.

Once the workplan is approved, ensuring that Project activities are properly interfaced with the overall CAREC MTP program will be the fulltime job of the Project Coordinator who will serve as the focal point for communications and planning. The Coordinator will be responsible for tracking workplan progress on a daily basis, for dialoging with the AIDSTECH and AIDSCOM CPCs and the CAREC AIDS Unit to keep all resources well focused and running smoothly.

At this immediate, micro-level, it is proposed that CAREC establish an MTP management working committee charged with ensuring coordinated implementation of the Plan. It is proposed that the membership of this working committee include at a minimum, the Head of CAREC's Special Program on STDs, the CAREC program coordinator, the ACTS Project Coordinator, the CIDA-sponsored evaluation specialist, and the AIDSTECH and AIDSCOM CPCs or the Technical Services and Communications Specialists. The role of this committee will be to develop the workplan, to plan upcoming collaborative activities to facilitate smoother operation of the various components as well as to share information. It is proposed that every six months the participation at these meetings shall include the USAID ACTS project officer. These special Project Management Meetings will serve to provide in-depth assessments of project accomplishments and planning sessions to update or revise the workplan for the following six month period. These special meetings will serve to provide in-depth assessments of project accomplishments and planning sessions to update or revise the workplan for the following six month period.

The implementation strategy proposed for this project is specifically designed to minimize concerns by governments about the relationship of organizations implementing the ACTS Project with the Medium Term Plans. At the same time the design should facilitate government participation in the Project since planned project activities for Phase I emanate directly from the medium term plans as enunciated by the host governments themselves. This should

ensure that implementing these activities is a priority equally shared by the governments and implementing agencies. In implementing this Project, however, special emphasis will also be placed in supporting the World Health Assembly Resolution WHA42.34 "Nongovernmental Organizations and the Global AIDS Strategy" adopted at the 42and World Health Assembly which promotes the role of NGOs in the implementation of the national plans for AIDS prevention and control.

As the implementing agency of the WHO/GPA and donor-approved Caribbean sub-regional plan, CAREC is in the ideal position to direct technical assistance and training efforts for AIDS prevention and control from the regional to country-specific levels. The collaborative working relationship which CAREC has established with its member countries should facilitate project implementation not only by CAREC staff, but by AIDSCOM and AIDSTECH technical consultants working with them. Additionally the CAREC/AIDSTECH/AIDSCOM coordinated approach ensures that the unique expertise which AIDSTECH and AIDSCOM can offer to the region will be institutionalized at CAREC and thus be available to the region after this project.

Since portions of CAREC's MTP not covered under this project will be financed by other donors, CAREC is in an ideal position to monitor the activities of all donor and GPA-financed activities in the region. This will facilitate maximum coordination among the interested parties and ensure that duplication of efforts by the various organizations is minimized.

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ANNEX A Page 1

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AIDAC BRIDGETOWN FOR J. WOOTEN, A. DEGEORGES

E.O. 12356: N/A
TAGS:
SUBJECT: IEE APPROVAL AIDS COMMUNICATION AND TECHNICAL SERVICES (538-0161)

REF: BRIDGETOWN 02520

1. LAC DEPUTY ENVIRONMENTAL OFFICER WILSON APPROVED REQUEST FOR NEGATIVE DETERMINATION FOR SUBJECT PROJECT ON APRIL 13, 1989. IEE NUMBER IS LAC-IEE-89-37. COPY OF IEE BEING POUCHED TO MISSION FOR INCLUSION IN PROJECT FILES. BAKER
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AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

LAC-IEE-89-37

ENVIRONMENTAL THRESHOLD DECISION

Project Location	:	Caribbean Regional
Project Title	:	AIDS Communication and Technical Services
Project Number	:	538-0161
Funding	:	$3.5 million
Life of Project	:	Four years
IEE Prepared by	:	John D. Wooten RDO/C
Recommended Threshold Decision	:	Negative Determination
Bureau Threshold Decision	:	Concur with Recommendation
Comments	:	None
Copy to	:	James Holtaway, Director RDO/C, Bridgetown
Copy to	:	John D. Wooten, RDO/C
Copy to	:	D. Blane, LAC/DR/CAR
Copy to	:	Andre DeGeorges, REMS/CAR
Copy to	:	IEE File

John O Wilson Date APR 13 1989

John O. Wilson
Deputy Environmental Officer
Bureau for Latin America
and the Caribbean

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ACTION AID-00

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AIDAC

PASS TO JAMES HESTER, LAC/DR

E.O. 12356: N/A
TAGS: NONE
SUBJECT: AIDS COMMUNICATION AND TECHNICAL SERVICES

1. FOLLOWING IS THE REQUISITE IEE FOR YOUR REVIEW AND APPROVAL FOR SUBJECT PROJECT.

PROJECT LOCATION: CARIBBEAN REGIONAL

PROJECT TITLE: AIDS COMMUNICATION AND TECHNICAL SERVICES

PROJECT NUMBER: 538-0151

LOP FUNDING: USDOLS 3,500,000

LIFE OF PROJECT: FOUR YEARS

IEE PREPARED BY: JOHN D. WOOTEN, RDO/C

DATE:

ENVIRONMENTAL ACTION RECOMMENDED: A NEGATIVE DETERMINATION IS RECOMMENDED. THE PROJECT IS NOT ONE WHICH WILL HAVE A SIGNIFICANT ENVIRONMENTAL EFFECT.

CONCURRENCE: JAMES S. HOLTAWAY
DIRECTOR
REGIONAL DEVELOPMENT OFFICE/CARIBBEAN

DATE:

I. PROJECT DESCRIPTION

THE PURPOSE OF THIS PROJECT IS TO IMPROVE THE CAPABILITY OF CARIBBEAN COUNTRIES TO COPE WITH THE PUBLIC HEALTH CRISIS THAT THE AIDS EPIDEMIC POSES TO THEIR PEOPLE AND THEIR FRAGILE AND ILL-EQUIPPED HEALTH CARE DELIVERY SYSTEMS. PRIORITIES FOR THE PREVENTION AND CONTROL OF HIV INFECTION AND AIDS IN THE REGION EMPHASIZE THE IMPORTANCE OF PREVENTING SEXUAL AND PERINATAL TRANSMISSION AND TRANSMISSION THROUGH BLOOD AND BLOOD PRODUCTS, AND STRENGTHENING OF EPIDEMIOLOGICAL SURVEILLANCE. ADDITIONALLY, ATTENTION IS FOCUSSED ON REDUCING THE IMPACT OF HIV ON INDIVIDUALS, GROUPS AND SOCIETIES, AND ON IMPROVING PROGRAM MANAGEMENT AT THE COUNTRY LEVELS.

THE STRATEGY BEING IMPLEMENTED INCLUDES ASSESSING BOTH THE LEVEL OF HIV SEROPOSITIVITY AND THE

KNOWLEDGE, ATTITUDES AND PRACTICES (KAP) AMONG SELECT HIGH RISK GROUPS AND THE GENERAL POPULATION; DEVELOPING EFFECTIVE COMMUNICATIONS STRATEGIES BASED ON THIS RESEARCH; TRAINING CLINICAL AND SOCIAL RESEARCHERS AND HEALTH CARE PROVIDERS TO CARRY OUT AIDS SURVEILLANCE AND EDUCATION STRATEGIES; AND TESTING AND REPLICATING EFFECTIVE AND INNOVATIVE MODELS FOR INCREASING KNOWLEDGE, CHANGING HIGH RISK BEHAVIORS, AND REDUCING THE FINANCIAL BURDEN ON HEALTH CARE SYSTEMS.

TO SUPPORT THIS STRATEGY, THE AIDS COMMUNICATIONS AND TECHNICAL SERVICES PROJECT (ACTS) CONSISTS OF THREE BROAD COMPONENTS: (1) ASSISTANCE UNDER A THREE YEAR COOPERATIVE AGREEMENT TO THE CARIBBEAN EPIDEMIOLOGY CENTRE (CAREC) TO SUPPORT TWO KEY STRATEGIES UNDER ITS MEDIUM TERM PLAN ON AIDS, (2) PROVISION OF TECHNICAL ASSISTANCE ON BOTH A BILATERAL AND REGIONAL BASIS FROM THE AIDS COMMUNICATIONS (AIDSCOM) AND AIDS TECHNICAL SERVICES (AIDSTECH) ACTIVITIES OF THE AIDS TECHNICAL SUPPORT PROJECT (936-5972), AND (3) DIRECT PROCUREMENT OF PROJECT MANAGEMENT SERVICES AND LIMITED COMMODITIES IN SUPPORT OF BOTH REGIONAL AND BILATERAL ACTIVITIES

II. ENVIRONMENTAL IMPACT

TECHNICAL ASSISTANCE, TRAINING ACTIVITIES AND COMMODITY SUPPORT FUNDED UNDER THE PROJECT WILL RESULT IN A REDUCTION OF THE CURRENTLY HIGH RATES OF HIV TRANSMISSION IN THE CARIBBEAN, THE MORBIDITY AND MORTALITY ASSOCIATED WITH HIV INFECTION, AND THE SOCIAL AND ECONOMIC IMPACT RESULTING FROM HIV INFECTION. ALSO, EXISTING HEALTH CARE INSTITUTIONS WILL IMPROVE THEIR CAPABILITIES TO MANAGE THE CRISIS

AND THEIR LIMITED AVAILABLE RESOURCES. THIS PROJECT WILL NOT RESULT IN NEGATIVE IMPACT ON THE ENVIRONMENT. IT WILL RESULT IN POSITIVE SUSTAINED IMPACTS ON THE ENVIRONMENT AS THE RATE OF HIV TRASMISSION IS CHECKED AND THE COUNTRIES' CAPABILITIES FOR IMPLEMENTING PREVENTION ACTIVITIES IS ENHANCED.

III. ENVIRONMENTAL DETERMINATION

THE PROPOSED PROJECT IS NOT ONE WHICH WILL HAVE A SIGNIFICANT ENVIRONMENTAL EFFECT. IN VIEW OF THE NATURE OF THE PROJECT, A NEGATIVE DETERMINATION IS RECOMMENDED.

2. PLEASE ADVISE. CLARK

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 88 to FY 94
Total RDO/C Funding:$7,000,000 Million (Grant)
Date Prepared: March 15, 1989

Project Title & Number: AIDS COMMUNICATIONS AND TECHNICAL SERVICES (538-0161)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
GOAL: To prevent and control the spread AIDS in the Eastern Caribbean.	- Slowing rate of STDs by 25% over 3 years - Preventing HIV from exceeding 1% prevention in general population groups - 50% increase in at risk populations reporting improved safe sex behaviour	- National official statistics - Interviews with Min Health Spec - Sero prevalence monitoring of STDs and HIV in certain groups - Increases in safe sex practices	- Men & Women can reduce risk by limiting sexual partners and avoiding oral intercourse - Use of condoms will reduce risk - If individuals are properly informed of risk, this will modify behaviour
PURPOSE: To establish a capacity to develop and implement cost-effective surveillance, information, education and intervention strategies in support of projecting future trends and reducing the transmission of HIV infection and AIDS.	END OF PROJECT STATUS: - Stronger bilateral and regional epidemiological surveillance and research programs collecting pertinent info on the extent and characteristics of HIV transmission and AIDS cases. - On-going introduction, improvement and evaluation of programs which are reducing the likelihood of sexual transmission of of HIV infection. - Government and community-based organizations have stronger technical, professional and social skills and are effectiively communicating AIDS prevention strategies, humanely counselling and treating AIDS patients and their families. - 75% of the region's population has a basic knowledge of HIV, including how it is transmitted and what behaviors should be avoided/adapted to reduce their risk of contracting AIDS.	- Project records - Evaluation reports - Official statistics from Government, CAREC - WHO/GPA statistics - Interviews with regional health specialists	PURPOSE - Combatting the spread of AIDS remains a high priority. - Regional cooperation remains a priority among CAREC countries. - Regional Governments will find the recurrent budgets to substain program activities initiated in the project.
OUTPUTS: - Pilot tested operations resea[illegible]h interventions studies to reduce the sexual transmission of HIV among high risk groups. - Comparative cost analyses of various intervention strategies, case management procedures and public education campaigns.	- Interventions tested in countries. - 1 analysis completed for each intervention or strategy.	- Site visits - Project records. - Evaluation Reports. - Quarterly Reports from AIDSCOM, AIDSTECH and CAREC.	OUTPUTS: - Project staff able to deal effectively with cultural sensitivities associated with sexually transmitted diseases. - CAREC will be effective in coordinating among the plathora of agencies and governments involved

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
- Communications material designed tested, disseminated and evaluated for effectiveness and cultural relevance	- Brochures, pamphlets, radio programs, posters, videos adaped for each country.		
- AIDS Hotlines communication systems organized and operational	- 1 system per participating country		
- Health care workers, counsellors, communicators trained in management prevention and care of sexual transmitted diseases	- Up to 400 trained.		
- Continous intensive, in-service training programs developed for health care workers, counsellors and communicators	- 1 program per participating country.		
- Analysis, design and implementation of cost-effective strategies for blood testing and screening programs	- 1 program per participating country.		
- Improved epidemiological sentinel and periodic seroprevalence surveillance and reporting systems at the national level for tracking (a) Prevalence of HIV (b) AIDS and STD cases	- 1 system per participating country		
- Changes in the knowledge, attitudes and behaviors of those at risk to STDs			
INPUTS			INPUTS ASSUMPTIONS
AID Grant (RDO/C)	- $7.0 million	AID records:	- OYB cuts will not severely effect this high priority projects
AIDSTECH Core Support (S&T/H)	- $172,000	Disbursements	- Counterpart financing, (which is not formally negotiated in a regional project) will be available in a timely manner to support staff and office costs.
AIDCOM Core Support (S&T/H)	- $382,000	S&T Contract/Grants	- Other donors will continue their support to combating AIDS in the region.
WHO/GPA Regional Support	- $300,000		
PAHO/CAREC in kind contribution			
Goverments' in kind contribution			

5C(2) - PROJECT CHECKLIST

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? — Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?

2. FAA Sec. 611(a)(1). Prior to an obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? — Yes.

3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? — Not Applicable.

4. FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, *et seq*.)? (See A.I.D. Handbook 3 for guidelines.)

   Not Applicable.

5. FAA Sec. 611(e). If project is capital assistance (*e.g.*, construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

   Not Applicable.

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

   Yes.

7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

   Not Applicable.

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

   Not Applicable.

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

   Participating Countries will be contributing the cost of in-country personnel and other specific costs to be negotiated in support of sub-activities in this regional project.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

    N/A

11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

    N/A

12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

    N/A

13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other

    N/A

wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?

Not Applicable.

15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

Not Applicable.

16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

Not Applicable.

17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained?

Not Applicable.

18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Not Applicable.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1989 Appropriations Act Sec. 548 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?

Not Applicable

b. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental

This is an AIDS prevention and education project aimed at high risk groups that cut across the population.

institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

c.	<u>FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1989 Appropriations Act (Development Fund for Africa)</u>. Does the project fit the criteria for the source of funds (functional account) being used?	Yes.
d.	<u>FAA Sec. 107</u>. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	Emphasis is placed on determining the most cost-effective methodologies to increase public awareness of AIDS/safe sex.
e.	<u>FAA Secs. 110, 124(d)</u>. Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	This is multilateral project. The 25% host country contribution is not applicable, although participating countries will contribute to the project.
f.	<u>FAA Sec. 128(b)</u>. If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	The beneficiaries will be primarily groups at high risk of contracting HIV and AIDS. Secondary beneficiaries are the general population. This is not a project which is targetted at the poor majority.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

Not Applicable.

h. FY 1989 Appropriations Act Sec. 536. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No.

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

i. FY 1989 Appropriations Act. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No.

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

Not Applicable.

j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Not Applicable. The project will buy-into an existing contract.

k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

None. Consideration will be given to the selection of a Gray Amendment firm to evaluate the project.

l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase

Yes.

No.

Not Applicable.

production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k)/utilize the resources and abilities of all relevant U.S. government agencies?

m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b)/take full account of the environmental impacts of the proposed activities on biological diversity?

Not Applicable.

n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

No.

o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

No.

p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA;

Not Applicable.

(c) being provided, when conistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

q. FY 1989 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified?

Not Applicable.

DETAILED BUDGETS

Table D-1

Phase I: Summary Project Budget by Funding Source

	WHO/GPA	AIDSTECH BUY-IN	AIDSTECH CORE	AIDSCOM BUY-IN	AIDSCOM CORE	CAREC GRANT	PSC, EVAL & COMMODITIES	TOTAL
Salaries	16,500	195,749	20,885	100,176	133,095	204,329	210,000	880,734
Consultants		33,921	10,079	88,792				132,792
Equipment/Materials	42,700	8,500					20,000	71,200
Travel		158,638	11,668	98,069	36,612	109,468		414,455
Subagreements		230,945	97,413	75,384	25,000	160,000	30,000	618,742
Other Direct Costs	240,800			280,144	108,879	933,282		1,563,105
G&A/Indirect Costs		222,247	31,565	157,435	78,505	182,921		672,673
TOTAL	300,000	850,000	171,610	800,000	382,091	1,590,000	260,000	4,353,701

Table D-2

Phase I: Summary Project Budget by Implementing Agency

	AIDSCOM BUY-IN	AIDSTECH BUY-IN	CAREC GRANT	PSC, EVAL & COMMODITIES	TOTAL
Salaries	100,176	195,749	204,329	210,000	710,254
Consultants	88,792	33,921			122,713
Equipment/Materials		8,500		20,000	28,500
Travel	98,069	158,638	109,468		366,175
Subagreements	75,384	230,945	160,000	30,000	496,329
Other Direct Costs	280,144		933,282		1,213,426
G&A/Indirect Costs	157,435	222,247	182,921		562,603
TOTAL	800,000	850,000	1,590,000	260,000	3,500,000

The above tables address Phase I costs only.

Table D-3
Phase I: Summary Project Budget by Implementing Agency and Line Item

LINE ITEM	FY 1989 AIDSCOM BUY-IN	FY 1989 AIDSTECH BUY-IN	FY 1989 CAREC GRANT	FY 1989 TOTAL	FY 1990 AIDSCOM BUY-IN	FY 1990 AIDSTECH BUY-IN	FY 1990 CAREC GRANT	FY 1990 TOTAL	FY 1991 AIDSCOM BUY-IN	FY 1991 AIDSTECH BUY-IN	FY 1991 CAREC GRANT	FY 1991 TOTAL	PHASE I PROJECT TOTAL
Salaries	38,570	97,249	17,000	152,819	46,031	74,000	89,205	209,236	15,575	24,500	98,124	138,199	500,254
Consultants	29,205	25,921		55,126	47,107	8,000		55,107	12,480			12,480	122,713
Equipment/Materials		8,500		8,500									8,500
Travel	30,457	92,111	29,468	152,036	58,368	50,027	40,000	148,395	9,244	16,500	40,000	65,744	366,175
Subagreements	41,920	127,315	35,000	204,235	21,464	73,630	80,000	175,094	12,000	30,000	45,000	87,000	466,329
Other Direct Costs	74,885		219,452	294,337	128,006		353,500	481,506	77,253		360,330	437,583	1,213,426
G&A/Indirect Costs	47,632	125,418	39,120	212,170	80,889	70,054	73,152	224,095	28,914	26,775	70,649	126,338	562,603
TOTAL	262,669	476,514	340,040	1,079,223	381,865	275,711	635,857	1,293,433	155,466	97,775	614,103	867,344	3,240,000
			PSC/Commodities	80,000			PSC/Commodities	75,000		PSC/Evaluation/Commodities		105,000	260,000
				1,159,223				1,368,433				972,344	3,500,000

LINE ITEM	1989 AIDSCOM BUY-IN	1990 AIDSCOM BUY-IN	1991 AIDSCOM BUY-IN	TOTAL	1989 AIDSTECH BUY-IN	1990 AIDSTECH BUY-IN	1991 AIDSTECH BUY-IN	TOTAL	1989 CAREC GRANT	1990 CAREC GRANT	1991 CAREC GRANT	TOTAL	PHASE I PROJECT TOTAL
Salaries	38,570	46,031	15,575	100,176	97,249	74,000	24,500	195,749	17,000	89,205	98,124	204,329	500,254
Consultants	29,205	47,107	12,480	88,792	25,921	8,000		33,921					122,713
Equipment/Materials				0	8,500			8,500					8,500
Travel	30,457	58,368	9,244	98,069	92,111	50,027	16,500	158,638	29,468	40,000	40,000	109,468	366,175
Subagreements	41,920	21,464	12,000	75,384	127,315	73,630	30,000	230,945	35,000	80,000	45,000	160,000	466,329
Other Direct Costs	74,885	128,006	77,253	280,144					219,452	353,500	360,330	933,282	1,213,426
G&A/Indirect Costs	47,632	80,889	28,914	157,435	125,418	70,054	26,775	222,247	39,120	73,152	70,649	182,921	562,603
TOTAL	262,669	381,865	155,466	800,000	476,514	275,711	97,775	850,000	340,040	635,857	614,103	1,590,000	3,240,000
										PSC, Evaluation & Commodities			260,000
													3,500,000

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY THIRD STREET N.W. WASHINGTON D.C. 20037 U.S.A. CABLE ADDRESS OFSANPAN

TELEPHONE 861-3200

IN REPLY REFER TO: HST-HIV/67/2CAREC

JUN 29 1989

Mr. Larry Armstrong
Acting Director
USAID RDO/C
Box 302
Bridgetown, Barbados

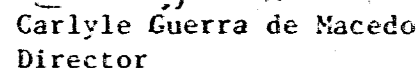
Dear Mr. Armstrong:

As you are no doubt aware, the Pan American Health Organization (PAHO), with the collaboration of the World Health Organization's Global Program on AIDS, organized a major donor's meeting in December, 1988, to raise funds for a major subregional Program for the Prevention and Control of AIDS in the Caribbean. We were very pleased by the enthusiastic support of the international donor community in terms of the pledges made at this meeting.

On behalf of PAHO's Member Countries and the Caribbean Epidemiology Center (CAREC), which is administered by PAHO for these countries, I wish to request your financial support for CAREC's portion of the subregional AIDS Program, as agreed upon at the Barbados meeting. After appropriate review of necessary documents, I will authorize Dr. F. White, Director, CAREC, to sign the final agreements on my behalf.

We look forward to continued collaboration with USAID in the Caribbean.

Sincerely yours,



Carlyle Guerra de Macedo
Director

CARIBBEAN SUBREGIONAL MEDIUM TERM PROGRAMME

FOR

THE PREVENTION AND CONTROL OF AIDS

1989 - 1991

CARIBBEAN EPIDEMIOLOGY CENTRE (CAREC)
P.O. Box 164
Port of Spain, Trinidad, W.I.
Telephone: (809) 622-4261/2; 3277
Telex: 22398
Fax: (809) 622-2792

September 1988

(1) EXECUTIVE SUMMARY

The Caribbean Epidemiology Centre (CAREC) is a Pan American Health Organization/World Health Organization (PAHO/WHO) administered Centre supported by eighteen English speaking Caribbean countries and Suriname, a Dutch speaking country. All member countries are islands except three - Belize in Central America and Guyana and Suriname in South America. The total population served is 5.5 million. CAREC was established as a result of recognition by these countries that it would be to their advantage to share resources which could not practically be supported individually. The Centre is supported by quota payments by member Governments, PAHO/WHO and extrabudgetary grants.

CAREC is a resource Centre for health surveillance, epidemic investigation, training, and laboratory services in Virology, Bacteriology, Parasitology and Entomology. Close links are maintained with national health authorities in member countries through a disease reporting system, the printing and distribution of a monthly Surveillance Report, and laboratory services including courtesy transport of specimens by regional airlines. The staff of CAREC has had very substantial experience in the management of subregional programmes funded by International Agencies, delivered on time and within budget. The laboratory facilities have been maintained to international standards for safety and quality.

CAREC has played an important role in establishing national awareness of AIDS among member countries and has distributed PAHO and WHO guidelines to national counterparts. The establishment of national committees was encouraged at a meeting of Caribbean Health Ministers, June 1986 and at a Workshop for designated National Epidemiologists held at CAREC in January 1986. Objectives were to review the epidemiological and health educational aspects of AIDS in the Caribbean and to develop a Caribbean action plan in respect of AIDS. The nineteen National Epidemiologists requested CAREC to act as the Caribbean Regional Coordination Centre in respect of surveillance, relevant research and for the production of appropriate education materials. This was endorsed by the nineteen Ministers of Health.

In November 1987, CAREC organised an AIDS Programming and Funding Workshop with funds provided by the WHO Special Programme on AIDS and technical inputs from PAHO and WHO staff. This workshop was attended by senior representatives of CAREC 19 member countries as well as donor agencies*, and provided an opportunity to agree upon a common approach to AIDS, including preparation of national plans (Short Term 1988 and Medium Term 1989-1991).

The late Director of CAREC presented to the representatives of the donor agencies a preliminary proposal for a Subregional Project which had been prepared in consultation with the Government representatives attending the Workshop. The consultation process underlined the commonality of needs between countries. The Subregional Project has been subsequently prepared in the light of the dialogue at the Workshop and the opportunity to review national plans. At all stages of its development, it was agreed that the Subregional Plan should complement national plans and cover those activities which are most effectively and efficiently undertaken subregionally.

The CAREC Subregional Medium Term Plan is intended to provide a working framework for providing assistance to member countries in their fight against AIDS. The document provides potential donors with a plan which, it is hoped, will stimulate and further strengthen the collaboration with member countries to achieve overall objectives and goals of AIDS Prevention and Control.

The plan has been prepared following guidelines by the World Health Organization Global Programme on AIDS, taking into account the internationally agreed policies and strategies to protect public health and individual rights, maintain the dignity of individuals and population groups, avoid discrimination of patients, infected persons, their families and friends.

Priorities and strategies in the plan document have been set based on the epidemiological patterns of AIDS in the subregion and the review of national Medium Term Plans. The major preventive strategies adopted by the member countries will be supported by the Subregional Programme through assistance in the Epidemiological Surveillance; promotion and exchange of information, education and communication; collaboration and coordination between member countries; promotion of national programme management including monitoring and evaluation.

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* Overseas Development Administration; Commission of the European Communities; United States Agency for International Development; United Nations Development Programme; Project Hope; UNFPA; International Planned Parenthood Federation/Western Hemisphere Region; Inter-American Development Bank; Canadian International Development Association.

AIDS was first reported in the Caribbean in 1982 in Jamaica. Since then, the number of cases has been rapidly increasing with 827 cumulative cases reported upto June 1988 and 492 (59.5%) deaths. The cumulative case rate in the Caribbean is amongst the highest in the world. The reported cases demonstrate a shift in the pattern of transmission from an initial preponderance of male homosexuals/bisexuals to a mainly heterosexual transmission, with increasing number of women and children affected with AIDS. Of the cases reported in 1986, 27% were among heterosexual contacts; this proportion increased to 53% in 1987. In all major countries, the numbers of heterosexuals with AIDS has been increasing. The male to female ratio among reported cases is declining.

The HIV seroprevalence in different population groups with risk behaviour show rates ranging from 14-40% among homosexual/bisexual males, 4-10% among prisoners, 1.5-10% among prostitutes, 2% among cocaine users and 0.1-2% among STD clinic attendees.

It can be estimated, based on current data, that by the end of 1988, the cumulative figure could reach 1,000 with an unknown, but many times larger number of seropositives. Given the prevailing pattern of sexual behaviour and the evidence of rapid spread of HIV from homosexual to heterosexual population, it is inevitable that the sexual transmission of HIV will continue to increase in the Caribbean. This will in turn have a direct bearing and implication on perinatal transmission of HIV. Perinatal transmission is already a substantial problem in many countries; 10% of all reported AIDS cases are among children under 15 years of age.

The priorities for the Prevention and Control of HIV infection and AIDS in the subregion respond to existing epidemiological evidence. It emphasizes the paramount importance to prevent sexual transmission of HIV. It further addresses the prevention of perinatal transmission, transmission through blood and blood products, and strengthening of epidemiological surveillance. It finally focuses on reduction of impact of HIV on individuals, groups and societies; and also on the promotion of programme management at country level. Each strategy includes discussion on background and justification and plan of action during the Medium Term Plan.

In the most critical area of sexual transmission, objectives of Subregional Plan focus on development and further strengthening of national education programmes following KAP surveys, development and distribution of locally acceptable health education materials, promotion and exchange of IEC experiences, and strengthening further collaboration and coordination between member countries.

Approaches planned for the prevention of transmission through blood/blood products stress the need to strengthen blood transfusion services and to maintain quality control for national laboratories. This calls for extensive training of health care personnel and laboratory technicians. Use of blood/blood products will be rationalized through the strict application of indications for blood transfusion. Voluntary donor self deferral will continue.

Specific approaches for the prevention of perinatal transmission in the member countries include design and implementation of education and counselling for infected pregnant women, HIV positive mothers and women at risk. This also calls for studies to quantify risk of perinatal transmission of HIV and to promote behavioural research relevant for prevention of perinatal transmission.

To reduce the impact of HIV on individuals, groups and societies, CAREC will provide support for national training workshops for health care workers, adapt counselling and nursing guidelines to the Caribbean situation, and assist, promote and coordinate studies related to assessment of social and economic impact of HIV.

The specific approaches for strengthening of Epidemiological Surveillance in the Caribbean will include the collection and analysis of reported data from all countries on AIDS and HIV infection, assisting in design and conduct of HIV seroepidemiological surveys in persons with high risk behaviour, establishing sentinel sites for serosurveillance to monitor rates of HIV infection and design, and conducting of case control and cohort studies. The Centre will assist in behavioural studies to evaluate knowledge, attitude and practice of the general population and those groups whose sexual behaviour places them at particular risk.

Most importantly, the Subregional Programme strives to promote effective management of the national programmes including the monitoring and evaluation of the programmes.

All these approaches and activities need assistance in terms of supplies and equipment, as well as support in institutional strengthening including training of present staff as well as hiring of additional staff.

Management of the Subregional Programme will be coordinated through CAREC (through the AIDS Prevention and Control Unit and the GPA Caribbean Education and Information Centre). The programme will be supported by the Laboratory and Surveillance Units. Technical advice and guidance will be provided by PAHO/WHO.

Indications for monitoring and evaluating specific activities have been built into the plan. These will guide periodic programme evaluation and policy review. Epidemiological Surveillance and behavioural research in countries will provide evidence to assess the programme accomplishments.

The programme outlined in this document contains a work plan for three years and a budget estimate. The financial requirements for three years is US$[illegible],798,8[illegible]6, of which US$1,7[illegible]5,447 will be required for the first year, 1989.

ILLUSTRATIVE IMPLEMENTATION PLAN
AIDS COMMUNICATIONS AND TECHNICAL SERVICES
(BY CALENDAR YEAR QUARTERS)

ACTIVITIES	1988	1989	1990	1991	1992	1993	1994
	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

STRATEGY 1: EPIDEMIOLOGY/KAP

HIV SURVEILLANCE
- Develop surveillance protocols
- Logistics: surveillance wkshop
- Training workshop (Jamaica)
- TA for systems implementation
- Analyze results
- Logistics: dissemination wkshop
- Dissemination workshop (Trinidad)

EPIDEMIOLOGICAL RESEARCH
- Design research program
- Logistics: research workshop
- Research program workshop (Trinidad)
- Evaluate proposals
- Announce awards
- TA to researchers
- Logistics: results workshop
- Results workshop (Grenada)

STD SYMPOSIA & GRANTS PROGRAM
- Design STD symposium program
- Logistics: symposium
- Symposium & grants announcements
- Evaluate proposals
- Announce awards
- TA to researchers
- Logistics: Follow-up symposium
- Follow-up symposium/results (St V)

KAP SURVEYS
- Develop KAP guidelines/models
- Logistics: KAP workshop
- Regional KAP workshop
- National KAP follow-up workshops
- TA for baseline KAP surveys
- TA for disseminating results
- TA for high risk group KAPs
- TA for follow-up surveys

ILLUSTRATIVE IMPLEMENTATION PLAN
AIDS COMMUNICATIONS AND TECHNICAL SERVICES
(BY CALENDAR YEAR QUARTERS)

ACTIVITIES	1988	1989	1990	1991	1992	1993	1994
	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
STRATEGY 2: SEXUAL TRANSMISSION							
COMMUNICATION/EDUCATION PROGRAMS							
Logistics: Carnival strategies wkshop		4					
Carnival strategies workshop (St L)			1				
Follow-up TA: Carnival strategies			1-4				
Logistics: other communications wkshps				1	1	1	1
Other communications workshops				2	2	2	2
Follow-up TA for workshops				2-4	2-4	2-4	2-3
INNOVATIVE COMMUNITY APPROACHES							
Develop guidelines for PVO grants		3					
Announce grants program		3		3	3	3	
Review/award grants		4	4	4	4	4	
TA/monitoring grant programs		4	1-4	1-4	1-4	1-4	1-3
Report results of small grants			3	3	3	3	3
TRAINING HEALTH & COMMUNITY PERSONNEL							
Logistics: health eductors workshop			2	2		2	
Health educators workshop (Barbados)			2	2		2	
Logistics: counselling workshop			3		3		3
Counselling workshop (Trinidad)	3	1	4		4		4
Prepare counselling manual	3-4	1-2					
Disseminate counselling manual		3-4	1-4	1-4			
Training workshop (Bah)		1					
AIDS INFORMATION HOTLINES							
Pilot test hotline (Trinidad)	4	1-3					
Develop hotline training materials	3	3					
Pilot test hotline materials	4						
Logistics: hotline workshop		3					
Hotline workshop (Antigua)		4					
Develop data collection systems		3					
Follow-on TA for hotlines		4	1-4	1-4	1-4	1-4	
Evaluate hotlines				4	4		
MEDIA COLLABORATION							
Develop media liaison program		4					
Design media training kits			1				
Logistics: media workshop			1	1	1	1	1
Media workshop			2	2	2	2	2
Develop & disseminate media info kits		4	2, 4	2, 4	2, 4	2, 4	2-3
STD CLINIC UPGRADING							
Identify target clinics for TA		1					
Develop upgrading strategy		3					
Prepare renovations workplan		4					
Design staff training programs		4					
Implement training programs			1-4				
Evaluate upgrading activity							

ILLUSTRATIVE IMPLEMENTATION PLAN
AIDS COMMUNICATIONS AND TECHNICAL SERVICES
(BY CALENDAR YEAR QUARTERS)

ACTIVITIES	1988	1989	1990	1991	1992	1993	1994
	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

MODEL COUNTRY PROGRAMS
- Needs assessment visit: country 1
- Develop country proposal
- Hire local advisor/begin TA
- Evaluate country 1: report results
- Needs assessment visit: country 2
- Develop country proposal
- Hire local advisor/begin TA
- Evaluate country 2: report results
- Follow-up TA for additional countries

BEHAVIOR INTERVENTION PROGRAMS
- Develop Antigua High Risk proposal
- Implement program
- Assess results
- Follow-on TA for replication
- Develop Barbados High Risk proposal
- Implement program
- Assess results
- Follow-on TA for replication
- Develop St. Lucia High Risk proposal
- Implement program
- Assess results
- Follow-on TA for replication
- Develop Trinidad High Risk proposal
- Implement program
- Assess results
- Follow-on TA for replication
- Logistics: results workshop
- Results workshop: St Lucia

CONDOM USE STUDIES
- Develop proposal
- Implement program
- Assess results
- Follow-on TA for replication

ILLUSTRATIVE IMPLEMENTATION PLAN
AIDS COMMUNICATIONS AND TECHNICAL SERVICES
(BY CALENDAR YEAR QUARTERS)

ACTIVITIES	1988				1989				1990				1991				1992				1993				1994			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
MANAGEMENT COSTING ALTERNATIVES																												
Develop T'dad Screened Blood proposal				----																								
Implement program					---	---																						
Assess results						-																						
Follow-on TA for replication						---	---	---	---	---	---	---	---	---	---	---												
Develop T'dad Cost Recovery proposal				----																								
Implement program						---	---																					
Assess results								-																				
Follow-on TA for replication								---	---	---	---	---	---	---	---	---	---	---	---	---								
Develop Barbados Hospice proposal				----																								
Implement program						---	---	---																				
Assess results								--																				
Follow-on TA for replication									---	---	---	---	---	---	---	---	---	---	---									
TA for project sustainability																	---	---	---	---	---	---	---	---	---	---	---	
Logistics: institutionalization wkshop																	----								----			
Institutionalization workshop																		-								-		
PROJECT EVALUATION																												
Interim Evaluation													----															
Final Evaluation																											----	

June 16, 1989

ACTION MEMORANDUM FOR THE ACTING DIRECTOR

FROM: Gail A.W. Goodridge, SHA,

THRU: Carol R. Becker, AC/HPE

Subject: AIDS Communications and Technical Services Project (538-0161)

Action Requested: That you (1) authorize the AIDS Communications and Technical Services (ACTS) Project (538-0161) by signing the Project Authorization and Project Data Sheet and (2) approve the two Project Implementation Orders for Technical Services to Family Health International and to the Academy for Educational Development for incremental funding of project services from the AID/W-managed AIDSTECH and AIDSCOM programs, respectively.

Background: In the 1988 AAP Cable the Mission was given approval to undertake a four-year $3.5 million AIDS prevention program through buy-ins to two AID/ST/H programs, AIDSCOM and AIDSTECH. Two buy-ins were effected that year. Following a December 1988 Donors' Meeting on the World Health Organization/Global Program on AIDS-assisted Medium Term Plans (MTPs) for the Caribbean, the Mission decided to expand its Project design to include more direct support for the region's MTPs via a grant to the Pan American Health Organization and its regional representative, the Caribbean Epidemiology Centre (CAREC). This expansion of the project required development of a full Project Paper as earlier obligations had been made pursuant to the authorization contained in the S&T/Health project on AIDS.

Discussion: On April 6, 1989 A PID Review Committee meeting was convened. As a result of the meeting, it was determined that the Mission should request AID/Washington to provide authority to extend the life of project length and funding to 7 years and $7 million, respectively. The Mission also decided that the activities which had been initiated under buy-ins to the S&T/Health project in FY 88 should be integrated into the overall project. The issue was reviewed and approved at the New Project Description Meeting on the FY90 Annual Action Plan of May 30, 1989 with AA/LAC Fred Schieck. To avoid unnecessary delay in obligations, AID/W provided the Mission preliminary notice of approval in STATE 182374, dated June 8, 1989 (attached). Confirmation of that approval is expected in the pending Action Plan Approval cable. Other issues in the PID Review were resolved and incorporated into the PID.

On June 12, 1989 the Project Review Committee met to discuss the AIDS Communications and Technical Services Project Paper. The following issues were raised in that meeting:

1. Institutionalizing social/behavioral and health communications skills at CAREC. The Committee determined that, since this was one of the important benefits of the Project, it should be stated as both a project output and an EOPS element. This has been incorporated into the Project Paper.

2. Geographic focus. The Committee questioned whether the Project should include Barbados and Trinidad/Tobago as eligible countries for assistance under the Project. Participation by the region's more advanced developing countries (e.g., Trinidad/Tobago and Barbados) while not prohibitted, is generally provided in AID-financed projects only on a limited or non-primary beneficiary basis, since the main thrust of RDO/C's assistance is intended for the OECS-member states. In the case of the AIDS Communications and Technical Services Project, there are several compelling arguments for including these two countries. Specifically, (a) the AIDS rates in both countries suggests that the need is great, (b) with larger population sizes, activities can be more effectively pilot-tested in these countries for later diffusion to our primary target countries, (c) the intense migration within the Eastern Caribbean suggests that successful AIDS control programming cannot be effected without including Trinidad and Barbados, and (d) the major implementing agency (CAREC) is based in Trinidad and is already closely linked to assisting Trinidad in specific areas of AIDS prevention and control. Clearly, the substantive involvement of both countries, through the undertaking of specific activities within them, will be essential to the attainment of Project objectives. Project activities directed at Trinidad/Tobago and Barbados should account for no more than $350,000 out of the $7 million of Project funds.

3. Length of Project. As noted above, the Mission requested and has received approval for authorizing a seven year, $7 million project, with a PACD of September 30, 1995.

4. Phase II Design Steps. The absence of specificity of Phase II (1992-1994) activities was noted, however, the Committee concurred with the rationale which mandated that Phase II activities be defined in broad terms at the present time. It was further agreed, nonetheless, that the Paper should be strengthened with a clearer description of the documentation and steps which will be required before Phase II activities are approved Specifically, the Project Paper notes that a comprehensive evaluation will be undertaken of Phase I activities. Based on the recommendations from this evaluation, worldwide AIDS program experience at that time, and the

epidemiological picture, a Project Paper Supplement/Amendment will be prepared to outline the exact project description, specific outputs, EOPS indicators and budget for Phase II. Should any changes be warranted in the implementation strategy for the Project, the PP Supplement/Amendment will include the revised requisite analyses.

5. Policy Dialogue. The Committee agreed that it was important to note RDO/C's support of the World Health Assembly Resolution WHA42.34 which promotes the inclusion of non-governmental (including private voluntary and private sector) organizations (NGOs) in the implementation of the national AIDS plans. The importance of using NGOs, including specific examples of relevant areas of collaboration, have been included in the Project Paper, the Project Grant Agreement with PAHO, and the Project Implementation Orders for Technical Services with AIDSCOM and AIDSTECH. It will remain in the forefront of all discussions and project activities and will provide ample basis for more direct policy level dialogue if warranted.

Justification: In accordance with Delegation of Authority No. 752, you have authority to approve projects within the parameters of this project. The FY 90 Action Plan approval cable, which will provide AID/W's concurrence with the specific proposal to extend the LOP time and funding is pending final clearance in AID/W. However, as noted above, STATE 182374 has provided tentative concurrence to approve a $7 million, 7 year AIDS Project. This project was included in the FY 1989 Global Report to Congress and, therefore, requires no further Congressional Notification.

Recommendation: That you (1) authorize the AIDS Communications and Technical Services (ACTS) Project (538-0161) by signing the Project Data Sheet and Project Authorization and (2) approve the two Project Implementation Orders for Technical Services to Family Health International and to the Academy for Educational Development for incremental funding of project services from the AID/W-managed AIDSTECH and AIDSCOM programs, respectively.

Approved Thomas Fal[signature]

Disapproved ____________

Date 6/19/89

Drafted by SHA:GAWGoodridge/PDO:JWooten:acw-o:0776c:6/16/89

CLEARANCES:

PDO:JWooten	Draft
C/PDO:DChiriboga	(draft)
CONT:TFallon	(draft)
A/C/PRM:RGrohs	(draft)
D/PRM:CKeller	(draft)
RLA:RJohnson	(draft)