Canadian International Development Agency | Agence canadienne de développement international

Evaluation of the CAREC-CIDA HIV/AIDS Project - Executive Summary

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Canada

Executive Summary

Introduction

The Caribbean has the second highest Acquired Immuno Deficiency Syndrome (AIDS) prevalence rate in the world – second only to sub-Saharan Africa – and the highest in the western hemisphere. This evaluation was carried out just as the Canadian International Development Agency (CIDA) had made a new funding commitment to support HIV/AIDS programming in the Caribbean. The evaluation marked the end of the funding for the first five-year project – Caribbean Epidemiology Centre (CAREC)/CIDA HIV/AIDS Project (CHAP). The focus of this evaluation was the identification of lessons, for each of CHAP's five key results areas, which could be applied in the new programme.

The first phase of the evaluation included a document review and selected interviews with key informants at CIDA and the Canadian Public Health Association (CPHA). The second phase was a field mission to the Caribbean to carry out country case studies in three countries (Antigua and Barbuda, St Kitts and Nevis, Trinidad and Tobago) and to meet with the staff of CAREC and other donor and regional Caribbean institutions.

The following sections highlight the results with respect to each result area and summarize lessons and recommendations.

Result Area #1: Effective Management of National AIDS Programmes (NAPs) with Non-Governmental Organizations (NGO)/Community Based Organization (CBO) participation

Promotion by the Special Programme on Sexually Transmitted Infections (SPSTI) of the expanded approach to responding to HIV/AIDS has the potential to make a significant contribution to the response in-country. The advocacy of the unit and external stakeholders has effectively set the stage, in some countries, for the strategic planning process. It has resulted, in some countries, in increased resources for the NAP and interest among other sectors in participating in a multi-sectoral response. It has accomplished this by:

- securing political commitment and the resources for, and increasing the level of interest in, an expanded response;
- using information on the economic impacts of the epidemic, provided in advocacy sessions with Parliamentarians and senior decision-makers to generate considerable political interest and commitment.
- involving a wide range of partners, as a means of increasing their participation in the response to HIV/AIDS.

Encouraging, and providing mechanisms for, National AIDS Programmes to involve a wide range of stakeholders, including People Living with HIV/AIDS (PLWHAs), other government ministries, non-governmental organizations (NGOs) and the private sector in developing an HIV/AIDS strategic plan has the potential to strengthen the HIV/AIDS response. However, the extent to which this will result in a more effective response to the epidemic remains to be seen as no country has yet completed the expanded response strategic planning process. Getting

stakeholder commitment to develop plans, allocate resources and then follow through on their commitments is a challenging process.

A challenge for SPSTI will be to ensure that countries "own" their strategic planning process and that it does not become an exercise to complete simply for SPSTI. This will require not only political and bureaucratic commitment, but also a strong in-country team. SPSTI should involve member countries that are successful in developing and implementing a strategic plan in providing technical assistance to other countries.

SPSTI's support for the non-governmental sector and, specifically PLWHAs, has been a positive contribution to expanding the response to HIV/AIDS. The direct support has been limited to one regional NGO, however plans are in place to develop a mechanism to support national NGOs. SPSTI needs to establish an approach for providing this support while not undermining the relationship between the NAPs and local NGOs. This should include organizations dealing with women's and family issues. HIV/AIDS is not seen as women's issue, yet there is an increased trend in infection rates for women. Ministries of gender or women's affairs, which exist in many Caribbean countries, have not yet become real stakeholders in addressing HIV/AIDS issues.

Local NAPs, often with funding from SPSTI, have encouraged and supported the participation and empowerment of PLWHAs. However, since the support has not had an impact either on lessening the discrimination and stigmatization of PLWHAs or increasing the availability of care and treatment for people who are HIV+, there is still little incentive for PLWHAs to disclose publicly their status and participate in the response to the epidemic.

Result Area #2 – Design and delivery of strong programmes promoting positive attitudes to PLWHA and healthy sexual behaviours

The implementation and encouragement of strong health promotion programmes has been key to the HIV/AIDS response, particularly at the country level. SPSTI has done much to support countries by providing materials and funding specific programmes. SPSTI has been particularly successful in promoting a more positive approach within the media to addressing HIV/AIDS issues. Key factors in this success have been:

- The commitment of politicians and senior decision-makers in promoting "buy-in" to the HIV/AIDS health promotion messages; and
- The involvement and training of a cross-section of stakeholders, including community members (particularly PLWHAs) in the development and promotion of health messages.,

HIV/AIDS messages are not sufficient to promote behavioural change. Regional and local efforts have reportedly resulted in a high level of awareness of HIV/AIDS, but limited change in behavioural practices. This is the next challenge facing SPSTI. This will require:

- innovative approaches that take into account the socio-economic and cultural environments in which behavioural decisions are made;

- supporting the development of behavioural science skills for the design and implementation of programmes, including working with universities and NGOs;
- designing, testing and evaluating specific behavioural changes initiatives; and
- long-term commitments to continuous interventions, interventions that emphasize training people to be leaders and provide new programmes, and sustainable funding.

More emphasis has been placed on promoting healthy sexual behaviours than on addressing the need for more positive attitudes to PLWHAs. Stigma and discrimination have effectively driven the epidemic underground which weakened prevention and care and support efforts. People are stigmatised in the community, in the workplace, as well as in the health care setting. This, coupled with the lack of treatment (in particular antiretroviral treatment) for HIV/AIDS, results in PLWHAs refusing to come forward and in behaviour change messages being largely ignored in this fatalistic atmosphere.

To its credit, CAREC has given major support to Caribbean Regional Network of People Living with HIV/AIDS (CRN+), in particular in the area of capacity building and providing opportunities for advocacy with policy-makers for a greater focus on HIV/AIDS. However, given the strategic importance of action against stigma and discrimination, CAREC needs to respond in a more vigorous, comprehensive manner, with a concomitant level of funding, to this issue. It needs to build on the credibility that it has in member countries to advocate for this framework as strongly as it has advocated for the strategic planning process.

Trinidad benefits particularly from the presence of CAREC in the country. SPSTI carries out IEC activities directly in the country – some of which are also destined for use in other countries – and provides support not provided in other countries. This raises the question of whether, because of a weak response to HIV/AIDS in Trinidad and Tobago, SPSTI is substituting itself for the NAP.

Result area #3 – Strengthening community-based diagnostic, care and support for persons infected with HIV and STDs

Testing

Support for HIV testing in the region represents a primary CAREC strength. Two units at CAREC have worked together effectively, with considerable presence in-country, to strengthen and monitor the HIV testing capacity. The result is a minimum quality of laboratory services in all member countries and a system for coding HIV test samples. This strengthening of national capacity has required a mix of supports (including technical policy-setting, development of guidelines, reference laboratory and intensive hands-on support) and in-country presence. The challenge for CAREC and SPSTI is to expand on that strength to address the implications and opportunities of new technologies and to strengthen the testing capacity in areas beyond HIV (including testing for Hepatitis B and C, and TB, and CD4, viral load and PCR testing).

CAREC and SPSTI will also need to develop a strategy for conducting the other tests required for the effective management of HIV/AIDS – CD4, viral load and PCR testing – either by developing the capacity at CAREC or in member countries. Since some countries are already accessing these tests outside the Caribbean, there is a risk that CAREC's credibility will be

diminished in the testing area and this will undermine efforts to improve HIV/AIDS surveillance.

The major weakness in the HIV testing capacity remains the lack of confidentiality in the system that has become normative in the absence of specific protocols, monitoring and evaluation, and sanctions. This is an area in which SPSTI needs to lobby for member country governments to take concrete action to provide safeguards for patients, by developing legal and ethical protections for PLWHAs, encouraging countries to provide more training, develop standards and guidelines for confidentiality in testing and impose sanctions against staff who breach confidentiality.

Care and treatment

SPSTI has supported successful workshops for health workers. However, the impact of these is limited in face of the great need to improve attitudes and practices among a wide range of health care workers providing care for patients who are HIV+. More needs to be done to identify specific problems in member countries and then identify country-specific solutions, implement them, monitor changes and provide sanctions for non-compliance.

The development of the regional clinical management guidelines has the potential to result in significant improvements in the care of PLWHAs. However, to date, there is no systematic plan for their dissemination and implementation. The advocacy capacity of CAREC and SPSTI needs to be directed towards the promotion of these guidelines in a systematic way through on-going educational and training programmes for physicians, nurses and other staff in health care institutions and in the community.

A major gap in care and treatment for PLWHAs is the lack of affordable Antiretroviral retroviral (ARV) drugs. Currently CAREC does not play a role in addressing this gap. However, the institution is well-positioned to lobby for the issue of drug accessibility to be addressed by partner organizations, such as Pan American Health Organization (PAHO), UNAIDS and Caribbean Community (CARICOM). CAREC could provide technical support to these initiatives in determining the basket of drugs best required by the region, in light of the strain of virus present, as well as identifying the testing equipment and supplies required and partnerships inside or outside the region for execution of more complex tests (e.g. viral load).

Improvements in care and treatment are important, not only for moral, ethical and economic reasons, but also because, until a minimum package of care is available for PLWHAs, individuals will not be motivated to come forward for testing, disclose their HIV+ status and be part of the response to the epidemic.

Support

Support arrangements for PLWHAs vary considerably from country to country. For the most part, support is provided outside the public health system. In some countries, the NAP plays a role in PLWHA support. In other countries, NGOs made up of PLWHAs are slowly developing and these provide informal support to PLWHAs. SPSTI should encourage member countries to offer a minimum package of services for PLWHAs that includes voluntary counselling and testing, adequate levels of care in institutions and the community, and the

provision of disability benefits.

Emphasis in the NAPs has been on developing more trained volunteers to provide resources. SPSTI needs to advocate for the inclusion of support within the health system and to promote the training of professional counsellors in HIV/AIDS issues.

Result Area #4 – Strengthening of the HIV/AIDS tracking systems at regional and country level

In spite of more than ten years of struggle to develop adequate HIV/AIDS surveillance systems, this is probably one of the weakest components of SPSTI's current activities and this is reflected in poor data from member countries. It is also an area in which there appears to be less effective collaboration between SPSTI and the CAREC Epidemiology Division than between SPSTI and other CAREC Divisions. SPSTI has also been hampered by a limited culture of using information for decision-making and limited development, implementation and evaluation of surveillance systems in member countries.

The recent establishment of the surveillance cluster has the potential to strengthen in-country surveillance. However, the work plan developed by the cluster does not reflect the on-going, hands-on support that is likely required to make signification changes in the surveillance capacity in member countries. Yet, to provide adequate support for all member countries, SPSTI needs more epidemiology capacity in the unit.

This is an area in which SPSTI needs to build on its experience with advocacy for the development of national strategic plans in order to develop the surveillance capacity in member countries that includes a mix of supports (including hands-on support) and promotes first, second and third generation surveillance.

In countries in which the on-going surveillance capacity is weak and will continue to be so for the medium-term, SPSTI should provide the necessary support for seroprevalence or sentinel site surveillance studies, particularly among easy-to-reach target populations at antenatal and STD clinics. More support from SPSTI might be required for the more difficult target populations – men who have sex with men (MSMs) and commercial sex workers.

Result Area #5 – Effective monitoring and evaluation of the Project

A common reporting framework for all donors has been developed and its implementation may be expected to result in improvements in reporting to partner agencies and may contribute to improved coordination among donors. Respondents identified that, generally speaking, donor coordination in the area of HIV/AIDS programming is weak in the Caribbean. There appears to be competition among the donors for funding and recognition in the area.

SPSTI needs to align its own planning processes with those of member countries. As national strategic plans are developed, it will be important that SPSTI orient its own planning to respond to the needs identified in national plans. In order to confirm its own plans and increase commitment of member countries, SPSTI might consider the development of memoranda of understanding between SPSTI and member countries that reflect the commitments of both to specific results.

The UNAIDS model for strategic planning calls for a monitoring and evaluation component in

the strategic plan. There will be a role for SPSTI, in collaboration with UNAIDS, in providing technical support to member countries for the implementation of monitoring and evaluation.

As a leadership organization in the region, SPSTI also needs to follow-up the programmes that it initiates with a systematic approach to evaluation. These evaluations might be conducted by SPSTI staff or by NAPs, with the technical assistance of SPSTI staff. SPSTI should strengthen its evaluation capacity to conduct, or support NAPs in conducting, evaluations of pilot initiatives carried out in member countries.

Other Issues

Organization and Management of CHAP Activities

CHAP has been managed by SPSTI, which is headed by the Inter-country Adviser on AIDS and includes staff in a range of specialized areas. Individual staff have a strong presence and credibility in member countries. All respondents in the case study countries spoke highly of the support they receive from SPSTI staff on an on-going basis. However, the risk of this highly personalized relationship is that it creates dependence on the part of member countries.

Although the strength of the organization lies in its staff members, there are also gaps in the unit's capacity that need to be addressed – particularly with respect to working with NGOs, counselling, the design and implementation of behavioural change initiatives and epidemiology.

Although individual staff members are aware of strengths and weaknesses of member countries, there is a need for an overall plan to guide the work in any given country – a plan that reflects the initiatives that need to be addressed to strengthen capacity to respond to HIV/AIDS. This planning should involve member countries to ensure harmonization of SPSTI work plans with annual country plans and help in the identification of the technical assistance required from SPSTI in member countries. This would also provide the mechanisms for SPSTI to highlight how its support would be expanded to address key issues, including the involvement of women's organizations, the development of legal and ethical frameworks to protect PLWHAs, voluntary counselling and testing, supporting home-based care, advocacy for increased access to antiretroviral treatments and increased monitoring and evaluation. It would also provide the mechanisms for SPSTI to identify the technical assistance required to carry out the programme.

Given the need to identify and integrate new staff and the need to find ways for SPSTI staff to work effectively with all CAREC units, there is a need for an organizational review which could address both the internal organization of work and on SPSTI's relationships with other CAREC units.

Canadian technical assistance

The technical assistance to CHAP, provided through the CPHA, was a successful, responsive component of the project. However, there does not appear to have been a strategic approach by SPSTI to identifying the technical assistance needs. SPSTI identified all the needs and CPHA responded to the best of its ability. It would be more effective if SPSTI could plan, early in the programming cycle, the technical assistance required to support its own strategic plan, although there should still be flexibility to respond to *ad hoc* requirements.

Almost all respondents – both in-country and at SPSTI – spoke very highly of the technical assistance provided to CHAP by CPHA. Respondents indicated that positive feedback came also from participants in workshops led by CPHA resource people. It was the presence of Canadian technical experts in the Caribbean that provided a profile for Canada in the project.

Responses to the Mid-Term Review

A Mid-Term Review (MTR) was conducted in 1999. For the most part, the Review's recommendations have been implemented. However, there were two recommendations that were not completely implemented and are worthy of mention because they reflect findings from this evaluation:

- The MTR team called for SPSTI to provide services to small, micro and mini-countries in a graded fashion with a minimal standard of service defined for each group, based on existing human resource capacity. SPSTI rejected this recommendation because it felt that funding based on size would not be appropriate. Funding should be determined based on other factors. However, the spirit behind this recommendation seemed to call for a more strategic approach to defining the services to be provided in each country – a recommendation reiterated in this report.
- A further recommendation called for CHAP to develop a work plan dealing with behaviour change and changes in attitudes to focus on achieving sustainable results. This evaluation noted that there is still much to do to achieve sustainable behavioural change results. Initiatives that have been promising in this area are not being repeated because of a lack of resources and they have not been evaluated to provide information for other countries. There is a need to ensure that SPSTI has the best available information on what works in prevention and behavioural change

Management Response

The Caribbean program has provided a management response, prepared by its partner, the Pan American Health Organization, which follows in the next section of the report.

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In Reply Refer To: HCP/194/01
1 October 2001

Ms. Blanka Pelz
Senior Programme Officer
Caribbean Program
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200 Promenade du Portage
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Dear Ms. Pelz,

I wish to acknowledge receipt of the letter of 26 July 2001 and the accompanying draft Final Evaluation Report of the CAREC-CIDA HIV/AIDS Project, and would like immediately to express my appreciation, on behalf of the CAREC team, for the very detailed assessment of the work we undertook under this project during 1996-2001.

We were indeed challenged by the purpose, the goal and the objectives of the project, and can say that we learned several lessons during its implementation. We also benefited tremendously from the collaboration it fostered with our newfound colleagues in Canada, facilitated by our very dependable partner under the agreement, the Canadian Public Health Association (CPHA).

We are quite pleased with the draft Final Evaluation Report, and we are deeply motivated and encouraged by the renewed confidence reposed in us by CIDA to continue in the battle against HIV/AIDS in the Caribbean with the signing of a new agreement to cover the period 2001-2005.

For the record, however, we would like to indicate the following:

- The relationship between CAREC and CPHA has been quite productive, and from our perspective, the association was more than responsive to our needs than the report indicates. CPHA was also intimately connected with our annual planning exercises, including offering advice, and suggesting opportunities for collaboration, and was always able to provide resources that were appropriate to our needs.
- In providing technical assistance to countries to develop their National Strategic Plans, we have always been on course in ensuring that countries "own" their related planning process since we have always considered this a critical success factor in implementing any such plan that demands an expanded response to the epidemic.

In welcoming the assessment and the many valuable recommendations in the report, and agreeing with your wish to share this report with other partners, we know we will also have to be guided by changes that will obviously occur as this epidemic evolves, and as new knowledge becomes available and technology is developed as fillips to our HIV/AIDS prevention and control efforts in our region over the years.

Accordingly, we believe that the new working relationship we have been able to forge with CIDA and our other partners, and which now forms the basis of the agreements in latest Memorandum of Understanding, will provide even greater opportunities to enhance our capabilities to address the many challenges which this epidemic will pose in the future.

Finally, we wish to again welcome you and look forward to working with you in pursuit of CIDA'S very strong indication of its commitment to continue to assist in the fight against HIV/AIDS in the Caribbean.

Please be assured of our highest consideration.

Sincerely yours,

Stephen J. Corber, MD
Director, Division of Disease
Prevention and Control

cc: Dr. C. James Hospedales, Director, CAREC
Dr. Bilali Camara, Head, SPSTI/Project Director