

4: MONITORING AND EVALUATING THE IMPLEMENTATION OF HIV PREVENTION PROGRAMS

In the last chapter, we suggested that an intervention plan is like a blueprint for a house: a clear and logical plan is an essential guide for building a functional and sturdy structure. However, unless the carpenters, plumbers, and electricians follow the blueprint carefully, they will not build the house expected.

The same is true for the processes that comprise the implementation of HIV prevention services. Because HIV prevention programs are complex, there are many reasons they may not be implemented as designed. The purpose of implementation evaluation, also referred to as process evaluation, is to objectively examine the qualities of intervention implementation and improve it if necessary.

Purpose of this Chapter

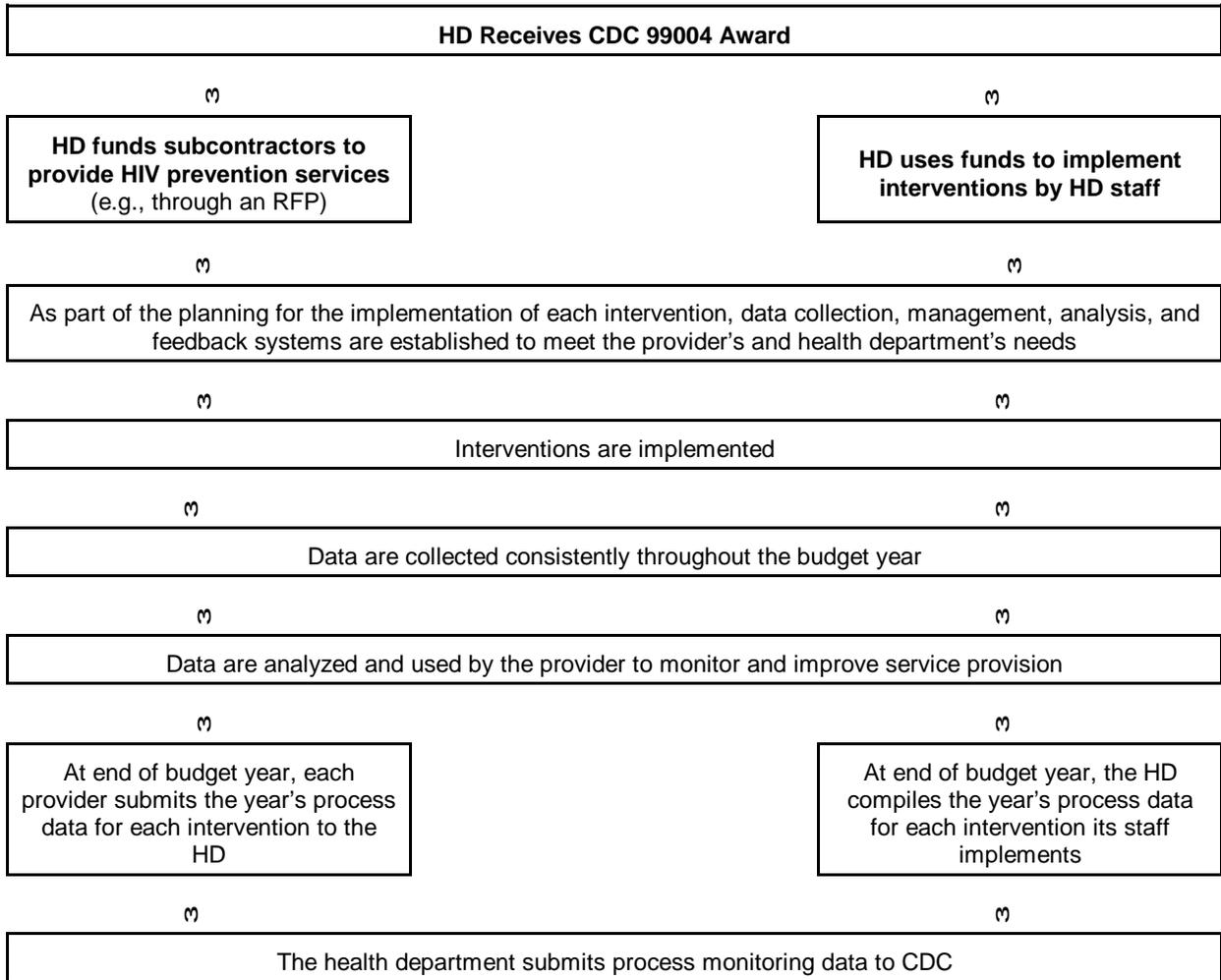
This chapter supplements Announcement 99004, which states that health departments should engage in “ongoing data collection and monitoring regarding the implementation of health department and health department-funded program activities” (CDC, 1998). To that end, this chapter will provide an understanding of the usefulness of process evaluation and guidance for conducting process evaluations of health department-implemented and -funded HIV prevention interventions. The chapter 1) discusses reasons for conducting process evaluation and types of data needed, 2) provides information about collecting and reporting process evaluation data, including the core elements to be reported in the aggregate to CDC for assessments of national progress in HIV prevention and determination of ongoing technical assistance needs, and 3) provides sample data collection forms for use by health departments as they collect information about HIV prevention interventions that they and their grantees implement. A typical set of steps in the preparation, collection, management, and analysis of process monitoring data is shown in Figure 4.1.

Process Evaluation

Assessment of a program’s conformity to its design, program implementation, or the extent to which it reaches its intended audience

For the purposes of this guidance, the term “monitoring” is used to refer to the routine documentation of characteristics describing the target population served, the services that were provided, and the resources that were used to deliver those services. Monitoring is contrasted here with “process evaluation” in which the data collected through process monitoring are used to answer more detailed questions about implementation (e.g., If the intervention did not conform to its design, what factors contributed to that difference?), the clients served (e.g., Did we reach the group at most risk? How could we improve our coverage of them?), and resources used in the delivery of the program.

Figure 4.1



Assessment of implementation can be evaluated on its own merits as well as compared with the intervention plan, which describes the intended objectives and steps of the intervention. Process evaluation data do not address the extent to which an intervention has achieved its desired outcomes (e.g., less risky behavior or attitudes and beliefs that support those behaviors). The evaluation of an HIV prevention intervention's outcomes will be the focus of the next two chapters.

Typical Issues Addressed by Process Evaluations

- C Appropriateness of the program for the intended participants
 - What needs to be in place for the intervention to work?

 - C Type and numbers of treatments and services provided
 - How is the intervention actually implemented?
 - How much effort was needed to achieve a given outcome (labor hours, materials distributed, shots administered, etc.)?

 - C Means of optimizing access to the intervention, including location and physical facilities of the service delivery site

 - C Participant retention, referral, and follow-up efforts

 - C Qualifications and competencies of staff
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REASONS FOR CONDUCTING PROCESS EVALUATION

The Links Between Intervention Plans and Outcomes

In the last chapter we suggested that it was reasonable to expect a good intervention plan to lead to desired outcomes (e.g., fewer risk behaviors) and impacts (e.g., less HIV transmission) *if* that design is implemented as it was proposed. Until such implementation occurs, the relationship between the intervention plan and outcomes is only hypothetical. This hypothetical model was described in Chapter 3 and is shown again in Figure 4.2.

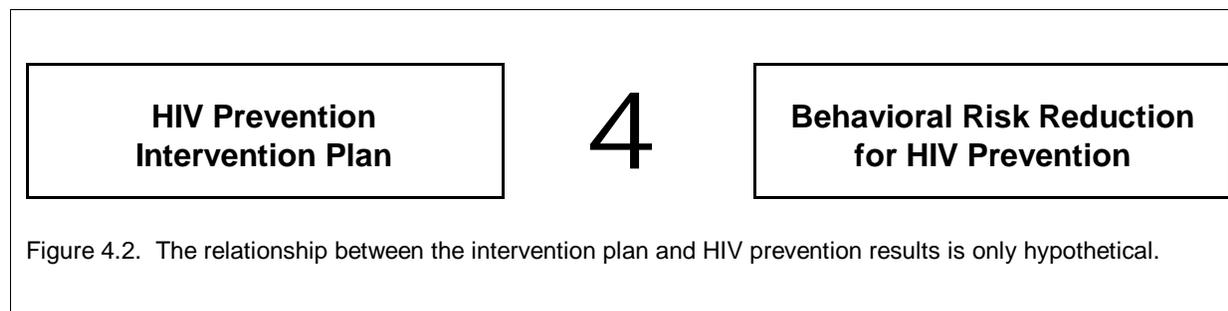


Figure 4.2. The relationship between the intervention plan and HIV prevention results is only hypothetical.

The real test of the intervention plan—*Will the intervention achieve its objectives?*—is in the “nuts-and-bolts” of intervention implementation. This issue can be framed simply by the question, “Did we *really* do what we said we were going to do?” Figure 4.3 illustrates this mediating role. Process evaluation is the way to assess the mediating role of intervention implementation. This is crucial, because focusing only on the intervention plan and outcomes can result in misleading interpretations of how certain outcomes (be they promising or disappointing) came to be.



Benefits of Process Evaluation

In general, process evaluation provides health departments, service providers, and CDC with information about whether the program has reached its intended audience, the level or extent of services provided, and what resources were required to support the prevention effort made. Table 4.1 outlines several distinct benefits that process evaluation generates for local, state, and federal stakeholders. The characterization of benefits of process data suggest three important purposes of process evaluation:

- 1) Providing information for improving intervention implementation
- 2) Providing a context for understanding intervention effectiveness
- 3) Meeting accountability needs

Purpose 1—Providing Information for Improving Intervention Implementation. Process evaluation consists of a set of procedures that can provide timely information for improving implementation by identifying a program’s strengths and weaknesses. For example, process data may indicate that an outreach program is failing to reach its target population because the times that outreach specialists are in the neighborhood are the same times that target population members are working, buying drugs, socializing, etc. A program manager can use this information to identify times of day during which potential clients would be willing to talk and to schedule her staff’s outreach activities accordingly.

Table 4.1

Benefits of Collecting Process Data		
Local & Agency Benefits	Health Department Benefits	Federal Benefits
<ul style="list-style-type: none"> C Ensures the quality of service delivery C Ensures that HIV prevention resources are successfully reaching target populations C Guides resource allocation C Documents progress of programs C Improves programs 	<ul style="list-style-type: none"> C Fulfills Federal reporting expectations C Describes the status of HIV prevention activities statewide C Provides the health department with quantifiable documentation of HIV prevention service delivery C Assists HIV Prevention Community Planning Groups in assessing statewide patterns of service provision C Documents the need for HIV prevention services to the state legislature and governor C Documents the need for HIV prevention services to the CDC C Guides resource allocation 	<ul style="list-style-type: none"> C Fulfills information needs of federal policymakers and CDC C Assists CDC project officers in providing necessary technical assistance to health department grantees C Improves policies regarding HIV prevention program implementation

It is essential to keep in mind that the driving force behind all evaluation is to optimize the effectiveness of HIV prevention services. It is hard to imagine an HIV prevention program whose developers and staff do not believe that they are offering helpful assistance to people with behaviors that put them at risk for contracting HIV. It also is reasonable to assume that people who want to help will also want to continually improve their capacity to help. However, even the best interventions require oversight and monitoring so that they can provide the most efficacious services to the most people and use resources efficiently.

Purpose 2—Providing a Context for Understanding Intervention Effectiveness. One underlying assumption of HIV prevention community planning is that resources will be directed to interventions with known effectiveness. For instance, one commonly hears about “looking to the scientific literature” for interventions with proven track records for achieving desired outcomes. However, for this approach to help a new provider, an intervention chosen for its known efficacy must be implemented the way its developers intended. That is, “effectiveness” can be claimed only when one knows which intervention was *intended* to be delivered and which intervention *actually* was delivered.

Process evaluation data allow evaluators to distinguish an ineffective intervention from one that is ineffectively implemented. This is a critical distinction when assessing how best to serve a population and when allocating resources for various interventions. By ensuring that interventions are carried out in keeping with their design, a health department can have increased confidence attributing changes in HIV transmission in its jurisdiction to interventions it funded.

Despite the known benefits of process evaluation, many decision makers continue to believe that the only valuable measure of a program is to conduct outcome evaluation to determine its effectiveness in achieving outcome objectives. In fact, as is discussed in the next chapter, some HIV prevention programs are unsuitable for outcome evaluation. For these programs, process evaluation may be the only—and therefore the most critical—means of ensuring accountability. In light of such considerations, Chen (1994) contends that asking “How does the program achieve its goals?” is almost as important as asking “Does the program achieve its goals?”

Purpose 3—Meeting Accountability Needs. It is important to note that process evaluation serves an accountability function. Because the HIV prevention efforts discussed in this document utilize public funds, CDC, health departments, and service providers have obligations to provide stakeholders with answers to basic questions about programs. A variety of federal policymakers in the Executive and Legislative branches and numerous state and local officials regularly demand information about what HIV prevention services are being provided. Process data serves stakeholders at all levels by informing them about the nature of HIV prevention efforts and documenting whether the efforts are heading in desired directions.

HIV prevention interventions must be accountable to their stakeholders in terms of two aspects: 1) the quality of implementation (measured through process evaluation) and 2) the effectiveness of the intervention (measured through outcome monitoring and outcome evaluation). One devaluing myth about process evaluation is that it is a “kinder and gentler” type of evaluation that yields no information for making difficult judgements about a program. However, process evaluation addresses management and operational issues that are critical to program managers, administrators, and funders (Chen, 1994).

TYPES OF PROCESS DATA TO COLLECT

In this and the previous chapter, the range of typical HIV prevention interventions has been discussed. Because process monitoring and evaluation assess the specific activities that comprise each type of intervention, the relevant process evaluation questions will vary by the kind of intervention in question. Similarly, the specific data elements needed are determined based on the nature of the process evaluation question.

The following tables show illustrative process evaluation questions, client-level data elements, and program-level data elements for the following types of interventions:

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|------------------------------------------------------------------------------|--------------------------|
| C Individual- and Group-Level Interventions | C Mass Media |
| C Community-Level Interventions | C Hotlines |
| C Outreach | C Clearinghouses |
| C Prevention Case Management | C Media Advocacy |
| C Counseling, Testing, Referral, & Partner
Counseling & Referral Services | C Materials Distribution |
| | C Needle Exchange |

Individual- and Group-Level Interventions

Potential Process Evaluation Questions
<p>In comparing implementation of our intervention plans, did we</p> <ul style="list-style-type: none"> C serve the numbers of people we anticipated? C serve people with the demographic and risk profile we anticipate? C provide the numbers of sessions to each client that we planned to? C follow the intervention protocol that was outlined? <p>Did clients get an intensive intervention?</p> <ul style="list-style-type: none"> C How many received only one session? How many only two sessions? Three or more? <p>Based on referrals to our ILI/GLI and the referrals we made to other services, what agencies do we need to develop strong collaborations with?</p> <p>Did we choose staff for this intervention who were appropriate for the audience? For the level of sophistication of the intervention?</p> <p>Have we provided staff with adequate training and supervision for this intervention?</p>

Client-Level Data	Program-Level Data
<p>Client Characteristics</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors C HIV/AIDS-related knowledge, attitudes, beliefs, and behaviors C Participants' reactions to sessions <p>Description of session</p> <ul style="list-style-type: none"> C Site/setting C Content C Facilitator's assessment of what transpired C Number of participants per group <p>Number of sessions provided to each person/group</p> <p>Length of contact/session</p> <p>Content covered (esp. if different than proposed content, e.g., some issues not covered or issues not on agenda covered)</p> <p>Safer sex materials made available (condoms, bleach kits, dental dams, alcohol wipes)</p> <p>Informational or educational materials made available</p> <p>Types of referrals made</p>	<p>Counselor Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Provider recruitment, training, and supervision</p> <p>Staff turnover during budget year</p> <p>Expenditures</p> <p>Methods used to promote sessions and recruit participants</p>

Outreach

Potential Process Evaluation Questions
<p>Are we deploying outreach in areas frequented by our target population?</p> <p>Are we providing outreach at times when clients are receptive?</p> <p>Do the demographics and risks of our target population match the characteristics of individuals actually being contacted by our outreach workers? Has this changed over time?</p> <p>Are our outreach workers following the protocols we have established?</p> <p>Are our outreach workers providing consistent information and referrals?</p>

Client-Level Data	Program-Level Data
<p>Client Characteristics</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors C HIV/AIDS-related knowledge, attitudes, beliefs, and behaviors (if feasible to determine) C Participants' reactions to sessions <p>Topics covered during the outreach encounter - Questions answered or subjects discussed</p> <p>Length of contact/encounter</p> <p>Content covered (esp. if different than proposed content, e.g., some issues not covered or issues not on agenda covered)</p> <p>Safer sex materials made available (condoms, bleach kits, dental dams, alcohol wipes)</p> <p>Informational or educational materials made available</p> <p>Types of referrals made</p>	<p>Outreach Worker Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Outreach Worker recruitment, training, and supervision</p> <p>Staff turnover during budget year</p> <p>Expenditures</p> <p>Methods used to promote sessions and recruit participants</p> <p>Number of outreach contacts made</p> <p>Schedule of outreach activities</p> <p>Locations where outreach was conducted</p> <p>Referrals made</p> <p>Materials and supplies used</p>

Prevention Case Management

Potential Process Evaluation Questions
Are we reaching our desired mix of HIV-infected and high-risk, uninfected clients?
Are we coordinating services with other providers to meet the needs of our clients?
Are counselors following protocols for initial and follow-up assessment of clients' needs, risks, and progress?
Is our referral system working? Are clients getting to the services they are referred to?

Client-Level Data	Program-Level Data
<p>Client Characteristics</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors C HIV serostatus C HIV/AIDS-related knowledge, attitudes, beliefs, and behaviors C Participants' reactions to sessions <p>Number of PCM counseling sessions per client</p> <p>Length of each PCM counseling session</p> <p>Number and type of referrals made</p> <p>Number of referrals followed through by client</p> <p>Number of HIV risk-reduction counseling sessions provided to each client</p> <p>Extent to which services were coordinated</p> <p>Documentation of monitoring and re-assessment of client's needs, risks, and progress</p>	<p>Provider Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Staff recruitment, training, and supervision</p> <p>Number of clients offered PCM services</p> <ul style="list-style-type: none"> # HIV infected # HIV negative, known to be at high risk # HIV status unknown <p>Number of clients with a client-centered prevention plan</p> <p>Array of services in PCM network</p>

Counseling, Testing, Referral, & Partner Counseling & Referral Services

Potential Process Evaluation Questions
What proportion of HIV-infected clients is offered PCRS?
What are the demographics (e.g., marital status, age, sex, race/ethnicity) of the clients and partners actually served? How does this compare to our projections of who we would serve with PCRS?
What are the reasons those clients either reject or accept PCRS?
What is the range of PCRS services (e.g., client referral, provider referral, combinations of referral approaches) offered to and accepted by each client?
How many sex or needle-sharing partners are identified?
What is the percentage of partners actually reached through PCRS, and how many of those partners are HIV infected?
Of those partners who are HIV infected, how many are being informed of their infection for the first time?
How many partners are offered referral services? How many receive these services? In what time frame do they receive referral services?

Client-Level Data	Program-Level Data
<p>Client Characteristics</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors C HIV serostatus C HIV/AIDS-related knowledge, attitudes, beliefs, and behaviors C Participants' reactions to sessions <p>Number of partners identified</p> <p>Number of partners reached by client and by counselor</p> <p>Number of partners receiving counseling</p> <p>Number of partners receiving testing</p> <p>Referrals made to partners</p>	<p>Provider Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Staff recruitment, training, and supervision</p> <p>Number of clients receiving PCRS services</p> <ul style="list-style-type: none"> C Number of HIV-infected clients interviewed C Number of partners identified by HIV-infected clients C Number of notified partners who were provided counseling services C Number of notified partners who were tested for HIV C Number of partners who tested positive for HIV

Mass Media

Potential Process Evaluation Questions
Did we choose media outlets that our target population uses and finds acceptable and credible?
Were our PSAs aired at times that our target population was listening or watching?

Client-Level Data	Program-Level Data
	<p>Number of ads that were developed</p> <p>Ways in which ads were distributed to media outlets</p> <p>Where and when ads actually ran</p> <p>Number of times ads ran</p> <p>If broadcast</p> <ul style="list-style-type: none"> C Times the ads ran C Size and demographics of audience at that time (compare to your audience's viewing patterns)

Hotlines

Potential Process Evaluation Questions
<p>Are hotlines providing high-quality information, referral, and counseling services to designated target populations in an efficient manner?</p> <p>Do we have enough staff to handle the volume of calls received?</p> <p>Have we anticipated the needs of the types of callers who are using our hotline?</p> <p>Are staff members adequately trained to respond to the issues being raised?</p>

Client-Level Data	Program-Level Data
<p>Characteristics of callers</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors C HIV serostatus C HIV/AIDS-related knowledge, attitudes, beliefs, and behaviors <p>Topics covered during each call - Questions answered or subjects discussed</p> <p>Referrals made for each caller</p> <p>Length of time to respond to each call</p> <p>Disposition of each call (Answered, put on hold, disconnected before connecting with information specialist)</p>	<p>Number of calls received</p> <p>Number of calls unanswered, put on hold, or eventually disconnected</p>

Clearinghouses

Potential Process Evaluation Questions
Who is using our clearinghouse? What are their information needs?
Do we have access to the types of materials they are requesting?

Client-Level Data	Program-Level Data
<p>Characteristics of callers</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors <p>Materials requested by each caller</p> <p>Other informational needs identified by caller</p> <p>Length of time between request and fulfillment of request</p>	<p>Information Specialist Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Staff recruitment, training, and supervision</p> <p>Number of requests</p> <p>Number of requests fulfilled</p> <p>Type of materials requested</p> <p>Number of materials distributed</p> <p>Average number of materials per request</p>

Media Advocacy

Potential Process Evaluation Questions
How were contacts made with the media?
How were spokespersons selected and trained?
Where and when were they interviewed?
What news and feature coverage resulted from your efforts?

Client-Level Data	Program-Level Data
	<p>Media Specialist Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Staff recruitment, training, and supervision</p> <p>Number of contacts with the media</p> <p>Media coverage resulting from media advocacy efforts</p>

Materials Distribution

Potential Process Evaluation Questions
Are we getting the appropriate safer sex materials to our intended target population?
Are we reaching those people most in need of these materials?
Are we engaging in distribution efforts at times when a significant number of the target population are available to receive them?
Are we distributing enough materials to make a difference in our target population?

Client-Level Data	Program-Level Data
<p>Client Characteristics</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors C HIV/AIDS-related knowledge, attitudes, beliefs, and behaviors <p>Description of distribution site/setting</p> <p>Safer sex materials made available (condoms, bleach kits, dental dams, alcohol wipes)</p> <p>Informational or educational materials made available</p> <p>Types of referrals made</p>	<p>Staff Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Staff recruitment, training, and supervision</p> <p>Staff turnover during budget year</p> <p>Expenditures</p> <p>Number of distribution events</p> <p>Schedule of distribution activities</p> <p>Locations where distributions occurred</p> <p>Materials and supplies distributed</p>

Needle Exchange

Potential Process Evaluation Questions
Are we reaching the injection drug using population we had anticipated?
How does the volume of needles/syringes we are distributing compare with the volume we anticipated?
Are our program's new needles coming back for exchange?
Are clients getting referrals for drug treatment; HIV counseling, testing, and treatment; and general health care?

Client-Level Data	Program-Level Data
<p>Client Characteristics</p> <ul style="list-style-type: none"> C Demographics (sex, sexual orientation, race/ethnicity, age, education, neighborhood) C Risk behaviors C HIV serostatus C Hepatitis serostatus C HIV/AIDS-related knowledge, attitudes, beliefs, and behaviors C Participants' reactions to exchange sites <p>Number of needles/syringes brought to exchange</p> <p>Number of new needles/syringes distributed</p> <p>Safer sex materials made available (condoms, bleach kits, dental dams, alcohol wipes)</p> <p>Informational or educational materials made available</p> <p>Types of referrals made</p>	<p>Staff Characteristics</p> <ul style="list-style-type: none"> C Employment status (staff, volunteer, consultant/part-time) C Demographics <p>Staff recruitment, training, and supervision</p> <p>Staff turnover during budget year</p> <p>Expenditures</p> <p>Number and frequency of exchange events</p> <p>Schedule of needle-exchange activities</p> <p>Locations where distributions occurred</p> <p>Materials and supplies distributed</p> <p>Number of new needles distributed by the program that are returned for exchange</p>

COLLECTING AND ANALYZING PROCESS MONITORING DATA

This chapter has articulated some of the value and benefits that can accrue through the collection and use of process data for HIV prevention interventions. In conjunction with the goals and objectives set forth in intervention plans, process data can help providers and funders assess achievement of desired results, pinpoint areas for refinement or improvement, and convey to stakeholders the successes that have been achieved (as well as the need for additional resources to meet remaining needs).

The previous chapter, *Designing and Evaluating Intervention Plans*, contained the beginning of a discussion of data collection, management, and analysis systems needed by health departments and local HIV prevention providers. Health departments need management information systems that will allow them to understand the technical assistance needs of their subcontractors, use data for program improvement throughout the jurisdiction, and use data for quality assurance and accountability purposes. Local providers also need data systems that help them derive information that can be used for these purposes; however, local providers must consider the logistics of data collection “on the front lines.”

Some front-line providers may have reservations about expending resources to collect data when the resources could be used to offer more prevention services. Similar reservations may be held by health department staff. Two questions seem to underlie their concerns and require responses to increase buy-in regarding evaluation:

- 1) Will the data be used and useful?
- 2) How much effort will it really take to collect these data?

First, program staff, health department staff, and technical assistance providers should demonstrate that the data being requested will, in fact, be put to use for important purposes. “Important” purposes for staff may mean that the data will be used and beneficial to them, their work, and the people they are trying to serve. An important message to convey is that it is by examining data in a systematic way that providers can ensure that prevention efforts are really helping the people they want to help. Without such data, providers may “feel good” about their efforts but cannot be assured that they are making a difference.

The message to staff about the importance of using data is also conveyed by deed. Putting a process in place to review and interpret data and to make needed changes is the concrete manifestation of the message. Once staff members see that the agency is serious about using data, their concerns about collecting “data for data’s sake” may diminish.

Second, the effort required to collect data should be gauged with respect for the situations, settings, and provider skills present with each intervention. Virtually every institution that is involved in data collection has been guilty at one time or another of asking for more data than it will eventually use. In this context, health departments and local providers should be mindful of the anticipated uses—and users—of the data they ask for. Users include providers, the health department, and CDC. An assessment should be made of the common and the unique needs of each of these users. For

instance, health departments may need additional data that would not be as useful at the national level, but which may be critical for their jurisdiction. Additionally, local providers may have needs for more detailed information about their staff's activities that goes beyond what the health department may be interested in.

Data collection must also be feasible for the setting in which the intervention occurs. For instance, the structured settings in which most individual- or group-level counseling interventions occur (e.g., clinics or agency offices) may allow time for data collection each time an intervention occurs. Similarly, the very nature of prevention case management seems to require record keeping to allow tracking of the service plan for each client and the types of services that each client receives.

With respect to outreach, the dynamic, unstructured nature of some street or community outreach may preclude the recording of extensive data about each encounter. Instead, the agency may decide to focus on a subset of critical variables that meet some threshold of importance and to forego other less important—albeit, interesting—data. On the other hand, many providers have found it manageable to collect a great deal of data about outreach encounters; consultation with peer agencies may help a provider determine what is feasible for staff members with similar experience and training.

Appendix A contains example forms that may be used to summarize process data from each of the following types of interventions:

- C Individual-level interventions
- C Group-level interventions
- C Outreach
- C Prevention Case Management
- C Partner Counseling and Referral Services
- C Health Communications and Public Information Activities
- C Community-level interventions

Appendix B contains the standard *HIV Counseling and Testing Report Form* that has long been used for collecting and reporting data about counseling and testing. This appendix also contains the guidelines to be used when filling out this report form.

REFERENCES AND RESOURCES

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APPENDIX A

Example Forms to Summarize Process Data

- C Individual-Level Interventions
- C Group-Level Interventions
- C Outreach
- C Prevention Case Management
- C Partner Counseling and Referral Services
- C Health Communications and Public Information Activities
- C Community-Level Interventions
- C Counseling and Testing

APPENDIX B

CHIV Counseling and Testing Report Form

C Guidelines for Completing Report Form