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EVALUATION REPORT ON HAPA PROJECT

IN

MALAWI

by

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Executive Summary

This HAPA study was different from other HAPA projects because it was more quantitative than qualitative. This therefore made most of the evaluation guidelines inapplicable.

All the objectives of this study were achieved except for objective 4 which has not been fully achieved because the data set is small.

This project has demonstrated that with good training in counseling, counseling can be effective. It is therefore recommended that the methods used in training counsellors in this project, and the lessons learned by the staff be documented. There is no health institution in Malawi which has the level of experience in counselling in AIDS/HIV as that now possessed by the project staff.

The training in counseling should be expanded to include other groups especially the clergy.

It is further recommended that if Malawi is to fully benefit from the lessons learned on counseling in this project, then there must be more direct involvement in the management of the project. This is the only way that sustainability can be assured

There is a need to implement, STD treatment guidelines that were used at the QECH in other hospitals.

I. INTRODUCTION

At the time the HAPA proposal was written (in 1989), The Johns Hopkins University School of Hygiene and Public Health had been implementing two HIV projects in Malawi. One was a project to train health workers in Malawi in epidemiologic methods with particular emphasis on AIDS. The funding for this project was from Forgy International Center. The other project, financed with a grant from the International Collaboration for AIDS Research (ICAR) an NIH funded program project grant, which focusses on perinatal transmission of HIV infection in pregnant women as well as the factors that influence the transmission of HIV in families.

These two projects were implemented in collaboration with Ministry of Health of Government of Malawi. Since the Malawi Government was not doing much research in HIV, the research activities of The Johns Hopkins University soon became an important source of information to government on HIV infection in Malawi.

The NIH ICAR grant project focusses on pregnant women attending antenatal clinic at the Queen Elizabeth Central Hospital (QECH) in Blantyre in the southern part of Malawi. It was felt that the project could be strengthened/enhanced by adding project components with highly targeted AIMS. The word **clinic** will be used in this report to mean the project site for all the activities of the project.

The HAPA proposal that was submitted to USAID for funding was not fully funded. Only a few of the project components were funded. Although the approved version of the HAPA project document was not available to the evaluation team, the components that were approved and implemented were written in various documents that were made available to the team. In the absence of the approved project documents, the team was able to establish the objectives of the project to be as follows:

Overall Objective

To assess the role of sexually transmitted diseases (STDs) as a risk factor for HIV seroconversion in low risk populations.

Specific Objectives

1. To get information/data on knowledge attitudes, behavior and practices (KABP) through the administration of questionnaires on HIV/AIDS on women who are seen on a regular basis at the antenatal/postnatal clinic.
2. Study of surrogate markers of STDs in women to evaluate the sensitivity, specificity and positive predictive value of leukocyte esterase as a marker of genital track infections in women.

3. Evaluate the relationship between Human Papilloma Virus and pre-cancerous changes in cervix of HIV-1 infected and uninfected women.
4. Obtain information to assess the risk factors for HIV-1 seroconversion.

It should be noted at the outset that this study is different from the other HAPA projects in that it was more quantitative than qualitative. For this reason most of the HAPA evaluation guidelines do not apply.

II. EVALUATION METHODOLOGY

A The terms of reference were received by the consultant and later discussed with project staff participating in the evaluation. The evaluation team was satisfied that the terms of reference covered all the issues on which the evaluation would focus. The following were the agreed terms of reference:-

1. Conduct, with project staff, an evaluation of the HAPA grants project that includes, at a minimum, an assessment of:
 - (a) the appropriateness and adequacy of the training in techniques of STD control and counseling provided by the project.
 - (b) the effectiveness of the project interventions in improving the quality of STD treatment available to the study population.
 - (c) the effectiveness and relevance of the counseling services provided to the study women.
2. Make recommendations for future priorities and assist in planning the projects future HIV/AIDS prevention strategies.
3. Prepare a final evaluation report that includes the above mentioned areas.

B Composition of the Evaluation Team

Most of the investigative (fact finding) was carried out by the consultant. However, the project staff did provide most of the tables used in this report from data available in the project's database. In this

regard therefore, Dr. G. Dallabetta and Dr. Paolo Miotti, although not physically present during the evaluation, did participate in the evaluation by sending (from USA) some of the documentation required for the evaluation.

C Methods Used

As briefly stated in the introduction, the Malawi HAPA project was unlike other projects in that it was more quantitative than qualitative. The project was designed in a way that would facilitate the collection of quantitative data on most of the project components. Even for the KABP survey, the questionnaire was designed to provide quantitative data that would help to determine the effectiveness of the STD/AIDS project interventions.

The conclusions and recommendations of this evaluation are therefore based mostly on quantitative data that was made available from the project's database. In order to assess the effectiveness of the training, we interviewed all the nurses who were at the time employed by the project.

In addition, the evaluation team had access to a summary of the nurses experience in counseling about 6000 women about HIV/STD during the project period. The summary was prepared from a focus group discussion conducted in December 1991. There was also a summary of a questionnaire the nurses filled out just before the evaluation. The questions the nurses had to answer are attached as Appendix II

Some of the findings and tentative conclusions from the quantitative and qualitative data, especially those that looked unusual, were discussed with the project staff. The final version of the conclusions and recommendations are the consultant's responsibility.

D Cost information

It was not possible, during the evaluation, to get the actual costs of the HAPA componet because the reconciliation of all the detailed expenditure information is kept in Baltimore.

III. FINDINGS OF THE EVALUATION

A Design

This project was designed to enhance other on-going project activities. The strategies for achieving the

objectives were to be by quantitative data, through various repeated laboratory tests and counseling. Over time trends were to emerge which would lead to conclusions on whether the AIDS/HIV education provided through the counselling sessions had been effective.

There were advantages in choosing to add the HAPA project components to an existing project because it would have been very costly to carry out these components as a separate project. These project components therefore benefited from the infrastructure (such as laboratories, staff) of the on-going projects--- especially the ICAR funded project.

The other advantage was that QECH, the site for the project activities was in an urban area. It would have been very difficult to enroll the required number of mothers into the study if the project was in a smaller town or a rural area. Locating the project in Blantyre was also an advantage in that shorter distances had to be travelled by the project team when tracing the mothers and by the mothers travelling to the clinic.

Except for the Malawian staff who were involved at the level of delivering services (the nurses and laboratory technicians), there were no counterparts at project manager level. There were however some senior Malawian physicians who were involved in the investigation of certain specific project components e.g., specific objective 2. For a project of this importance there should have been more direct involvement by national health organizations at policy level or NGOs. This did not affect the implementation, but rather future sustainability.

The project had two project managers, five nurses, one peace corp volunteer and four laboratory technicians. Only part of the staff time for was used for the HAPA project componets.

B Process

The training of the nurses took several months (about 5 months). Nurses were trained on the theory of counseling. After this, they were involved in designing the questionnaire to be used in the study. Because a questionnaire used elsewhere had to be adopted to the local situation, the nurses became involved in editing the questions as part of their training. Not only did they find themselves heavily modifying the questions, but in some cases they completely rejected certain questions.

At the time the project nurses were being trained there were some other nurses within the hospital (QECH) who already had some training in counseling. These helped train project nurses in counseling. They observed project nurses counsel patients and then discussed the counseling sessions. The project nurses also translated the questionnaire to the vernacular. This activity further consolidated their understanding of the questions. After the questions had been translated, discussed, and a final version produced; pretesting was carried out in the clinic. The testing of questionnaires by the nurses in the clinic gave the nurses more preparation for the start of the project. It was after pretesting that the final version was printed for use in the study.

For STDs, the training of the nurses was equally thorough. A combination of lectures, question and answer sessions, video pictures of patients with AIDS and those with STDS were presented to the nurses during the five month period. The nurses were taught how to do examinations, how to collect specimens and the dosages for the various STDs.

The approach taken in training the nurses aimed at making counseling services as relevant as possible to the local situation.

The results of the KABP are shown on Tables 1 to 5. These are further discussed in the next section. Because this study was quantitative, most of the activities were translated into the figures we have in various tables presented in this report.

Although the nurses had been thoroughly trained to fill out the questionnaires of the KABP, this task was later delegated to two clerks. This happened because the nurses became very busy in counseling. These clerks did not have as much training as the nurses. Although these clerks appear to have done a good job, overall there were indications (in one specific question) where they always asked the question wrongly. This affected the response to the particular question for most of the study period.

The data entry programs were designed and implemented on microcomputers. The programs had several range checks to ensure that there would be no duplication of data. Although data is not double entered (verified) the range checks in place were sufficient to ensure good quality data. Arrangements were also in place for keeping copies of the data (backups)

To continue to ensure the quality of the project activities, the project managers instituted weekly meetings. At these meetings progress in project

activities were discussed. These included changes in schedules, review of numbers of mothers recruited, problems encountered, reports by nurses on seminars attended elsewhere etc. The nurses say they found these meetings very useful.

The staff and target populations had many opportunities to assess the quality and relevance of the activities. As stated earlier, the questionnaire for the KABP was edited and modified by the staff. During counseling sessions, the staff gave mothers opportunities to raise any questions or objections to the manner in which the services were being delivered to them. Mothers who did not turn up at the appointed time were traced to their homes. Such mothers gave reasons why they had not come to the clinic. This process helped the nurses to understand why they were doing the project. In short, it can be said that the project was designed to respond to the needs of the mothers without losing touch of project objectives.

Since mothers had to be followed over a period of time, the counselling sessions had to be structured in a way that would leave the mother fully convinced that her involvement in the project was to her benefit.

From impressions of the nurses, the reasons some mothers were lost to follow up had nothing to do with the quality of the services being provided. The most frequent quoted reasons have been recorded. These would be very valuable in an expanded project.

It should be noted that there were many mothers who declined joining the project.

One of the things nurses unanimously agree would need to be done better is the preparation of the mothers for the decision on whether to join the study or not. Most nurses feel that this part of the study was rushed because some of the problems they had to deal with later, showed that they were not given enough time to decide.

C Outputs and Outcomes

Since the project was designed to produce quantitative data, the following tables present some of the primary outputs of the project.

The results of the KABP Survey in tables 1 to 6 show, overall, that with each subsequent visit, the knowledge, attitudes, beliefs and practices changed. There are however certain inconsistent data. In Table 1, the discrepancies are in items blood, inoculation and donate which refer to questions 64, 65 and 66 in

Appendix I. There is almost no change in response to question 64 while as there is a big change in response to question 65. All these questions were correctly translated into the vernacular but they are the type of questions which required amplification at the time the form was being filled.

Had it been that the filling of the questionnaire was done by the nurses (and not the clerks) we should have observed the correct pattern in this data. It was surely disadvantageous to have delegated this task to the clerks who did not receive sufficient training.

The other inconsistency is in Table 2. The item offensive (question 48 in Appendix I) was incorrectly translated. The results for this item are therefore meaningless.

Despite these minor inconsistencies, the arrangements for training and implementation of counselling were excellent.

Can we attribute all the changes in knowledge, attitudes beliefs and practices to the education the mothers received from the project? We cannot be certain because in the last three years, there have been many public health education messages on AIDS/HIV by the MInistry of Health and other organizations.

For specific objective 4, it is difficult to make any meaningful conclusions because very few women of the cohort have seroconverted from HIV-1 negative to HIV-1 positive. This data can be seen in Table 6.

Although the project established a very sophisticated system of confidentiality, the issues that mothers continued to raise during the study shows that they were not fully convinced of this fact. Moreover word soon got around that all the mothers in the study had HIV. Although the project nurses dealt with most of these misconceptions, this indicates that this issue needs to be addressed in another way. The set up in our society is that the church ministers/priests are individuals people can confide in. It would therefore be beneficial to use some of the knowledge gained in this study on counseling training programmes of the clergy.

One of the studies on STDs was to establish the diagnostic utility of cervical friability (CX FRIAB) and cervical discharge (CX DIS) on physical exam and leukocyte esterase dipstick (LED) for cervicitis caused by N.gonorrhoea (GC) or C.trachomatis (CT) in an STD clinic.

RESULTS OF KABP SURVEY

Table 1

Among HIV negative women who have heard of AIDS, proportion who believe in certain of transmission, by visit

	<u>VISIT</u>					
	<u>0</u>	<u>1</u>	<u>4</u>	<u>6</u>	<u>8</u>	<u>10</u>
N	685	584	499	396	166	20
Touch	10.0%	5.0%	0.6%	0.2%	0.0%	0.0%
Share	9.4	2.6	1.0	0.2	0.0	0.0
Sex	95.5	96.4	99.0	99.5	100.0	100.0
Lavatory	12.4	4.6	1.6	0.5	0.0	0.0
Injection	96.9	98.3	99.2	99.0	99.4	100.0
Mosquito	23.4	9.6	3.0	1.8	0.6	0.0
blood	64.6	54.2	49.5	52.3	55.4	40.0
Donate	36.7	64.2	85.0	97.7	95.8	100.0
Inocul.	43.1	65.7	86.6	98.5	98.8	100.0
Mother	93.3	97.4	98.2	99.0	99.4	100.0
Avoid	96.8	97.6	99.4	99.2	97.6	100.0
Have chg	53.5	74.7	89.2	97.7	96.3	100.0
Will chg	14.6	9.1	3.0	0.5	0.0	0.0

changes:

N	392	378	369	350	151	18
Sex	55.4	78.8	94.8	99.7	100.0	100.0
Inject.	37.2	19.3	4.0	0.3	0.0	0.0
Condoms	0.3	0.3	0.0	0.0	0.0	0.0
Trad.Med.	0.8	0.0	0.0	0.0	0.0	0.0
Tatoos	3.8	0.0	0.0	0.0	0.0	0.0
Cut Warts	2.5	1.6	0.5	0.0	0.0	0.0

Table 2

Proportion of women agreeing to various statements about condoms, by visit

N	1017	756	338	39
Less enjoyable	3.9%	3.8%	3.2%	7%
Casual Partner	1.6	0.5	1.2	0.0
Against religion	3.2	1.5	1.2	0.0
Climb womb	1.5	0.3	0.3	0.0
Cost too high	2.5	0.3	1.2	0.0
Offensive	4.1	6.7	9.8	5.1
Prevent pregnancy	97.3	98.1	98.8	97.4
Prevent VD	97.6	98.5	99.4	97.4
Wife/regular partner	2.4	0.7	0.0	0.0
Easy to use	42.5	25.8	20.2	17.9

Table 3Proportion of women who don't know various things about condoms, by visit

N	1017	756	338	39
Less enjoyable	32.8	30.9	31.1	20.5
Casual partner	9.5	6.9	7.1	15.4
Against religion	32.7	32.8	32.8	32.5
climb womb	42.1	43.9	43.5	33.3
Cost too high	21.6	10.7	7.7	7.7
Offensive	36.3	33.3	31.4	30.8
Prevent pregnancy	2.2	1.3	0.6	2.6
Prevent VD	2.1	1.2	0.0	2.6
Wife/regular partner	3.1	1.3	1.2	0.0
Easy to use	25.5	34.1	38.6	
38.5				

Table 4Proportion of women who used condoms, by visit with husband:

N	565	620	281	35
Used at all	19.1%	28.1%	36.3%	5.7%
used always	56.3	37.2	18.7	6.7
with other partner				
N	6	6	5	0
used at all	33.3	0.0	80.0	
0.0				
used always	50.0	---	33.3	---

Table 5Proportion of women using condoms with husband, by HIV status and visit

HIV-positive:

N	259	278	122	17
Used at all	27.8	39.2	43.4	58.8
Used always	52.9	43.1	14.0	11.1

HIV-negative:

N	306	342	159	18
Used at all	11.8	19.0	30.8	33.3
Used always	62.9	27.4	23.9	0.0

Table 6

HIV seroincidence by six-month period ("semester") following delivery. Point of seroconversion is defined as midpoint between visit where HIV was first found to be positive and previous visit at which HIV test was negative.

<u>Period</u>	<u>reeroconvertive</u>	<u>Persons-semester</u>	<u>Rate</u>
0-6 months	5	551.0	0.91
6-12	8	409.3	1.95
12-18	4	187.5	2.13
18-24	1	27.3	3.66
24-30	0	0.25	0.00

Table 7

STD PREEVALENCE BY SEMESTER (6 month period)

STD	<u>SEMESTER</u>					
	<u>SCR</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
N	1380	1380	796	722	706	37
Gonorrhoea	6.8%	2.7%	3.2%	1.7%	3.0%	5.8
Trichomonas	36.1	24.1	18.3	15.3	10.6	5.1
Syphilis	14.3	10.0	6.6	6.1	4.6	0.0
GUD:						
vulvar only	2.1	1.5	2.3	1.9	1.3	5.4
vaginal only	4.3	1.7	1.4	2.3	2.0	0.0
either	7.7	3.5	4.1	4.4	3.9	5.4
Warts:						
vulvar only	1.0	0.4	0.6	0.8	0.6	0.0
vaginal only	1.9	1.2	1.9	2.2	3.9	2.8
either	5.2	2.8	3.3	3.7	6.5	2.8

The method used was that 505 consecutive women presenting to an STD clinic had a pelvic exam; women were assessed for presence of endo-cervical discharge (after removal of ectocervical discharge), for cervical friability (bleeding with the first endocervical swab), and for genital ulcers (GUD). Cervical samples were obtained for GC culture, CT ELISA and LED, vaginal fluid for wet mounts, and blood for syphilis serology.

The results were that the prevalence of STD in these women was: GC 14%, trichomonas 26%, CT 5% (175 women only), syphilis 25%,

and GUD 6%. The sensitivity (SENS), specificity (SPEC) and positive predictive value (PPV) of markers for cervicitis was as follows:

<u>SENS</u>	POS GC (N=505)			<u>SENS</u>	POS GC orCT(N=175)		
	<u>SPEC</u>	<u>PPV</u>			<u>SPEC</u>	<u>PPV</u>	
LED	.49	.70		.21	.48	.76	.27
CX FRIAB	.14	.90		.19	.15	.90	.22
CX DIS	.01	.99		.33	---	---	---

The performance characteristics of LED remained unchanged when stratified by presence or absence of inflammatory vaginitis (trichomonas or yeast on wet mount)

The conclusion from this is that LED was only able to identify about one half of the women with GC or CT, but had a much higher sensitivity than classic clinical indicators of cervicitis. LED may be useful for detection of cervicitis in peripheral settings where other diagnostic tests are unavailable. LED should be evaluated in an algorithmic approach to the diagnosis of lower genital tract infections in women.

The other study on STD was to assess the association between cervical squamous intraepithelial lesions (SIL), HPV infection in Malawian women.

The method used was that 286 post-partum women of known HIV-1 serostatus were administered a questionnaire and had an STD screen and PAP smear. Blood samples were obtained for measurement of T-cell subsets using monoclonal antibodies and flow cytometry. HPV infection was determined by PCR on cervico-vaginal cells collected by lavage.

The results were that 17 of 128 (13%) HIV-1 positive women had cervical SIL compared with 10 of 158 (6%) HIV-1 negative (OR 2,3, p=0.046) with a trend of increasing SIL with increasing immunosuppression (CD4 cells of over 500, 300 to 500, and under 300) (p=0.06). HPV was detected in 27 of 135 (20%) HIV-1 negative women; among HIV-1 positive HPV was found in 22 of 53 (42%) with CD4 cells over 500, in 15 of 31 (48%) with CD4 cells between 300 and 500, and in 8 of 14 (58%) with CD4 cells under 300 (p-trend <0.001). There was a decreasing association between cervical SIL and HPV in HIV-1 positive women with greater immunosuppression.

	<u>HIV-1 pos <300</u>		<u>HIV-1 pos 300-500</u>		<u>HIV-1 pos >500</u>		<u>HIV-1neg</u>	
	SIL	NO SIL	SIL	NO SIL	SIL	NO SIL	SIL	NO SIL
HPV+	1	7	3	12	8	14	5	22
HPV-	1	5	1	15	1	30	4	104

OR=0.7 (P=NS) OR=3.8 (P=0.3) OR=17.1 (P=.002) OR=5.9(P=.02)

This study shows that HIV-1 infected women have a higher risk of SIL than uninfected ones, and that women co-infected with HPV and HIV-1 with CD4 cells over 500 had almost three times the risk for

abnormal cytology than HIV-1 negative, HPV-positive women. PCR allows for HPV detection in low copy numbers, possibly explaining the lack of association between SIL and HPV in HIV-1 positive women with greater immunosuppression (CD4 cells under 500).

D Lessons Learned and Recommendations

1. All the objectives of this study were achieved except for objective 4 which has not been fully achieved because the data set is small.
2. This project has demonstrated that with good training in counseling, counseling can be effective. It is therefore recommended that the methods used in training counsellors in this project and the lessons learned by the staff be documented. There is no health institution in Malawi which has the experience which is now possessed by the project staff.
3. There is need to use the lessons gained to train other groups especially the clergy.
4. It is further recommended that Malawians participate more directly in the management of the project. This is the only way sustainability can be assured
5. There is a need to implement, STD treatment guidelines that were used at the QECH in other health facilities in the country.

APPENDIX I

People think many things about condoms. I am going to read some of the things they say. [Read out and ask:] Do you agree or disagree?

	AGREE	DISAGREE	DON'T KNOW
43) Condoms make sex less enjoyable.....	1	2	3
44) Condoms are most appropriate for use with casual partners.....	1	2	3
45) Condoms use is against my religion..	1	2	3
46) Condoms can climb up into the womb or stomach.....	1	2	3
47) The price of condoms is too high to use regularly.....	1	2	3
48) Condoms are offensive to wives or regular sex partners.....	1	2	3
49) Condoms are good at preventing pregnancy if used properly.....	1	2	3
50) Condoms can prevent venereal diseases if used properly.....	1	2	3
51) Condoms are most appropriate for use with wife/regular partner.....	1	2	3
52) Condoms are easy to use.....	1	2	3

KNOWLEDGE OF AIDS/STD'S

	YES	NO	DON'T KNOW
53. Have you ever heard of a disease called AIDS?.....	1	2	3
54. Have you yourself ever known anyone with AIDS?.....	1	2	3
55. Do you think that a person can be infected and have the virus that causes AIDS but not have any symptoms?.....	1	2	3
56. How does AIDS affect you health?	1	2	3
57. Can AIDS be cured?.....	1	2	3
Do you think can person get AIDS by:			
58. By touching a person with AIDS?.....	1	2	3
59. By sharing for or cups with a person who has AIDS?.....	1	2	3

- | | | | |
|--|---|---|---|
| 60. By having sex with a person who has AIDS? | 1 | 2 | 3 |
| 61. By using public lavatory?..... | 1 | 2 | 3 |
| 62. By injection using needles which have
already been used by a person who has
AIDS?..... | 1 | 2 | 3 |
| 63. By being beaten by a mosquito or similar
insects?..... | 1 | 2 | 3 |
| 64. By contact with blood of a person who
has AIDS?..... | 1 | 2 | 3 |
| 65. By donating blood?..... | 1 | 2 | 3 |
| 66. By having inoculation or vaccination?. | 1 | 2 | 3 |
| 67. From infected mother to baby during
pregnancy?..... | 1 | 2 | 3 |
| 68. Can a person avoid getting AIDS BY
changing his or her behaviour?..... | 1 | 2 | 3 |
| 69. Have you made any changes in your own
behaviour or way of life as a result of
what you have learned about AIDS?..... | 1 | 2 | 3 |
| 70. Do you intend to make any changes in the
future?..... | 1 | 2 | 3 |
| 71. What changes? _____ | | | |

Do you think that a person can get AIDS by:

- | | | | |
|---|----------------|---|---|
| 72. By kissing a person with AIDS?..... | 1 | 2 | 3 |
| 73. By holding hands with a person with AIDS? | 1 | 2 | 3 |
| 74. By having sexual intercourse with an
infected partner?..... | 1 | 2 | 3 |
| 75. What are chances that you yourself might
catch an AIDS?..... | | | |
| 1- Not likely at all | 4- Good chance | | |
| 2- Very small chance | 5- Don't know | | |
| 3- Moderate chance | | | |

APPENDIX II

JOHNS HOPKINS PROJECT, ANC AT QECH PERIOD OCT 1989 TO DATE

We would like to know your ideas about the project, and your experience in working with it. Please help us by briefly answering the following questions and feel free to add important ideas and experiences that you have encountered, which we have forgotten to include. Thank you very much.

SCREENING

How did the women react to the pelvic exam?

What were their reason to refuse?

What argument did you use in convincing them?

To counsel for blood drawing , what did you tell the women?

What was the response of women to be tested for HIV?

COUNSELLING

How did you explain what HIV virus is?

What did the women understand about the effect of the virus on the body and the modes of transmission?

When positive for HIV, what did you tell the woman?

When negative to HIV, what did you tell the woman?

What did you tell the woman regarding their partners?

Did the women have questions about how and when they got the virus and from whom? What did they say?

Were they concerned about their unborn child/pregnancy?
What did they say?

ENROLMENT

What did the women say when approached to be enrolled?

The negative women, what argument did you use to convince her?

What argument to the positive women?

Which difficulties did you find in trying to enrol the women at the ward/the labor ward?

What did the hospital staff say - to you, to the women?

VISITS

What do women think about coming in for routine visits?
Are they too often?

Are the time periods OK?
Do they have any questions concerning what we are investigating and why?

What is the most common reason to refuse blood drawing of the woman, of the baby.

What is the fear of drawing blood?

CLINICAL IMPRESSION

What are your clinical impressions from vaginal examinations?

Do you find mwamkala mauka or trace of it upon examinations?

Do you see ulcers, genital sores, cuts and wounds?

Do you often find indications of traditional medicine, with the woman with the baby?

What signs of AIDS symptoms do you think that you see among the women?

What signs of symptoms do you see among the babies?

Positive mothers with babies, what kind of concern/fear/worries do they express regarding the health of the baby?

TRACING

When you go tracing what do the women say to you?

By now your experience with the project, is there anything you would have changed?

Regarding the screening?

Regarding the enrolment?

Regarding the visits?

Regarding the sample routines?

APPENDIX III

LIST OF PROJECT STAFF CONSULTED

1. Ms Mushanga
2. Mrs Mwafulirwa
3. Mrs J. Thomson
4. Mrs Mondywa
5. Mrs Mwambetania
6. Mr J. Piringu
7. Ms S. Kukhada
8. Mr J Canner
9. Ms A. M. Wangel
10. Dr G. Dallabetta