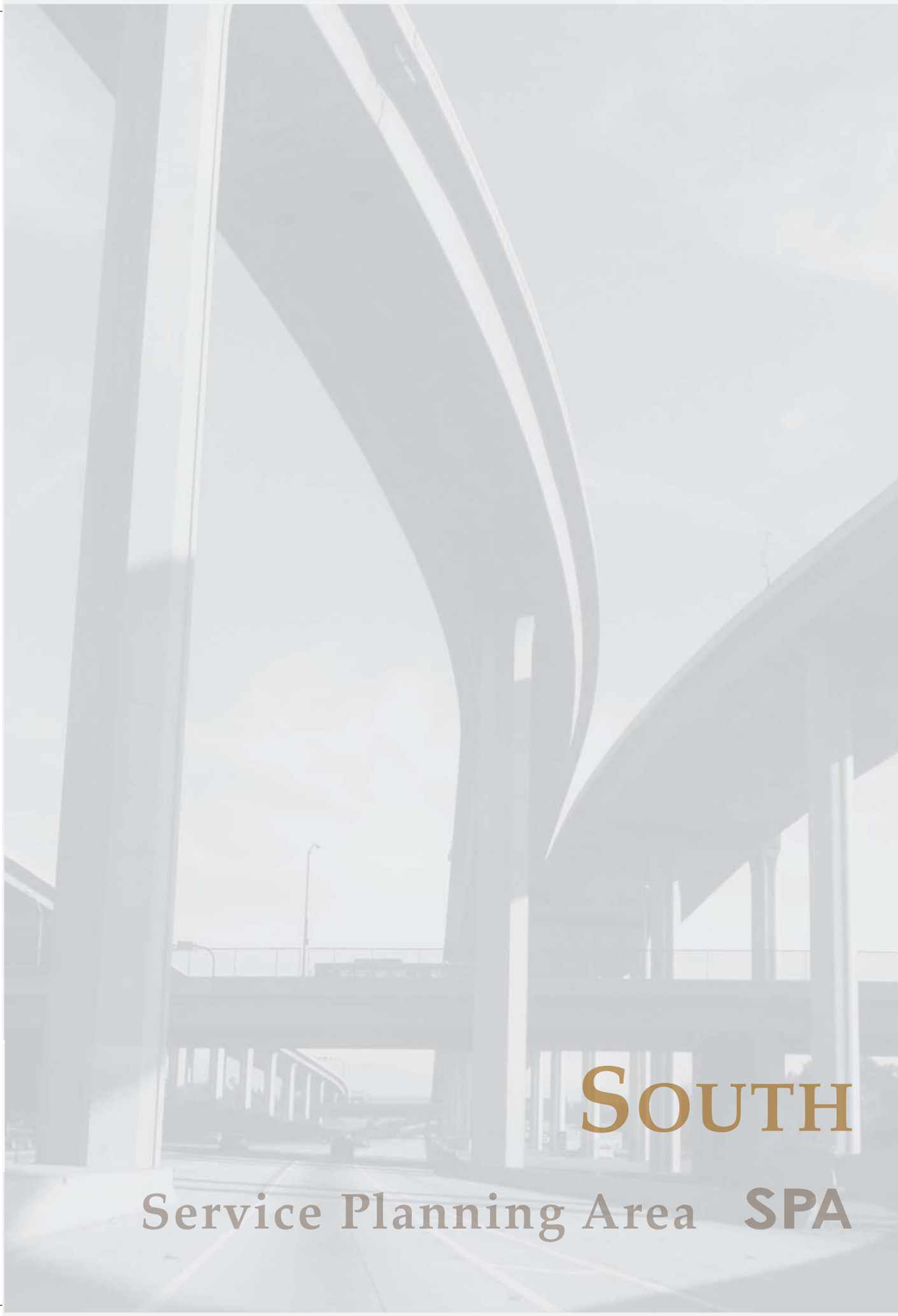

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Service Planning Area SPA 6

Chapter 6: Evaluation

Overview

This chapter:

- Describes the purpose of evaluation within the context of HIV prevention and community planning, as well as the program evaluation requirements of the Centers for Disease Control and Prevention (CDC);
- Outlines the program performance indicators for interventions utilized by the Los Angeles County Department of Public Health Office of AIDS Programs and Policy (OAPP);
- Offers information on how to develop an evaluation component for an HIV prevention program, including evaluation examples; and
- Presents the recommendations of the Evaluation Subcommittee of the Los Angeles County HIV Prevention Planning Committee (PPC).

Evaluation has always been an integral component of HIV prevention and community planning. In recent years, as funding becomes increasingly competitive, the spotlight on evaluation has become more focused and its importance cannot be overstated. The purpose of this chapter is to help organizations understand evaluation within the context of both the federal and local environment, as well as to help them understand the basics of how to evaluate their HIV prevention interventions. Lastly, there are a number of evaluation resources available that organizations can access to assist them in creating an evaluation plan for their interventions. A brief list of these resources is also provided.

Evaluating HIV Prevention in Los Angeles County

The Centers for Disease Control and Prevention (CDC) offers extensive guidance to health departments and community planning groups on both what needs to be evaluated as well as how to evaluate those elements. These resources include several guidance documents:

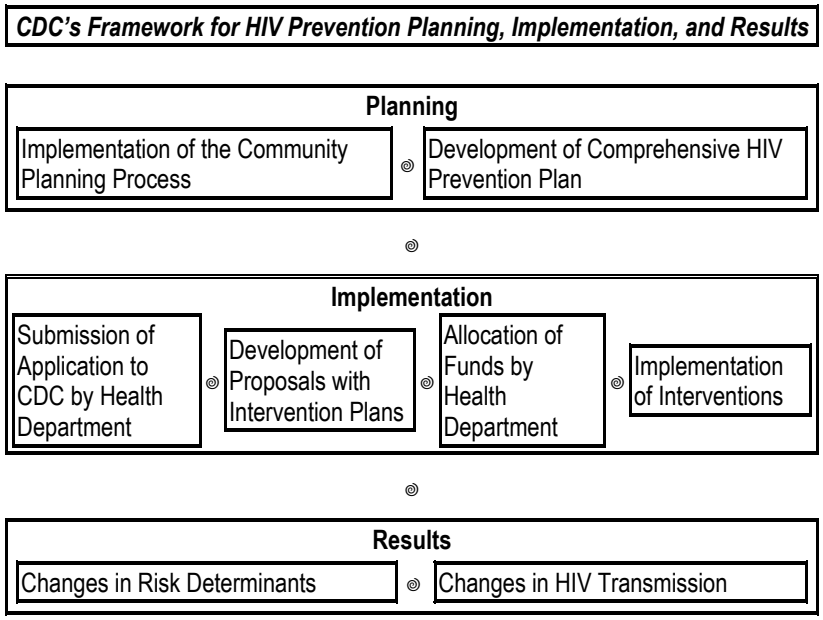
1. Evaluating CDC-Funded Health Department HIV Prevention Programs: Volume 1 – Guidance & Volume 2 – Supplemental Handbook (December 1999);

2. 2003-2008 HIV Prevention Community Planning Guidance (July 2003); and

3. HIV Prevention Strategic Plan: Extended through 2010 (October 2007).

These documents outline the CDC's framework for evaluation, which health departments and community planning groups are responsible for implementing. This framework outlines the continuum of steps from community planning to achieving reductions in HIV risk behavior at the client level. Figure 6.1 below depicts this framework.

Figure 6.1 CDC's Conceptual Framework for HIV Prevention and Evaluation



Source: CDC. Evaluating CDC-Funded Health Department HIV Prevention Programs: Supplemental Handbook

As seen in Figure 6.1, evaluation encompasses all aspects of HIV prevention including planning, implementation, and results. Although the specific evaluation activities vary across these prevention components, they ultimately serve the same purpose to reduce the transmission of HIV across Los Angeles County.

■ Community Planning

Evaluation begins with the HIV prevention community planning process. The CDC's *2003-2008 HIV Prevention Community Planning Guidance* outlines three goals and eight specific objectives to which it holds local health departments and community planning groups accountable. In Los Angeles County, the Los Angeles County Department of Public Health Office of AIDS Programs and Policy (OAPP) and the Los Angeles County HIV Prevention Planning Committee (PPC) are the public and community entities responsible for ensuring that each of these goals and objectives are monitored closely. Thus, the first level of evaluation in Los Angeles County is to track progress in meeting the CDC requirements for community planning as described below:

CDC Goal 1: Community planning supports broad-based community participation in HIV prevention planning.

- *Objective A:* Implement an open recruitment process (outreach, nominations, and selection) for Community Planning Group (CPG) membership.

- *Objective B:* Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.

- *Objective C:* Foster a community planning process that encourages inclusion and parity among community planning members.

CDC Goal 2: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

- *Objective A*: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

- *Objective B*: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.

- *Objective C*: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

CDC Goal 3: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

- *Objective A*: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.

- *Objective B*: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

As the Grantee for CDC funding, OAPP works with the PPC to assess their progress in achieving the above mentioned objectives. This ensures congruence between all components of HIV prevention in Los Angeles County from the community planning process through funded interventions. OAPP is responsible for tracking and reporting progress on these objectives to both the PPC and the CDC.

Los Angeles County's Program Performance Indicators

As part of the previous HIV prevention comprehensive planning process, Los Angeles County integrated the CDC's national program performance indicators into its own evaluation efforts. OAPP incorporated these indicators into the 2004 HIV prevention request for proposal process as requirements for contracted service providers. In this way, the CDC's national program performance indicators became Los Angeles County's program performance indicators.

In October 2007, the CDC released its new *HIV Prevention Strategic Plan: Extended Through 2010.* This document replaces it previous national overarching goal to reduce new HIV infections with a more concrete short-term goal to "reduce the number of new HIV infections in the United States by 5% per year, or at least by 10% through 2010, focusing particularly on

eliminating racial and ethnic disparities in new HIV infections." In this document, the CDC has also expanded its original 11 indicators to 25 indicators in order to better address racial/ethnic disparities as well as the continued disproportionate impact on men who have sex with men (MSM).

Los Angeles County will update its program performance indicators to be in alignment with the CDC's new milestones and objectives (see Tables 6.1-6.5). As part of the extended strategic plan, the CDC also provides specific program performance indicators for each stated objective. OAPP will work with the PPC to update Los Angeles County's baseline measures and annual targets to meet the CDC's new requirements.

Short-Term Goal: *"Reduce the number of new HIV infections in the Los Angeles County by 5% per year, or at least by 10% through 2010, focusing particularly on eliminating racial and ethnic disparities in new HIV infections."*

Table 6.1 Transmission Objectives that Respond to Short-Term Milestone 1

Short-Term Milestone 1: *By 2010, decrease by at least 10% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.*	
TRANSMISSION OBJECTIVES	
1	Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission.
2 **Modified**	Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV.
3 **Modified**	Among sexually active, HIV-infected women and HIV-infected sexually active heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV.
4 **Modified**	Among injection drug users (IDUs), increase the proportion who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk of HIV transmission.
5 **Modified**	Among adolescents living with HIV, increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV, particularly among out-of-school high-risk youth.
6 **New**	Increase the proportion of persons living with HIV who effectively access partner notification services.
7 **New**	Among persons living with HIV, increase the proportion who receive evidence-based interventions, including mental health, substance abuse, and other appropriate interventions for co-morbid conditions.
8 **New**	Among persons with acute HIV infection, increase the proportion reached by appropriate HIV behavioral interventions.
9 **New**	Increase the proportion of persons living with HIV who disclose their HIV infection before a risk encounter with a new partner and increase the proportion of persons at risk for HIV infection who disclose their HIV status before their first risk encounter with a new partner.
10 **Modified**	Increase the proportion of HIV-infected pregnant women who are routinely tested and access prevention interventions including antiretroviral medication, caesarean sections (when appropriate) and infant formula feedings to interrupt perinatal transmission of HIV.

Table 6.2 Acquisition Objectives that Respond to Short-Term Milestone 1

Short-Term Milestone 1: *By 2010, decrease by at least 10% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.*	
ACQUISITION OBJECTIVES	
1a **Modified**	Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for acquisition of HIV.
2a **New**	Increase the number of proven effective behavioral prevention interventions for African Americans and other racial and ethnic groups disproportionately affected by HIV/AIDS.
3a **New**	Increase the number of proven effective behavioral prevention interventions for MSM.
4a **Modified**	Among at-risk sexually active women, and at-risk sexually active heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition.
5a **Modified**	Among adolescents, increase the proportion who consistently engage in behaviors that reduce risk for acquisition of HIV, particularly among out-of-school high-risk youth.
6a **Modified**	Among injection drug users (IDUs), increase the proportion who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk of HIV acquisition.
7a	Increase the proportion of people at risk for HIV who are tested for STDs and treated appropriately
8a **Modified**	Increase the number of and access to proven effective biomedical HIV prevention interventions including circumcision, vaccines, microbicides, and oral chemoprophylaxis.
9a	Reduce the number of workers who are occupationally exposed to and infected with HIV.
10a **Modified**	Continue to support the safety of blood, tissue and organ supplies in the United States.

Table 6.3 Objectives that Respond to Short-Term Milestone 2

Short-term Milestone 2: *By 2010, through voluntary testing, increase from the current estimated 75% to 80% the proportion of HIV-infected people in the United States who know they are infected.*	
OBJECTIVES	
1 **New**	Increase the percentage of all ethnic/racial minorities who, if infected, are aware of their HIV infection, with a focus on African Americans.
2 **New**	Increase the percentage of all MSM who, if infected, are aware of their HIV infection.
3 **Modified**	Increase the number of providers who routinely provide screening in health care settings (e.g., STD clinics, substance abuse treatment programs, family planning clinics, emergency rooms, community health centers), as well as voluntary counseling and testing (VCT) in non-clinical venues (e.g., social venues, street outreach).
4 **New**	Increase the use of rapid testing technology that is user friendly and produces same day results.
5 **New**	Increase availability of HIV screening to incarcerated persons.
6 **Modified**	Improve access to voluntary, client-centered counseling and testing (VCT) in high seroprevalence communities and populations at risk, focusing particularly on populations with high rates of undiagnosed infection.
7 **New**	Reduce structural and policy barriers to implementing routine HIV screening (e.g., barriers to rapid testing, counseling and consent requirements).
8 **New**	Increase the percentage of people who know their results after testing.
9 **Modified**	Increase the motivation of at-risk individuals to know their infection status and decrease real and perceived barriers to HIV testing, such as stigma and discrimination.

Table 6.4 Objectives that Respond to Short-Term Milestone 3

Short-term Milestone 3: *By 2010, increase from the current estimated 50% to 65% the proportion of newly diagnosed HIV-infected people in the United States, who are linked to appropriate prevention, care and treatment services.*	
OBJECTIVES	
1 **Modified**	Increase the proportion of persons newly diagnosed with HIV who are successfully linked to medical care within 3 months of learning their HIV infection or being re-identified as HIV-infected but out of care, including African Americans and other racial and ethnic groups disproportionately affected by HIV/AIDS.
2 **Modified**	Increase the proportion of persons newly diagnosed with HIV who are successfully linked to culturally competent, science-based prevention services.
3 **Modified**	Integrate prevention services, including adherence to treatment and partner notification services for persons diagnosed with HIV and AIDS, into the delivery of patient care in both public and private sectors.
4 **Modified**	Reduce the disparities, stigma and discrimination in access to prevention and care services that are experienced by communities of color, women, and MSM.
5	Increase the proportion of HIV care providers offering routine, periodic STD screening and treatment to HIV-infected clients.
6	Promote the optimal level of medical services for patients diagnosed with HIV to benefit individual health and reduce the likelihood of further transmission of HIV.
7	Increase the proportion of correctional facility detainees (incarcerated for at least 30 days) identified as HIV-infected who are provided HIV prevention, treatment and care services and who, upon release, are successfully linked to those services in the communities to which they return.
8	Increase the proportion of HIV care providers offering routine, periodic TB screening and treatment to HIV-infected clients.
9 **Modified**	Increase the proportion of persons newly diagnosed with HIV (including pregnant women) who need substance abuse treatment services that are successfully linked to those services.
10 **Modified**	Increase the proportion of persons newly diagnosed with HIV who need social and mental health services that are successfully linked to those services.

Table 6.5 Objectives that Respond to Short-Term Milestone 4

Short-term Milestone 4*: By 2010, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs.*	
OBJECTIVES	
1 **Modified**	Improve the capacity to measure incidence of new infections; track the prevalence of disease and its complications; monitor the transmission and prevalence of drug resistant virus; monitor behaviors, including behaviors that increase the risk of HIV infection (among persons who are HIV-uninfected) and behaviors that increase the risk of HIV transmission and the risk of disease progression (for persons who are living with HIV); and provide locally relevant data for community planning.
2	Increase the number of evidence-based interventions and the proportion of prevention providers funded by CDC who successfully provide demonstrably effective HIV prevention interventions.
3 **Modified**	Support realistic and feasible evaluation efforts to ensure the delivery of interventions at the highest possible quality.

Developing an Evaluation Plan for HIV Prevention Programming

There are a number of excellent resources that provide information and tools to help agencies evaluate their HIV prevention and related programs. The following information has been compiled from several of these resources including a Los Angeles-based directly-funded CDC capacity building assistance (CBA) program; the American Psychological Association's Office on AIDS; the CDC; and the National Prevention Information Network.

The information presented below is offered in order to help organizations build and strengthen the evaluation component of their programs. This is simply a beginning and is not intended to answer all the questions an agency may have regarding how to put together a comprehensive evaluation plan. The PPC and OAPP encourage all agencies to take advantage of the many resources available both locally and nationally to guide their ongoing evaluation efforts.

■ Program Evaluation

CDC defines Program Evaluation as:

> *The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development.* [1].

There are several benefits to program evaluation, which include helping organizations to:

1. Improve decision-making and program planning;
2. Stay on track in meeting goals and objectives;
3. Improve program and service delivery;
4. Fulfill grant or contract requirements;
5. Determine the cost-effectiveness of a program;
6. Make budgetary decisions; and
7. Provide evidence for future funding.

However, despite these benefits, there are also several barriers to successful evaluation. These include: (1) lack of evaluation skills among staff, (2) limited resources, (3) lack of support, (4) fear of consequences, and (5) a burden on staff and program participants. To better understand the benefits and barriers to program evaluation, it is important to understand the types of program evaluation that are possible. This includes understanding the differences between process monitoring and process evaluation, and outcome monitoring and outcome evaluation. There are different costs and requirements associated with different types of evaluation. Not all types of evaluation are necessary to conduct an effective evaluation of a typical HIV prevention program.

■ Evaluating HIV Prevention Programs

In today's environment to ensure program accountability, having a strong evaluation plan is essential for any organization seeking funding. It is through program evaluation that an agency can showcase its success and demonstrate that an intervention works, i.e., creates positive behavior change to reduce the risk of acquiring or transmitting HIV. Thus, it is important to

develop an evaluation component that measures this success, as well as lessons learned in order to improve the program later on. There are many web-based and local resources including the Center of HIV Identification, Prevention, and Treatment Services; *Acción Mutua* a Los Angeles-based CDC CBA program at AIDS Project Los Angeles; and OAPP to help agencies with the evaluation component of their programs. The information presented offers one guide to help agencies design an evaluation plan for their specific programs.

❖ *HOW TO EFFECTIVELY EVALUATE YOUR HIV PREVENTION PROGRAM*

The first step in the process is to begin thinking about *how* to evaluate an HIV prevention program. Consider the following questions and key points:

Why evaluate my program?

- ➡ Ensure program effectiveness and appropriateness
- ➡ Demonstrate accountability
- ➡ Contribute to HIV/AIDS knowledge base
- ➡ Influence policy makers
- ➡ Improve program operations and service delivery

Key Points to Consider:

- ➡ Collect data in systematic manner
- ➡ Focus on program activities, characteristics, and outcomes
- ➡ Can serve multiple purposes

The following framework provides agencies with a systematic guide to successfully evaluate their HIV prevention programs. This same framework is utilized to describe the process of *"how to effectively evaluate HIV prevention programs"* as well as to understand the specific details regarding process monitoring and evaluation, and outcome monitoring and evaluation, which is described later.

Table 6.6 Framework for Understanding Evaluation

STEP	DESCRIPTION
STEP 1	Determine Purpose and Uses
STEP 2	Develop Measurable Objectives
STEP 3	Develop Evaluation Questions
STEP 4	Collect / Gather Credible Evidence
STEP 5	Analyze Information & Develop Conclusions
STEP 6	Report Findings

STEP 1 - DETERMINE PURPOSE AND USES
One of the most important steps that will guide the rest of the evaluation process. To begin, can the following questions be answered?

1. Who is most likely to need and use the information obtained?
2. What is the primary purpose of the evaluation?
3. How will the information be used?

Once you know these answers, you need to develop objectives.

STEP 2 - DEVELOP MEASURABLE OBJECTIVES
Objectives are specific statements which describe what is planned for the proposed program within a given time period (CDC, 1999).

Each objective should include the following components:

Table 6.7 Components of Measureable Objectives

When	How Much	For Whom	What	Where
Time (date) by or during which it is to occur	Target rate or the amount of change	Refers to the target population	Problem/behavior/ outcome to be changed or intervention to be accomplished	Area in which target population is located

STEP 3 - DEVELOP EVALUATION QUESTIONS
For each objective, develop evaluation questions:

- ➡ Help focus the evaluation
- ➡ Vary from one program to another
- ➡ Based on purpose, objectives, resources, and timeframe of the evaluation

STEP 4 - COLLECT/GATHER CREDIBLE EVIDENCE
For each evaluation question, 2 elements (variables and measures) must be identified to develop evaluation tools (e.g. surveys).

STEP 5 - ANALYZE INFORMATION & DEVELOP CONCLUSIONS
Data analysis is the process of categorizing, ordering, manipulating, and summarizing data to obtain answers to evaluation questions.

1. Enter data and check for errors (e.g. create a database-paper or electronic);
2. Tabulate data (e.g. count how many desirable or undesirable results exist);
3. Analyze data by key characteristics (e.g. compare what was planned with what resulted); and
4. Provide interpretation of findings (e.g. explanation of findings).

STEP 6 - REPORT FINDINGS

Reports can help improve a program, inform others about a program and show the effects of a program. Reports should include:

- ➡ Description of program services being evaluated
- ➡ Purposes of the evaluation
- ➡ Methods of data collection
- ➡ Results of data analysis
- ➡ Discussion of strengths and weaknesses and implications of the results

❖ ***PROCESS MONITORING AND PROCESS EVALUATION***

Process Monitoring is the routine documentation of data describing the characteristics of the population served, the services provided, and the resources used to deliver those services (CDC 2002). In short, it helps staff identify problems with program operations and delivery and provides evidence for making needed changes.

Table 6.8 Types of Data to Collect for Process Monitoring

THE CORE SET OF DATA TO COLLECT	OTHER TYPES OF DATA TO COLLECT (depending on intervention)
➡ Type of agency	➡ Number of clients served by setting
➡ Number of clients served, categorized by race/ethnicity and gender (Age is also encouraged.)	➡ Number of clients receiving 1, 2, or 3 or more sessions
➡ Number of full time equivalent (FTE) staff used	➡ Number of prevention materials distributed
➡ Expenditures for the intervention	➡ Number of partners identified, counseled, tested, and tested positive

Process evaluation is the assessment of a program's conformity to its design, program implementation, and the extent to which it reaches its intended audience (CDC 1999). It allows determinations of whether or not the program is being delivered as planned.

Process monitoring is distinct from process evaluation. Process evaluation collects additional data to answer detailed questions about program implementation. Questions may include:

1. Was the intervention implemented in a manner consistent with its design?
2. Did the intervention reach the population most at risk?
3. What barriers did clients experience in accessing the intervention?

Process evaluation greatly enhances an evaluation plan. Process evaluation assists an agency in knowing whether or not the implementation of the program adheres to the original program design. This is especially important if an agency wants to create their locally developed intervention (LDI) in a manner so that it can be replicated elsewhere. Process evaluation is also useful when an agency decides to adapt a CDC effective behavioral intervention (EBI) to ensure that the adaptation remains true to the CDC-defined core elements of the intervention. Core elements are those components of an intervention that cannot be changed.

Framework for Successful Process Monitoring

The following framework provides agencies with a systematic guide to successfully evaluate their HIV prevention programs using process monitoring.

Table 6.9 Framework for Successful Process Monitoring

STEP	DESCRIPTION
STEP 1	Determine Purpose and Uses
STEP 2	Develop Measurable Objectives
STEP 3	Develop Evaluation Questions
STEP 4	Collect / Gather Credible Evidence
STEP 5	Analyze Information & Develop Conclusions
STEP 6	Report Findings

STEP 1 - DETERMINE PURPOSE AND USES FOR YOUR PROCESS MONITORING

Table 6.10 Purpose and Uses of Process Monitoring

PURPOSE	USES
The main purpose of process monitoring is to improve how things get done by answering questions about program operations, implementation, and service delivery.	➡ To improve program implementation ➡ Context for understanding effectiveness ➡ Accountability ➡ Quality management

STEP 2 - DEVELOP MEASURABLE PROCESS OBJECTIVES

Process objectives are statements that describe the specific implementation activities of an intervention for a specified population within a given timeframe. Process objectives focus on "implementation activities" e.g. number of condoms distributed, number of sessions conducted.

EXAMPLE:	By December 31, 2008, 250 condoms and 100 bleach kits will be distributed to clients as part of the one-on-one counseling intervention.

STEP 3 - DEVELOP PROCESS EVALUATION QUESTIONS

Once objectives are identified, specific questions requiring specific answers need to be developed. The focus of evaluation questions in process monitoring is describing the intervention activities including the human and other resources needed to carry them out, the level of effort needed to accomplish each activity, and the time frames in which the activities will be conducted.

STEP 4 - COLLECT/GATHER CREDIBLE EVIDENCE FOR PROCESS MONITORING

Process data can be collected at two levels: client-level and program-level. Client-level data directly involves, pertains, or derives from program participants. Program-level data are information related to program operations and structure. Below are some examples client- and program-level process data.

Table 6.11 Examples of Client-Level and Program-Level Process Data

CLIENT-LEVEL PROCESS DATA	PROGRAM-LEVEL PROCESS DATA
➡ Demographics ➡ Risk behaviors ➡ HIV/AIDS-related knowledge, attitudes, beliefs and behaviors ➡ Number of participants ➡ Length of contact/session	➡ Staff training background ➡ Staff demographics ➡ Staff turnover ➡ Expenditures ➡ Recruitment methods

STEP 5 - ANALYZE DATA & JUSTIFY CONCLUSIONS ABOUT YOUR PROCESS MONITORING
Data analysis is the process of categorizing, ordering, manipulating, and summarizing data to obtain answers to evaluation questions.

STEP 6 - REPORT FINDINGS ABOUT YOUR PROCESS MONITORING
Often times process monitoring serves an accountability function. Because HIV prevention and care efforts utilize public funds, service providers have obligations to provide stakeholders with answers to questions about programs. Specifically, data from process measures can provide information about the quality of the program or services.

❖ *OUTCOME MONITORING AND OUTCOME EVALUATION*

Outcome Monitoring is the collection of data about participant knowledge, attitudes, beliefs and behaviors (KABBs), and intentions to change behavior before, during, and/or after the intervention. It identifies what components are working as expected and which ones are not in order to improve program effectiveness.

Outcome Evaluation is the collection of data on changes in participant KABBs and compares these results to another group of participants not participating in the intervention. It provides evidence that the intervention is causing the intended changes. It allows determinations of whether or not the program is being delivered as planned.

Both outcome monitoring and outcome evaluation can be used to assess whether an intervention achieved its specified objectives (measurable outcomes). The primary difference between the two is that a rigorous research method is essential to outcome evaluation which is why program evaluation focuses on outcome monitoring and rarely conducts outcome evaluation.

The Performance Indicators developed by the CDC to guide local health departments are predominantly measures to be used for outcome monitoring. They provide good examples of measures that organizations may use in their own programs where appropriate.

Table 6.12 Comparing Outcome Monitoring and Evaluation

OUTCOME MONITORING	OUTCOME EVALUATION
➡ NO comparison group needed	➡ COMPARISON group needed
➡ CANNOT make the claim that effectiveness is due to the intervention	➡ CAN make the claim that effectiveness is due to the intervention
➡ CAN track changes of participants in intervention	➡ CAN track changes of participants in intervention
➡ COLLECT data at least 2 points in time	➡ COLLECT data at least 2 points in time
➡ CANNOT predict risk behaviors of target population	➡ Can predict risk behaviors of target population

Types of Prevention Interventions Suitable for Outcome Monitoring

Outcome monitoring should be applied to programs whose clients or patients are accessible for a follow-up measure of program outcomes. Interventions and services best suited for outcome monitoring are:

- ➡ Individual or group-level interventions
- ➡ Comprehensive Risk Counseling & Services (CRCS)
- ➡ Counseling done in the context of HIV testing
- ➡ Ongoing medical services

It is more difficult to conduct outcome monitoring of outreach, social marketing, and community-level interventions.

Framework for Successful Outcome Monitoring

This framework provides agencies with a systematic guide to successfully evaluate their HIV prevention programs using outcome monitoring. It follows the same steps as described earlier under process monitoring.

Table 6.13 Framework for Successful Outcome Monitoring

STEP	DESCRIPTION
STEP 1	Determine Purpose and Uses
STEP 2	Develop Measurable Objectives
STEP 3	Develop Evaluation Questions
STEP 4	Collect / Gather Credible Evidence
STEP 5	Analyze Information & Develop Conclusions
STEP 6	Report Findings

STEP 1 - DETERMINE PURPOSE AND USES FOR YOUR OUTCOME MONITORING

Table 6.14 Purpose and Uses of Outcome Monitoring

PURPOSE	USES
➡ To assess client's progress	➡ To improve program implementation
➡ To understand differences among subgroups	➡ Context for understanding effectiveness
➡ To determine factors that contribute to client's progress	➡ Accountability

STEP 2 - DEVELOP MEASURABLE OUTCOME OBJECTIVES

Outcome objectives are statements of the amount of change expected (for a health problem, knowledge, behavior, etc.) for a specified population within a given time frame.

EXAMPLE:	By December 31, 2008, a minimum of 200 participants who completed the HIV prevention workshop will have reduced one risk behavior and/or maintained one risk reduction behavior.

STEP 3 - DEVELOP OUTCOME EVALUATION QUESTIONS

Once objectives are identified, specific questions requiring specific answers need to be developed. The focus of evaluation questions in outcome monitoring is describing the progress of clients based upon the outcome measures set forth in the program goals and objectives.

STEP 4 - COLLECT/GATHER CREDIBLE EVIDENCE FOR OUTCOME MONITORING

Outcome data can be collected at two levels: client-level and program-level. Client-level outcome data are the changes that individual clients experience as a result of participating in a program or services. Program-level outcome data are the change in a population or health care delivery system that results from a service program or intervention (HRSA, 1999). Below are some examples of client- and program-level outcome data.

Table 6.15 Examples of Client-Level and Program-Level Outcome Data

CLIENT-LEVEL OUTCOME DATA	PROGRAM-LEVEL OUTCOME DATA
➡ HIV/AIDS-related knowledge, attitudes, beliefs and behaviors ➡ HIV/AIDS-related behaviors ➡ Physical function status ➡ Role and/or social functioning ➡ Mental health ➡ Satisfaction with care	➡ Morbidity rate ➡ Mortality rates ➡ Health services utilization

STEP 5 - ANALYZE DATA & JUSTIFY CONCLUSIONS ABOUT YOUR OUTCOME MONITORING

Data Analysis is the process of categorizing, ordering, manipulating, and summarizing data to obtain answers to evaluation questions.

STEP 6 - REPORT FINDINGS ABOUT YOUR OUTCOME MONITORING

Remember that we cannot say that the changes identified through the outcome measures are a result of the intervention. We can say that the changes identified occurred during the intervention and evaluation period of the program.

PPC's Evaluation Recommendations

Historically, evaluation of HIV prevention programs in Los Angeles County has primarily consisted of collecting and analyzing *process* information. That is, numbers and demographic information of individuals participating in HIV prevention interventions. However, a more systematic approach is needed to improve how *outcome* monitoring and possibly outcome evaluation are conducted to better assess the effectiveness of HIV prevention programs in Los Angeles County.

In its efforts to guide the direction of the County, the PPC endorsed the following recommendations made by the Evaluation Subcommittee of the PPC for inclusion in the *Los Angeles County HIV Prevention Plan 2009-2013.* As part of the 2009-2013 community planning process, the Evaluation Workgroup implemented the following activities:

- Reviewed the current evaluation efforts in Los Angeles County;
- Identified effective strategies and activities for evaluating HIV prevention programs, and build evaluation capacity among HIV prevention providers;
- Gathered feedback from community members regarding evaluation issues; and
- Formulated recommendations to be considered by the PPC.

The members of the Evaluation Workgroup recommend that the Los Angeles County HIV Prevention Planning Committee in conjunction with the Public Health Department reinvest in evaluation activities by supporting the following recommendations:

1. Provide **ongoing evaluation training** to HIV prevention providers, Office of AIDS Programs and Policy (OAPP) staff, and PPC members. Trainings should range in skill levels (beginner to advanced) to address the varying needs of participants and address topics such as data collection, evaluation design, data analysis, data management, and measuring performance indicators. Collaboration among those who have existing evaluation training curricula is strongly encouraged.

2. Provide **evaluation-related technical assistance support** to HIV prevention providers. It is critical for technical assistance providers, OAPP staff, and HIV prevention providers to work closely together in developing and implementing evaluation plans. Technical assistance services could be available through partnership with research/academic institutions or organizations with evaluation/research departments. Another cost-effective strategy is to collaborate with local college campuses to establish a program where graduate students would be trained in program evaluation by faculty and then provide technical assistance to prevention providers. These students could receive internship credit and/or a stipend or assistantship for their service.

3. Similar to efforts conducted in San Francisco, the evaluation subcommittee recommend that all **HIV prevention providers be required and be given the resources necessary to measure and report on process evaluation and select behavioral outcomes** for their funded intervention. Funding for evaluation activities should not be counted under the administrative cap.

4. Allocate support for **outcome evaluation activities of individual HIV prevention programs**. The evaluation subcommittee recommends that funds be made available to evaluate a select number of individual programs (e.g., 3 to 5 interventions). For the latter option, it is recommended that OAPP, the PPC, and community members determine the process for determining which programs receive evaluation funds. For example, there could be a RFP process where organizations apply for additional funds e.g. $30,000-50,000, which would not be counted under the administrative cap, to support enhanced evaluation activities. The applications would be reviewed and selected by a committee consisting of OAPP staff, PPC members, evaluation/research experts, community members, etc. For effective evaluation of these selected programs, it is critical for HIV prevention providers, OAPP staff, and evaluation/research representatives to work closely together.

5. Fund at least one **collaborative evaluation project** (e.g. to evaluate a specific type or class of intervention). A RFP process similar to the one described above (in recommendation #4) could be used to select the research study. The research team would need to include staff from at least one community-based organization and an academic research institution. The purpose would be to conduct a multi-year outcome evaluation of a particular type or class of HIV prevention intervention.

6. Fund two-year **HIV-related research studies** (qualitative/quantitative/both) on topic(s) that are specific to Los Angeles County and require additional research. The purpose of the research is to contribute to the development of new, effective prevention strategies and in the furtherance of Los Angeles' efforts to contribute to the body of HIV prevention research. Examples might include: an investigation of the role of HIV services and treatment services in the active methamphetamine users' lives; an ethnography of Los Angeles bath and sex clubs; long range follow-up on a select population; a newly created intervention strategy; or investigation of a single population's risk, in detail, with a variety of complimentary strategies. A collaborative process would be used in selecting and developing the research study and would involve an advisory committee of community participants, service providers, OAPP staff, and PPC members. The research team needs to include qualified researchers and community partnerships facilitated by both the PPC and OAPP.

7. Data generated through the above noted, including publicly funded or OAPP evaluation and research initiatives needs to be made available to the public. Data should not be disseminated solely for the purpose of sharing of findings, but for the following: further research, examination and inquiry; additional exploration of issues and questions in the data sets; use by researchers and community-based organizations for program development, and/or seeking additional grants and other research funding; and by agencies and individuals analyzing and presenting such data to help guide and contribute to further program and service contract funds being made available.

8. Support or provide opportunities for sharing and disseminating evaluation findings**.** Examples of such activities might include:

(a) having monthly presentations from providers to showcase their interventions and evaluation results (e.g., during PPC meetings);
(b) hosting an annual mandatory summit for HIV prevention providers funded by OAPP to exchange lessons learned and to discuss future program planning; and
(c) encouraging HIV prevention providers to present their findings at local and national conferences (e.g., CHRP Annual Investigators Conference, the annual meeting of the American Public Health Association (APHA), the United States Conference on AIDS (USCA), the National HIV Prevention Conference, and the HIV Prevention Leadership Summit (HPLS) among others.

The subcommittee also recommended for there to be opportunities for public health programs to share countywide data (e.g., to present aggregate summaries of programs' monthly reports).

Table 6.16 Summary of the PPC's Evaluation Recommendations

RECOMMENDATIONS	PURPOSES
Training/TA	
1) Ongoing training for CBO/PPC/OAPP 2) Evaluation technical assistance support	1) To increase knowledge and skills in evaluation 2) To receive more specific, hands-on training
Evaluation/Research	
3) Process evaluation of all HIV prevention programs 4) Outcome evaluation activities of individual programs 5) Collaborative evaluation project of type or class of interventions 6) HIV-related research	4) To collect process and select behavioral outcomes of interventions 5) To collect behavioral outcomes of select interventions 6) To conduct an outcome evaluation study of particular interventions 6) To conduct an HIV research study (e.g. HIV risks of an emerging population)
Dissemination/Planning	
7) Availability of all collected data to be used by public 8) Forums for dissemination • Monthly presentations at PPC • Annual Evaluation Summit • Local/national conferences • Presentations of county-wide program data	7) To facilitate further research, program development and refinement 8) To acknowledge work/celebrate accomplishments To meet reporting requirements To share findings and lessons learned to others To gain information for program improvement and planning

■ Successful Strategies for Program Evaluation

1. Evaluation training is effective in providing community organizations with the basic knowledge and skills needed to conduct evaluation of their interventions and/or services. This training gives providers the foundation from which to build their evaluation capacity. More advanced and substantial trainings are needed by community providers.

2. Evaluation-related technical assistance is needed to reinforce and to further develop community organizations' evaluation skills. This allows agencies to address more specific evaluation questions and concerns that cannot be addressed in group-level or workshop settings. To be effective, technical assistance must be provided by individuals who are experts in the field.

3. Community partnerships can offer many benefits including sharing evaluation ideas, expertise, and resources. Partnerships between community-based organizations are highly encouraged as well as with research institutions, college/campus programs, and health department evaluation staff.

■ Review of Available Data

The Evaluation Subcommittee reviewed the following sources to develop the preceding recommendations:

- Los Angeles County HIV Prevention Plan 2004-2008
- San Francisco HIV Prevention Plan 2004
- Chicago HIV Prevention Plan 2001-2003
- Findings from the County-wide Evaluation Needs Assessment 2005
- Centers for Disease Control and Prevention. (2002). CDC Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-funded HIV Prevention Programs
- Myrick, R, et al. (2005). Building capacity through partnerships: The use of community collaborative evaluation and research to build capacity for HIV/AIDS prevention

The PPC Evaluation Recommendations were approved by the PPC on November 16, 2007.

■ Selected Evaluation Terms

TERM	DESCRIPTION
Continuous quality improvement	Continuous Quality Improvement (CQI) is an ongoing process that involves service providers in ongoing activities to continuously improve service delivery. Activities include monitoring and evaluating inputs, processes, outputs, and outcomes. In contrast to quality assurance, which focuses on identifying and solving problems, CQI seeks to prevent problems and to maximize the quality of care. *Source: HRSA, HIV /AIDS Bureau website. Available at: http://hab.hrsa.gov/tools/title2/t2SecVIIIChap5.htm.*
Dissemination	The communication of the actions--by written, oral, and/or audio-visual reporting--of evaluators to foster knowledge of the evaluation findings among all right-to-know audiences. *Source: The Program Evaluation Standards (2nd Edition), Sage Publishing 1994.*
Outcome Evaluation	This form of evaluation assesses the extent to which a program achieves its outcome-oriented objectives. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness but may also assess program process. *Source: United States General Accounting Office, Performance Measurement and Evaluation Definitions and Relationships (April, 1998). Available at http://www.gao.gov/special.pubs/gg98026.pdf.)* The collection of data on changes in participant knowledge, attitudes, beliefs and behaviors (KABBs) and compares these results to another group of participants not participating in the intervention. It provides evidence that the intervention is causing the intended changes. *Source: AIDS Project Los Angeles, Acción Mutua, Evaluation Series No. 3: Outcome Monitoring and Evaluation. Available at: http://www.apla.org/accionmutua/resources/AM/Evaluation3.pdf*

TERM	DESCRIPTION
Outcome Monitoring	The collection of data about participant knowledge, attitudes, beliefs and behaviors (KABBs), and intentions to change behavior before, during, and/or after the intervention. It identifies what components are working as expected and which ones are not in order to improve program effectiveness. *Source: AIDS Project Los Angeles, Acción Mutua, Evaluation Series No. 3: Outcome Monitoring and Evaluation. Available at: http://www.apla.org/accionmutua/resources/AM/Evaluation3.pdf*
Prioritized Target Populations	Focuses on a set of target populations (identified through the epidemiologic profile and community services assessment) that require prevention efforts due to high rates of HIV infection and high incidence of risky behaviors.
Process Evaluation	This form of evaluation assesses the extent to which a program is operating as it was intended. It typically assesses program activities' conformance to statutory and regulatory requirements, program design, and professional standards or customer expectations. *Source: United States General Accounting Office, Performance Measurement and Evaluation Definitions and Relationships (April, 1998). Available at: http://www.gao.gov/special.pubs/gg98026.pdf.* The assessment of a program's conformity to its design, program implementation, and the extent to which it reaches its intended audience. (CDC 1999). *Source: AIDS Project Los Angeles, Acción Mutua, Evaluation Series No. 2: Process Monitoring and Evaluation. Available at: http://www.apla.org/accionmutua/resources/AM/Evaluation2.pdf*
Process Monitoring	The routine documentation of data describing the characteristics of the population served, the services provided, and the resources used to deliver those services. (CDC 2002) *Source: AIDS Project Los Angeles, Acción Mutua, Evaluation Series No. 2: Process Monitoring and Evaluation. Available at: http://www.apla.org/accionmutua/resources/AM/Evaluation2.pdf*
Qualitative Research	Research that focuses on data in the form of words, pictures, descriptions, or narratives. *Source: Applied Social Research: Tool for the Human Services (4th Edition), Harcourt Brace Publishers, 1998.*
Quantitative Research	Research that uses numbers, counts, and measures of things. *Source: Applied Social Research: Tool for the Human Services (4th Edition), Harcourt Brace Publishers, 1998.*

Chapter References

1. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. Introduction to program evaluation for public health programs: A self-study guide. Atlanta, GA: Centers for Disease Control and Prevention, 2005.