Chapter 6 Evaluation


PEACE

Purpose

This chapter has two main purposes: (1) to provide an overview of San Francisco's approach to evaluation of HIV prevention efforts, and (2) to outline the specific objectives, activities, and timeline related to evaluation for 2004 through 2008.

This chapter is intended to help all who are involved in HIV prevention – consumers, providers, the San Francisco Department of Public Health (SFDPH), researchers, and others – to understand the HIV Prevention Planning Council (HPPC) perspective on the role of evaluation and research in combating the epidemic. Historically, researchers have not always conducted their research in an ethical or community-friendly manner, and so even the mention of the words "evaluation" and "research" can create anxiety among consumers and service providers. In contrast to this approach, the HPPC supports evaluation that is community-oriented, community-driven, collaborative, and inclusive.

This chapter also attempts to reconcile the multiple evaluation requirements imposed by local, state, and federal institutions with the need to keep evaluation efforts in line with the HPPC's philosophy. Evaluation is how we know what we know about HIV and HIV prevention; therefore, it is essential that San Francisco find a way to meet these requirements, in addition to collecting locally relevant data, while avoiding unduly burdening service providers and consumers. One of the first tasks the HPPC will take on in 2004 is to have a community dialogue about these challenges, using the ideas in this chapter as a starting place for finding solutions.

Evaluation can help us claim ownership of our successes – it provides a way for the San Francisco HIV prevention community to demonstrate how well we do what we do. It helps us keep pace with the changing local epidemic. San Francisco can use evaluation to show that the innovative HIV prevention models used here are effective and can serve as models for the rest of the nation.

How to Read This Chapter

Those interested in an overview of San Francisco's approach to HIV prevention evaluation should focus on Sections II and III. Those interested in the step-by-step plan and timeline for evaluation activities should also read Section IV. Service providers are invited to read the chapter in its entirety to understand how their data collection requirements fit into the overall picture of evaluation, but specific attention should be paid to Exhibit 6 on pp. 243-244, which lists evaluation requirements. Appendix 3 provides a list of resources that providers can use to help them design and implement program evaluations.

ELI

Evaluating Local Interventions. California's statewide web-based data collection and entry system developed to meet the CDC's 2000 Evaluation Guidance.

Logic Model

A framework for understanding program development, implementation, and evaluation.

Needs Assessment

A research method used to assess HIV-related knowledge, attitudes, and behavior among specific populations. A needs assessment provides information that informs the prioritization of populations and the development of appropriate interventions.

Outcome Evaluation

Determines whether a particular intervention (as opposed to some other factor) is causing changes in knowledge, behavior, attitudes, or beliefs, using a scientific research design, usually with a control group.

Outcome Monitoring

Reveals what progress individual clients are making toward an intervention's objectives. It measures change in behavior (or other factors, such as knowledge or attitudes) but cannot determine with certainty what is causing the behavior change (it might be the intervention, or it might be some other factor).

PEMS

Program Evaluation and Monitoring System. CDC's national web-based data collection and entry system for tracking national prevention indicators developed in 2002.

Performance Indicators

CDC's new set of 20 indicators for HIV prevention for which all jurisdictions are required to collect data.

Prevention Indicator

A data element that points to trends in the HIV epidemic (e.g., STD data). Prevention indicators can provide information about where prevention efforts should be focused.

Process Evaluation

An evaluation process used to improve the delivery of HIV prevention interventions and programs. Process evaluation answers the questions: Is the prevention program being implemented as planned? How many people are being served? What are the demographics of the people being served? Is the intervention reaching its intended population?

Surveillance

The ongoing process of collecting, analyzing, and interpreting data related to a disease on a large scale to provide a "big picture."

Chapter Outline

Section I: San Francisco's Evaluation Approach

Reviews San Francisco's evaluation philosophy, current approach to evaluation, and vision for the future of evaluation.

Section II: San Francisco's Evaluation Framework for 2004 - 2008

Presents a model to guide evaluation for the next five years.

Section III: Implementation Plan for Evaluation

Outlines the requirements, activities, timeline, and party responsible for evaluation efforts in 2004 - 2008.

Appendix 1: Evaluation Successes in San Francisco

Appendix 2: CDC Performance Indicators

Appendix 3: Resources for Implementing Program Evaluation

SECTION I

San Francisco's Evaluation Approach

What is Evaluation?

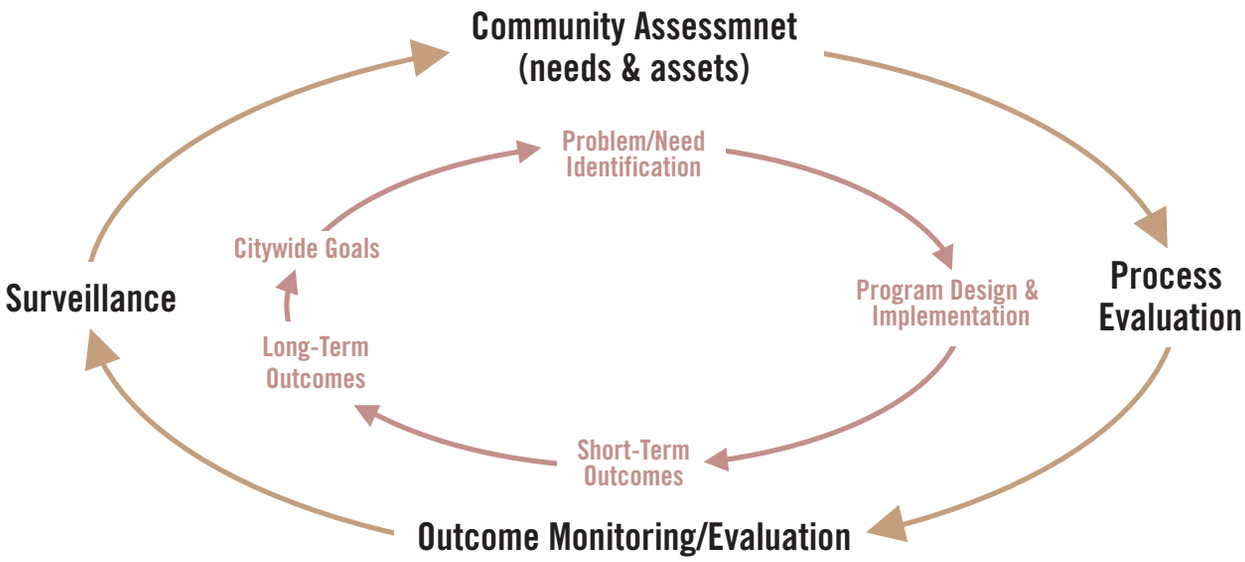
Evaluation is the process of collecting and analyzing information using scientific research methods to better understand an issue, a population, a program or service, or any other phenomenon. For example, in HIV prevention, the evaluation process can be used to:

- Identify the needs of at-risk populations
- Show whether HIV prevention programs and interventions are effective
- Determine whether new HIV infections are increasing or decreasing

In summary, evaluation is one of they ways we know what we know about HIV and HIV prevention, and it can help guide us in our efforts to address the epidemic. Evaluation can be thought of as an ongoing process that follows the path of program development and implementation. For each step in program implementation, there is a corresponding evaluation component. Exhibit 1 depicts this evaluation cycle.

EXHIBIT 1

The Evaluation Cycle



Note: The inner circle indicates program activities; the outer circle indicates the corresponding evaluation activities.

Evaluation Rationale and Philosophy

Overall, the HPPC's commitment to evaluation stems from a desire to better understand: Where have we succeeded and why? Where have we failed and why? What lessons have we learned? How can we do better? Specifically, there are five benefits of evaluation that represent the HPPC's rationale for why HIV prevention evaluation is important for San Francisco:

1. **Evaluation is critical for reducing the transmission of HIV.** Evaluation research is used to (1) determine whether individual HIV prevention programs are working; (2) improve the design and implementation of programs; (3) inform front-line workers and managers how to improve their work; (4) ascertain which interventions reduce different risk behaviors in different populations; and (5) identify gaps in services. These benefits of evaluation all facilitate the goal of eliminating the transmission of HIV in San Francisco.
2. **In this rapidly changing epidemic, evaluation is the only way to ensure that prevention efforts meet the changing needs of affected groups.** Evaluation activities can (1) determine whether prevention programs are responding to consumer perceptions about issues such as HIV transmission, HIV "curability," and vaccine availability; (2) demonstrate whether prevention efforts are keeping pace with the changing epidemiologic distribution of HIV infection and risk behaviors in the city; and (3) show whether new, creative, and innovative programs are effective in the context of the changing epidemic.
3. **Evaluation data can improve prevention planning and resource allocation.** Evaluation results (1) demonstrate whether individual programs are reaching their intended populations, meeting client needs, and are effective at reducing risk behaviors; (2) show which interventions work best in which populations; and (3) indicate trends in HIV infection and risk behavior over time at the citywide level. Thus, evaluation can help HIV prevention planners make informed decisions about the most effective and efficient use of scarce funding and technical assistance resources.
4. **Evaluation gives a voice to consumers of HIV prevention services.** Collecting information from those using services allows their perceptions and experiences to be heard by prevention providers, researchers, policy makers, and funders. Good evaluation (1) continually integrates the consumer voice into design, implementation, and analysis; and (2) considers consumer needs and perspectives when conducting evaluation research.
5. **Evaluation gives credibility to the local HIV prevention strategy.** The San Francisco HIV Prevention community knows that local HIV prevention efforts are effective because providers can see the results in their everyday interactions with clients and communities. Evaluation offers an important opportunity for the city to (1) define "effectiveness" from a local perspective, and (2) showcase and promote its innovative community-based HIV prevention model using scientific methods designed to truly capture the essence of the local work.

Current Evaluation Approach (Through 2003)

EVALUATION APPROACH

To date, San Francisco's HIV prevention evaluation efforts have been focused in three primary areas: (1) documenting numbers, demographics, and risk behaviors of consumers of HIV prevention services, (2) measuring behavioral outcomes associated with particular types of interventions, and (3) tracking the course of the epidemic through surveillance and HIV prevention indicators (Exhibit 2). These methods have provided a solid foundation for the ongoing evaluation and improvement of HIV prevention in San Francisco.

EXHIBIT 2

San Francisco's Evaluation Framework (Through 2003)

EVALUATION FOCUS	RATIONALE	SOURCES OF DATA
Documenting numbers, demographics, and risk behaviors of consumers served	To ensure that: • HIV prevention interventions are reaching high-risk populations (i.e., the populations identified in the HPPC's priority-setting model) • HIV prevention providers are meeting the goals and objectives set out in their contracts • Services to high-risk populations not identified among the HPPC's priorities are being documented, to inform future priorities	• Service data that providers enter into the ELI system • Provider monitoring reports • Needs assessments with particular populations
Assessing behavioral outcomes	To ensure that: • Consumer needs are being met • Interventions are effective at addressing the behaviors that lead to HIV transmission • Resources are allocated to the most effective interventions for affected populations	• Behavioral outcomes measured by providers • Outcome evaluation studies conducted by researchers
Tracking the course of the epidemic	• To assess to what extent HIV prevention efforts are contributing to the overall goal of reducing new HIV infections • To monitor changes in the epidemic that might require a shift in prevention focus or resources	• HIV prevention indicators (e.g., community-wide behavioral surveys, STD trends) • HIV counseling and testing data on new infections (detuned ELISA and repeat tester data) • Population-based studies • AIDS case data

Partnerships and Accountability

SUMMARY

San Francisco's current approach to HIV prevention evaluation is based on the principles of partnership, collaboration, and feedback loops. The HPPC and the HIV Prevention Section encourage and facilitate collaborative efforts for evaluation with the following partners.

- Consumers of HIV prevention services in San Francisco
- The HIV-affected community in San Francisco
- HIV prevention providers in San Francisco
- Academic research institutions, such as the University of California, San Francisco's (UCSF) Center for AIDS Prevention Studies (CAPS), that conduct prevention research with San Francisco populations
- Centers for Disease Control and Prevention (CDC)
- State of California Office of AIDS
- SFDPH (e.g., evaluation researchers, epidemiologists, Program Managers, support staff to the HPPC)
- HIV Health Services Planning Council
- Consultants (e.g., contractors to HIV prevention providers and the HPPC)

Some examples of evaluation successes as a result of such collaborations include the following (a comprehensive list of evaluation-related achievements is presented in Appendix 1):

- Completion of several studies and needs assessments prioritized by the HPPC
- Implementation of Evaluating Local Interventions (ELI), a web-based data system for tracking the demographic and behavioral characteristics of HIV prevention consumers
- HIV prevention provider documentation of client behavioral outcomes since 1998

It is critical that linkages, collaboration, communication, accountability, and feedback loops be in place among all stakeholders in order for HIV prevention evaluation to be successful in San Francisco. One of the mechanisms HPPC has implemented to ensure that HIV prevention evaluation and research findings translate into improved programs is to hear an update on the epidemic twice annually, presented by researchers, after which action steps are brainstormed (e.g., how to make appropriate adjustments to the priority-setting model).

Scientific research, including behavioral, outcome evaluation, and epidemiologic studies, provides the foundation for the priorities outlined in this Plan. Therefore, an ongoing dialogue among the HPPC, researchers, and community members about gaps in information and research priorities is necessary for continual improvement of HIV prevention. Two HPPC committees developed recommendations designed to facilitate this dialogue:

- **Guiding Principles for Research**. In 2002, the HPPC Research Committee adopted a set of guiding principles for research, borrowed from Communities Creating Knowledge – A Consensus Statement on Community-Based Research from The International Network for Community-Based Research on HIV/AIDS (*http://hiv-cbr.net/files/1032743040/CCK%20eng%20statement.pdf*). These guiding principles are outlined in Exhibit 3.
- **Requirements for Researchers**. In 2000, the HPPC's Strategic Evaluation Committee outlined the requirements for researchers funded by SFDPH through the Cooperative Agreement with CDC, those conducting HPPC-prioritized studies, and those seeking letters of support from the HPPC (Exhibit 4). All researchers conducting HIV prevention-related studies are strongly encouraged to share results with the larger San Francisco community.

Overall, the HPPC concurs with the overarching philosophy stated in Communities Creating Knowledge – A Consensus Statement on Community-Based Research: "We believe that all research must be conducted according to accepted ethical standards." The information presented in Exhibits 3 and 4 supports this philosophy.

For more information on the HPPC's specific research priorities, see Chapter 3: Community Assessment, pp. 45-136.

Vision for the Future

The evaluation plan presented in the rest of this chapter builds on the strengths of San Francisco's current approach by (1) mapping out a more detailed framework for evaluation, and (2) presenting the objectives, activities, timelines, and roles and responsibilities for implementing this improved framework in 2004 - 2008. The HPPC's vision is that a comprehensive evaluation framework will be in place that assesses the effectiveness of HIV prevention efforts at many different levels and that provides ongoing information so improvements can be made continually.

EXHIBIT 3

The HPPC's Guiding Principles for Research*

GUIDING PRINCIPLE	DESCRIPTION
Community Benefit	Community-based research is research conducted by and for communities. Its purpose is to build community capacities that will provide knowledge with which to improve community conditions.
Capacity Building	In its conduct, community-based research promotes and develops the inquiry skills of all participants. The aim of community-based research is to build sustainable capacities within communities for self-informed, self-inspired transformation.
Collaboration	A community's experience is a resource that belongs to the community. As such, research initiatives should invite community participation as early as possible in their formation, to shape cooperative agreements about ethical issues, the treatment of data and the dissemination of findings.

*From "Communities Creating Knowledge – A Consensus Statement on Community-Based Research" from The International Network for Community-Based Research on *HIV/AIDS (http://hiv-cbr.net/files/1032743040/CCK%20eng%20statement.pdf)*.

EXHIBIT 4

Requirements for Researchers Conducting CDC- Or HPPC-Supported Research and for Researchers Seeking Letters of Support From the HPPC

REQUIREMENT*	DESCRIPTION
Hold a community forum	Convene at least one community forum and at least one provider forum (they may be done jointly as one forum) that allow a diversity of viewpoints regarding the study and its results to be shared. The forum(s) shall be appropriately publicized and advertised.
Prepare a written report for a community audience	Disseminate a final written community report to all appropriate stakeholders (e.g., providers, SFDPH, community members, other researchers) and anyone requesting a report.
Present results to the HPPC	Request to present results at an HPPC meeting.
Make results available on the Internet	Post results on the Internet and inform community members about the site.

*Researchers are required to complete these tasks within six months of the conclusion of data analysis. If researchers who receive a letter of support from the HPPC do not fulfill the above requirements within this time frame, the HPPC will write a letter of concern stating such, indicating that the researchers' failure to fulfill the requirements will be considered should they request letters of support in the future.

SECTION II

San Francisco's Evaluation Framework for 2004 - 2008

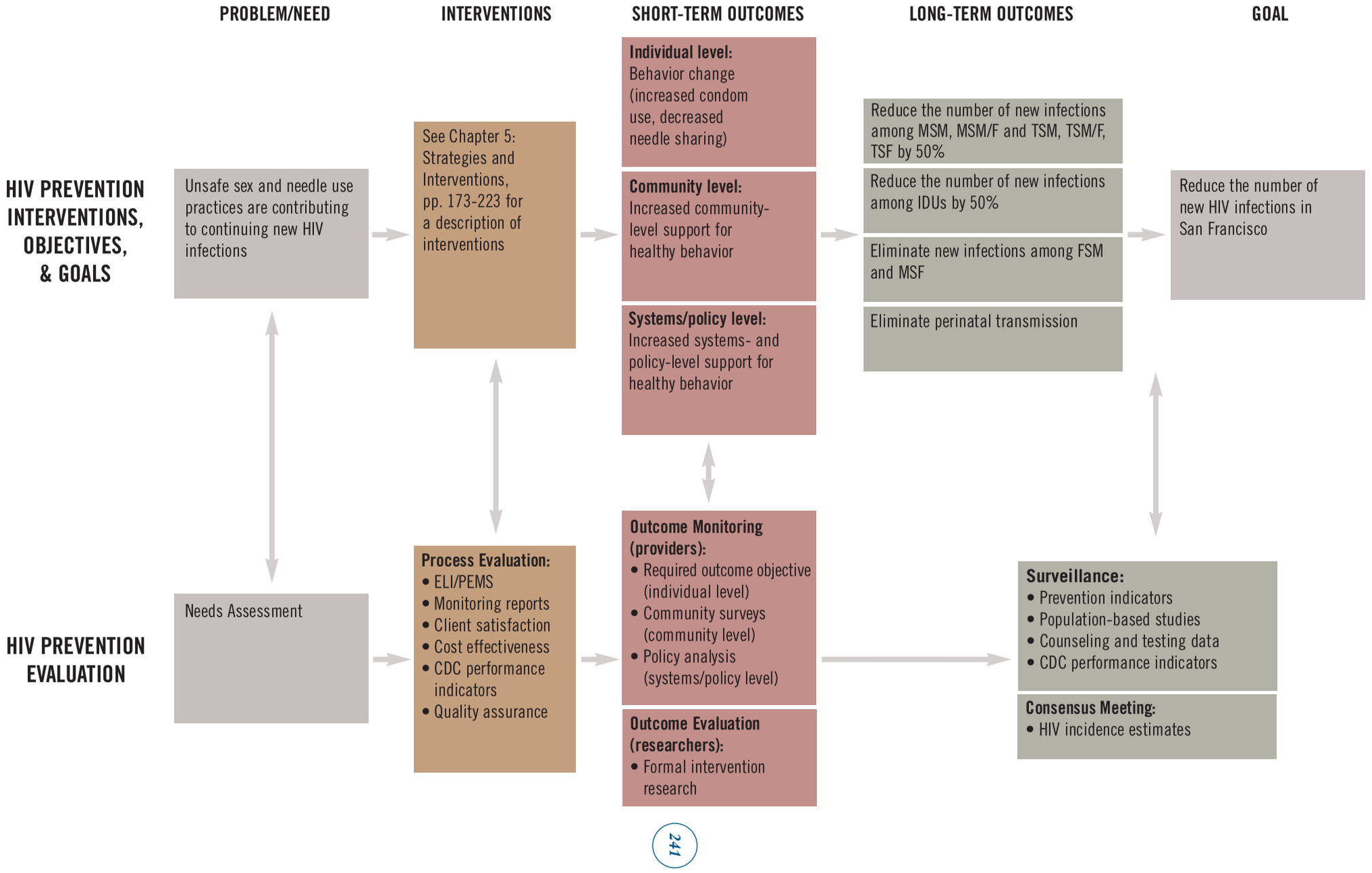
A detailed depiction of San Francisco's evaluation framework is presented in Exhibit 5 (Exhibit 1 presents a simpler version of the framework). This logic model illustrates the relationships between HIV prevention program planning, implementation, and evaluation in San Francisco. It outlines the HIV prevention needs, interventions, objectives, and goals (top row) and the corresponding evaluation activities (indicated by matching colors) implemented at each stage (bottom row). In Section III, the evaluation activities are described in more detail according to who is responsible for their implementation.

As discussed earlier, evaluation activities do not exist in a vacuum; they are part of a feedback loop, which leads to continual program improvement. At every stage – needs assessment, process evaluation, outcome monitoring, and outcome evaluation – information is given to the HPPC and the HIV Prevention Section. This information is then used to:

- Prioritize needs assessments and outcome evaluation studies.
- Identify new areas for HIV prevention focus (e.g., the effects of non-injection drug use on sexual risk behavior).
- Update and revise the HPPC's priority populations, strategies, and interventions
- Allocate resources in accordance with epidemiologic trends.
- Support HIV prevention providers in providing the most effective HIV prevention interventions for their populations.
- Inform HIV-affected communities about the current state of the epidemic and priorities for HIV prevention.

EXHIBIT 5

A Logic Model for HIV Prevention in San Francisco



SECTION III

Implementation Plan for Evaluation

Introduction

This section outlines the required evaluation activities for San Francisco for 2004 through 2008, who is responsible for implementing them, and the timeframe for implementation. The activities represent a combination of CDC, State, and SFDPH requirements. (HPPC does not set the final evaluation requirements; however, many of the SFDPH evaluation requirements are based on HPPC recommendations.)

The three groups responsible for evaluation are HIV prevention providers, SFDPH, and HPPC. Exhibit 6 summarizes the requirements (without timeframes) for each of these groups, according to the type of evaluation. Exhibits 7 through 11 outline the specific activities necessary to meet each requirement with timeframes for completion. The theme that links the evaluation activities into a coherent whole is the feedback loop, which continually ensures that evaluation and research findings are disseminated in a way that can be used to improve HIV prevention. Therefore, several activities relate to collaborating with or sharing information and data among the HPPC, SFDPH, and HIV prevention providers.

Beginning in 2004, CDC is implementing two new requirements:

- The collection, entry, and reporting of data using a web-based system called the Program Evaluation and Monitoring System (PEMS). The overall goal for implementing PEMS is to find a mechanism to combine it with the ELI requirements to avoid duplication in data collection and entry.
- The collection and reporting of data related to a set of 20 CDC-defined performance indicators (Appendix 2).

In order to plan for implementation of these new requirements, as well as the other evaluation requirements, the HPPC will form an Evaluation Committee in 2004 to work closely with SFDPH. The activities outlined in the HPPC column of Exhibit 6 represent a recommended scope of work for this committee. Special effort will be made to ensure that non-HPPC providers and consumers are represented on the committee.

EXHIBIT 6

San Francisco's Evaluation Requirements by Type of Evaluation and Party Responsible

	HPPC	SFDPH*	HIV PREVENTION PROVIDERS
Needs Assessment	• Prioritize needs assessments in accordance with Step 3 of the priority-setting model (see Chapter 4: Priority-Setting, p. 150)§	• Conduct needs assessments as prioritized by HPPC	• Participate in needs assessment by assisting with participant recruitment§
Process Evaluation	***Measuring CDC Performance Indicators***		
	• Review SFDPH's annual reports to CDC on progress toward meeting performance indicator targets and recommend any necessary action steps • Work with SFDPH to develop a set of locally relevant indicators and/or evaluation processes	• Report on progress toward performance indicator targets to CDC† • Develop and track a set of locally relevant indicators and/or evaluation processes	N/A
	Implementing ELI and PEMS		
	• Work with SFDPH to explore and implement procedures for streamlining data collection while meeting CDC, State, and local requirements	• Explore and implement procedures for streamlining data collection while meeting CDC, State, and local requirements • Provide technical assistance to HIV prevention providers for implementing ELI/PEMS	• Provide input to SFDPH regarding streamlining data collection • Collect and enter data on all funded interventions according to ELI/PEMS requirements†,‡,§
	Evaluating the Community Planning Process		
	• Work with SFDPH to collect and report on CDC performance indicators for community planning	• Collect and report on CDC performance indicators for community planning† • Evaluate the community planning process with respect to parity, inclusion, and representation†	N/A
	Conducting Quality Assurance		
	• Work with SFDPH to develop quality assurance policies and procedures	• Develop and implement quality assurance policies and procedures (both for program performance and data collection), including assessing cost-effectiveness†	• Adhere to quality assurance policies and procedures

EXHIBIT 6 (continued)

	HPPC	SFDPH*	HIV PREVENTION PROVIDERS
Process Evaluation (cont.)	***Assessing Client Satisfaction***		
	N/A	• Provide technical assistance to HIV prevention providers for implementing client satisfaction surveys or other activities	• Implement and report on results of client satisfaction surveys or other activities†
Outcome Monitoring	• Review SFDPH's annual reports to CDC on provider behavioral outcomes and recommend any necessary action steps	• Report results of provider behavioral outcomes to CDC annually†	• Measure and report on behavioral outcomes for at least one funded intervention§
Outcome Evaluation	• Prioritize one outcome evaluation study	• Complete one outcome evaluation study†	• Collaborate with SFPDH and HPPC as necessary to conduct an outcome evaluation study
Surveillance	• Hear a presentation twice annually on trends in the epidemic, including surveillance data, and develop any necessary action steps§	• Respond to HPPC and HIV Prevention Section needs for surveillance data, including any data related to the CDC performance indicators†	N/A

*In addition to its own evaluation responsibilities, SFDPH will also provide support to, collaborate with, and provide technical assistance to HPPC and HIV prevention providers to fulfill their evaluation responsibilities.
†CDC requirement.
‡State requirement.
§SFDPH or HPPC requirement.

EXHIBIT 7

Needs Assessment: Requirements, Activities, Timeframe, and Party Responsible

PARTY RESPONSIBLE	REQUIREMENT	ACTIVITIES (TIMEFRAME)
The HPPC will:	**1.** Prioritize needs assessments in accordance with Step 3 of the priority-setting model (see Chapter 4: Priority-Setting, p. 150)	**1a.** Review current data (annually) **1b.** Identify populations with possible increasing incidence (annually) **1c.** Recommend up to two needs assessments to SFDPH (annually)
SFDPH will:	**2.** Conduct needs assessments as prioritized by HPPC	**2a.** Review HPPC recommendations for needs assessments (annually) **2b.** Assess logistical and financial feasibility (annually) **2c.** Secure funding (annually) **2d.** Conduct needs assessment (pending funding) **2e.** Disseminate findings to HPPC, other researchers, and community members (within six months of completion)
HIV Prevention Providers will:	**3.** Participate in needs assessments by assisting with recruitment of participants	**3a.** Identify whether agency clients may be eligible to participate in needs assessments (as applicable) **3b.** Refer potentially eligible clients to needs assessment researchers (as applicable)

EXHIBIT 8

Process Evaluation: Requirements, Activities, Timeframe, and Party Responsible

PARTY RESPONSIBLE	REQUIREMENT	ACTIVITIES (TIMEFRAME)
Planning for Process Evaluation		
SFDPH (with input from HPPC and HIV prevention providers) will:	**1.** Explore and implement procedures for streamlining data collection while meeting CDC, State, and local requirements	**1a.** Work with the 2004 HPPC Evaluation Committee to develop a plan for meeting both ELI and PEMS requirements while minimizing provider and client burden (January – March 2004) **1b.** Identify and secure financial and other resources to implement plan (April – June 2004) **1c.** Implement plan (ongoing beginning in July 2004)
Measuring CDC Performance Indicators		
SFDPH (with feedback from HPPC) will:	**2.** Report on progress toward performance indicator targets to CDC	**2a.** Identify baselines and targets for CDC performance indicators and submit report to CDC (annually, by July 15) **2b.** Analyze relevant ELI/PEMS data (annually, by February) **2c.** Present annual report to HPPC on progress toward CDC performance indicator targets and obtain feedback regarding improving HIV prevention efforts and improving data collection on the performance indicators (annually, March) **2d.** Submit report on progress toward performance indicator targets (annually, by April 1)
	3. Develop and track a set of locally relevant indicators and/or evaluation processes	**3a.** Identify indicators/evaluation processes that will document local successes and areas for improvement (January – December 2004) **3b.** Assess availability of data and resources to measure these indicators (January – March 2005) **3c.** Implement regular tracking of these indicators (ongoing beginning in April 2005)
Implementing ELI and PEMS		
HIV Prevention Providers (with technical assistance from SFDPH) will:	**4.** Collect and enter data on all funded interventions according to ELI/PEMS requirements	**4a.** Collect required data on all funded interventions as specified in the most current Units of Service document (ongoing) **4b.** Enter all data into the ELI system within two weeks after it is collected (ongoing) **4c.** Make any adjustments to ELI data collection and entry to meet PEMS requirements (as necessary)

PARTY RESPONSIBLE	REQUIREMENT	ACTIVITIES (TIMEFRAME)
Evaluating the Community Planning Process		
SFDPH (with input from HPPC) will:	**5.** Collect and report on CDC performance indicators for community planning	**5a.** Work with HPPC 2004 Evaluation Committee to develop targets for CDC performance indicators and a plan for measuring them (January – June 2004) **5b.** Present data on progress toward performance indicators to HPPC for feedback (annually) **5c.** Submit report to CDC on progress toward performance indicators (annually)
	6. Evaluate the community planning process with respect to parity, inclusion, and representation	**6a.** Contract with an external process evaluator to observe HPPC processes and provide feedback to HPPC and the HPPC Co-chairs (annually, by January)
Conducting Quality Assurance		
SFDPH (with input from HPPC) will:	**7.** Develop and implement quality assurance policies and procedures (both for program performance and data collection), including assessing cost-effectiveness	**7a.** Work with HPPC 2004 Evaluation Committee to develop quality assurance policies and procedures for (1) delivery of interventions/programs, and (2) collection and entry of required data (July – December 2004) **7b.** Train providers on quality assurance policies and procedures (January – March 2005) **7c.** Include new quality assurance requirements in provider contracts (ongoing, beginning in July 2005)
Assessing Client Satisfaction		
HIV Prevention Providers (with technical assistance from SFDPH) will:	**8.** Implement and report on results of client satisfaction surveys or other activities	**8a.** Conduct a client satisfaction survey or other activity as specified in their contracts (annually) **8b.** Report results of client satisfaction activity in monitoring reports (annually)

EXHIBIT 9

Outcome Monitoring: Requirements, Activities, Timeframe, and Party Responsible

PARTY RESPONSIBLE	REQUIREMENT	ACTIVITIES (TIMEFRAME)
HIV Prevention Providers (with technical assistance from SFDPH) will:	**1.** Measure and report on behavioral outcomes for at least one funded intervention	**1a.** Select one intervention for which behavioral outcomes will be measured (during program development) **1b.** Work with HIV Prevention Section Program manager to write an outcome objective and design a plan for measuring it (during contract negotiations) **1c.** Collect data on outcome objective (ongoing) **1d.** Report data on outcome objective in monitoring reports (annually)
SFDPH (with input from HPPC) will:	**2.** Review and report on results of provider behavioral outcomes to CDC	**2a.** Assemble behavioral outcome data from provider monitoring reports and assess overall progress toward outcomes (annually) **2b.** Present provider behavioral outcome data to HPPC to obtain feedback on action steps (annually) **2c.** Report results of provider behavioral outcomes to CDC (annually)

EXHIBIT 10

Outcome Evaluation: Requirements, Activities, Timeframe, and Party Responsible

PARTY RESPONSIBLE	OBJECTIVE	ACTIVITIES (TIMEFRAME)
The HPPC will:	**1.** Prioritize one outcome evaluation study by 2004	**1a.** Develop a list of potential topics for outcome evaluation (June 2004) **1b.** Present the list to the HPPC Steering Committee for prioritization of one of the listed studies (August 2004) **1c.** Present prioritized study to HPPC for a vote (December 2004)
SFDPH will:	**2.** Complete one outcome evaluation study by 2008	**2a.** Identify a principal investigator (March 2005) **2b.** Develop a research proposal (December 2005) **2c.** Secure funding (March 2006) **2d.** Implement study (2006 – 2008)

EXHIBIT 11

Surveillance: Requirements, Activities, Timeframe, and Party Responsible

PARTY RESPONSIBLE	OBJECTIVE	ACTIVITIES (TIMEFRAME)
SFDPH will:	**1.** Respond to HPPC and HIV Prevention Section needs for surveillance data	**1a.** Provide data upon request to HPPC, HIV Prevention Section staff, and the HPPC Technical Support Consultant (ongoing)
HPPC will:	**2.** Hear a presentation twice annually on trends in the epidemic, including surveillance data, and develop any necessary action steps	**2a.** Request a presentation from an SFDPH or other epidemiologist/researcher (twice annually, by January and by June) **2b.** Review draft of presentation and give feedback (twice annually, by February and by July) **2c.** Schedule presentation (twice annually, by March and by August)

APPENDIX 1

Evaluation Successes in San Francisco

- SFDPH has completed several studies and needs assessments prioritized by the HPPC, including:
  - The Transgender Community Health Project study (Clements et al 1999, Clements-Nolle et al 2001)
  - The Prevention Case Management (PCM) Outcome Study (Sebesta 2003)
  - The Party & Play Study (Pendo et al 2003)
  - Needs assessments with men who have sex with male-to-female (MTF) transgendered persons (Coan et al, in press), Latino immigrant MSM (Harder+Company 2001), heterosexually identified African American and Latino MSM (Harder+Company 2004a), Native American two spirit individuals (result available in 2004), and male and MTF homeless and marginally housed sex workers in the Tenderloin (Harder+Company 2004b)
  - Investigation of the High HIV Prevalence in the Transgender African American Community in San Francisco (2003)
  - An assessment of existing Prevention with Positives programs (DeMayo 2003)
  - HIV prevention capacity assessments in two San Francisco neighborhoods: Bayview/Hunter's Point (Harder+Company 2004c) and Tenderloin (Harder+Company 2004d)
- The HIV Prevention Section, in collaboration with HIV prevention providers, the State Office of AIDS, and technical assistance consultants, has implemented Evaluating Local Interventions (ELI), a web-based data system for tracking the demographic and behavioral characteristics of HIV prevention consumers.
- The HPPC and the HIV Health Services Planning Council have joined forces to explore opportunities for assessing, implementing, and evaluating prevention with positives programs, as well as to collaborate in conducting needs assessments.
- HIV prevention providers have been measuring behavioral outcomes for their HIV prevention interventions for several years.
- CAPS and other UCSF researchers have supported the HPPC in its needs assessment efforts by sharing survey protocols, brainstorming to avoid duplication of efforts, and making recommendations for recruitment and implementation.
- Evaluation has documented the effectiveness of needle exchange, which has helped promote continued local funding for needle exchange programs. This has helped keep HIV incidence stable and relatively low among IDUs in San Francisco.
- The implementation of regular HIV Consensus Meetings resulting from a collaboration between SFDPH, the HPPC, and researchers, has generated critical data for the HPPC's planning and prioritization processes.

APPENDIX 2
CDC Performance Indicators

EXHIBIT 12
CDC's HIV Prevention Program Performance Indicators

PROGRAM PERFORMANCE INDICATOR	AREA OF INTEREST
Overall HIV	
A.1: Number of newly diagnosed HIV infections.	
A.2: Number of newly diagnosed HIV infections, 13–24 years of age.	
Counseling, Testing, and Referral Services	
B.1: Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites.	Overall HIV positive test yield
B.2: Percent of newly identified, confirmed HIV-positive test results returned to clients.	Knowledge of HIV positive serostatus
B.3: Percent of facilities reporting a prevalence of HIV positive tests equal to or greater than the jurisdiction's target set in B.1.	Targeted services
Partner Counseling and Referral Services	
C.1: Percent of contacts with unknown or negative serostatus receiving an HIV test after PCRS notification.	Contact use of services
C.2: Percent of contacts with a newly identified, confirmed HIV-positive test among contacts who are tested.	Knowledge of serostatus by newly identified HIV positive contacts
C.3: Percent of contacts with a known, confirmed HIV-positive test among all contacts.	Contacts known to be HIV positives
Perinatal Transmission Prevention	
Applicable only to those jurisdictions with supplemental funding for perinatal transmission prevetion through the Health Department Cooperative Agreement	
D.1: Proportion of women who receive an HIV test during pregnancy.	Pregnant women's knowledge of their serostatus
D.2: Proportion of HIV-infected pregnant women who receive appropriate interventions to prevent perinatal transmission.	Provision of preventive treatment to minimize perinatal HIV transmission
D.3: Proportion of HIV-infected pregnant women whose infants are perinatally infected.	Perinatal HIV transmission
All jurisdictions	
D.4: Proportion of women who receive an HIV test during pregnancy.	Pregnant women's knowledge of their serostatus

EXHIBIT 12 (continued)

PROGRAM PERFORMANCE INDICATOR	AREA OF INTEREST
Community Planning	
E.1: Proportion of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one CPG member that reflects the perspective of each population.	Representativeness
E.2: Proportion of key attributes of an HIV prevention planning process that CPG membership agreed have occurred.	Community planning implementation
E.3: Percent of prevention interventions/other supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.	Linkages between community planning priorities and funding priorities
E.4: Percent of health department-funded prevention interventions/other supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan	Linkages between community planning priorities and resource allocation
Evaluation	
F.1: Proportion of providers reporting representative process monitoring data to the health department in compliance with CDC program announcement.	Capacity to monitor programs
Capacity Building	
G.1: Proportion of providers who have received at least one health department supported capacity building assistance, specifically in the form of trainings/workshops in the design, implementation or evaluation of science-based HIV prevention interventions.	Capacity building assistance in the design, implementation or evaluation of science based HIV prevention interventions.
In the future, an indicator will be developed to measure increased capacity to design, implement, or evaluate science based HIV prevention interventions	
Health Education/Risk Reduction	
H.1: Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).	Retention
H.2: Proportion of the intended number of the target populations to be reached with any of the following specific interventions (ILI or GLI or PCM) who were actually reached.	Reach of intended target populations
H.3: The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM.	Impact of outreach and utilization of services
Prevention for HIV Infected Persons	
I.1: Proportion of HIV infected persons that completed the intended number of sessions for Prevention Case Management.	Retention among infected persons
I.2: Percent of HIV infected persons who, after a specified period of participation in Prevention Case Management, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.	Impact of PCM among infected persons

APPENDIX 3
Needs Assessment and Program Evaluation Resources

On-Line Needs Assessment Resources

- National Minority AIDS Council needs assessment guide
  http://www.nmac.org/tech_assistance/ta_resources/Org_Effectiveness/NdsAmt.pdf

- Synergy Project APDIME Tool Kit
  http://www.synergyaids.com/apdime/index.htm

On-Line Program Evaluation Resources

- National Minority AIDS Council program evaluation guide
  http://www.nmac.org/tech_assistance/ta_resources/Org_Effectiveness/ProgEva.pdf

- UCSF Center for AIDS Prevention Studies, "Developing and Evaluating HIV Prevention Programs"
  http://www.caps.ucsf.edu/toolbox/devindex.html

- Synergy Project APDIME Tool Kit
  http://www.synergyaids.com/apdime/index.htm

- Sociometrics Corporation
  http://www.socio.com/eval.htm

Resources for Trainings on Evaluation

- Academy for Educational Development, Center for Applied Behavioral and Evaluation Research, Washington DC
  http://caber.aed.org/, 202-884-8796

- California HIV/STD Prevention Training Center, Berkeley, CA
  http://www.stdhivtraining.org/cfm/staff.cfm, (510) 883-6600

- Sociometrics Corporation, Los Altos, CA
  http://www.socio.com/eval.htm, 650-949-3282