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Evaluation of COMCAVI HIV/AIDS Umbrella Grant Program in Honduras

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EVALUATION OF COMCAVI HIV/AIDS UMBRELLA GRANT PROGRAM IN HONDURAS

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Finally, we thank GH Tech for its support in launching the mission and facilitating logistics, without which this work could not have been realized.

ACRONYMS

AED	Academy for Educational Development
AIDS	Acquired immune deficiency syndrome
BCC	Behavior change communication
BSS	Behavioral Surveillance Survey
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CONASIDA	National Commission on AIDS (Honduras)
DHS	Demographic and Health Survey
FY	Fiscal year
GH Tech	Global Health Technical Assistance Project
HCP	Health Communication Partnership
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
KAP	Knowledge, attitudes, and practices
M&E	Monitoring and evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental organization
PAHO	Pan-American Health Organization
PCS	Population Communications Services Project
PENSIDA III	Third National Strategic Plan to Fight HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PASMO	Pan American Social Marketing Organization
PMTCT	Prevention of mother-to-child transmission
PR	Principal Recipient
PSI	Population Services International
RCC	Rolling Continuation Channel
STI	Sexually transmitted infection
ULAT	Unidad Local de Apoyo Técnico
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAT	Unidad Normativa de Apoyo Técnico
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	Voluntary counseling and testing

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EXECUTIVE SUMMARY

In February 2008 USAID/Honduras contracted with the Global Health Technical Assistance Project (GH Tech) to conduct an evaluation of its umbrella grants program, *Comunicando Cambio para La Vida* (COMCAVI). The scope of work delineated six elements to be assessed:

1. COMCAVI's effectiveness in building the capacity of local nongovernmental organizations (NGOs)
2. Its effectiveness (likely impact) in reducing high-risk behaviors among most-at-risk populations and people living with HIV/AIDS
3. The extent and quality of its voluntary counseling and testing (VCT) services
4. The extent, quality, and likely impact of its care and support services for people living with HIV/AIDS
5. The effectiveness of its coordination with other programs
6. Recommendations for future directions for the USAID HIV/AIDS Program.

Comunicando Cambio para la Vida (COMCAVI)

Beginning in 2002 USAID began a new phase of HIV/AIDS work with Honduran NGOs. The Academy for Educational Development (AED), in collaboration with Population Services International (PSI), won a cooperative agreement to implement the two-year "Communicating Life" (*Comunicando Vida*) project (2002–2004).

When that agreement expired, USAID awarded a new agreement on a competitive basis (2004–2008) to AED, with PSI as the subcontractor. Its purpose was to implement the *Comunicando Cambio para la Vida* (Communicating Change for Life; COMCAVI) Honduras HIV/AIDS Program that helps Honduran NGOs to implement HIV/AIDS prevention and support programs to reach some of the highest-risk populations. Several groups that were awarded grants by *Comunicando Vida* continued as grantees with COMCAVI.

The high-risk populations targeted for this program were men who have sex with men, commercial sex workers, the Garífuna (Afro-Hondurans), and people living with HIV/AIDS in the Central and North Atlantic regions of Honduras. The work is done primarily through a grants program and technical assistance.

The objectives of the program are to

- Strengthen NGO capacity to implement sustainable HIV/AIDS activities.
- Support NGO implementation of high-quality programs that provide care for people living with HIV/AIDS.
- Support NGO implementation of effective HIV/AIDS interventions for most-at-risk populations.
- Assure coordination among NGOs in the program and with other programs and institutions throughout Honduras.

The core areas of capacity building COMCAVI supports are organizational development, programming, and monitoring and evaluation (M&E). COMCAVI awarded grants in three 13- to

15-month Standard Grant Cycles. In Cycle I (February 2005–March 2006), eight NGOs successfully completed the proposed work plan; 11 successfully completed Cycle II (April 2006–March 2007), and 11 are now engaged in Cycle III (April 2007–June 2008).

COMCAVI pioneered a community-based VCT system in collaboration with the Ministry of Health (MOH) to provide two trainings on community-based VCT for Cycle II grantees that were licensed to provide counseling and testing. It also provided rapid test kits and technical assistance to NGOs working with target populations that have the highest HIV prevalence in the country. Guided by the MOH, COMCAVI is using Determine as the diagnostic test and Oraquick as the confirmatory test.

COMCAVI also creates and distributes information, education, and behavior change communication (BCC) tools; supports M&E; and facilitates collaboration and sharing of lessons learned, materials, and best practices among NGOs. To stimulate development of culturally acceptable BCC tools, 10 Replication Grants were awarded to support NGOs in adopting effective, science-based HIV behavioral interventions adapted from tools produced by the Diffusion of Effective Behavioral Interventions (DEBI) project of the U.S. Centers for Disease Control and Prevention (CDC), which offers interventions on prevention and healthy living specifically tailored to at-risk groups. In 2007 COMCAVI aligned the Standard and Replication grant cycles and incorporated these interventions into the programming of all grantees funded for Cycles III.

From the beginning, all grantees were responsible for developing M&E plans to assess their execution and progress in meeting project objectives. COMCAVI provided both training and technical assistance to help them collect data and produce reports. As part of the M&E plan COMCAVI required that grantees carry out knowledge, attitudes, and practices (KAP) studies with each target population two months before the design of a new cycle's projects. The KAP survey instrument used was designed during the *Comunicando Vida* agreement and adapted by grantees with assistance from COMCAVI. The purpose was to allow both program and grantees to map the target population along the behavior stage spectrum using the Transtheoretical Model, instituted in mid-2006, and to determine whether any changes needed to be made to the interventions.

In 2006 COMCAVI also began establishing indicators and collecting data in accordance with the President's Emergency Plan for AIDS Relief (PEPFAR) standard indicators. Targets were established based on COMCAVI's experience and updated as data were collected.

Methodology

A three-person team conducted the evaluation in Honduras February 24–March 20, 2008, visiting 26 locations to interview more than 160 informants from the main national and international stakeholder agencies, project NGOs, and other NGOs working in the same areas; some were formerly funded by COMCAVI, others were Global Fund umbrella grantees.

Interviews were designed to answer the questions USAID posed and identify factors associated with success. The evaluation team used a qualitative methodological approach to gather information and analyze COMCAVI performance. The methods included

- *Review of documents* related to the epidemic in Honduras, material provided by USAID and COMCAVI in Honduras, and other documents collected during the evaluation.

- *In-depth interviews* with the director and staff at the COMCAVI office in Tegucigalpa and with staff in the field.
- *Semistructured interviews* with representatives of stakeholder institutions from government, civil society, and the international community, including the Global Fund Country Coordination Mechanism (CCM), the Principal Recipient (PR)/UN Development Program (UNDP) HIV Program, CHF, UNAIDS, the Pan-American Social Marketing Organization (PASMO), the Pan-American Health Organization (PAHO), the National Aids Forum (FORO SIDA), the USAID-funded PSP-One Project, ULAT/Management Sciences for Health (MSH), the National HIV/AIDS Laboratory, and the National AIDS Program.
- *Field visits* carried out March 2–10 to NGOs supported by COMCAVI or the Global Fund that work in La Ceiba, Tela, Puerto Cortez, San Pedro Sula, Comayagua, and Tegucigalpa. USAID scheduled field visits with 26 NGOs.
- *Semistructured interviews* with NGO managers, trained educators, local promoters, community leaders, and beneficiaries at project locations.
- *Observation* of VCT services and NGO evening interventions with commercial sex workers and men who have sex with men.

Summary of Findings

The COMCAVI umbrella is a well-structured program with a sound technical design. It uses innovative approaches to build NGO capacity to implement BCC interventions targeted to changing the behavior of high-risk populations. Some of the target groups are hard to reach, and it is difficult to earn their confidence. COMCAVI has successfully improved the institutional capacity of its grantees to do so, as reflected in high technical and financial project implementation rates.

Competitive selection of grantees for each of the three cycles was carried out satisfactorily, as was negotiation of project implementation. The flow of funding to grantees was timely.

Delivery of training and technical assistance to support the grantees contributed to good performance: the majority of NGO grantees reached performance ratings of 85 percent or more. The five that did not were terminated or chose not to continue in the next cycle. A majority of grantees indicated that they would have preferred more training and technical assistance to cover broader needs, such as drafting proposals, budgeting, and building alliances. Some reported that while they had received M&E training, reinforcement would be helpful.

Of the NGOs supported by COMCAVI, eight were established and experienced, with considerable technical, managerial, and financial capacity. Some of them had support from international NGOs with broad experience in health and development. Others were smaller and newer local NGOs that required much more capacity development. The program seems to have had difficulty in meeting the needs of both types with a single training and technical assistance program. Though it did tailor activities to some extent, constraints emerged in Cycle III, apparently due to staff turnover at COMCAVI.

The M&E system was well-designed, with structured monthly reporting forms for technical and financial implementation. Process-level results, that is, percentage of tasks completed, are high, but evaluation of likely impact could be more structured. As the baseline for its program COMCAVI

uses the final KAP survey developed during the *Comunicando la Vida* program and adapted during Cycles 1 and 2. KAP surveys were conducted by program NGOs after the first two cycles and will be carried out at the end of Cycle 3.

The data have shown improvement among beneficiaries of the grantees on knowledge about the risk of HIV, condom use, and whether a respondent was tested for HIV/AIDS. There are limitations to using the data, however: the NGOs that implement the interventions also conduct the surveys, and the data cannot be generalized. Nevertheless, they are useful in assessing progress of the target populations served.

COMCAVI has built an important base of data and information that needs to be analyzed in depth to determine the gains made by beneficiaries, the NGOs, and the program as a whole.

Varying costs per beneficiary among projects with similar interventions point to the need to analyze the cost-effectiveness of interventions by grantees working with similar populations.

Other challenges relate to the relationships between COMCAVI and some of its grantees, which have apparently declined over the past several months. COMCAVI appears to have cooperated successfully with the National AIDS Program and the National AIDS Laboratory, but there are reports that relationships with Global Fund and others involved with HIV/AIDS programming may need to be improved.

Several grantees received support from COMCAVI over two or three cycles; some were also supported by the prior program, *Comunicando Vida*. There is a need for a mechanism to assess the extent to which each NGO has fully developed its capacity to be more self-sufficient and to shift to other funding sources. Since the performance of the NGOs funded was reported by COMCAVI to be above 85 percent in both technical and administrative areas in both Cycles I and II, these measures would not be ideal for assessing readiness for "graduation"; other criteria are needed. Consideration should be given to such measures of NGO performance as quality of training manuals and activities, volunteer performance, education, and outreach. Another important consideration is readiness to secure funding from other sources, particularly the Global Fund. For this it would probably be necessary to provide training and technical assistance in proposal development and related areas to some, though not all, the NGOs.

Recommendations

The evaluation team has identified three aspects of the COMCAVI program that warrant priority attention:

1. Take full advantage of the database COMCAVI has built over the past four years to improve measurement of results of each grantee and the program as a whole and to better manage the program:
    - Analyze the data to improve decision making for technical programming. For instance, some questions raised in this evaluation were:
        - How cost-effective are each grantee's intervention strategies for most-at-risk populations and people living with HIV/AIDS? There were, for instance, differences in Cycle III budgets among grantees that serve people living with HIV/AIDS.

- How many cycles are necessary to effect positive behavior change, such as increasing condom use or seeking VCT? Should new cohorts of most-at-risk populations be targeted each cycle? Is there a marked difference in effect from participation in more than one cycle?
- What is the accumulated impact of the work of grantees, especially those funded over three cycles, on the behavior of most-at-risk populations? It is likely that there is some behavior change not only among most-at-risk populations but also among partners and clients that is not fully appreciated.

2. Enhance coordination and collaboration with grantees and stakeholders.
    - Reinvigorate cooperation with the Global Fund program and reinforce linkages and cooperation between COMCAVI and Global Fund grantees so the programs can be better harmonized.
    - Systematize communications so that information can circulate more freely between COMCAVI and the NGO grantees and other stakeholders to assure that information and issues can flow from both bottom up and top down. No matter what the cause, communications issues contribute to frustration and may affect performance over the long run.

3. Create a mechanism through which COMCAVI grantees and other NGOs can build skills, especially in the area of BCC interventions.
    - Set a transition deadline for NGOs with high technical and financial implementation rates to shift to other sources of funding.
        - Plan a program through which NGO grantees can acquire the knowledge and skills necessary to secure funding from other sources, such as proposal, budget, and logframe preparation, and building alliances and cooperative arrangements with other entities.
    - Set up a mechanism so that grantees can continuously exchange information and experiences, educational tools and materials, data, and data analysis.
    - Examine with USAID and the MOH the feasibility of expanding training for NGOs to provide VCT services.

I. INTRODUCTION

HIV/AIDS EPIDEMIC IN HONDURAS

Honduras has an estimated adult HIV prevalence of 1.5 percent. With 18 percent of the population of Central America, it reports 38.5 percent of the AIDS cases in the region. The male:female ratio of AIDS cases is 1.4:1, suggesting that transmission is predominantly heterosexual. Although prevalence in the general population is above one percent, Honduras is considered to have a concentrated epidemic, with specific populations showing significantly higher prevalence.

Within the general population, the age group most affected is between 15 and 39 years old, which has represented about 70 percent of the cases for the past two decades. The epidemic is concentrated along the central corridor between Choluteca and the North Coast. While all departments have reported HIV/AIDS cases, those most affected are Cortés, Atlántida, Francisco Morazán, Valle, Choluteca, and Islas de la Bahia. A 2004 study found an antenatal HIV prevalence of 0.5 percent, which is consistent with the 0.58 percent rate the MOH prevention of mother-to-child transmission (PMTCT) program reported in 2005.[1]

In 2006 a Behavioral Surveillance Survey (BSS, 2006) measured knowledge, attitudes, and practices (KAP) in four populations: men who have sex with men, commercial sex workers, people living with HIV/AIDS, and the Garífuna (Afro-Hondurans). The study also collected biomarkers through blood and urine testing for various sexually transmitted infections (STIs) and HIV. Data were gathered from Tegucigalpa, San Pedro Sula, Comayagua, and several Garífuna communities on the North Coast. The data below compare the results from a 2001 multicentric study[2] (EMC, 2001) with those from the recent 2006 BSS:

HIV prevalence among men who have sex with men (approximate total population: 90,000):

- EMC (2001): 8.2% in Tegucigalpa, 16% in San Pedro Sula
- BSS (2006): 5.7% in Tegucigalpa, 9.7% in San Pedro Sula

HIV prevalence among commercial sex workers (approximate total population: 13,208):

- EMC (2001): 8.0% in Tegucigalpa, 13% in San Pedro Sula
- BSS (2006): 5.5% in Tegucigalpa, 4.6% in San Pedro Sula

In 1998 the estimated HIV prevalence in the Garífuna community was 8.4 percent (1998 MOH Syphilis, Hepatitis B, and HIV Investigation),[3] but the 2006 BSS showed a prevalence of 4.5 percent. Because different methodologies were used the data from these two studies may not be directly comparable, but they do suggest that the country's response has been effective in limiting expansion

[1] Honduras, Secretaria de Salud, Departamento ITS/VIH/SIDA, Epidemiologic Profile 2007: "El perfil epidemiológico de ITS/VIH/SIDA en Honduras, 2007: ¿A dónde debemos dirigir recursos, y qué otros datos necesitamos?"
[2] Honduras, Secretaría de Salud, Departamento de ITS/VIH/SIDA, 2002, Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en hombres que tienen sexo con otros hombres en Honduras; and Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en mujeres trabajadores comerciales del sexo en Honduras.
[3] Honduras, Departamento de ITS/VIH/SIDA, Secretaría de Salud, 1999. Estudio seroepidemiológico de Sífilis, Hepatitis B y VIH en población Garífuna de El Triunfo de la Cruz, Bajamar, Sambo Creek y Corozal.

of the epidemic. However, the generalized epidemic on the North Coast, coupled with the sociocultural vulnerability of subgroups in the population, calls for a sustained multilateral effort based on the third National Strategic Plan to Respond to HIV/AIDS (PENSIDA III).

Based on available data, PENSIDA III categorizes the populations at greatest risk into three groups (see Table 1).

Table 1: Categorization of Population at Risk in Honduras

At Highest Risk	At High Risk	Risk and Vulnerability Need Further Investigation
-Garífuna -People living with HIV/AIDS -Commercial sex workers (male and female) -Prisoners -Men who have sex with men	-Adolescents & youth 10-24 years old -Pregnant women -Orphans -Factory workers -Uniformed services	-Housewives -Domestic workers -Victims of gender based violence -Sexually diverse groups (lesbians, transvestite, transgender, bisexual, men who have sex with men) - Others (other ethnic groups, persons with special needs, mobile populations, drug users)

Source: PENSIDA III, 2007.

THE RESPONSE TO HIV/AIDS IN HONDURAS

Government of Honduras

For the past decade the Government of Honduras and its partners have taken great strides in addressing the AIDS epidemic. The first HIV/AIDS National Strategic Plan (PENSIDA I) was in effect from 1998 to 2001. In 1999 the Government of Honduras passed legislation to protect the rights of persons living with HIV/AIDS and formed a National Commission on AIDS (CONASIDA) to coordinate national policies and programs. The second HIV/AIDS National Strategic Plan (PENSIDA II) was implemented through 2007, and a third, PENSIDA III is currently being implemented from 2008–2012. In the third plan, prevention efforts for men who have sex with men, Garífuna, commercial sex workers, prisoners, and pregnant women are to be scaled up, and more resources are to be provided for HIV diagnosis and treatment in the Sula Valley, the North Coast, and southern Honduras, where prevalence is higher, and for monitoring and evaluation of progress.

Representatives of CONASIDA, civil society, and the UN who were interviewed during the evaluation stated that reform of the law and approval of a national budget for CONASIDA are imperative to make national coordination of the response more effective. The actual structure is functioning primarily at the technical level; it needs to be developed more fully at the political level. There was a consensus on the need for consistent technical support to CONASIDA itself, especially

in establishing a national M&E system and providing leadership to move the agenda forward.

Global Fund to Fight AIDS, Tuberculosis, and Malaria

In 2003 the Global Fund Country Coordinating Mechanism (CCM) was awarded US$41 million in its first round of funding by the Global Fund. The allocation was US$27.2 million to Honduras for its five-year strategy to fight HIV/AIDS, of which US$13 million was approved for Phase I and the rest for Phase II. Recently, Honduras was approved for a Rolling Continuation Channel (RCC) HIV grant, which will bring funding to a total of US$47 million through 2014.

In Phases I and II, the Global Fund project covered 39 municipalities and initiated large-scale interventions for prevention. Under the RCC grant, keeping to its original goals, interventions in human rights, health promotion, and comprehensive integral attention will be expanded, as will the number of municipalities, which will then total 69 throughout Honduras. This grant will enable the country to expand its BCC strategy, emphasizing face-to-face methods with commercial sex workers, men who have sex with men, prisoners, vulnerable youth, and the Garífuna ethnic group; expand MOH coverage of the VCT program; and expand the PMTCT program.

Multilateral and Bilateral Cooperation

Among the multilateral and bilateral agencies helping the Government of Honduras to implement its PENSIDA plans are the consortium of UN agencies working on HIV/AIDS (UNAIDS, UNDP, UNFPA, and UNICEF) and the Pan-American Health Organization. The main bilateral partners providing technical and financial support to help expand the national response are USAID, the Swedish International Development Cooperation Agency, the Canadian International Development Agency, and the Japan International Cooperation Agency.

USAID's HIV/AIDS Activities in Honduras

Since 1995 USAID/Honduras has supported four umbrella-grant activities to prevent HIV and strengthen local organizations. A September 1999 evaluation of these activities concluded that the focus on building an effective NGO AIDS-prevention network was sound, but that USAID should give more attention to NGOs working with high-risk groups.[4] A number of changes were made in the Mission's AIDS program as a result.

In 2000, USAID asked PASMO to initiate a condom social marketing program for high-risk groups and invited the Population Communications Services (PCS) Project to work with the Mission and the MOH on a national mass media campaign. In 2002, a cooperative agreement was awarded on a competitive basis for the USAID umbrella grants program. The Academy for Educational Development (AED), with Population Services International (PSI) as subcontractor, was selected and undertook the two-year *Comunicando Vida* project.

Following this cooperative agreement, USAID awarded a new agreement on a competitive basis (2004–2008) to AED with PSI as the subcontractor. Its purpose was to implement the *Comunicando Cambio para la Vida* (COMCAVI; Communicating Change for Life) Honduras HIV/AIDS Program,

[4] C. Cortez et al. "Evaluation of the AIDS/STD Prevention and Control Project" (522–0216). USAID/Honduras. Under Contract No. HRN-C-00-99-00005-00. November 1999.

which helps local NGOs to implement HIV/AIDS prevention and support programs reaching most-at-risk populations. Several *Comunicando Vida* grantees have continued as grantees with COMCAVI.

COMCAVI program objectives are to

- Strengthen NGO capacity to implement sustainable HIV/AIDS activities.
- Support NGO implementation of high-quality programs for the care of people living with HIV/AIDS.
- Support NGO implementation of effective HIV/AIDS interventions reaching most-at-risk populations.
- Assure coordination between NGOs in the COMCAVI program and with other programs and institutions throughout Honduras.

The populations targeted for this program are the four high-risk groups that live in the Central and North Atlantic regions of Honduras. This work is achieved primarily through grants and provision of technical assistance.

The award of COMCAVI coincided with the launch of the Mission's current four-year HIV/AIDS strategic plan (2004–2008), now entering its final year. The current program funds

- Local NGOs to support reduction of risk behaviors, expand organized community responses among beneficiary populations, and make VCT services more accessible to priority populations through the COMCAVI project;
- Mass media communication activities that promote risk-reduction strategies, most recently for youth and Garífuna populations (Until recently this was managed by Health Communication Partnership [HCP], the Bureau for Global Health's successor to PCS, but these activities are now handled by *Unidad Local de Apoyo Técnico* [ULAT], which provides locally hired technical assistance to the MOH as part of the Management Sciences for Health (MSH) Leadership, Management and Sustainability Program, a Bureau for Global Health field support project.
- Condom social marketing focused on sales in high-risk outlets (PASMO, PSP-One);
- Strengthening of the MOH national epidemiologic surveillance and program M&E (budget support and complementary technical assistance from the CDC); and
- Technical assistance to the Global Fund's CCM to improve oversight and management of the Global Fund field support grant.

Core areas of capacity building supported by COMCAVI are organizational development, programmatic needs, and M&E. COMCAVI awarded grants in three consecutive 13- to 15- month Standard Grant Cycles. In Cycle I (February 2005–March 2006) eight NGOs successfully completed the proposed workplan; in Cycle II (April 2006–March 2007, there were 11 grantees; and there are 11 grantees for Cycle III (April 2007–June 2008).

COMCAVI pioneered a system in collaboration with the MOH to provide training on community-based VCT for Cycle II grantees that were licensed by the Department of Regulation to provide counseling and testing. The program also provided rapid test kits and technical assistance to NGOs working with target populations that have among the highest HIV prevalence in the country. With

MOH guidance, COMCAVI is using Determine as the diagnostic test and Oraquick as the confirmatory test.

COMCAVI also creates and distributes information, education, and BCC tools; supports M&E, and facilitates collaboration and sharing of lessons learned, materials, and best practices among NGOs. To enhance the development of culturally acceptable BCC tools, it awarded 10 Replication Grants to help NGOs adopt effective, science-based HIV behavioral interventions adapted from tools produced by the CDC's Diffusion of Effective Behavioral Interventions (DEBI) project, which offers interventions on prevention and healthy living specifically tailored to at-risk groups. In 2007 COMCAVI aligned the Standard and Replication grant cycles and incorporated these adaptive interventions into the programming of all of the NGO grantees funded for Cycle III.

From the beginning of Cycle I all grantees have been responsible for drafting their own M&E plans to assess their execution of funding and their progress in meeting project objectives. COMCAVI provided both training and technical assistance to help them collect and report data. As part of its continuous M&E plan, COMCAVI established with its grantees the practice of carrying out KAP studies with each target population two months before the design of a new cycle's projects. The KAP survey instrument was prepared during the *Comunicando Vida* cooperative agreement and adapted by the grantees with assistance from COMCAVI. The purpose was to allow the program and grantees to map the target population along the behavior stage spectrum using the transtheoretical model and to determine whether any changes to interventions were needed.

In 2006 COMCAVI also began to establish indicators and collect data in accordance with the President's Emergency Plan for AIDS Relief (PEPFAR). Targets were set based on COMCAVI's experience and updated as needed as additional data came in.

PURPOSE AND SCOPE OF WORK

The purpose of this evaluation was to assess COMCAVI's progress in meeting its program objectives, appraise its efforts to coordinate activities with other donor programs, in particular the Global Fund, and make recommendations for future programming for USAID Honduras.

Guided by the scope of work (Appendix A), the evaluation team assessed five areas of COMCAVI progress:

1. Effectiveness in building the capacity of local NGOs
2. Effectiveness or likely impact in reducing high-risk behavior among most-at-risk populations and people living with HIV/AIDS
3. Extent and quality of COMCAVI's VCT services
4. Extent, quality, and likely impact of COMCAVI's care and support services for people living with HIV/AIDS
5. Effectiveness of COMCAVI's coordination with other programs.

The sixth element of the scope of work is to prepare recommendations for future directions for the HIV/AIDS program supported by USAID Honduras. These were submitted separately at USAID's request.

GH Tech deployed a three-person team to conduct the evaluation in Honduras February 24–March 20, 2008. USAID Honduras set up a seven-day schedule of visits for the team, developed in concert with COMCAVI, to 26 NGOs, both those funded by COMCAVI and those funded by other sources, including the Global Fund, in five municipalities: La Ceiba, Trujillo, Tela, San Pedro Sula, Comayagua, and Tegucigalpa. USAID Honduras also prepared a list of national and international stakeholder agencies to be visited.

In La Ceiba and San Pedro Sula, observations of evening activities were scheduled with PASMO, Marie Stopes, and Comunidad Gay. The team divided the daily schedule so that each team member met with representatives of different NGOs so that the schedule could be met as proposed. The schedule did not allocate time for reviewing documentation or observing activities at each NGO site. Some activities were not in session, and some were not implemented at the NGO headquarters; some visits were scheduled at times when activities were not conducted; and some NGOs were not easily located.

The team prepared the evaluation methodology and drafted four interview guides that were approved by USAID before any interviews were done.

After completing all the interviews, the evaluation team met twice for three hours each with USAID staff to discuss the findings and recommendations. The team also met with senior COMCAVI staff for a five-hour briefing in which findings were presented and remaining questions clarified.

Evaluation Methodology

The team used a qualitative methodological approach to gather information and analyze COMCAVI performance as defined in the scope of work (Appendix A). The approach consisted of

- *Document review* related to the epidemic in Honduras: documents provided by USAID before the team arrived in country, additional material provided by USAID and COMCAVI in Honduras, and other documents, materials, and Web site information collected by the team during the evaluation (see Appendix F, References).
- *In-depth interviews* with the director and staff at the COMCAVI office in Tegucigalpa and with staff in the field (see Appendix B for a list of people interviewed).
- *Semistructured interviews* with representatives of government, civil society, and international institutions, including the Global Fund CCM, the PR/UNDP HIV Program, UNAIDS, PASMO, PAHO, the National Aids Forum, PSP-One, the National HIV/AIDS Laboratory, UNFPA, Peace Corps, and CHF, the incoming Global Fund PR (see Appendix C, Interview Schedule).
- *Field visits* (March 2–10) to NGOs supported by COMCAVI or the Global Fund that work in La Ceiba, Tela, Puerto Cortez, San Pedro Sula, Comayagua, and Tegucigalpa. Of the 26 NGOs listed by USAID, 17 are current or former recipients of COMCAVI grants; 12 are recipients of grants from the Global Fund and operate in the same regions of the country (eight of these have received grants from both sources); and one is a well-known NGO that applied unsuccessfully for a grant from COMCAVI. All 13 Cycle III COMCAVI NGOs were visited, as well as eight NGOs funded by the Global Fund and other sources, and 12 key stakeholders (see Appendix C, Interview Schedule).

- *Semistructured interviews using interview guides* with NGO managers, trained educators/local promoters, community leaders, and beneficiaries at NGO project locations.
- *Observation* of evening interventions with commercial sex workers and men who have sex with men by teams from some of the NGOs interviewed at workplaces or points of congregation.

The GH Tech evaluation team prepared data collection instruments in Spanish (open-ended interview guides) to collect the required information from different kinds of interviewees (Appendix D contains the instruments in English).

When field work was completed, informal meetings with COMCAVI and USAID staff helped clarify issues and answer questions. After this report was drafted, the main ideas were discussed with the COMCAVI management team. A final debriefing was held for USAID staff on March 18; their observations are incorporated herein.

The effectiveness of COMCAVI's activities was analyzed against criteria established by the team in the original evaluation methodology:

1. *Relevance*: pertinence of interventions to the AIDS epidemic in Honduras and to the regions and populations targeted by COMCAVI.
2. *Efficiency:* effective use of available resources to accomplish goals (qualitative appreciation). This analysis examined such issues as distribution of effort among interventions; adequacy of the financing of interventions or subprojects; cost efficiency; and the ease with which the NGOs were able to use the procedures, materials, reporting instruments, and other features to comply with COMCAVI objectives and to impact the epidemic.
3. *Institutional capacity:* evidence that NGOs are better able to implement the interventions targeted for each population group because of COMCAVI training and technical assistance. The team considered not only the availability and quality of the technical support provided in six institutional capacity areas listed in the December 2007 semi-annual report, but also financial sustainability and capacity for pursuing non-USAID funding, along with other areas that interviewees identified as essential to meeting project goals and curbing HIV/AIDS in Honduras.
4. *Quality of interventions:* tailoring of methods, contents, and outcomes to meet the needs of specific most-at-risk population groups, considered in terms of degree of cultural adaptation, degree and durability of behavior change achieved, and increase in the sustainability of interventions.
5. *Coverage*: the extent to which the activities reach the most-at-risk populations with the full range of technical approaches and services required to address the epidemic, considered from two points of view: the degree to which the coverage planned would actually cover needs, and the degree to which the implementer succeeded in reaching those targeted. Gaps in technical and geographic coverage were identified where possible.
6. *Sustainability:* durability of results at all levels, from the KAP achieved through BCC interventions to the capacity of NGOs to sustain themselves and their work through networking and fundraising. Sustainability, a multidimensional concept, is increased by knowledge and skill transfer, assumption of ownership by participants, consolidation of collaborative arrangements, and building technical, financial, and institutional resilience.

II. EVALUATION FINDINGS

How effective is the COMCAVI program in building the capacity of local NGOs to reduce high-risk behaviors among most-at-risk populations and people living with HIV/AIDS? To find out, the team assessed the extent and quality of COMCAVI's VCT services and its care and support for people living with HIV/AIDS, and then examined how effectively it coordinates with other programs in Honduras.

BUILDING NGO CAPACITY

The first of COMCAVI's objectives is to build NGO capacity to implement sustainable HIV/AIDS activities. NGOs whose competitive bids were funded received training and technical assistance in technical (particularly BCC) interventions and financial and administrative management. They were also introduced to all the technical and management tools COMCAVI has developed.

Umbrella Grants

In addition to the Standard Grants awarded in three cycles ending in June 2008, in January 2006, COMCAVI awarded 10 Replication Grants competitively for 6–12 month periods to NGOs to implement effective, science-based behavior interventions (see below).

Eight NGOs (PRODIM, Catholic Relief Services [CRS], Hope, ECOSALUD, Bolsa Samaritana, Comunidad Gay, ANEDH, and Cruz Roja), received support in all three cycles; two (CEPROSAF and COCIDA) were funded in Cycles II and III; and one (Marie Stopes, which had been funded in the previous program) was funded only in Cycle III.

The COMCAVI grants program is summarized in Appendix E, Tables 1–3. The tables state the name of the grantees for each cycle and their funding, location, and target group, and present programmatic and financial measures of performance (see below).

NGO Capacity Building

According to the continuing application documents and its own semi-annual reports (2006 and 2007), COMCAVI staff drafted a master technical assistance and training plan for the NGOs selected in each cycle, based on information gathered in the grant application process and needs assessment. The plan used the grant cycle as the basis for planning the training and technical assistance that followed the stages of program implementation.

Core areas of capacity building supported by COMCAVI are

- Organizational development: governance, financial management, human resource management, community relations, and resource development, including fundraising.
- Programmatic needs: basic understanding of HIV/AIDS, modes of transmission and prevention, and issues related to care and support; understanding of behavior change, social marketing, structural interventions, and materials development; and VCT.
- M&E: planning; qualitative and quantitative measurements of process and outcomes for accountability and continual quality improvement.

To build capacity in these areas COMCAVI used training sessions, technical assistance liaisons, and assistance from administrative and finance staff. Training sessions (1–3 day workshops) on the technical (practical application of BCC theories) and financial (grant management) aspects of the program have been carried out for the past four years. COMCAVI also developed and published print and Web-based educational materials tailored to each target population, including HIV prevention materials and interactive tools developed jointly with grantees. Many of the materials were posted on the COMCAVI Web site.

Three technical assistance liaison officers were assigned to provide technical assistance through scheduled monthly visits to each grantee to help them elaborate their monthly operations plans. Because of staff turnover, especially in the past several months, coverage of some grantees has been limited recently. Finance and administration staff also make site visits to train NGOs in how to complete the administrative tables and draw up specific budgets for monthly disbursements. They were also trained in the topics covered in the COMCAVI administrative manual.

COMCAVI tracks training and technical assistance using a standardized form that helps monitor grantee activity and identify areas where additional assistance is needed. Technical assistance hours averaged between 1,000 and 1,200 hours per reporting period. The major categories of technical assistance are operations planning, M&E, financial management, VCT, BCC, and management capacity. Semi-annual reports (2006-2007) show that during each period BCC and M&E absorbed the most hours of technical assistance and VCT the least.

Most NGO staff interviewed reported that these efforts have helped to build the capability of both individual staff members and of the NGOs themselves. Nevertheless, they saw the need for additional training in M&E, BCC, operations management, feelings management, program development, and resource mobilization. Several reported that they do not receive regular visits from technical assistance liaisons, although they are given technical assistance by phone and email. NGO staff also see a need for training and technical assistance in other areas, such as stress management for staff working with most-at-risk populations in somewhat dangerous situations.

Measuring Organizational Results

COMCAVI has structured an impressive system for monthly monitoring and reporting on technical progress as well as financial data. Preconstructed spreadsheets are filled out by the NGO, often checked by a technical assistance liaison, and sent to COMCAVI by the fifth of the month, along with the next month's work plan. This helps to keep the NGOs on track and allows timely correction of errors, both of which are positive. It also allows COMCAVI to track its organizational development results, a measure of how much the NGOs have been strengthened, by calculating a percentage of the technical and financial implementation rates. A grantee is allocated five percent for each initiative, such as broadening the geographic area or the most-at-risk populations covered, incorporating VCT services, or complying with the counterpart funding requirement. The organizational development results for Cycles I and II are shown in Appendix E (Table 4).

For the purpose of evaluation, COMCAVI assigned different percentages to different components of the project:

- Technical index, 30 percent
- Geographical areas, five percent
- Widening (or expanding) target population, five percent
- Incorporating VCT, 10 percent

These comprised an ideal of 60 percent. The program then assigned 40 percent for overall financial implementation (30 percent for compliance with budgets, 10 percent for compliance with the matching funds requirement). The eight NGOs selected for Cycles I and II improved on average by 7.4 percent between the two cycles.

For the NGOs in Cycle I (see Appendix E, Tables 1–3), all measures are in the range of 84 to 100 percent on technical performance and 59 to 100 percent on financial performance. Cycle II grantee technical performance ranged from 87 to 100 percent and financial performance from 87 to 100 percent. As of February 2008 technical performance in Cycle III ranged from 58 to 85 percent and as of January 2008 financial performance ranged from 59 to 78 percent. Overall, then, NGO project technical and financial implementation has been very high.

The program has used these technical and financial performance rates to measure NGO performance monthly since it began. COMCAVI measures average technical completion rates by the ratio of activities implemented by the end of the cycle for each grant.

The team found that this approach was useful for monitoring grantee progress in both program and grant management. COMCAVI reported finding it useful in determining whether grantees were able to manage all aspects of their programming and to give them monthly feedback. It was also able to warn grantees that were not performing as expected. COMCAVI was able to identify low performers early in each cycle. Grantees reported that they received technical assistance and training regularly as follow up to any problems arising with their performance. Five NGOs that did not perform well were not invited to bid on the following cycle.

Some NGOs considered the system inflexible. Some felt that they are treated arbitrarily. However, their reports were not specific enough for the team to determine what aspects of the system had created problems. In general, the team found the system to be useful for tracking organizational development and performance. The criteria concentrate on the needs of this project, which is important. It is not clear, however, that the system was used to assess which skills the grantee needs. This is especially important considering that at some point NGOs should be ready to graduate from USAID funding.

Training and Technical Assistance Needs

NGOs told the evaluation team about additional learning needs they feel could be met by COMCAVI, such as reinforcing BCC interventions, upgrading M&E capability, identifying outside financial resources, exchange of experiences and best practices between NGOs, training for community leaders, project and proposal development, building alliances, operations management, and financial planning.

The NGOs often mentioned that they feel pressured to meet monthly quotas. Some staff members noted that despite the workshop on feelings management, there is enormous stress and anxiety dealing daily with hard-to-reach populations.

From the documents reviewed, it is not clear whether there has been significant NGO staff turnover since Cycle I, but the NGOs visited specified that this is a difficult problem to address. The team heard that experienced and VCT-certified staff have left NGOs or were let go because of lack of funds. The team was unable to substantiate the "lack of funds" problem.

In terms of NGO strengthening, sustainability, M&E, and achieving outcomes, COMCAVI worked best when it concerned itself with the immediate needs and goals of the project rather than taking a more strategic longer-term view. Training and technical assistance were adequate to manage standardized formats. The organizational skills COMCAVI imbued in its 11 current grantees provide an excellent platform from which they can help other NGOs to build their capacity.

However, COMCAVI did not undertake to build the skills NGOs need to design new initiatives and interventions and formulate proposals; addressed only indirectly were liaising with sources of technical and financial support, building alliances, and mobilizing funding and expertise. Nearly all COMCAVI-funded NGOs reported the need for technical assistance in these areas. Many mentioned that there are few opportunities to upgrade knowledge or skills for professional advancement. This is particularly important considering that many of the grantees have been funded by *Comunicando Vida* and COMCAVI for more than five years.

There is thus a need for a mechanism for assessing the extent to which each NGO has fully developed its capacity to be more self-sufficient and graduate to other funding sources. Since COMCAVI reports that the performance levels of NGOs funded in the first two cycles are above 85 percent in both technical and administrative areas, these measures would not be the best to assess readiness for graduation. Therefore, consideration should be given to other measures of NGO performance, such as quality of training manuals and activities conducted by the NGO, volunteer performance, education, and outreach. Another important consideration is readiness to secure funding from other sources, particularly the Global Fund. In this regard, it would likely be necessary to provide additional training and technical assistance in proposal development and related areas to some, though not all, of the NGOs.

REDUCING HIGH-RISK BEHAVIOR

COMCAVI designed BCC interventions jointly with its grantees for each of the high-risk target populations: men who have sex with men, commercial sex workers, people living with HIV/AIDS, and Garífuna youth (9-12 years, 12-15 years and 16-24 years of age).

BCC Interventions

The program developed a repertoire of information, education, and communication (IEC)/BCC interventions, starting with information about the risk of HIV transmission and prevention measures. As participants acquire this knowledge, they move on to activities designed to motivate them to prepare themselves for action and adopt healthy behaviors. Safe behaviors promoted include delay of sexual initiation, faithfulness or partner reduction, consistent and correct condom

use (including proper use of lubricants), seeking VCT services and treatment for STIs, and adherence to antiretroviral therapy among people living with HIV/AIDS.

Multiplier effects are achieved when a cascade of learning is promoted to increasingly larger groups. Typically, each paid project educator trains a number of volunteers from the high-risk population as peer educators (also called promoters, facilitators, or leaders). Each peer educator then educates one to ten more peers during a given project cycle. This two-step cascade has the potential to leverage the number of persons reached by at least one to two orders of magnitude. Peer educators are considered direct participants/beneficiaries and the peers they educate are indirect participants/beneficiaries. However, often the benefits received and the behavior changes made are very similar, and indirect participants often become peer educators.

The initial educational messages set out the knowledge necessary to support and motivate behavior change. Those used with targeted most-at-risk populations can be summarized as follows:

- *Commercial sex workers*: information about the main forms of HIV transmission (unprotected sex, blood transfusion, mother-to-child, breastfeeding, shared needles); correction of myths about transmission by insects, kissing, household utensils, etc.; and information about means of prevention (condom use with all partners, not sharing needles, treating STIs, etc.).
- *Men who have sex with men:* information about the main risk factors for HIV transmission (unprotected sex, blood transfusion, many partners, sharing needles, improper condom use) and about methods of prevention (proper condom use and lubrication with all partners, not sharing needles, getting treatment for STIs, reducing number of partners, etc.)
- *Garífuna*: information about the main forms of HIV transmission (unprotected sex, exchange of blood or body fluids, and mother to child—not mosquitoes, kissing, utensil sharing, etc.); and about methods of prevention (delaying sex, protected sex, not sharing needles, waiting to start sexual activity, fidelity or partner reduction, etc.).

Once the knowledge base is established, behavior change is facilitated by continuing interventions to motivate and support participants. A range of approaches—introspection using diaries and personal planning, peer education, support groups, self-motivation, and empowerment techniques—is used to move participants to action.

Replication Grants promote development of culturally acceptable BCC tools. They focus on three interventions:

- Popular Opinion Leader: an intervention that engages opinion leaders of social networks among most-at-risk populations in risk reduction, advocacy, and role modeling. COMCAVI calls this intervention *Amigos Educando Amigos*.
- Video-based Opportunities for Innovative Condom Education and Safer Sex: video-based, group-level activities promoting condom education and negotiation for safer sex. COMCAVI calls this *Videoforos Educativos*.
- Healthy Relationships: a small group-level intervention that encourages reduction of sexual risk and positive coping skills among individuals living with HIV/AIDS. COMCAVI calls this *Relaciones Saludables*.

The materials for these were first translated into Spanish and adapted to the Honduran context; then the approach and materials were tested and modified to ensure that they were culturally acceptable. In 2007 COMCAVI aligned the Standard and Replication Grant cycles and incorporated these interventions into the programming of all grantees funded for Cycles II and III. This consolidated the COMCAVI BCC model for both the final cycles.

In principle, larger multiplier effects might be obtained if new peer educators are identified and trained regularly (e.g., with each new cycle) than if most stay in place over the years. Figures on turnover among volunteers were not available, but it was evident that many or most of the facilitators among commercial sex workers and men who have sex with men had been playing their roles for more than a year or two. Thus, when an NGO proposes to train 100 commercial sex workers in the coming cycle and they will educate 1,000 peers, it may be that most of them had already been through this process and are not learning anything new. That might be useful as a maintenance strategy, but it would require a different set of training activities. The team was not clear from the information provided by COMCAVI and its NGOs exactly what the policy was in this regard, nor how many facilitators are actually trained most-at-risk populations that have participated for two to three years.

The Transtheoretical Model

In Cycle I NGO grantees were not provided with a framework that allowed them to recognize stages in the progress of beneficiaries: from initial learning, to becoming convinced of the need to change, and then to consolidating the desired behavior change. As a result, there was a tendency to repeat well-known initial activities with groups where some or all participants had already been through them, rather than proceeding through a sequence of activities designed to move the groups on. It was not clear which types of activities were most appropriate for each stage. Much to its credit, COMCAVI recognized this and in 2006 introduced a unifying conceptual framework for behavior change processes: the transtheoretical model (summarized in Appendix F).

In principle COMCAVI's adaptation of the model has added depth to the analysis of behavior change processes and makes it easier to manage them, as well as build toward sustainability. The approach is an advance in conceptualizing behavior change processes directed at high-risk groups and in managing HIV/AIDS prevention projects; it could substantially improve the capacity of the NGOs and the quality of their results. However, its application to NGO operations seems to have been less than optimal. None of the NGO staff or managers interviewed was able to adequately describe it and its usefulness. Several expressed frustration. Rather than feeling strengthened, grantees felt pressured, perhaps in part because they did not understand the model. Training and technical assistance on this topic need to be improved.

BCC Impact

COMCAVI has an assessment procedure for reviewing change as reported in the KAP surveys as each cycle is ending. The surveys not only measure knowledge and practices and levels of change during the cycle that is closing, but they also are used as a baseline for the following cycle. (See below, Behavior Change Results, for analysis and discussion.) COMCAVI has also begun tracking and reporting on a number of PEPFAR indicators with KAP data collected since October 2006.

To assess NGO contribution to behavior change among most-at-risk populations, there are indicators measuring how well the objectives of each project were accomplished. Nine grantees proposed as Objective 1 to contribute to reducing HIV transmission through activities aimed at increasing condom use in commercial sex workers and men who have sex with men, promoting fidelity, and delaying sexual activities in Garífuna youth. Ten grantees proposed as Objective 2 the promotion, education, and delivery of VCT in their communities. Three grantees proposed as Objective 3 the improvement of care and treatment of people living with HIV/AIDS and their families.

Measures of COMCAVI's success in behavior change are available on five levels, which are examined next. They have not always been used as fully as they might. The evaluation team observed that there was little emphasis on indicators of likely impact, either by the NGOs or in project documentation; before-and-after data were seldom compared in reporting results. Instead, there was considerable concern with process-level results and reporting. While monitoring is strong, evaluation is not. Some promising results in behavior change have certainly been obtained—the question is whether they might have been even better.

Process Level Results

COMCAVI assesses process-level results during and after each cycle by calculating the degree to which the goal for each task has been approached by the end of a given month (percent completion). If 200 commercial sex workers are to attend a certain kind of activity by the end of the grant and 60 have done so by May, percent completion is 30 percent. The figures are averaged for each project objective and for the project as a whole. Percent completion of financial goals is also assessed so that technical and financial implementation rates can be compared.

Table 5 in Appendix E shows the final percent completion of the activities planned in Cycles I and II. The evaluation team has no standard against which to judge how satisfactory these rates are, given the particular conditions of the country and the projects. Subjectively, they seem to reflect competent management of the umbrella. It is also clear that the group of eight NGOs that continued from Cycle I to II improved by an average of three percent; which again is positive. However, many of the NGOs allege that with less hassle and more flexibility, these completion rates could be improved. They point to time and effort lost in the monthly review and approval exchanges, and field crews at times being unable to continue their interventions as planned.

Five NGOs did not continue to the subsequent cycle (three after Cycle I; two after Cycle II). This raises a question about whether COMCAVI's NGO strengthening interventions met the challenge. Interviews with two of the NGOs that were discontinued suggest that the answer is not simple. Both COMCAVI and the two NGOs mentioned difficulties (poor performance) with fund management and implementation of program strategies as the main reasons.

Grantees criticized process controls as well. For instance, financial reporting required photocopies of ID cards for Garífuna community members that sold refreshments to workshops; very small amounts were involved ($15-$25), there were no copy services in the area and sometimes no electricity, and the participants were made to feel they were not trusted. The evaluation team has no way to determine where the balance lies, but this may reflect an overinsistence on rules. There may have been good reasons for this type of practice, but if it is perceived as arbitrary it can undermine

relationships. The frequency of these types of comments led the team to conclude that there is a need to improve relations with grantees.

In sum, the process-level results are respectable; the steps of the behavior change and other interventions were reliably carried out; but it is possible the processes might have been even better implemented.

Behavior Change Results

The standardized KAP surveys carried out two months before the end of each grant cycle verify the levels of behavior change attained by the participants in each targeted population. The KAPs permit calculation of the degree to which goals set for each objective were attained. They also position groups and populations within the transtheoretical framework and make it possible to follow behavior change in most-at-risk population target groups by comparing earlier and later surveys.

Table 6 in Appendix E shows the evolution in six principal areas of behavior change over three grant periods for five targeted most-at-risk populations: commercial sex workers, men who have sex with men, Garífuna adults, Garífuna youth, and people living with HIV/AIDS. The data series begins with a baseline taken in 2002 by *Comunicando Vida*, and finishes in 2007 with the Cycle II KAP survey. In two populations the 2007 results were influenced by inclusion of a new NGO working with a population that had not previously been targeted. These groups show lower levels of learning and behavior change than do those with longer intervention periods, lowering the averages for the target population. To assess the effect, those cases are calculated with and without the data from the new NGO. A similar situation arose with men who have sex with men, where the inclusion of new geographic areas diluted the data and lowered averages from previous levels, but since only one NGO worked with men who have sex with men, the with/without comparison could not be made.

There was a change in the KAP for Cycle II that made the last question in the table for each group "knew at least three ways to prevent the transmission of HIV." Previously subjects had been asked to choose from a list of three or more options that help prevent HIV transmission; in Cycle II they were asked to provide three ways from memory. This was expected to lower the percentage answering correctly, as it did in four of the five cases. The question was not asked in its original form in order to monitor the magnitude of that effect.

The KAP data show that COMCAVI has obtained very important behavior changes in each of the most-at-risk populations who are beneficiaries of the NGO interventions it supports.

- Commercial sex workers with multiple years of BCC have attained 100 percent condom use with clients (including those with only one cycle of BCC the level is still 98 percent). This is an outstanding result and vital to reducing HIV transmission in this population. It built on years of previous work, which is reflected in the 2002 baseline of 86 percent.
- Commercial sex workers have doubled their initial level of condom use with stable partners.
- Condom use by men who have sex with men has risen by over 70 percent since 2002, reaching an average usage above 90 percent. Use among people living with HIV/AIDS went from zero percent to 85 percent, and Garífuna (both adults and youth) likewise made impressive gains.

- All five groups increased their knowledge of ways to prevent HIV transmission from under 40 percent to over 80 percent, more than doubling the knowledge level for all groups and practically tripling it in the case of commercial sex workers.
- Those who had been tested for HIV reached 100 percent among men who have sex with men, about 90 percent for commercial sex workers, and 84 percent in adult Garífuna—all substantially above the 2002 baselines.
- 96 percent of people living with HIV/AIDS knew about the risk of reinfection.
- Knowledge of people living with HIV/AIDS rights increased from zero to 89 percent.

The KAP system is useful, though it has both limitations as well as strengths. So far the data have been collected by the grantees, involving them and building M&E capacity but at the same time raising the possibility of bias because data are not collected by an independent party. Some questions could also be leading the participants by the way they are constructed and who is asking. In fact, some were modified in the Cycle II KAP survey to avoid that problem, at the cost of lessening comparability with previous surveys.

The indicators by project objective often do not directly address impact by measuring actual behavior change but rather show what was reported on the questionnaire. That leaves open the possibility that all or part of the behavior change measured consisted in the participants' learning to answer "correctly," but not necessarily truthfully. Given the difficulty of objectively verifying behaviors like condom use, these limitations are impossible to overcome entirely. However, partial verification can be obtained by designing studies that provide cross-checks; for instance, if x percent of commercial sex workers report using condoms with their clients, a similar portion of clients should confirm this; and as reported condom use with clients climbs over the years, VCT testing should reflect a decline in HIV incidence in the same group. Corroboration may also be possible by requesting and analyzing BSS data from the same areas as those the NGOs target (for example for PRODIM, just Comayagua rather than all of Tegucigalpa).

KAP Data and Attainment of Objectives

For each cycle NGO projects set two or three objectives and several indicators to measure whether each was attained. An example of an objective could be "increase correct and consistent condom use in the target population." Indicators could include "percent of the population that report condom use with stable partners in the last sexual encounter" as well as others on occasional partners and use of condoms during the past three months. Target levels are set for each indicator; then KAP questions are used to obtain data on whether the goals were attained. The degree to which the targets were met, on average, by NGOs in Cycles I and II is given in Tables 3 and 4 under the heading "% Attainment of Results Indicator Goals." Attainment is generally high, between 72 percent and 100 percent. In Cycle I, 12 of 16 are above 90 percent in fulfillment of objectives; for Cycle II all are. This suggests that the COMCAVI program of behavior change is effective.

Comparative Cost Efficiency

Costs per beneficiary appear to vary widely among projects with similar interventions.

Support for people living with HIV/AIDS. The most obvious example is that of the three NGOs that support people living with HIV/AIDS. Each offers a number of services and benefits, including work with family members and others (secondary beneficiaries). Hope and CRS train volunteer support personnel to establish a multiplier effect. For purposes of an initial approximation, Table 2 treats family members and others as part of the package that each NGO has devised to support people living with HIV/AIDS in its region (i.e., support of people living with HIV/AIDS entails working with family members and others). The figures originally budgeted are shown for Hope to show the spread in unit costs incorporated in the plans for Cycle III (the number of people living with HIV/AIDS targeted by Hope was later reduced to 450, and the budget adjusted downward by an unknown amount—thus we use the originally budgeted figures for all three NGOs in the comparison).

Table 2. NGOs Supporting People Living with HIV/AIDS in COMCAVI Cycle III

NGO	Level of Funding	People Living with HIV/AIDS Targeted	(Gross) Per Capita Cost	Secondary Beneficiaries*
CEPROSAF	$82,000	75	$1,089	65 family members of people living with HIV/AIDS and 2,668 others in community
Project Hope	$159,000**	800**	$199	505** family members; 15 field educators
CRS	$149,000	200	$743	120 family members, 120 counselors and leaders, and 6,000 community members

*Treated here as part of the package of support for people living with HIV/AIDS.

** As originally budgeted; the figures have been adjusted downward due to low recruitment rate; per capita costs may have changed somewhat. The figures used here show the unit costs as originally planned.

The fivefold difference between the lowest and highest per capita cost suggests that the latter may be too costly, the former ineffective, or both. According to the staff at Hope, there was a question of not recruiting enough participants to meet the established goal, which had to be reduced at mid-cycle because the NGO apparently could not compete with other NGOs providing services to people living with HIV/AIDS. It was reported that at least six NGOs overlap with Hope's capitation area, and several of them offer a variety of benefits that Hope does not, such as school equipment and scholarships for children of people living with HIV/AIDS, food, job training, and other economic opportunities. Informants stated that those who join the Hope program tend to be those who are unable to locate a vacancy in one of the competing NGO programs.

With limited knowledge of the particular details of each situation, the evaluation team is not in a position to state categorically that the differences in unit costs need to be reduced. It may be that the higher unit costs respond to more difficult field conditions or to a more appropriate package of services for people living with HIV/AIDS. But the substantial amounts involved and the urgent

need of funds in other places makes it incumbent on COMCAVI to thoroughly analyze costs per target population served per project.

COMCAVI reported that CEPROSAF was asked to improve its cost efficiency, but it argues that the amounts it receives should not be attributed entirely to those small target groups, since educational, VCT, and other activities in the community add to its costs while benefiting some 2,668 more persons. Here there is a need to examine an approach in which these costs can be allocated to activities. COMCAVI would be better positioned for rational decision making if it had a more rational system for analyzing cost.

Commercial Sex Workers. A similar situation arises with the four projects that work with commercial sex workers (see Table 3). Each trains volunteer commercial sex workers as facilitators to educate peers, but Cruz Roja and PRODIM use much higher ratios of peers to facilitators (17.5:1 and 10.3:1) than do COCSIDA (Tela) and Marie Stopes (2:1 and 1:1). There are obvious differences in the order of magnitude when calculating numbers of indirect beneficiaries, that is, peer-educated sex workers, clients, and spouses. Taking into account the differences in funding (Cruz Roja has the smallest budget, the highest leveraging ratio, and the greatest number of commercial sex workers reached), unit costs range even more widely with this group. COCSIDA is relatively new at this, some working environments may be more difficult, and additional services may be provided by some other NGOs, but the differences are large enough to merit close examination.

Table 3. NGOs Working with Commercial Sex Workers in COMCAVI Cycle III

NGO	Level of Funding	Targeted Groups				Per Capita Cost	
		Facilitator commercial sex worker (Direct)	Peer commercial sex worker (Indirect)	Total commercial sex worker	Clients, Partners, & Others	Total commercial sex worker (only)	Commercial sex workers, Clients & Partners
Cruz Roja	$74,000	100	1,750	1,850	1,260	$40	$24
PRODIM	$115,000	100	1,030	1,130	2,290	$101	$34
COCSIDA Tela	$105,000	60	120	180	470	$585	$162
Marie Stopes	$80,000	195	195	380	100	$210	$167

Independent Corroborating Evidence

The 2008 UNGASS report for Honduras summarizes BCC data from multiple sources. One of the most important is the CDC-supervised BSS reported in late 2007. The measurements are generally consistent with and provide reasonable corroboration of the COMCAVI KAP survey data, with some exceptions.

The UNGASS report gives HIV seroprevalence rates for commercial sex workers that seem to confirm the results of the very successful campaign, spearheaded by COMCAVI and its NGOs, to raise condom use with clients to nearly 100 percent in places like Tegucigalpa and Comayagua.

VCT SERVICES

With USAID support COMCAVI pioneered a community-based VCT system in which NGOs working directly with target populations are trained and provided with the resources to offer rapid testing and counseling. VCT by peers in nontraditional settings not only gives the target populations access to high-quality and appropriate testing and counseling, it also helps reduce ignorance, stigma, and discrimination. COMCAVI coordinated closely with the MOH HIV/AIDS National Program, National Laboratory, and Regulation Bureau, to ensure adherence to the country's VCT and reporting protocols and regulations.

To improve the quality of and access to this widely accepted activity, COMCAVI provides rapid test kits and technical assistance to its NGOs. Traditionally, HIV testing services have been offered through MOH medical centers, including local health clinics, reproductive health clinics, and hospitals. However, confidentiality concerns and high levels of stigma and discrimination against members of the target populations with which COMCAVI is working have hindered most-at-risk populations from accessing this service.

Coordination with MOH

COMCAVI's VCT component began with intensive preparation, consisting of strategic planning, coordination and negotiation with the MOH and selection, training, and licensing of the NGOs, spanning March through December 2005.

COMCAVI staff and VCT specialists identified MOH requirements for VCT practice and negotiated approval for COMCAVI's proposed strategy. A detailed plan was approved by the National HIV/AIDS Laboratory for joint implementation.

The requirements for VCT licensing issued by the Bureau of Regulation include adequate physical space and training of NGO personnel in counseling, rapid testing for HIV, and epidemiological surveillance. Also, each NGO's legal status had to be documented. The National Laboratory supervises NGO-administered VCT services.

Training of VCT Personnel

After an initial pool of grantee staff was identified as potential VCT administrators, they were given psychological testing and individual interviews to assess their capacity. After selection they were required to participate in a series of MOH training sessions: a two-day module on counseling for HIV/AIDS/STI, a five-day workshop on supporting measures to improve quality of life in the fight against AIDS, training in rapid test kit administration followed by supervised practicum, and a two-day course on epidemiological surveillance. Direct technical oversight secured 100 percent accuracy.

After the second semester of 2006, grantees made some changes with the technical support of the COMCAVI VCT Specialist. Information collection and reporting was standardized, and a registration book was instituted for beneficiaries counseled and tested. A data certification mechanism was established, and NGOs were given instructions to report testing and counseling to COMCAVI as part of monthly reporting. During the VCT Lessons Learned Workshop in

September 2007, grantee VCT specialists discussed their experiences and were given individualized advice in areas COMCAVI had identified as in need of improvement.

As the end of Cycle III neared almost 14,000 rapid tests had been completed by 10 certified NGOs. The MOH reports that 128,000 tests were carried out in 174 MOH units and NGO VCT sites supported by COMCAVI. According to the National Laboratory, COMCAVI grantees thus provided about 11 percent of the 128,000 tests. Some NGOs report expanding services to the partners of beneficiaries.

There is evidence of very positive promotional activities, such as distribution of invitations, information, and flyers in both Spanish and Garífuna in at-risk areas to recruit individuals for VCT. There are stations for testing in some NGOs and they organize "brigades" to go out in the community, especially at night, to designated places to do counseling and testing that meet confidentiality and privacy criteria.

In the VCT services offered by Marie Stopes at night in a van in the street in San Pedro Sula and at morning group support sessions offered to commercial sex workers in Tela, the NGO staff observed by the team treated beneficiaries in a most respectful manner and with dignity. There was an effort to accommodate to the recipients' needs and ways of life. Staff exhibited commitment to both pre- and post-test counseling. They were very knowledgeable and very professional, adhering to international standards.

Table 4 shows the results of VCT activities at the end of Cycle II and the responses given in the KAP survey for that cycle. Note the differences between percentages of those who received a complete package of services and those who received counseling only. COMCAVI staff explained that in the sample studied some beneficiaries were tested by other NGOs (funded by other sources) without being given complete pre- and post- counseling.

The low percentage of Garífuna youth (16–24) was explained by the fact that youth who are under 18 years of age need parental permission to have the test done, so the numbers of persons receiving the complete service might be inaccurate.

Table 4. Results of VCT Program at the End of Cycle II

	Commercial sex worker (%)	Men who have Sex with Men (%)	Garífuna Adults (%)	Garífuna Youth (16-24) (%)
Perceive themselves at risk for HIV infection	81	77	67	57
Have been tested for HIV	92	100	84	48
Receive a complete package of pre- and post- counseling	94	89	97	56

Source: COMCAVI KAP Survey post Cycle II, 2007

Needs

Effective NGO promotion and performance of VCT activities has increased the perception of risk among target groups and motivated them to take action in response to the increase in services. NGOs reported more requests for tests and repetitions every two to three months, which shows awareness of the need to keep their status negative. Beneficiaries, NGO staff, and MOH personnel interviewed all see expansion to more people as a great need. They also emphasized the need to broaden coverage to not only more of the current target groups but also a wider selection of at-risk youth, children nine and older, men, and homemakers.

A general complaint is the stigma, discrimination, and violation of human rights that the person who tests positive suffers in schools, jobs, family, and health services. Confidentiality, social support, and support groups should be put in place as VCT services expand.

Challenges

The NGOs reported turnover of trained personnel, overworked staff who are not relieved of other job responsibilities, and the pressure to reach people at high risk as the major challenges they encounter in establishing these services.

They also report continuing resistance to VCT in some areas, especially from the Catholic Church and other religious groups. Alliances with municipalities and community leaders have facilitated outreach, as have the agreements with local clinics reported by PRODIM and Hope and coordination with other NGOs, as in the case of CEPROSAF.

The majority of NGOs rated VCT as first priority on the evaluation team's interview guide. Some would like to expand VCT to isolated communities. They also point out a need to expand MOH clinic services, particularly in areas that are not reached by the MOH VCT services. Also mentioned were other underserved regions of the country. However, some NGOs consider the expansion of VCT services lower priority than other activities.

NGOs and the National Laboratory cited a need to improve coverage of NGO-provided community-based VCT services under the auspices of the MOH. According to the UNGASS report, less than 80 percent of MOH facilities offer VCT. Moreover, not all communities have Centers for Integrated Attention (CAIs)–which are specialized HIV/AIDS treatment centers–or health centers.

CARE AND SUPPORT SERVICES FOR PEOPLE LIVING WITH HIV/AIDS

UNAIDS (2004) estimates the number of adults and children living with HIV/AIDS in Honduras to be around 63,000, including 61,000 adults (15 years and more) and 2,400 children under 15 years.

Over the three grant cycles COMCAVI has supported three NGOs to provide care and support to people living with HIV/AIDS: CEPROSAF (Cycles II and III), CRS, and Project Hope (both for all three cycles). The projects maintain a close relationship with the MOH and local clinics and centers of care for people living with HIV/AIDS to identify persons who require support. This is reflected in agreements with MOH that are included in grant requests to COMCAVI.

The primary objectives of these grants are to increase healthy lifestyle practices among people living with HIV/AIDS, improve the capacity of self-help groups to meet member needs, and promote prevention of STIs and HIV/AIDS reinfection.

Services Offered

CRS offers training camps for stress management, workshops on free expression, and *Fuerzas Vitales*. CRS cares for 200 people living with HIV/AIDS directly plus 50 family members, 60 counselors, 60 community leaders, and 70 children of people living with HIV/AIDS in three colonies: Fuerzas Unidas, La Pagoda, and Barrio Morazan. The strategy includes home visits, psychology consults (400 each in the cycle), and training of children of people living with HIV/AIDS. Activities offered by CRS that are not supported by COMCAVI include formation of a Committee on Human Rights and a microcredit program.

Project Hope works closely with Catalina Rivas Hospital to reduce the impact of HIV/AIDS and strengthen integrated services to 480 people living with HIV/AIDS and 350 families in San Pedro Sula, El Progresso, Choloma, and Puerto Cortes. The project works to strengthen counseling on healthy lifestyle practices among people living with HIV/AIDS, families, and self-help groups. It engages in a large number of home visits aimed at preventing opportunistic infections and re-infection and offering emotional support.

CEPROSAF seeks to increase healthy lifestyle practices among 75 people living with HIV/AIDS, support 50 families, secure community participation in care and support efforts, and strengthen rapid testing and counseling for families, friends, and neighbors in Atlántida (Arizona, La Masica, El Porvenir, La Ceiba, and Jutiapa) and Colon (Tocoa and Trujillo).

Education and Behavior Change Interventions

The interventions of the three NGOs have led to positive behavior change (see Table 5), as discussed above. The gains as measured in the Cycle II KAP survey have been impressive:

- Knowledge among people living with HIV/AIDS of how to prevent HIV transmission increased from 33 percent to 81 percent.
- 96 percent of people living with HIV/AIDS knew about the risk of reinfection, up from 77 percent in 2003.
- Knowledge of the rights of people living with HIV/AIDS increased from zero to 89 percent in the same five-year period.

Table 5. Cumulative KAP Data: People Living with HIV/AIDS

People Living with HIV/AIDS	Comunicando Vida		CICLO I	CICLO II*
	Initial KAP	Final KAP	Final KAP	Final KAP
Were knowledgeable about the risk of reinfection	77	92	95	96
Were knowledgeable about their rights (HIV Law)	0	78	80	89
Used condom during last sexual encounter	0	79	90	85
Knew at least three ways of preventing HIV transmission	33	76	74	81

Source: COMCAVI Cycle II KAP survey (2007)

The grantees established appropriate support and care services for 755 people living with HIV/AIDS and 450 family members. Interventions emphasize protection of human rights, reduction of stigma, adherence to antiretroviral treatment, family support, and self-help initiatives. This component of the program may have been the most challenging because the potential beneficiaries and their families have multiple and complex needs. NGOs reported some funding constraints, but the team was unable to determine their extent.

This is likely to be a fast-growing area of need in Honduras over the next decade, one that will require much more capacity building as the number of people living with HIV/AIDS being treated grows. It is probably as crucial to the control of the epidemic as continuity of the BCC interventions with the other three high-risk groups. While the needs of people living with HIV/AIDS for care and support are distinct from those of other high-risk groups who are still HIV negative, there is no doubt that BCC interventions are a critical component for both populations, with care and support to people living with HIV/AIDS being considerably more complex. This has complicated COMCAVI's task because it has to provide technical assistance and training to projects that are distinctly different.

COORDINATION

The final objective of COMCAVI is to assure collaboration and coordination with the NGOs, grantees, and other programs and institutions in the country. The evaluation team assessed five areas of collaboration.

Cooperation with the National Laboratory

One of the most important areas of successful collaboration was the agreement established between COMCAVI and the National Laboratory for certifying NGOs and their staff to carry out VCT. This effort made quality counseling and rapid testing much more accessible; COMCAVI contributed 11 percent of the total national effort in VCT and provided outreach to communities and populations that are difficult to reach.

Relations with COMCAVI Grantees

Two contrasting views arose during interviews with NGO staff about COMCAVI operations and grantee results. One point of view was largely positive: NGO interviewees expressed pride in their accomplishments within the COMCAVI program—their capacity to meet goals and the resultant

behavior changes reported in the KAPs. Others pointed to areas of concern: The main issue is that since Cycle III began there has reportedly been lack of consistency, timeliness of response, and continuity in technical support; sometimes conflicting instructions are sent by phone and by email. Pressures to meet monthly beneficiary quotas were also mentioned as a source of stress beyond what they considered to be routine. Grantees mentioned what seemed to be arbitrary treatment and inflexibility especially about review and approval of monthly work plans after a technical assistance liaison left COMCAVI in late 2007.

COMCAVI staff and many of the NGOS have worked together for nearly six years. Periods of disagreement may be cyclical. Many opinions seemed to reflect reasonable and natural differences that can arise from time to time. For example, while NGOs indicated that they wanted to offer better and more complete services to each beneficiary; COMCAVI has an established BCC intervention strategy and must keep costs under control. The evaluation team had no way to determine objectively where the best balance might lie but was impressed by the number and often the vehemence of the statements. It is clear that both the umbrella organization and the NGOs it funds need to address this cooperatively as soon as possible.

Relations with the Global Fund

Other stakeholders and NGOs not funded by COMCAVI regard the educational materials and training it has produced to be of very high quality. It was suggested that perhaps COMCAVI could more actively share these resources and related training. This may be an opportunity to enhance the relationship. Since many materials and manuals are already posted on the COMCAVI Web site, it would be useful and perhaps not too difficult to establish a formal mechanism for the exchange of information and experiences.

Both COMCAVI and the NGOs funded by the Global Fund CCM and PR had sharp differences of opinion about how each should proceed to meet its objectives without duplicating efforts. In several cases, identical comments were made by each about the other. These concerns seem to persist despite the fact that the Global Fund CCM and COMCAVI have been working to reduce duplication. USAID, COMCAVI, and Global Fund reviewed reports of overlap of services and instances where NGOs funded by COMCAVI and the Global Fund were reaching out to each other's agreed target areas and groups. Although an agreement was reached, NGOs funded by both COMCAVI and Global Fund reported persistent problems.

Moreover, in interviews, NGOs funded by one or the other or both stated that applying for funding from both is strongly discouraged. However, COMCAVI cited two NGOs that do receive funding from both. Again, there was no way for the evaluation team to determine what actually occurred, but it would certainly seem to make sense for NGOs working with COMCAVI to begin to explore future funding options with the Global Fund. COMCAVI should consider actively supporting such sustainability initiatives.

Disagreements or tensions between the two main groups working on HIV/AIDS prevention in Honduras inevitably lessen cooperation and undermine the struggle against the epidemic.

Relations with USAID Cooperating Partners

PASMO implements behavior change activities to motivate adoption and maintenance of preventive behaviors among most-at-risk populations by promoting delayed sexual debut, fidelity, and correct and consistent use of condoms. These activities are carried out by partner NGOs, consultants, and PASMO's own staff at places like bars, border crossings, parks, truck stops, brothels, red-light districts, and zones that are known to have high numbers of HIV cases.

MSH is a USAID cooperating partner that provided technical support to the organization and structuring of the Global Fund CCM. This work included technical advice on establishing the executive secretariat and design of the CCM communication and M&E strategies. ULAT/MSH provides technical support to the 19 member Garífuna IEC Committee comprised of representatives of the diverse communities along the Atlantic coast. This assistance has been primarily to support production and distribution of soap operas, videos, and promotional materials that are also used by COMCAVI NGOs and others in the community.

There was no evidence of direct agreements for collaboration between PASMO, ULAT, and COMCAVI except for a working meeting with USAID every two months. However, the three organizations do not seem to perceive problems or difficulty in coordinating activities.

Coordination with Local Health Authorities and Other NGOs

NGOs informed the evaluation team that COMCAVI encourages them to maintain close collaboration with local health authorities and other NGOs within the areas they serve. An interview with Dr. Juana Aldana of the MOH Regional Office in San Pedro Sula confirmed that COMCAVI had written letters to local authorities about its program and priorities and that its staff has coordinated efforts in that city. All COMCAVI-funded NGOs reported the existence of such relationships. In fact, applications for COMCAVI grants must present evidence of coordination with local health authorities.

III. DISCUSSION AND RECOMMENDATIONS

DISCUSSION

Effectiveness

The effectiveness of COMCAVI's activities was analyzed against criteria established by the team in the original evaluation methodology.

The COMCAVI program is very well structured, with a sound technical program design. It uses innovative approaches to build NGO capacity to implement targeted BCC interventions for hard-to-reach and difficult populations. The program has successfully built the institutional capacity of grantees, which have shown positive results for the past four years.

The program has not taken full advantage of the database that has been developed over the past few years. It could be used more routinely to establish likely impacts, especially by constructing before-and-after comparisons and by conducting studies of the effectiveness of technical and management aspects of the program. For instance, how many cycles are required to reach the ideal prevention behavior changes promoted by the program? How sustainable are key behaviors like condom use?

The program was able to design mechanisms for integration and cooperative arrangements with other entities and projects. Cooperation with the MOH was more effective than that with Global Fund CCM, PR, and grantees; the last are particularly important. However, it is fair to say that written documentation shows that COMCAVI made a major effort to avoid duplication of services, though despite the efforts of USAID, COMCAVI and the Global Fund, duplication persists in some communities. The recent strained relationships with grantees demand prompt attention.

Relevance

There is ample evidence from documentation and interviews that the COMCAVI strategies were developed on the basis of a needs assessment of each target population and were designed to intervene directly with the most-at-risk populations in the geographic regions identified by CONASIDA (in PENSIDA II) and its national and international partners. There was ample consultation with each target group before creating educational materials. In selected communities, persons representing the targeted populations actually were filmed in the videos designed for each subgroup.

The educational materials and BCC interventions are both authentic and culturally acceptable. The approach is systematic, following similar methodologies used in many other countries. It is perhaps true that some NGO staff used the *video foro* too often and did not use the other materials enough, so some target groups may have found the approach repetitive. However, on balance grantee educators discussed how each approach was used with the target groups and adapted to capture nuances of their everyday life.

Establishing community-based VCT services jointly with the MOH was a pioneering effort. These services are provided with the utmost care and respect for the needs and rights of the target populations, who indicated that the services are very much needed.

Quality

At several project sites the team was able to observe first-hand that the services (self-help groups, VCT, afternoon discussions, and other activities) were carried out with the utmost care, confidentiality, and respect for the human rights of beneficiaries. COMCAVI and its grantee NGOs agreed to and put into practice mechanisms to inform target populations of their human rights. As already reported, training materials, observations of VCT sites, documentation, and interviews with beneficiaries attest to the fact that a human rights approach is observed even in activities undertaken off-site.

The KAP data from Cycles I and II show that the percentage of preventive behaviors improved over the first two cycles, indicating that the interventions developed and applied by COMCAVI and its grantees likely were appropriate to the target audience and of the quality needed to promote change. Similarly, with the people living with HIV/AIDS groups the KAP surveys show positive prevention behaviors and increases in knowledge about their rights.

Training and certification of NGOs to carry out VCT services were not only carried out efficiently, but also the services observed comply with international standards and seem to be valued by beneficiaries, who also help disseminate information about these services.

As already noted, the methods and materials were found to be pertinent to the needs of the target populations. There is some question about the validity of the KAP surveys, given that they were often filled in by the NGO grantees that implement the projects and in nearly all cases were conducted without a population reference base as the denominator. Nevertheless, the team considers the results to show positive changes in terms of prevention behaviors, particularly knowledge of risk, use of VCT, and use of condoms in each target group with whom the grantees work.

Efficiency

In terms of management of the funds awarded, financial and technical project implementation rates are high for most grantees, indicating that most projects are being carried out as planned with relative efficiency. Where this was not the case, the grants were terminated early in each cycle.

As noted, COMCAVI and its grantees may not be fully aware of the unit costs of interventions. The team did not have time to gather data on cost by activity and do a meaningful analysis of the reported results. Nonetheless, there appear to be differences in the cost per beneficiary in the projects serving people living with HIV/AIDS and their families that should be assessed more carefully.

Another important question is the extent to which results emanate from educating a new cohort of participants each cycle rather than continuing with the same target in each cycle. The evaluation team may not have fully appreciated this factor. Yet there are important and relevant questions: Are the favorable KAP figures attained from prolonged efforts with relatively few participants over the

years (sometimes four or more) or from more effective BCC with a new group in each cycle? If the latter is the case, to what extent do "graduates" continue to use and teach their safe practices?

Evaluation of the cost of interventions might demonstrate the results in a much more positive light. Impacts may have been understated. For example, PRODIM reports that the project educates over 1,000 commercial sex workers whose condom use with clients is 99 percent. At 40 regular clients per commercial sex worker, more then 40,000 persons are kept safe from HIV transmission, not counting spouses and others. Yet only 4,000 are listed in project documents. The impact may thus be more impressive than currently appears.

Review of Cycle III budgets shows that NGOs with similar interventions have very different unit costs. Those working with people living with HIV/AIDS range from $200 to around $1,100 per person living with HIV/AIDS served. Costs for those working with commercial sex workers range from $40 to $210 per commercial sex worker educated.

Although COMCAVI experienced delays in meeting its timetable for initiating VCT with the National Laboratory, the tasks required to anchor this service in the target communities were done effectively and the programs seem to have quickly gained the confidence of the target populations. This is an excellent initiative that bears replication.

Institutional Capacity

The training plans submitted to the evaluation team demonstrated that COMCAVI made a significant effort to prepare grantees to manage grants and implement the BCC interventions proposed. Most of the NGOs demonstrated capacity to implement the projects with ability and creativity. However, in recent months COMCAVI staff turnover has resulted in poor coverage of grantees by technical assistance liaisons. This was a point of concern and frustration voiced by several NGOs.

Given the high technical and financial implementation rates during the first two cycles of the program, it can be concluded that most NGOs were prepared to manage their projects with relative ease. Most NGO staff interviewed seemed to be confident, though again they expressed concern about technical assistance being provided long distance.

In the opinion of the evaluation team, NGOs that have received funds in more than one cycle, such as CRS, PRODIM, Hope, Samaritan's Purse, and Marie Stopes, have enough knowledge and skills to be able to secure support from other funding sources. It is fair to ask whether they would have had favorable results with or without COMCAVI support, whether COMCAVI should have a graduation point for NGOs, and whether it should have focused on smaller NGOs that did not have such a strong experiential base.

Coverage

Although the total number of most-at-risk populations reached by this umbrella program is relatively small compared to the potential reach of Global Fund-supported NGOs, the reports and analysis of technical and financial implementation indicate that program goals were successfully accomplished. Geographically, the program reached out to target populations in five municipalities prioritized by the country because of higher HIV/AIDS prevalence.

Though COMCAVI's progress in achieving positive results with most-at-risk population groups is noteworthy, it might have been even more so if the database had been comprehensively analyzed. The high-risk populations covered in this program are both hard to reach and critical to the larger effort to control the epidemic. Examples already noted are the experience of PRODIM with commercial sex workers in Tegucigalpa, and the coverage of 11 percent of reported VCT administered nationally by the ten NGOs certified.

Sustainability

Although there have been some problems with staff turnover and with some of the COMCAVI'S relationships with grantees and other stakeholders, there is no question that its staff is firmly committed to the program's goals, building NGO capacity, and in particular implementing BCC interventions for its target populations.

COMCAVI has built a substantial knowledge base and has provided its NGO grantees with up-to-date knowledge about the AIDS epidemic in Honduras, BCC models, feelings management, financial and operations management, and VCT testing and reporting, among other topics. The NGOs have had ample time to put this knowledge into practice and incorporate into their activities M&E principles and concepts. The grantees have also gained significant experience in reaching out effectively to high-risk targeted populations. This is perhaps COMCAVI's most significant contribution to the sustainability of the NGOs with which it has worked.

It may not be realistic to expect that the NGOs and the interventions they direct at these populations will become institutionalized and have long-lasting effect. Factors that support the sustainability of the NGOs, however, are the degree of ownership of their beneficiaries, technical know-how, and installed capacity; and their integration and cooperative arrangements with other entities, especially the MOH. In the end, sustainability will depend on national or international funding flows to support them when the COMCAVI grants end.

COMCAVI does not seem to have provided grantees with the knowledge and skill they need to secure other funding sources; prepare proposals, budgets, and logframes; and build alliances and cooperative arrangements with other entities, all of which will be necessary when the COMCAVI program ends.

As for members of the at-risk groups, it is not clear how durable their behavior change will be. This is a question that might be partially answered by studies of the attitudes and practices of COMCAVI populations.

The degree of COMCAVI integration and cooperative arrangements with other entities and projects is somewhat mixed. There were, as previously discussed, difficulties in coordination with Global Fund grantees and a need to improve communication between COMCAVI and its NGOs. The agreement with the National AIDS Program and the National Laboratory for training NGO staff members for certification to carry out VCT is probably the most successful collaboration.

COMCAVI has encouraged its grantees to build collaborative working relationships with local health authorities and has in some cases written letters to them on behalf of the NGOs. The NGOs themselves appear to have positive working relationships with other NGOs and local health

authorities in the municipalities where they are active. Among examples mentioned by interviewees are the relations with the MOH to recruit people living with HIV/AIDS at the CAIs and participation in monthly coordination meetings with health authorities and local NGOs.

RECOMMENDATIONS

The evaluation team has identified three aspects of the COMCAVI program that are priorities for attention:

1. Take full advantage of the database COMCAVI has established over the past four years to better measure results for each grantee and the program as a whole and use it as a program management instrument:
   - Analyze data from the database to make better decisions for technical programming. Some questions that this analysis might answer are:
     - What is the cost-effectiveness of intervention strategies for both most-at-risk populations and people living with HIV/AIDS by grantee? Differences in Cycle III budgets were noted among grantees that serve people living with HIV/AIDS.
     - What is the ideal number of cycles necessary for positive behavior change to occur (e.g., increase condom use or acceptance of VCT)? Should new cohorts of most-at-risk populations enter the program each cycle? Is there a marked difference in the effect of participation in more than one cycle?
     - What is the cumulative impact of the work of grantees, especially those funded over three cycles, on the behavior of most-at-risk populations? There are likely to be impacts that are not fully appreciated not only on most-at-risk populations but also on partners and clients.

2. Enhance coordination and collaboration with grantees and stakeholders:
   - Reinvigorate cooperation with the Global Fund program and tighten the linkages and coordination between COMCAVI and Global Fund grantees so their programs can be harmonized.
   - Systematize communications by developing a mechanism in which information can circulate more freely between COMCAVI, grantees, and other stakeholders to assure that information and issues can flow both bottom up and top down. No matter what the reason, problems in communications contribute to frustration and loss of trust and may affect performance over the long run.

3. Create a mechanism through which COMCAVI grantees and other NGOs can learn new skills, especially related to BCC interventions:
   - Establish a transition period for NGOs with high technical and financial implementation rates to shift to other sources of funding:
     - Design an approach for teaching NGO grantees what they need to know to secure funding from other sources. This might include proposal, budget, and logframe preparation and building alliances and cooperative arrangements with other entities.

- Establish with grantees a mechanism for exchange of information, educational tools and materials, experiences, data, and data analysis.
- Examine with USAID and the MOH the feasibility of expanding training for NGOs to provide VCT services.

APPENDICES

A. SCOPE OF WORK

USAID/Honduras Draft Statement of Work
COMCAVI Evaluation
(GH Tech revised: 12-07-07)

I. Purpose

This is a Statement of Work (SOW) for an evaluation of USAID/Honduras' HIV/AIDS umbrella-grants program, Comunicando Cambio para la Vida (COMCAVI). This evaluation will focus on COMCAVI's progress in meeting the program objectives, coordination of COMCAVI's activities with other donor programs, especially Global Fund (GFATM), and recommendations for future programming. The results of this evaluation will inform decisions about the future of USAID's HIV program, including possible continued support for umbrella-grants activities.

II. Background

In September 2004 USAID/Honduras awarded Cooperative Agreement 522–A-00-04-00466-00 to the Academy for Educational Development (AED), with Population Services International (PSI) as a sub-partner, to implement COMCAVI through September 2008. To date, COMCAVI has awarded 45 sub-grants to local NGOs to provide HIV/AIDS prevention and support services to most-at-risk populations, viz., men who have sex with men, commercial sex workers and their clients, the Garífuna (Afro-Hondurans), and people living with HIV/AIDS in Tegucigalpa, Comayagua, and the Sula Valley and North Coast regions of Honduras. COMCAVI provides financial and technical assistance to: (1) support the implementation of HIV prevention interventions to reach most-at-risk populations; (2) support the implementation of care-and-support programs to reach people living with HIV/AIDS and their caregivers and family members; (3) assure coordination and synergies between its NGO programs and other HIV programs in Honduras; and (4) build NGO capacity to sustain HIV/AIDS interventions in the future. As part of these efforts, COMCAVI also supports implementation of voluntary HIV counseling and testing (VCT) by NGOs, in coordination with the Ministry of Health (MOH). Currently, ten NGOs are providing VCT services through COMCAVI. Total funding is $7m over a 4-year period.

The HIV Epidemic in Honduras

Honduras has an estimated adult HIV prevalence rate of 1.5%. With 18% of the population of Central America, it reports 38.5% of the AIDS cases in the region. The male:female ratio of AIDS cases is 1.4:1, indicating what is believed to be a predominantly heterosexual mode of transmission. Within the general population, the age group most affected is between 15 and 39 years old, representing approximately 70% of the cases over the past two decades. The epidemic is concentrated mainly along the central corridor between Choluteca and the North Coast. While all departments have reported HIV/AIDS cases, accumulated incidence rates show the most affected departments to be Cortés, Atlántida, Francisco Morazán, Valle, Choluteca, and Islas de la Bahia. A 2004 study found an antenatal HIV prevalence rate of 0.5%, which is consistent with the 0.58% prevalence rate that the MOH reported through its prevention-of-mother-to-child transmission (PMTCT) program in 2005.[5]

[5] Secretaria de Salud, Honduras, Departamento ITS/VIH/SIDA, Epidimiologic profile 2007: "El perfil epidemiológico de ITS/VIH/SIDA en Honduras, 2007: ¿A dónde debemos dirigir recursos, y qué otros datos necesitamos?"

Although the general-population prevalence rate is above 1%, Honduras is considered to have a concentrated epidemic, with specific populations showing significantly higher prevalence rates. In 2006, a Behavioral Surveillance Survey (BSS, 2006) was implemented to measure knowledge, attitudes and practices in four populations, including men who have sex with men, commercial sex workers, people living with HIV/AIDS and the Garífuna. This study also collected biomarkers through blood and urine testing for various STIs and HIV. Data were gathered from Tegucigalpa, San Pedro Sula, Comayagua and several Garífuna communities on the North Coast. The below data compares the results from a 2001 multicentric study[6] (EMC, 2001) with those from the recent 2006 BSS:

HIV prevalence among men who have sex with men (approximate population of men who have sex with men is 90,000):

- EMC (2001): 8.2% in Tegucigalpa, 16% in San Pedro Sula
- BSS (2006): 5.7% in Tegucigalpa, 9.7% in San Pedro Sula

HIV prevalence among commercial sex workers (approximate commercial sex worker population is 13,208):

- EMC (2001): 8.0% in Tegucigalpa, 13% in San Pedro Sula
- BSS (2006): 5.5% in Tegucigalpa, 4.6% in San Pedro Sula

In 1998 the estimated HIV prevalence rate in the Garífuna community was 8.4% (1998 MOH Syphilis, Hepatitis B and HIV Investigation).[7] However, the 2006 BSS showed a prevalence rate of 4.5% in the Garífuna population. As a result of different methodologies, the data from these two studies may not be directly comparable.

The Government of Honduras' Response to HIV/AIDS

Over the past decade, the Government of Honduras (GOH) has taken various steps to respond to the AIDS epidemic. The first HIV/AIDS National Strategic Plan (PENSIDA I) was put into effect from 1998 to 2001. In 1999, the GOH passed legislation to protect the rights of persons living with HIV/AIDS and formed a National Commission on AIDS (CONASIDA) to coordinate national HIV/AIDS policies and programs. A second HIV/AIDS National Strategic Plan (PENSIDA II) is currently being implemented, and a third, PENSIDA III, for 2008-2012, is to be finalized by December 2007. Under PENSIDA III, prevention efforts for men who have sex with men, Garífuna, commercial sex workers, prisoners, and pregnant women are to be scaled up; the Sula Valley, North Coast, and southern Honduras are to be prioritized due to their higher prevalence rates; and more resources are to be provided for HIV diagnosis and treatment in the priority regions and monitoring and evaluation of PENSIDA.

Although these actions indicate positive efforts on the part of the GOH to address HIV/AIDS, they have not always been effective in their application. The planned budget for PENSIDA II far exceeded available resources in country and no systematic monitoring and evaluation of the plan

[6] Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en hombres que tienen sexo con otros hombres en Honduras. Departamento de ITS/VIH/SIDA, Secretaría de Salud, Honduras, 2002; Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en mujeres trabajadores comerciales del sexo en Honduras. Departamento de ITS/VIH/SIDA, Secretaría de Salud, Honduras, 2002.

[7] Estudio seroepidemiológico de Sífilis, Hepatitis B y VIH en población Garífuna de El Triunfo de la Cruz, Bajamar, Sambo Creek y Corozal. Departamento de ITS/VIH/SIDA, Secretaría de Salud, Honduras, 1999.

made it difficult to determine progress in its implementation. Even with significant technical assistance from UNAIDS, CONASIDA has struggled to work effectively and produce measurable results.

USAID's HIV/AIDS Activities in Honduras

USAID/Honduras has supported four umbrella-grants activities to prevent HIV and strengthen local organizations since 1995. A September 1999 evaluation of these activities concluded that USAID's focus on building an effective NGO AIDS-prevention network was sound but that USAID should focus more on NGOs working with high-risk groups.[8] A number of changes were made in the Mission's AIDS program as a result. In 2000, USAID asked the Pan American Social Marketing Organization (PASMO) to initiate a condom social-marketing program for high-risk groups and invited the Population Communications Services (PCS) Project to assist the Mission and the MOH to develop a national mass-media campaign. Also in 2000, the Mission re-competed the cooperative agreement for its umbrella grants program. In August 2002, AED was selected and began to implement "Comunicando Vida." In 2004, COMCAVI was awarded, again to AED, through another competitive process as a follow-on to Comunicando Vida.

The award of COMCAVI coincided with the launch of the Mission's current four-year HIV/AIDS strategic plan (2004–2008), now entering its final year. Per that strategy, USAIDs' current program funds:

- Local NGOs to support reduction of risk behaviors, expand organized community responses among beneficiary populations, and make VCT services more accessible to priority populations (COMCAVI);
- Mass-media communication activities that promote risk-reduction strategies, most recently for youth and Garífuna populations. Until recently this was managed by Health Communication Partnership (HCP), the Global Health Bureau's successor to PCS. However, the mass media activities are now housed under the *Unidad Local de Apoyo Técnico* (ULAT), an activity providing locally hired technical assistance to the MOH (MSH/LMS, a Global Health field support project);
- Condom social marketing focused on sales in high-risk outlets (PASMO, Global Health's PSP-One project);
- Strengthening of the MOH's national epidemiologic surveillance, and program monitoring and evaluation systems (budget support and complimentary technical assistance from the U.S. Centers for Disease Control and Prevention); and
- Technical assistance to the Global Fund's Country Coordinating Mechanism (CCM) to improve oversight and management of the GFATM grant (MSH/LMS, a Global Health field support project).

The Global Fund in Honduras

USAID and GFATM are the largest HIV/AIDS donors in Honduras. The Global Fund program is in its final year of a $27.3 million, five-year HIV/AIDS grant that will end in April 2008. At GFATM's invitation, Honduras has submitted a proposal to extend this grant, and approval is

[8] Cortez, C. and Fitzgerald, A. et al. EVALUATION OF THE AIDS/STD PREVENTION AND CONTROL PROJECT (522–0216). USAID/Honduras.Under Contract No. HRN-C-00-99-00005-00. November 1999.

pending on a $47 million extension of the current program to 2014. Activities would be scaled up from 39 to 69 municipalities. The three main objectives of the GFATM program are to:

1. Promote and defend the human rights of people living with HIV/AIDS;
2. Protect at-risk populations through adoption of risk-reducing behaviors; and
3. Strengthen comprehensive, integrated services for people living with HIV/AIDS.[9]

Under Objective 2, GFATM has awarded over 45 grants to local NGOs, mostly to work with the same priority populations that COMCAVI NGOs work with, often in overlapping geographic areas. For the most part, efforts to coordinate these two programs and avoid duplication have been successful, but the significant scale-up proposed for the GFATM program could make this more difficult in the future and calls into question the need for two separate programs.

III. Methodology

The evaluators should consider a range of possible methods and approaches to collecting and analyzing the information which will be required to assess the evaluation objectives and questions outlined in section IV below – including but not limited to review of background documents (preliminary list provided in Appendix 1), key informant interviews (preliminary list provided in Appendix 2), site visits and a team planning meeting, among others. Data collection methodologies will be discussed with and approved by USAID prior to the start of the evaluation. To the extent possible, the approach taken to the evaluation should be positive and participatory. The outcome should be a summary of progress to date and a set of recommendations to improve performance and ultimate impact.

The team will conduct a 1½ day team planning meeting (TPM) upon arrival in Honduras and before starting the in-country portion of the evaluation. The TPM will review and clarify any questions on the SOW, draft an initial work plan, develop a data collection plan, finalize the evaluation questions, develop the evaluation report table of contents, clarify team members' roles, and assign drafting responsibilities for the evaluation report. The TPM outcomes will be shared with USAID/Honduras (and the health team will participate in sections of the TPM, as appropriate).

IV. Scope of Work

Based on a review of relevant materials, field visits, and in-country consultations with key contacts, the evaluation team will assess:

1) COMCAVI's effectiveness in building the capacity of local NGOs
   - What have been COMCAVI's capacity building activities targeted at local NGOs? What skills have been transferred to local NGOs? What specific training has been given to NGO staff?
   - Which NGOs have been targeted?
   - Has the performance of the local NGOs to deliver services improved? How? Were there NGOs that did not benefit from the capacity building exercises? Why?
   - Has improved capacity been institutionalized in the NGOs? Is this improved capacity sustainable? If so, how?
   - What have been the constraints to capacity building interventions?

2) COMCAVI's effectiveness (likely impact) in reducing high-risk behaviors among

[7] Honduras, CCM. GFATM Proposal Form Rolling Continuation Channel, Phase III. July 2007.

most-at-risk populations and people living with HIV/AIDS:

- What high-risk behaviors have been targeted for interventions (by most-at-risk population category)?
- What interventions have been used to impact high-risk behaviors (by most-at-risk population category?
- How many most-at-risk population or people living with HIV/AIDS have been reached by COMCAVI interventions (by intervention type)?
- How has behavior change been measured?
- How have COMCAVI behavior change interventions changed the practice of high-risk behavior in most-at-risk populations and people living with HIV/AIDS (by behavior and by most-at-risk population type)?
- What have been the constraints to implementing behavior change interventions?

3) The extent and quality of COMCAVI's VCT services:

- Has COMCAVI made VCT services available to significant numbers of most-at-risk populations that would otherwise have limited access? How? Is there any overlap with MOH VCT services? What has been done to harmonize COMCAVI VCT activities with those of the MOH and others? How many clients have received VCT as a result of COMCAVI VCT activities?
- What steps has COMCAVI taken to ensure high-quality VCT services? What training has been given and to whom? What is the quality of COMCAVI's VCT services, especially the counseling component? Does counseling adequately address the importance of future behavior change? Has COMCAVI been able to retain VCT staff?
- What have been the constraints to scaling up VCT services?

4) The extent, quality, and likely impact of COMCAVI's care-and-support services for people living with HIV/AIDS:

- What have been COMCAVI's care and support services activities?
- What care and support training has COMCAVI offered?
- How many people living with HIV/AIDS have been reached by COMCAVI care and support activities? How many were targeted?
- What have been the constraints to COMCAVI care and support interventions?

5) The effectiveness of COMCAVI's coordination with other programs:

- What mechanisms have been put in place to allow COMCAVI to coordinate efforts with GFATM and PASMO?
- How have these mechanisms reduced redundancy of effort? How have they produce synergy of effort?
- Where redundancy of effort exists, what steps could be taken to eliminate overlap?
- What service gaps would exist if COMCAVI wasn't offering services?

6) The team will also recommend future directions for USAID's HIV/AIDS program:

- In light of GFATM's large NGO program and PASMO, should USAID continue an umbrella-grants program for local NGOs?

- Are there populations and geographic areas that are not being effectively reached by current programs (USAID or GFATM) that should be prioritized for future programming?
- Are there populations that need access to VCT from NGOs because they cannot or will not access VCT through the MOH? Are there populations that COMCAVI is not reaching that should be included in a scale-up of the VCT from NGOs?
- Are there components that are not currently included in COMCAVI that should be included in a new NGO program?

IV. Team Composition

The team will consist of three people, including at least one local team member who is familiar with the HIV/AIDS situation in Honduras. The Team Leader must have strong analytical and writing skills (in English). Team members are not required to have medical backgrounds but should have public health backgrounds and solid experience in working with local NGOs, HIV/AIDS prevention for most-at-risk populations, and care-and-support services for people living with HIV/AIDS.

V. Timeline and Level of Effort

USAID/Honduras anticipates that the entire evaluation will be completed within 4 weeks in country. This includes preparation days, in-country work in Tegucigalpa and site visits, as well as drafting (and finalizing) the evaluation report.

A 6-day work week is authorized while working in-country.

The Level of Effort for this assessment will roughly be as follows:

Task	**LOE (Days)**
Preparation	3
Team planning meeting	2
Interviews and discussions with key stakeholders	8
Field studies at implementation sights—possibly 1-2 flights involved (e.g., LaCeiba and the NGOs situated along the corridor)	10
Group discussions/Briefing	5
Report drafting	5
Report revisions – out of country	5/3
Total Consultant LOE (6-day work week)	**38 – TL; 36 – team members**

The above tasks are to include adequate time for consultations, exchanges of findings, team planning, and report preparation and discussion with Mission staff.

The evaluation should be completed in six weeks, including preparation days, all in-country work, and report writing and finalization. However, final editing and formatting may take an additional 3-4 weeks after Mission sign-off on the document.

VI. Logistics

This evaluation will be carried out by the GHTECH Project. The contractor should provide all other logistical arrangements, such as flight reservations, country cable clearance, in-country travel, airport pick-up, lodging, and interpreters, as necessary.

USAID/Honduras will provide key documents and background materials for reading and help arrange the in-briefing and debriefing. The Mission may choose to participate in the evaluation as much as possible. Exact participation will be determined during the TPM but someone from USAID will participate in key meetings with the Ministry of Health and other stakeholders and at least some field visits.

The team should schedule meetings as appropriate. USAID/Honduras staff will be available for consultations regarding contacts, sources, and technical issues before and during the evaluation.

VII. Deliverables

1. **Framework:** Present USAID with the **framework** for the evaluation on day two TPM including all the materials produced during the TPM. The first days of the team's visit will include meetings with Mission staff and other relevant personnel. Among other matters, the Statement of Work will be explained, discussed, and amended as appropriate for clarification of expectations.

2. **Mission Debriefing:** The team will conduct final debriefing. The final debriefing will be with USAID and include the presentation of main findings and recommendations, and will be presented both orally and in writing. The debriefing should present key findings and recommendations in a power point format.

3. **Draft Report:** The **first draf**t of the final assessment report will be due at the end of the team's visit. This draft will include findings, conclusions, lessons learned, and recommendations for Mission review and comment. Mission comments will be provided NLT two weeks (10 working days) after the team departs country.

3. **Final Report:** The final report will be due within 10 days after the team receives comments from USAID/Honduras and reviewed in final before editing/formatting and printing. USAID/Honduras requests both an electronic vision of the final report (Microsoft Word or PDF format) as well as XX hardcopies of the report. The report will be a public document.

Draft Table of Contents (to be discussed and finalized during TPM)

Executive Summary
Evaluation Findings and Conclusions
    Overall
    Components
    Other Observations
    Management Findings
    Observations
Recommendations
    For USAID
    For Partners
    For the Future

Appendixes
- SOW
- List of People Met
- Schedule
- Data Collection Instruments

VIII. Estimated Budget

USAID/Honduras estimates a total cost of not more than $125,000.

Appendix 1. Preparatory Materials

USAID/Honduras will provide GH Tech electronic copies of background and other relevant materials to be distributed to team members. The team members will be expected to review the materials prior to arrival in Honduras and will be given 5 person days of preparation time prior to departure from the United States. The materials will include, but not be limited to:

- USAID/Honduras HIV/AIDS Country Strategy 2004-2008
- BSS 2006 and DHS Reports
- PENSIDA III
- GFATM Rolling Continuation Channel Proposal
- COMCAVI Continuing Applications, M&E Plans, program descriptions for the local NGO grants, and reports on OP indicators
- COMCAVI "end of grant cycle" data
- Cortez, C.; Fitzgerald, A., et al. EVALUATION OF THE AIDS/STD PREVENTION AND CONTROL PROJECT (522–0216), USAID/Honduras.Under Contract No. HRN-C-00-99-00005-00. November 1999.
- Epidimiologic profile 2007: "El perfil epidemiológico de ITS/VIH/SIDA en Honduras, 2007: ¿A dónde debemos dirigir recursos, y qué otros datos necesitamos?"

Appendix 2. List of Key Stakeholders and Partners

Dra. Licida Bautista, Director, COMCAVI
Dra. Mayte Paredes, Director, Department of ITS/HIV/AIDS,
Dr. Rolando Pinel, Executive Secretariat, Global Fund CCM
Lic. Justa Suazo, President, Global Fund CCM
Lic. Fatima Valle, HIV Program Manager, UNDP/Global Fund
Lic. Julio Zuniga, Country Manager, PASMO
Lic. Ana Luisa Nuñez, Behavior Change Communications Coordinator, PASMO
Lic. Perla Alvarado, Director of Communications Activities, MSH/ULAT
Dra. Martha Merida, Resident Advisor, PSP-One
Dr. Alberto Stella, UNAIDS Representative
Dr. Juan Ramon Gradelhy, Senior Technical Advisor, UNAIDS
Select local NGOs participating in COMCAVI and Global Fund programs

B. PERSONS CONTACTED

USAID/Honduras
Kellie Stewart, Health Officer, Human Resources Development Office
Clifford Lubitz, Health Officer, Human Resources Development Office

COMCAVI
Dr. Licida Bautista, Director
Dr. Ritza Yamileth Aviles, Project Manager and BCC Specialist
Saul Rodriguez, Technical Assistant
Luis Cruz, Technical Assistant
Luiz E. Suarez, Manager of Finances and Contracts
Monica Palencia, Logistics Assistant

STAKEHOLDERS

National AIDS Forum
Lic. Xiomara Bu, National Coordinator
Hector Osorio, Coordinator, League of Youth Against AIDS
Gilberto Granados, Policy Advocacy Officer
Janet Flores, Program Manager

UNAIDS
Alberto Stella, Inter-Country Coordinator for Honduras, Nicaragua, and Costa Rica
Juan Ramon Gradelhy, Senior National Technical Advisor

Pan American Social Marketing Organization (PASMO)
Julio Zuniga, Country Manager
Ana Luisa Nuñez, Behavior Change Communications Coordinator
Daniel Martinez, Educator, La Ceiba
Henry Sabillon, Educator, San Pedro Sula

Ministry of Health, Honduras
Rita Meza, National STI/VIH-AIDS Laboratory
Mayte Paredes, Former Director, National ITS/HIV/AIDS Program
Juana Aldana, Miguel Paz Barahona Health Center
Regional Metropolitan Office, San Pedro Sula

Country Coordinating Mechanism, Global Fund for AIDS, Malaria and Tuberculosis
Justa Suazo, Vice-President
Rolando Pinel, Executive Secretary

UNFPA
Hernando Clavijo, Country Representative

UNDP, Global Fund Principal Recipient (outgoing)
Fatima Valle, HIV Program Manager

CHF, Global Fund Principal Recipient (incoming)
Mayte Paredes, Technical Director

Management Sciences for Health (MSH)/ ULAT
Perla Alvarado, Director of Communications Activities

PSP-One (Abt Associates)
Martha Merida, Resident Advisor

Pan American Health Organization
Lilian Renau, Representative
Maria Dolores Perez Rosales

Peace Corps
Helmut Castro, Prevention of HIV/AIDS Project Director

NONGOVERNMENTAL ORGANIZATIONS

AMA Asociacion Manos Amigos
Marco Aurelio Lopez, Executive Director
Roberto Rivas Mejia, Vice President, Board of Directors

AMDA
Lersa Amalia Medina, Administrator
Sakiko Watanabe, Global Fund Project Director

ANEDH
Ludin Maritza Quezada, COMCAVI Project Coordinator
Olga Tinoco, ANEDH Administrator (National Organization)
Helydy Judith Duarte, Certified VCT Technician
Joselina Sambula, Educator
Ana Vilma Batise, Educator
Beneficiaries (10)

ASONAPHSIDA
Jesús Escobar, National Coordinator
Luis Perez, Home Visits Project Coordinator
Karen Bogran, GAA Strengthening Project Coordinator
Julio Velasquez, Accountant/Administrator
Beverly Ramirez, Administrative Assistant

Bolsa Samaritana
Monica Napier, Director, COMCAVI Project
Evelyn Ramirez, Administrator
Emily Church, Coordinator COMCAVI Project
Maria Luz Alvarez, Administrator, COMCAVI Project
Educators (2)

Casa Renacer
Sandra Zambrano, Administrator
Santos Maria Ordoñez, Community leader

CASM
Olga Urbina, COMCAVI Project Coordinator
Alma Miranda, Administrator
Blanca Angel Ramirez, Educator
Yolanda Lopez, Educator
Beneficiaries (11)

Catholic Relief/Caritas
Jack Byrne, CRS Representative/Director
Maria Antonia Alvarado, CRS Financial Manager
Marlin Medina, CRS Health Area Manager
Glenda Hernandez, COMCAVI Project Coordinator
Saneyda Castañeda, COMCAVI Project Subcoordinator
Carlos Patin, Caritas General Project Coordinator
Jose Manuel Bustos, Caritas Field Coordinator
Suyapa Colindres, COMCAVI Educator
Marta Teresa Santos, COMCAVI Educator
Alex Perez, COMCAVI Project Administrator
Alex Aguilar, Psychologist

CEPROSAF
Melba de Castro, Executive Director
Caridad Martinez, Coordinator, COMCAVI Project
Leticia de Foot, Coordinator, Global Fund Project
Miriam de Valenzuela, Treasurer, Board of Directors and Global Fund Project
Victoria de Mahoudeau, Administrator, Global Fund Project
Nolbia Nuñez, Educator, COMCAVI Project
Marta Pereira, Educator, COMCAVI Project
Beneficiaries (3)

CIDH
Nelson Lenin Gonzalez Morales, Director

COCSIDA/ La Ceiba
Lidia Afonso, Secretaria
Maria Luisa de Gonzalez Trimirio, General Coordinator
Patricia Amador, Psychologist and Coordinator, COMCAVI DEBI Project

COCSIDA/ Tela
Maria Teresa G. deAndrade, Executive Director
Kenia Carcamo Canelas, COMCAVI Project Coordinator
Jackeline Martinez, Educator
Dunia Elizabeth Leums Diaz, Educator
Diana Mabel Milla Mejia, Coordinator, Rapid Testing
Lisbyn Reyes, Administrator, COMCAVI Project
Kenia Maturo Moran, Volunteer
Beneficiaries (13)

Communidad Gay
Oscar Carrion, COMCAVI Project Coordinator
Daisy Maldonado, COMCAVI Project Administrator
Rigoberto Zelaya, Educator
William Acosta, Educator
Ramon Valladares, Executive Director and VCT Technician
Hector Castillos, Educator
Beneficiaries (3)

Cruz Roja
Julio Martin Lagos, Council President, Comayagua Department Cruz Roja
Lilian Gonzalez, COMCAVI Project Coordinator
Marlen Ordaniz, Educator
Janey Maldonado, Educator
Beneficiaries (11)

ECOSALUD
Melida Quevedo, Executive Director
Sonia Monica Guity, Coordinator, COMCAVI Project
Roselyn Lamberto Sabio, Administrator, COMCAVI Project
Indira Garcia, Volunteer/Educator program "Aprender"
Beneficiaries and volunteers (15)

Fundación Llaves
Ada Melindez
Erick Javier Turcisos

Garífuna IEC Committee
Emelina Azel, representing Jutiapa and Nueva Armenia
Apolonia Alvarez, La Moskitia
Reynaldo Guerrero, representing Limon
Gilberto Castillo, Communicator; owner of radio station Voz Garífuna
Billermina Loredo, Tornabe
Nelson Lenin Gonzales Morales, Trujillo, CIDH Coordinator
Claudio Mejion
Feliz Caballero, representing Santa Fe youth
Norma Zuriga, Barranco

Sergia Zapata, Administrator, 22 centers for bilingual education and HIV, in Atlanida
Erika Reyes, Pastoral Garífuna Coordinator, Colon
Fran Alvarez, Trujillo Social Worker; Youth and IEC Subcommittee, La Ceiba
Gregorai Jiménez
Sonia Guity, ECOSALUD
Melida Quevedo, ECOSALUD Director
Edna Martinez, Counselor
Sara Doris Sambulá, Bilingual Educator.
Esther Vargas, Technical Coordinator, local unit on HIV prevention

Iglesia Episcopal
Pascual Torres, HIV/AIDS Project Director
Armando Oliva, Siloe Project Coordinator
Miguel Angel Torres, Administrator
Emiliana Amaya, Educator

KUKULKAN
Danny Rodriguez, Coordinator of Projects

La Liga de la Lactancia Materna
Ingrid Carol Lopez, Director
Tracy Cortez, Technician (Social Worker)
Biliana Munoz, Field Technician

Marie Stopes
Dra. Maria Concepción Caceres, Executive Director
Dra.Karla Mendieta, Coordinator, COMCAVI Project
Ilian Madrid, Administrator, COMCAVI Project
Sara Cortes, Educator and Counselor, Rapid Testing
Leonel Martinez, Driver and Promoter, COMCAVI Project

Patronato de Tornabé
Andrea Valerio, President and HIV/AIDS Project Coordinator
Ramon Bastes, Vice President
Ansela Santos, Secretary
Jorge Castillo, Vocal
Virginia Mejia, Vocal
Carmen Argentina Chauamen, VIH/AIDS Project Administrator
Lilian Leticia Serrano, VIH/AIDS Project Promoter
Mirtha Gladis, Volunteer
Marycruz Lopez, Volunteer

PRODIM
Sadith Caceres, PRODIM Director
Italia Valladares, COMCAVI Project Coordinator
Javier Calix Borges, PRODIM Program Manager
Maria de Jesus Flores, COMCAVI Administator
Leonel Mauricio Cruz, Educator
Marta Luz Berrios, Educator
Ana Ruth Tezama Amador, Educator
Beneficiaries (4)

Project Hope
Marco Antonio Suazo, Country Director
Erica Bernhardt, Honduras HIV/AIDS Program Manager
Marvin Pineda, Coordinador COMCAVI Project
Norma Centeno, Adminiatrative Assistant
Oneira Flores, Educator
Beneficiaries (2)

Transvestite Collective
Claudio Esperma, Executive Director
Osmin Almendares, Global Fund Project Coordinator
Fernanda Vallejo, Educator
Valeria Gomez, Educator

C. SCHEDULE

Domingo 2	***Lunes 3***	***Martes 4***	***Miércoles 5***	***Jueves 6***	***Viernes 7***	***Sabado 8***	***Lunes 10***
Salida a La Ceiba	9am –10:45am **CEPROSAF** como sombrilla de (GF) and COMCAVI grant recipient 9:30am-10:30. Reunión en **COCSIDA** 11:30-12:30 Reunión en **AMA**	**6 a.m salida a Trujillo** 10 a.m -noon **CASM** (ver alguna actividad de video foro) 10:30 a.m - 11:30am **CIDH**	8:00a.m. Salida Ceiba a Tela 9:30-noon. Reunión en **ANEDH** **Meet with beneficiarás**	9:00-noon Reunión en **BOLSA SAMARITANA** 10am-11am **Iglesia Episcopal**	9a.m-11 a.m **Asociacion de personas que viven con el SIDA (ASONAPHSIDA)** 9:30a.m-11:30a.m **Fundacion Llaves**	Salida a Comayagua 8:00 a.m.	8a.m -10:30 a.m **Catholic Relief /Caritas** 9 a.m-noon **PRODIM** 11:30a.m-12:30 **Casa Renacer**
	1:30p.m-4:30 p.m **ECOSALUD (visita personas beneficiadas puede ser Sambo Creek o alli mismo Corozal**	Salida a Ceiba 1 p.m	1:00-2p.m. Reunión en **Patronate de Tornabe (GF) in Tela** Salida a SPS 2:30pm.	1:30-2:30 p.m. Reunión con **La Liga de la Lactancia Materna** 3-4 p.m. **MARIE STOPES** 4:30-5:30 p.m. Reunión en **COLECTIVO TRAVESTI**	2-4pm **Garífuna IEC comité** 2:30p.m-4 p.m: **COMUNIDAD GAY SAMPEDRANA** 4pm-6pm **COMUNIDAD GAY SAMPEDRANA** Participate in activity with Ramon for VCT	1pm-3pm Reunión en **CRUZ ROJA COMAYAGUA (hablar con esta ONG si puede recibirles un sabado**	2 p.m-4 p.m **AMDA** 3p.m-5pm p.m **Kukulkan**
	PASMO Participate in promoter activity 9pm-midnight		**PASMO** Participate in promoter activity 9pm-midnight	**Marie Stopes** Participate in night activity 9pm-midnight	**Comunidad Gay** Participate in Comunidad Gay outreach 9pm-midnight	2 p.m leave for Tegucigalpa	
Dormir en la Ceiba	Dormir en la Ceiba	Dormir en la Ceiba	Dormir en SPS	Dormir en SPS	Dormir en SPS	Dormir en Teg	Dormir en Teg

(DRAFT) AGENDA
February 25, 08 – March 16, 2008

DATE	TIME	CONTACT	CONFIRMED
02/27/08	8:00 am – 5:00 pm	Dr. Licida Bautista Director, COMCAVI	YES
02/28/08	8:00 am – 9:00 am	Lic. Xiomara Bu, AIDS National Forum	YES
02/28/08	10:00 am – 11:00 am	Dr. Alberto Stella, UNAIDS Representative	YES
02/28/08	11:00 am – 12:00 pm	Dr. Juan Ramon Gradelhy Señor Technical Advisor, UNAIDS	YES
02/28/08	1:00 pm – 2:00pm	Lic. Julio Zuniga, Country Manager PASMO, Lic. Ana Luisa Nuñez, Behavior Change Communications Coordinator, PASMO	YES
02/28/08		Lic. Justa Suazo, Vice-President of Global Fund CCM	
02/29/08	3:30 pm – 4:30 pm	Dr. Rolando Pinel, Executive Secretariat, Global Fund CCM	YES
03/03/08	10:00 am	Lic. Fatima Valle, HIV Program Manager for UNDP/Global Fund	Call to double check on Friday at 10:00am
3/03/08	5:00 pm	Dra. Mayte Paredes, former Director STI/HIV/AIDS/ Technical Director PR/Global Fund	Call to check the location of meeting
3/4/08	9:00 am – 10:00 am	Dr. Ma. Dolores Perez Rosales, PAHO, Dr. Lilian Renal, PAHO Representative	YES
03/11/08	9:30 am – 10:30 am	Lic. Perla Alvarado, MSH/ULAT DIRECTOR OF COMMUNICATIONS Activities Dr. Martha Merida, Resident Advisor, PSP-One	YES

D. DATA COLLECTION INSTRUMENTS

Instrument 1: Interview Guide—NGO Project Managers, Staff, Community Leaders

This evaluation is to assess COMCAVI's progress in meeting its program objectives, and the program's efforts to coordinate its activities with other donor programs. According to the Scope of Work for this evaluation, the team will assess the following areas of the COMCAVI Program implementation:

6. Effectiveness in building the capacity of local NGOs
7. Effectiveness (or likely impact) in reducing high-risk behaviors among most-at-risk populations and people living with HIV/AIDS
8. Extent and quality of COMCAVI's Voluntary Counseling and Testing Services
9. Extent, quality, and likely impact of COMCAVI's care and support services for people living with HIV/AIDS
10. Effectiveness of COMCAVI's coordination with other programs

Thank you for completing this questionnaire

Name: _____
Name of NGO _____
Information about the NGO: .....
Locale of the NGO:.....
Year HIV/AIDS activities began.....
Intervention strategies used: .....
Donor(s) support for your NGOs HIV/AIDS Programming
COMCAVI: _____Years _____Amount _____
Global Fund: _____Years _____Amount _____
Other: _____Years _____Amount _____

Instructions: In the following boxes please put a mark in the relevant response.

1. Which of the situations below contributed to the development of your NGO's project *(Mark the relevant response (you can mark more than one))*

	Strongly Contributed	**Somewhat**	**Not at All**
Prior experience of the NGO with this type of activity			
Needs of the population identified by your NGO			
Needs of the population identified by members of the community			
Data about the HIV/AIDS epidemic in this region			
Other, please indicate			

Comments: .....
.....

2. Which of the problems listed below contribute to the epidemic of HIV/AIDS in your region?

	Strongly influences	**Somewhat Influenced**	**Did not influence**
Insufficient public information about HIV/AIDS and its transmission			
Insufficient knowledge of HIV/AIDS among at-risk groups (youth and targeted most-at-risk populations)			
Insufficient or inadequate promotion of condom use			
Insufficient condom use			
Insufficient support and (material) for persons at risk for HIV/AIDS			
Insufficient support for people living with HIV/AIDS			
Discrimination against most-at-risk populations and people living with HIV/AIDS			
Other			

Comments: .....
.....

3. Please mark the intervention strategies that your NGO developed to meet these needs and rank the importance of each.

	Most Important	**Somewhat Important**	**Not Impor tant**	**Don't know**
Providing information to target groups about HIV/AIDS				
Providing sexual education and counseling				
Promoting use of condoms				
NGO-led group sessions				
Organize self- help groups				
Promoting voluntary testing and counseling				
Community education to reduce discrimination against targeted most-at-risk populations and people living with HIV/AIDS				
Others, please list				

4. Please describe the specific strategies that your NGO uses to meet the needs of the targeted most-at-risk populations or people living with HIV/AIDS you serve: .....
.....
.....
.....

5. Please indicate whether your NGO received the following types of training to be able to implement the project, and your level of satisfaction.

Training Topics	**Yes/No**	**Fully Satisfied Needs**	**Somewhat Satisfied**	**Did Not Satisfy Needs**
Operations planning				
Monitoring & evaluation				
Financial management				
Behavior change communication				
Management capacity				
Fundraising				
Program development and proposal writing				
Coordination/ cooperation with local and national stakeholders				
Other, please specify				

Do you think that this training fully met your NGO's needs? Please explain

.....

.....

6. Please indicate whether your NGO received the following types of technical assistance to be able to implement the project, and your level of satisfaction.

Training Topics	Yes/No	Fully Satisfied Needs	Somewhat Satisfied	Did Not Satisfy Needs
Operations planning				
Monitoring & evaluation				
Financial management				
Behavior change communication				
Management capacity				
Fundraising				
Program development and proposal writing				
Coordination/cooperation with local and national stakeholders				
Other, please specify				

Do you think that this training fully met your NGO's needs? Please explain

.....

.....

7. Did your NGO face any of the following problems or constraints during the implementation of your project (COMCAVI and / or Global Fund)? Please rank the seriousness of the problem: 1) not a problem, 2) a small problem, 3) a serious problem.

Issues	Rank of Problems 1-2-3	How Resolved
Delays in disbursement of financial resources		
Lack of interest of most-at-risk populations or people living with HIV/AIDS		
Insufficient capability of the NGO to implement the project		
Insufficient technical support from COMCAVI		
Difficulty in filling out monitoring and evaluation forms		
Difficulty in filling out financial management forms		
Staff turnover and availability of capable personnel		
Resistance to voluntary counseling & testing		
Resistance from community leaders		
Discrimination against most-at-risk populations and/or people living with HIV/AIDS		
Other, please specify		

8. Do you think that your project was able to resolve these problems because of the COMCAVI training and technical assistance? _____

9. Do you think this project has contributed to achieving the following objectives?

	Yes	No	Please Explain
Improved information to most-at-risk populations and PLVA about the risk of HIV/SIDA			
Reduced discrimination against most-at-risk populations and PLVA.			
Involved more community members in the struggle against the epidemic.			
Increased use of voluntary counseling and testing			
Improved care and support for PLVA.			
Increase use of condoms			
Improved community participation			
Improved the technical capacity of your organization			
Improved coordination with other NGOs, local authorities, Ministry of Health, religious groups			

Comments: .....
.....

10. Please rank the areas that you consider to be the highest priority for national HIV/AIDS programming.

Priority Areas	Highest 1-2-3			Who should do it?
Expansion of behavioral change communication projects				
Expand VCT coverage (numbers in current groups targeted, additional groups & geographic areas)				
Support & care for people living with HIV/AIDS				
Improving national infrastructure for HIV/AIDS programming				

Instrument 2: Interview Guide for Discussion with NGO Staff

Name of NGO _____
Town _____
Names of persons present:
_____

_____

_____

1. Discussion Questions

1) What are the principal results that your project has achieved in this community to
   - improve services to most-at-risk populations
   - improve services to people living with HIV/AIDS
   - increase use of voluntary counseling and testing
   - increase use of condoms

2) How did the project achieve these results?

3) What were the principal difficulties your project encountered?

4) What were the causes of the difficulties?

5) How did the project resolve the difficulties?

6) Did you receive technical assistance to resolve the difficulty? If yes, from whom _____?

7) What were the main lessons learned from the experience of this project?

8) What do you consider to be the highest priority for national HIV/AIDS programming over the next few years?

Instrument 3: Interview Guide for Discussion with Beneficiaries

1. Introduction of Participants

Name of NGO _____
Town _____
Names of persons present:
_____

_____

_____

2. Interview Questions

1) In your opinion, what are the main problems of
   Most-at-risk populations in this area of the country?
   People living with HIV/AIDS in this area of the country?
   The Garífuna community

2) How did you find out about the project?

3) How were you invited to participate?

4) What did you receive from this project?
   Information _____
   Materials _____
   Condoms _____
   Training for self-help groups _____
   HIV voluntary counseling and testing ____

5) Were you satisfied with
   the activities of the project? ____
   the educators? ___

6) In what way do you think the project could be improved?

7) Do your friends also participate in a project like this one?

8) Do you know about other similar projects in your area? If so, which are they?

E. TABLES

Table 1. COMCAVI NGOs Cycle I: Level of Funding, Target Groups and Performance Measures (February 2005–March 2005)

Name of NGO	Funding	Place	Target Groups	Grantee Performance Measures				
				% Implemented		% Attainment of Results Indicator Goals		
				Technical	Financial	Obj. 1	Obj. 2	Obj. 3
Iglesia Episcopal ***	1,534,501.71	SPS, Ceiba, Roatan	TS	63%	63%			
Cruz Roja Comayagua	1,534,508.13	Comayagua	TS	93%	95%	95%	90%	
Prodim	1.821.647,69	Tegucigalpa Comayagua	TS	100%	100%	100%	100%	
Project HOPE	1,878,201.13	San Pedro Sula	People living with HIV/AIDS	97%	100%	98%	95%	
Catholic Relief Services	2,341,459.39	Tegucigalpa	People living with HIV/AIDS	99%	99%	100%	98%	
ANEDH	2,371,191.83	Tela	Garífuna	94%	91%	87%	100%	
Comunidad Gay SPS	1,908,840.66	San Pedro Sula	HSH	90%	100%	100%	80%	
Ecosalud	1,746,596.73	Atlantida	Garífuna	88%	95%	80%	95%	
ODECO I*	438,698.56	Cortes	Garífuna	29%	100%			
ODECO II**	946,788.37	Trujillo, Colon	Garífuna	50%	74%			
Bolsa Samaritana	1,529,911.87	Cortes	Garífuna	84%	59%	72%	96%	

*ODECO I was terminated in August 2005 for very low technical performance. Bolsa Samaritana continues to work in the same area as ODECO I.
**ODECO II was terminated in December 2005 for low technical and financial performance.
***Iglesia Episcopal finished in February 2006 with low technical performance.

Table 2. COMCAVI NGOs Cycle II: Level of Funding, Target Groups, and Performance Measures (January 2006–March 2007)

Name of NGO	Level of Funding	Place	Target Groups	Grantee Performance Measures				
				% Implemented		% Attainment of Results Indicator Goals		
				Technical	Financial	Obj. 1	Obj. 2	Obj. 3
CAUSE	1,699,487.28	Trujillo, Colon	Garífuna	96%		97%	93%	98%
CEPROSAF	1,658,775.79	La Ceiba	People living with HIV/AIDS	99%		99%	98%	100%
CIDH*	471,918.87	Trujillo, Colon	Garífuna	27%	100%			
COCSIDA	1,645,490.08	Tela	TS	99%	100%	99%	100%	
CRS	2,529,484.21	Tegucigalpa	People living with HIV/AIDS	97%	95%	97%	96%	98%
ANEDH	1,949,381.82	Tela	Garífuna (youth)	96%	100%	99%	90%	100%
Bolsa Samaritana	1,942,076.77	Cortes	Garífuna (youth)	87%	96%	99%	75%	
PRODIM	1,631,117.54	Tegucigalpa	TS	100%	100%	100%	100%	
Comunidad Gay	2,299,238.91	San Pedro Sula, Cortes, Progreso	HSH	90%	97%	92%	88%	
Project HOPE	2,505,644.00	SPS, Cortes	People living with HIV/AIDS	98%	87%	96%	100%	
Cruz Roja Comayagua	1,578,995.65	Comayagua	TS	99%	99%	97%	100%	
Ecosalud	1,324,592.75	Atlantida	Garífuna (youth and adult)	98%	93%	99%	99%	96%
*CIDH terminated activities in May 2006 and financial accounts in September 2006.								

Table 3. COMCAVI NGOs CYCLE III: Level of Funding, Target Groups, and Performance Measures (April 2007–June 2008)

Name of NGO	Level of Funding	Place	Target Groups	Grantee Performance Measures				
				% Implemented		% Attainment of Results Indicator Goals		
				Technical to Feb 08	Financial to Jan 08	Obj. 1	Obj. 2	Obj. 3
Marie Stopes	1,520,000	San Pedro Sula, Progreso, Puerto Cortés	Commercial sex worker	84%	78%	96%	73%	
PRODIM	2,177,014.09	Tegucigalpa, Comayaguela	Commercial sex worker	80%	65%	82%	78%	
Cocsida	2,001,500.00	Tela	Commercial sex worker	85%	67%	86%	84%	
CRS	2,824,006.43	Teg.	People living with HIV/AIDS	80%	66%	94%	81%	66%
Project HOPE	3,018,390.19	SPS	People living with HIV/AIDS	81%	62%	79%	84%	
Ecosalud	1,420,459.43	Atlantida	Garífuna (youth and adults)	84%	64%	88%	79%	
Bolsa Samaritana	2,246,793.43	Cortes	Garífuna (youth)	71%	53%	71%	63%	
Comunidad Gay	2,193,797.04	San Pedro Sula, Cortes, Progreso	Men who have sex with men	79%	57%	81%	72%	
ANEDH	1,919,662.45	Tela	Garífuna (youth)	70%	58%	76%	62%	
Ceprosaf	1,553,170.83	La Ceiba	People living with HIV/AIDS	79%	64%	77%	91%	
Cruz Roja	1,407,122.66	Comayagua	TS	76%	61%	82%	71%	
CASM	769,225.00	Trujillo	Garífuna (youth and adults)	58%	50%	69%	47%	

Table 4. Organizational Development of COMCAVI NGOs, Comparing Cycles I & II

NGO Name	Technical Completion Index (max 30%)	Widened Geo-graphic Coverage (5%)	Widened Population Number & Type (5%)	Incorpor-ated VCT (10%)	Developed Innovative BCC Strategy (10%)	Tech-nical Subtotal	Financial Completion Index (max 30%)	Com-pliance with Match (max 10%)	Finan-cial Subtotal	**Total Ciclo II**	**Total Ciclo I**	**Difference (Ciclo II - Ciclo I)**
PRODIM	30%	0%	5%	10%	10%	55%	30%	4%	34%	**89%**	**83%**	**6%**
Proj. HOPE	30%	5%	5%	0%	10%	50%	30%	8%	38%	**88%**	**78%**	**10%**
CRS/Caritas	30%	0%	5%	10%	10%	55%	30%	6%	36%	**91%**	**95%**	**-4%**
ANEDH	30%	0%	5%	10%	0%	45%	30%	6%	36%	**81%**	**80%**	**1%**
Comunid. Gay	20%	5%	5%	10%	10%	50%	30%	4%	34%	**84%**	**66%**	**18%**
Ecosalud	30%	5%	5%	10%	0%	50%	30%	4%	34%	**84%**	**76%**	**8%**
B. Samaritana	20%	5%	5%	10%	0%	40%	30%	4%	34%	**74%**	**55%**	**19%**
Cruz Roja	30%	0%	5%	10%	10%	55%	30%	6%	36%	**91%**	**90%**	**1%**
CAUSE	30%	0%	0%	10%	0%	40%	30%	4%	34%	**74%**		
CEPROSAF	30%	0%	5%	10%	0%	45%	30%	6%	36%	**81%**		
CIDH	10%	0%	0%	0%	0%	10%	10%	4%	14%	**24%**		
COCSIDA	30%	0%	0%	10%	10%	50%	30%	10%	40%	**90%**		
ODECO I	10%	0%	0%	0%	0%	10%	30%	4%	34%		**44%**	
ODECO II	10%	0%	0%	0%	0%	10%	20%	4%	24%		**34%**	
Igles. Episcopal	15%	0%	0%	0%	10%	25%	15%	4%	19%		**44%**	

Source: COMCAVI, personal communication, March, 2008.

Table 5. Percent Completion over Cycles I and II by COMCAVI-funded NGOs

	Cycle I Completion Rates			Cycle II Completion Rates			Difference (II minus I)
NGO Name	**Technical**	**Financial**	**Average**	**Technical**	**Financial**	**Average**	
Prodim	100.0%	100.0%	100%	99.9%	100.0%	100%	minus 0.1%
Project HOPE	97.0%	99.6%	98%	97.9%	87.1%	93%	minus 5.8%
CRS / Caritas	99.0%	99.4%	99%	96.7%	94.5%	96%	minus 3.6%
ANEDH	94.0%	90.7%	92%	96.2%	99.8%	98%	5.7%
Comunidad Gay	90,0%	100,0%	95%	90,1%	97,1%	94%	minus 1.4%
Ecosalud	88.0%	95.3%	92%	98.4%	93.4%	96%	4.3%
Bolsa Samaritana	84.0%	58.6%	71%	86.8%	96.4%	92%	20.3%
Cruz Roja	93.0%	94.9%	94%	98.8%	98.7%	99%	4.8%
ODECO I	29.3%	100.0%	65%				
ODECO II	49.8%	74.2%	62%				
Iglesia Episcopal	63.0%	63.0%	63%				
CAUSE				96.2%	96.5%	96%	
CEPROSAF				98.9%	100.0%	99%	
CIDH				26.5%	100.0%	63%	
COCSIDA				99.3%	100.0%	100%	

Source: COMCAVI, personal communication, March, 2008.

Table 6. Successive KAP Results in Key Areas for Five Target Populations (%)					
COMMERCIAL SEX WORKERS	***Comunicando Vida***		***CICLO I***	***CICLO II****	***CICLO II****
	Initial KAP (2002)	Final KAP (2004)	Final KAP (2006)	Final KAP (2007) **with** COCSIDA	Final KAP **without** COCSIDA
Perceive themselves at risk for HIV infection	65%	83%	80%	80%	81%
Has been tested for HIV	74	83	84	87	92
Receive a complete package of pre-post counseling	24	53	88	90	94.2
Use a condom during their last sexual encounter	**Client** 86	96	94	98	100
	Partner 22	54	54	43	43
Knew at least three ways to prevent the transmission of HIV	31	89	97	89	91.3

* COCSIDA Tela began CSW activities in Cycle II. CSW interventions had never been done there, so the first year indicators are expected to be low and will pull down the average. Similarly, Marie Stopes is re-iniciating in San Pedro Sula after a year without interventions.

MEN WHO HAVE SEX WITH MEN	***Comunicando Vida***		***CICLO I***	***CICLO II****
	Initial KAP	Final KAP	Final KAP	Final KAP
Perceive themselves at risk for HIV infection	85%	87%	96%	77%
Has been tested for HIV	65	67	57	100
Receive a complete package of pre-post counseling	0	68	48	89
Used a condom during their last sexual encounter	**Stable** 17	95	97	90
	Occasional 22	100	100	94
Knew at least three ways to prevent the transmission of HIV	31	96	98	89

* In Cicle II, the NGO working with MSM widened its geographic coverage to areas never before intervened.

GARIFUNA ADULTS	***Comunicando Vida***		***CICLO I***	***CICLO II****	***CICLO II****
	Initial KAP	Final KAP	Final KAP	Final **with** CAUSE	Final **with-out** CAUSE
Perceive themselves at risk for HIV infection	46%	47%	48%	52%	67%
Has been tested for HIV	43	54	73	67	84.4
Receive a complete package of pre-post counseling	0	29	44	82	91.2
Use a condom during their last sexual encounter	**Occasional** 32	35	79	65	76
	Stable 0	32	70	36	50
Knew at least three ways to prevent the transmission of HIV	37	81	94	81	90.3

* In Cycle II CAUSE began activities with communities that had never had access to information, lowering the averages.

GARIFUNA YOUTHS (16-24 YEARS)	***Comunicando Vida***		***CICLO I***	***CICLO II****
	Initial KAP	Final KAP	Final KAP	Final KAP
Perceive themselves at risk for HIV infection	0	42	43	57
Has been tested for HIV	23	37	70	48
Receive a complete package of pre-post counseling	4	28	47	74
For those who were sexually active, used a condom during last sexual encounter	**Stable** 0	50	40	56
	Occasional 0	91	50	76
Knew at least three ways to prevent the transmission of HIV	35	83	95	80

PEOPLE LIVING WITH HIV/AIDS	***Comunicando Vida***		***CICLO I***	***CICLO II****
	Initial KAP	Final KAP	Final KAP	Final KAP
Were knowledgeable about the risk of re-infection	77	92	95	96
Were knowledgeable about their rights (HIV Law)	0	78	80	89
Used condom during last sexual encounter	0	79	90	85
Knew at least three ways of preventing HIV transmission	33	76	74	81

F. TRANSTHEORETICAL MODEL

To provide a unifying conceptual framework for behavior change processes, COMCAVI adapted the transtheoretical approach of Prochaska and DiClemente (1982).[10] An integrative model of change, it focuses on nine major processes directly relevant to the behavior change activities being used by the NGOs:

Consciousness Raising: Provides information on the nature and risk of unsafe behaviors and the value and drawbacks of the safer behavioral alternatives.

Dramatic Relief: Fosters the identification, experiencing, and expression of emotions related to the risk of the safer alternatives in order to work toward adaptation

Self Reevaluation: Entails the reappraisal of one's problem and the kind of person one is able to be, given the problem.

Environmental Control: Allows the individual to reflect on the consequences of his or her behavior for other people. It can include reconsideration of perceptions of social norms and the opinions of people important to him or her.

Countering: Weighs the "pros" and "cons" of the behavior change. The challenge is to tip the balance in favor of making positive changes.

Commitment: Encourages the person to consider their confidence in their ability to change and their commitment to doing so.

Helping Relationship: Assists the person in a variety of ways, including providing emotional support, modeling a set of moral beliefs, and serving as a sounding board.

Reward: Develops internal and external rewards and makes them readily but contingently available to improve the probability of the new behavior occurring or continuing.

Social Liberation: Seeks to help others in similar situations.

Stages of Change. The transtheoretical model defines stages in the behavior change process through which participants (or the entire target population) advance:

Precontemplation: Has no intention to take action within the next 6 months

Contemplation: Intends to take action within the next 6 months.

Preparation: Intends to take action within the next 30 days and has taken some behavioral steps in this direction.

Action: Has changed overt behavior for less than a certain number of months (e.g., three or six).

Maintenance: Has changed overt behavior for more than that number of months.

Termination: Overt behavior will never return, and there is complete confidence that you can cope without fear of relapse (not used by COMCAVI, but potentially useful for moving toward sustainability).

[10] Prochaska, J.O., & DiClemente, C.C. 1982. Transtheoretical therapy: toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*(3), 276–287.

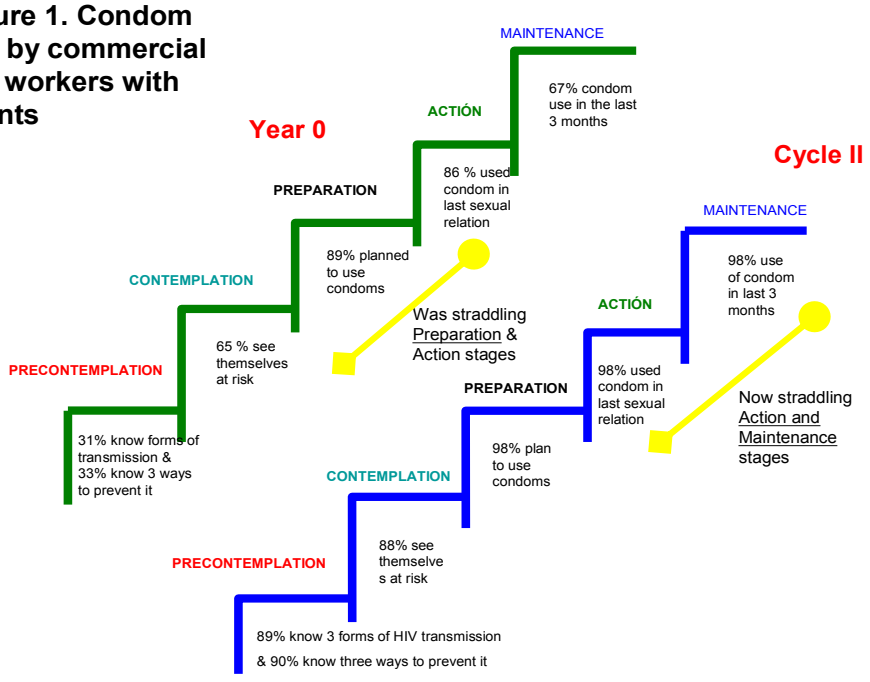
Determine where each group of participants is located in the overall process and plan interventions appropriate to the next stage. The KAP data will also help.

Relation to KAP data. In the COMCAVI adaptation, these stages are operationally defined in relation to certain questions in the KAP surveys carried out after each cycle of grants (see Figure 1 below; more detail is in the Cycle II KAP report, in press). Thus in principle, the NGOs can determine where each group of participants is located in the overall process and plan interventions appropriate to the next stage. The KAP data will also help them to understand if a particular group is too heterogeneous to take advantage of a single set of interventions and should be subdivided. The same questions can also be used to determine the status of participant groups within cycles.

1. Transtheoretical Comparisons

These and other KAP results can be used to map the change in a population as it moves from one stage to another. An example is given in the following diagram on use of condoms with clients by commercial sex worker. In the baseline year (2002), a range of behaviors was found among the participants, centered on the Preparation and Action stages. By Cycle II (2007), the distribution had shifted upward and was straddling Action and Maintenance. This is a way to visualize progress and to see what kinds of interventions will be appropriate for the next phase.

Figure 1. Condom use by commercial sex workers with clients



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