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CARE INTERNATIONAL IN RWANDA

FINAL EVALUATION REPORT

SOUTHEAST BYUMBA INTEGRATED
AIDS EDUCATION AND TRAINING PILOT PROJECT
(JULY 1989 - FEBRUARY 1992)

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GLOSSARY OF TERMS AND ABBREVIATIONS

Rwandan Government Structure:

Prefecture	A region. There are 10 prefectures in Rwanda. Byumba is a prefecture.
Commune	A district. There are seventeen communes in Byumba Prefecture. AETPP works in five of these communes.
Bourgmestre	The head administrator at the commune level.
Sector	A sub-district. There are approximately ten sectors in a commune.
Cellule	The smallest structure of Rwandan government, generally corresponding to one hill. There are ten cellules in a sector.

Abbreviations:

AETPP	Southeast Byumba AIDS Education and Training Pilot Project
CCDFP	Communal Center for Development and Permanent Training/ Centre Communal de Developpement et Formation Permanente
CIDC	AIDS Information and Counselling Center/ Centre d'Information et
DIP	Detailed Implementation Plan- A HAPA Report Requirement
FGD	Focus Group Discussion
HAPA	HIV/AIDS Prevention in Africa Program of USAID
IEC	Information, Education and Communication
KABP	Knowledge, Attitudes, Beliefs and Practices
MOH	Ministry of Health (MINISANTE)
NACP	National AIDS Control Program/ Programme National de Lutte contre le SIDA (PNLS)
ONAPO	National Population Office
RTA/PHC	CARE Regional Technical Advisor for Primary Health Care
TOT	Training of Trainers

AETPP FINAL EVALUATION SUMMARY

The AIDS Education and Training Pilot Project (AETPP) was implemented during a two year period in five rural communes in Rwanda. The purpose of the project was to promote changes in attitudes and behavior to decrease personal risk and help prevent the spread of HIV/AIDS. Using a strategy of training community leaders to diffuse information on AIDS the project successfully reached 25% of the target population directly with educational sessions and up to 72% through its educational materials.

Knowledge levels regarding AIDS prevention increased substantially over the baseline survey findings as did perception of risk and reported condom use. While anecdotal evidence indicates these increases are due to project activities, the lack of a control group in the evaluation design limits attribution.

A project objective regarding the establishment of a commune-level counselling system proved to be too ambitious for the two-year project, due to the lack of testing facilities in the project area.

AETPP was one of the first HIV/AIDS prevention projects to be implemented in rural Africa. While the project time frame was short and implementation difficulties did occur, AETPP provided valuable information regarding HIV/AIDS prevention in a rural setting. Major lessons learned from the project include:

1. Pilot AIDS IEC projects in rural areas require a careful assessment of constraints during the planning process. For example, the reliability of condom distribution mechanisms and the availability of blood testing services should both be carefully examined and the project role clearly defined.
2. Successful IEC programs can be established in rural areas. The project did not encounter the anticipated resistance at the local level from conservative attitudes. Local authorities and community members enthusiastically supported and participated in IEC activities.
3. In rural areas, special attention should be given to the identification of high risk individuals and settings which are likely to serve as foci for HIV transmission. Appropriate IEC activities need to be targeted to these groups.
4. The results of the baseline KABP surveys and focus group discussions are extremely useful in the development and adaptation of messages and IEC materials. The involvement of the NACP and other local organizations facilitates this process.
5. AIDS IEC projects in rural areas require a supply of condoms to distribute in educational sessions since most participants have never seen or used one.
6. A pilot project should test and evaluate variations in the content and number of messages in a single session, the number of

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sessions used to transmit basic information, visual aides and the composition in age, sex and marital status of session participants.

7. The training of community AIDS educators requires a longer period of time than three days. In order to provide basic AIDS education sessions, leaders require intensive supervision and periodic retraining sessions throughout the life of the project. As a result, only a limited number can be trained in a project of short duration.
8. The recruitment, training and supervision of AIDS counsellors is substantially more complex and requires a higher level of professional expertise than that required for community-based AIDS educators.
9. Blood testing services must be locally available or established in a AIDS project which includes counselling.
10. Collaboration during training events with a variety of organizations such as NACP, the Red Cross and others can contribute to the effectiveness of project activities and help to widely disseminate information.
11. IEC projects should, whenever possible, work with other agencies (public or private) to assure a sufficient supply of condoms to distribution points in the project area.
12. Pilot projects require data from control groups in order to measure the outcomes and impacts of interventions on the target population.
13. Indicators for a pilot IEC project should focus on measures such as changes in knowledge, attitudes and reported behavior. Increased demand for condoms is also a good indicator. Other measures should focus on the variety and quality of educational sessions, training materials and the participation of local institutions. Impact indicators such as STD rates are less useful during the first few years of this type of project.
14. The strategy for sustainability should be carefully planned and reviewed early in the implementation cycle. Institutions expected to assume a role in sustaining activities should be involved in early stages of planning implementation. Actions to overcome obstacles and constraints should begin as early as possible and alternative plans developed if necessary.
15. Incentives for those who function as unpaid community AIDS educators should include educational support materials for IEC activities and periodic rewards to serve as encouragement.
16. The cross visit is an effective mechanism for the dissemination of project information to other countries. CARE staff can contribute useful suggestions to strengthen the project and obtain the information they need to design and/or modify AIDS projects in their countries.

E

1. INTRODUCTION

The CARE AIDS Education and Training Pilot Project (AETPP) was a two-year project, funded through the HIV/AIDS Prevention in Africa (HAPA) grant from USAID, the British Overseas Development Administration, CARE International and Shering Plough. The purpose of AETPP was to promote attitudinal and behavioral change to decrease personal risk and help prevent the spread of HIV/AIDS in a selected rural area. The project began in July 1989 and spent the majority of the first year training project staff, carrying out the baseline KABP survey, focus group discussions and developing educational materials. In its second year, AETPP focused on community training and outreach education activities. (See Project Time Line, following page).

The project has worked in five rural communes in Byumba district with a total population of 231,000, approximately 102,000 of whom are in the 15-49 year age range (see Map, Appendix A). The vast majority of the population are subsistence farmers with minimal educational levels. AETPP has concentrated on reaching this rural population with HIV/AIDS prevention information. Using trained CARE extensionists based in each commune, the basic strategy of the project was to train community leaders to present standard AIDS educational sessions to groups of community members.

The primary counterpart of the project was the National AIDS Control Program (NACP) in the Ministry of Health. At the communal level, AETPP coordinated closely with the Bourgmestre and the Communal Center for Development and Permanent Training (CCDFP).

It is important to note that the rebel activity near the border with Uganda presented important delays in implementing project activities. There was a four month period, from October 1990 to February 1991, in which the movement of project staff was severely limited and meetings in the rural areas were impossible to organize.

This evaluation was conducted per the requirements of the HAPA grant program. A six month no-cost extension was requested in order to complete planned activities. The project will formally end in February 1992 and HIV/AIDS education activities will be absorbed into other CARE projects in the region.

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AETPP TIME LINE

MARCH 1989	PROJECT PROPOSAL SUBMITTED TO USAID/HAPA
JULY 1989	FINANCING OBTAINED
AUGUST 1989	PERSONNEL RECRUITMENT CARE AIDS MEETING IN KAMPALA, UGANDA
OCTOBER - DECEMBER 1989	BASELINE INFORMATION COLLECTION IN PROJECT AREA
DECEMBER 1989	TRAINING OF PROJECT PERSONNEL IN BASIC AIDS EDUCATION, EXTENSION TECHNIQUES AND FOCUS GROUP DISCUSSION BY NACP AND PATH/AIDSCOM CONSULTANT.
JANUARY- FEBRUARY 1990	KABP SURVEY AND 48 FOCUS GROUP DISCUSSIONS IN PROJECT AREA.
FEBRUARY 1990	DETAILED IMPLEMENTATION PLAN
FEBRUARY- APRIL 1990	TRAINING OF PROJECT AND NACP PERSONNEL IN THE DEVELOPMENT OF TRAINING CURRICULUM AND EDUCATIONAL MATERIALS BY PATH/AIDSCOM CONSULTANT.
JUNE 1990	EDUCATION AND TRAINING ACTIVITIES BEGIN IN THREE COMMUNES, MURAMBI, MUHURA AND GITUZA. PROJECT AGREEMENT SIGNED WITH GOVERNMENT OF RWANDA.
JULY 1990	MID-TERM PROGRESS REPORT
SEPTEMBER 1990	TRAINING OF PROJECT AND OTHER NGO PERSONNEL IN COUNSELLING FOR HIV/AIDS PREVENTION BY PATH/AIDSCOM CONSULTANT.
OCTOBER 1990	WAR WITH REBELS ON UGANDAN BORDER- ADJACENT TO PROJECT AREA. PROJECT EDUCATIONAL ACTIVITIES INTERRUPTED.
JANUARY 1991	ACTIVITIES RESUMED.
FEBRUARY 1991	EXTENSION OF PROJECT ACTIVITIES TO TWO COMMUNES- GITI AND NGARAMA, 32 FOCUS GROUP DISCUSSIONS HELD IN NGARAMA AND GITI COMMUNES.
APRIL 1991	TRAINING OF TRAINERS IN COUNSELLING FOR AIDS PREVENTION AND MATERIAL DEVELOPMENT FOR COUNSELLING BY PATH/AIDSCOM CONSULTANT.
JUNE 1991	CROSS VISIT TO AETPP BY REPRESENTATIVES OF FOUR CARE MISSIONS AND FOUR RWANDAN ORGANIZATIONS
JULY 1991	REPETITION OF KABP
SEPTEMBER 1991	FINAL EVALUATION OF AETPP

2. EVALUATION METHODOLOGY

2.1. Evaluation Purpose

The purpose of the final evaluation of AETPP was to evaluate the effectiveness of key interventions and project strategies. The specific evaluation objectives were:

Evaluate the accomplishment of project objectives.

Identify messages, techniques and communication channels which were the most effective in changing attitudes and behaviors in the target population.

Evaluate the sustainability of activities and the degree to which they can be continued by community leaders trained by the project.

Share information on lessons learned with other organizations working in AIDS prevention. Specifically, recommend which strategies, messages and materials might be used in other regions in Rwanda.

Make recommendations for the continuation and integration of activities through CARE Rwanda programs.

Report to donors on the use of project resources.

2.2. Evaluation Team

The evaluation team was composed of four Rwandans and two expatriates representing a variety of organizations. All of the Rwandans on the team had been involved in project activities and were generally acquainted with the activities of the project. The team members were:

Mr. François Ndayishibiye	Bourgestre, Muhura Commune
Mr. Théoneste Ndibeshye	IEC Coordinator, National AIDS Control Program
Mr. Patrice Nzahabwanamungu	Health, Population and Nutrition Office, USAID Rwanda
Mr. Thaddée Singira	Rwandan Red Cross
Mr. Ronald Schwarz	Independent Consultant, Evaluation Team Leader
Ms. Catharine McKaig	Regional Technical Advisor for Primary Health Care, West Africa, CARE International

The Project Advisor, Ms. Martha Campbell and the Project Coordinator, Mrs. Vénantie Nyabyende, served as resource persons for the evaluation team.

The report was prepared in English by the two anglophone members of the evaluation team and the AETPP Project Advisor.

2.3. Information Collection

The evaluation team used a combination of information collection methods, but relied primarily on observation, group and individual interviews and document review. (Lists of persons interviewed and documents reviewed can be found in Appendices B and C.)

While all related project documents were reviewed, the mid-term progress report served as the point of departure for the evaluation activity, particularly for the project objectives and targets.

The evaluation team decided to organize information collection and synthesis sessions according to the major project themes. These themes included: Information, Education and Communication (IEC), training, collaboration and community participation, project management, counselling and sustainability. The following section of the report on the findings of the evaluation is organized according to these themes.

The evaluation team developed question guides for group and individual interviews according to the general themes of project activities. The guides were used for interviews with the Bourgmestre and his assistants, project extensionists, community leaders and community members. A standard guide was also used for observation during the AIDS educational sessions. In Kigali, a variety of organizations were contacted for information on collaboration and related activities.

Following the information collection in Kigali and in the field, one day was spent on synthesizing information, discussing project strengths and weaknesses and developing recommendations.

A debriefing session on major findings and recommendations was held in Kigali with CARE, USAID, the NACP and other organizations working in AIDS in Rwanda including UNICEF, the Red Cross, Catholic Relief Services and the Presbyterian Church. Similar debriefing sessions will be held with the local authorities and community groups in the project area.

In order to provide comparative data on the accomplishment of the project objective related to increased awareness, a repeat KABP was conducted in July 1991, two months prior to the final evaluation activity. (A copy of a report of the preliminary findings from the KABP survey can be found in Appendix D. The survey is discussed in more detail in Section 4.3.)

2.4. Evaluation Schedule

The evaluation took place during a ten day period, from September 11-20, 1991 (see schedule, Appendix E).

2.5. Limitations of the Evaluation

The evaluation team felt the ten day period was not adequate to fully examine and discuss different aspects of the project and the one day allotted to synthesis and recommendations was not enough. The section on lessons learned and part of the section on recommendations were completed without the input from the entire team.

Time did not permit for all documents to be examined by all members of the team. Many, for example the reports of the PATH/AIDSOM consultant and project reporting documents, were only available in English.

3. FINDINGS OF THE EVALUATION

3.1. Design

3.1.1. Project Objectives

The overall goal of AETPP was to decrease the incidence and prevalence of HIV/AIDS in the project area. The purpose of AETPP was to promote attitudinal and behavioral change to decrease personal risk and help prevent the spread of HIV/AIDS in five communes in rural Rwanda.

The five project objectives were not substantially changed during the course of the project. According to the Mid-Term Progress Report, these objectives and their respective targets were:

1. To increase awareness of the problem and prevention of HIV/AIDS in the target communities.

Target 1: >90% of the target population will be able to cite the three main ways AIDS is transmitted.

Target 2: 75% of the target population will know that condoms can be used to prevent HIV transmission and will know how to access condoms.

Target 3: 10% of the target population will have a more positive attitude to condoms and condom use as measured by the KA&P.

Target 4: 5% of the target population will have changed to safer behavior as a result of AIDS education (fewer sexual partners, fewer high risk injections).

2. To support community groups in designing, implementing and evaluating educational and training activities which disseminate information on how to prevent the transmission of HIV.

Target 1: 36 community groups will have been given general AIDS training in the first year.

Target 2: 10 Training of trainers courses will have taken place in the first year, training at least 60 community leaders to act as AIDS resource persons.

Target 3: During the first year, integrate HIV/AIDS education into the activities of the CCDFP.

3. To pilot creative community generated educational information dissemination methods and materials that can be replicated in other areas of Rwanda.

Target 1: A project area KABP and 18 focus groups will have taken place.

Target 2: Technical assistance will be provided to the project with possible outputs being: flip charts, brochures, skits, songs and other community generated methods.

Target 3: Two people per cellule will have received training in orienting HIV positive people and their families to counselling.

4. To put in place in each commune a system that is able to orient and counsel people with AIDS, HIV and their families.

Target 1: Three hospital based workers will have been trained in counselling.

Target 2: One persons in each of the ten health facilities in the target area will have undergone intensive AIDS education training and will be able to identify where to send people interested in voluntary testing and counselling.

5. To disseminate lessons learned on how to integrate AIDS education and training activities into existing CARE community-based development projects in Africa.

Target 1: A cross visit workshop will have taken place with representatives of six CARE offices.

It should be noted that there are differences between the French and English versions of the documents, particularly in the way the objectives are written apparently due to translation difficulties. In the English version of the Mid-term Progress Report the objectives contain much more emphasis on prevention than does the French version.

The targets for the objectives were changed during the life of the project as follows:

The percentage targets for the first objective were increased based on the findings from the baseline survey which indicated high levels of knowledge among the target population.

The third target concerning community level counselling for the fourth objective was added as a result of the HAPA review comments for the Detailed Implementation Plan (DIP).

Several of the targets for the second and third objectives addressed only the first year of the project activities. Although all the targets for the second and third objectives were accomplished at the time of the Mid-term Progress Report, these targets were not revised at that time. Thus targets were not useful in monitoring progress of project activities nor in evaluating accomplishment of objectives.

- The evaluation team felt that the fourth objective concerning counselling was too ambitious in light of the short duration of the project, the lack of testing facilities in the project area and the different skills required in undertaking counselling activities. (See Section 6, Counselling)

3.1.2. Strategy

AETPP's strategy was to use CARE extensionists to train leaders of community groups to reach the population and serve as local resources on HIV/AIDS prevention education. Overall the evaluators felt this strategy was sound and an appropriate way to introduce activities quickly in a rural area.

However, the issue of coverage doesn't appear to have been closely examined during the project design. Project documents fail to describe either numbers or percentages of persons belonging to community groups and thus provide no target for monitoring project progress. In light of management decisions made during project implementation, it is evident that more research concerning the extent of coverage through existing community groups should have been done in the initial stages of the project.

The training of community leaders to work as community AIDS educators is a central feature of the implementation strategy for objectives 1-4. Key aspects of the strategy included:

- Local leaders volunteered their time.
- There was to be a diffusion of information through existing organizations and networks.
- Local leaders were to serve as information resources to the communities on HIV/AIDS prevention.

During the first year of the project, essentially two groups were trained to conduct AIDS education activities. These were the community leaders and members of the Communal Center for Development and Permanent Training, the CCDFP. The members of the CCDFP included the director, assistant director and members of the Pedagogic Council. The number of CCDFP members trained per Commune averaged approximately 12 persons per commune. The content of training for both groups was similar with greater attention to communication skills for the CCDFP members. There were two major changes in the training strategy which are described in Section 5, Training.)

3.1.3. Impact area

AETPP attempted to reach a rural area with HIV/AIDS prevention information. As CARE works primarily in rural areas in Africa, the fact that this type of impact area was chosen is important. AETPP was one of the first HIV/AIDS prevention projects to work in a rural area in Africa.

Initially, CARE staff experienced some difficulty in gaining community support for HIV/AIDS prevention as it was not seen as a high priority by many people in the project area. During the early stages of the project, bourgmestres and other communal authorities apparently were not enthusiastic about the amount of attention placed on HIV/AIDS relative to other health problems in the communes. According to the findings of the evaluation, this attitude had changed by the end of the project, as communal authorities expressed support for HIV/AIDS education activities and emphasized the importance of AIDS education in their communes. Community leaders and members interviewed also expressed support for project activities.

According to project documents, targeting specific groups, particularly prostitutes, was seen to be difficult in the rural setting. It was found that in small communities women would not identify themselves as prostitutes and men would not admit to having sex with women other than their wives. Although some efforts were made to reach the sub-section of the population congregating at truck stops, no special messages or approaches were developed for this group.

At the time the project began, seroprevalence in the rural areas of Rwanda was estimated at 2%. It was unclear how quickly it might increase, possibly following the rapid rises in neighboring Tanzania and Uganda. As the perception of risk was cited as key to behavior change, AETPP made the decision not to select "high risk" groups, but to emphasize the message that everyone was at risk.

The decision to work in the rural area also had important implications for the materials which were developed. Educational materials were basic and included brochures and flip charts as there was little electricity and no access to videos or other audiovisual equipment. As many of the people in the project area are illiterate, an emphasis was placed on oral communication.

3.1.4. Strengths and Constraints of the Project Design

The evaluation team cited as a major strength of the project, the fact that it attempted to reach the rural population directly with IEC activities. It was felt that the basic strategy which assisted community leaders to educate their communities about HIV/AIDS prevention was sound and a valid approach.

Another strength of the design was that it worked with existing structures in introducing the project into the rural area. The leaders of groups were easy to identify and provided ready access to a large number of persons.

The third strength of the project design was that it targeted a rural area. Few other HIV/AIDS prevention projects have attempted to work outside urban areas.

The most evident constraints in the design were both cited in the Mid-term Evaluation Report. These were the condom supply and the lack of testing facilities available in the project area.

The role of the project in supporting condom distribution in the project area was not made clear in the project design. While condoms were used in educational sessions as an IEC support, AETPP also acted as a provider to the project area. The project distributed over 50,000 condoms in the five communes primarily through IEC sessions.

The counselling component of the project was not felt to have been well conceived. Acknowledging that it was overly ambitious for a two year project and not appropriate due to the difference in skills required for implementation, the most serious constraint was the lack of testing facilities in the project area. This severely limited the application and relevance of any counselling training which could be carried out by the project.

A final constraint in the design was the designation of the CCDFP as the primary collaborating group at the commune level. It is clear that CCDFP lacks the material capability to sustain AIDS education activities in light of the other demands on its time and resources.

4. IEC PROCESS, OUTPUTS AND OUTCOMES

4.1. IEC Process

The IEC activities related directly to the first and third project objectives, concerning increased awareness and prevention of HIV/AIDS and the piloting of creative community generated educational materials.

It is important to note the role that technical assistance played in the development of the IEC component of the project. This assistance was provided through a PATH/AIDSCOM consultant.

4.1.1. Message Development

AETPP drew its basic messages from the results of the 1990 baseline KABP survey and the focus group discussions. Technical assistance from PATH/AIDSCOM was used in developing the protocol for the focus group discussions. The major findings from these activities included:

People in the project area consistently confused the modes of transmission with the cause of AIDS.

The use of condoms for preventing HIV infection was not well known, especially among the older population.

There were many false beliefs concerning AIDS transmission in the area.

Attitudes towards people with AIDS were negative. Many believed that people with AIDS are dangerous for their family and their community.

For the majority, AIDS was a problem for other people and they did not feel themselves to be personally at risk.

Thus messages were developed concerning the definition of AIDS, the modes of transmission, the modes of prevention with an emphasis on condom use, and attitudes towards and advice on the care of people with AIDS.

In examining the IEC component, it is important to note that it revolved around a single session approach. It was anticipated that participants would only be reached once, and thus the standard session needed to include all of the essential information the project hoped to convey. However, by including all the above listed topics in the educational session the project encountered other problems in IEC. Specifically:

- There were 16 key messages in addition to a demonstration on condom use included in the educational session.
- The session time averaged two hours.
- Due to the length of the sessions, systematic evaluation was difficult. Extensionists and AIDS educators found it difficult to pose the additional questions concerning comprehension in order to evaluate the quality of the sessions.

4.1.2. Development and Pretesting of Materials

The educational materials used by AETPP were developed with the assistance of a PATH/AIDSCOM consultant during a four week visit. Project staff and two members of the NACP participated in the development of messages and the corresponding illustrations. Through the baseline activities, brochures were identified as an appropriate source of information for the target population. Thus a brochure was drafted by a local artist and pretested during three separate visits to the project area. After each visit the illustrations were revised along with the messages. The brochure was pretested with different target groups varied by sex, age, educational level and profession.

After the pretesting and finalizing of the brochure, a flip chart was developed, based on the same images, to be used in the educational sessions. A guide on how to use the flip chart and brochure was also developed.

4.2. IEC Outputs

The primary project outputs for the IEC component were the number of education sessions conducted for community members, the number of persons who participated in the AIDS education sessions, and the educational materials produced and distributed in support of the IEC activities.

4.2.1. IEC Sessions and Participants

IEC SESSIONS BY COMMUNE

Target Group	Muhura	Murambi	Gituza	Giti	Ngarama	Total Number of Sessions	Total Number of IEC hour
Community Members	257	361	346	34	158	1,156	2,312
Other CARE project staff	1		1		1	3	18
TOTAL	258	361	347	34	159	1,159	2,330

NUMBER OF PEOPLE REACHED THROUGH IEC SESSIONS

Target Group	Muhura	Murambi	Gituza	Giti	Ngarama	Total # of Pop Reached	Total Target Popultn	Percent of target Pop Reach
Community Members	8,843	4,754	5,939	610	4,022	24,168	102,000	24%
Other CARE project staff	9		14		8	31	67	46%

According to the DIP, AETPP expected to reach 50% of the target population through IEC sessions by the end of the project. Assuming a 3.7% annual growth rate, the 1990-91 target population of adults 15-49 years of age was 102,000. According to project records, the project directly reached 24% of the target population with HIV/AIDS education prevention sessions, or approximately half of the project target of 50%.

According to the repeat KABP, the percentage of the target population reached indirectly through project educational materials was substantially larger. Of the 648 people surveyed in the 1991 KABP over 38% said they had seen the flip chart and 72% said they had seen the brochures developed by the project. Eighty-eight percent said they had seen condoms.

4.2.2. Educational Materials

The project developed a set of flip charts and brochures with the assistance of PATH/AIDSCOM and in collaboration with NACP. The project financed the printing of 90 sets of colored flip charts and 100,000 brochures. AETPP distributed the flip charts and wooden replicas of penises to AIDS educators in the project area for use as teaching and discussion aides in education sessions. These included the six project extensionists, the health personnel responsible for health education at health facilities in the project area, the CCDFP members in each commune, and the three community AIDS educators selected and trained in the three communes where project activities were first initiated.

The project extensionists and the community AIDS educators distributed condoms to participants during AIDS educational sessions. The AIDS educators also made condoms available in bars and the offices of the CARE extensionists. Other communal extensionists associated with the CCDFP received supplies of condoms for distribution through their networks. The project distributed a total of 50,092 condoms over the period September 1990 to August 1991.

AETPP extensionists also held competitions in their respective communes to encourage the production and application of other educational methods. The presentations included plays, poems, songs and story-telling. Competitions were organized in the three communes where the project was first introduced.

4.3. IEC Outcomes

4.3.1. KABP Results

The results from the follow-up KABP survey demonstrate high knowledge levels regarding HIV/AIDS prevention in the project area (see summary report, Appendix D). Many differences between the 1990 baseline and the 1991 follow-up surveys are dramatic. However, methodological differences between the two surveys and the lack of a control group demand that the results be interpreted with some caution.

Key findings from the follow-up survey include:

Knowledge regarding AIDS prevention- Survey findings indicate that knowledge of AIDS prevention increased substantially as demonstrated by the following table:

TABLE 1: COMPARISON OF AETPP BASELINE (N=361) AND FOLLOW-UP (N=743) SURVEYS: PREVENTION OF AIDS

You can protect yourself against AIDS by:	Baseline (%)	Follow-up (%)
Not having sex with prostitutes	34	97
Using condoms	3	98
Avoiding injections by charlatans	16	98
Sexual relations with regular partner	23	46

Attitudes concerning condom use- Similarly the follow-up survey found increased positive attitudes regarding condom use.

TABLE 2: COMPARISON OF AETPP BASELINE (N=361) AND FOLLOW-UP (N=743) SURVEYS: ATTITUDES TOWARDS CONDOMS

Your opinion of condoms is:

	Baseline (%)	Follow-up (%)
Make sex less enjoyable	29	39
Prevent STD/AIDS	60	98
To be used with non-regular partner	57	96
Are poisoned	8	5

Reported Practices concerning condoms- Over half of the persons interviewed in the follow-up survey said they had experience using a condom compared to 7% in the baseline survey. Forty-four percent said they had used a condom during the last month compared with 4% in the baseline. An overwhelming majority (97%) of those who said they had used a condom recently, said they would continue to use condoms in the future.

Personal Risk- Perceptions of risk also increased. In the baseline only 36% of those interviewed said it was possible that they could get AIDS. At the time of the follow-up, 57% said they believed they were at risk for AIDS.

Again, the evaluators would like to point out the lack of comparison data which makes it difficult to attribute these changes to AETPP. A national AIDS education campaign (including radio announcements and leaflets) was also carried out by the NACP during the project period.

The project documentation included several other indicators which intended to measure project impact on behavior change. These included the number of condoms distributed and the number of sexually transmitted disease cases seen in project area health centers. In light of the IEC focus of the project and the short project time frame, the evaluators felt these indicators were too ambitious in attempting to measure behavior change and were not considered in the evaluation.

4.3.2. Strengths/Positive Results

There appears to be a high level of knowledge regarding HIV/AIDS due to project activities. The community members interviewed by the evaluation team consistently cited the AETPP educational sessions as a major way in which they got information about AIDS.

Another positive result of the project was the increased demand for condoms in the project area. According to community members and health facilities, the use of condoms has increased in the project area.

The educational materials used seemed to be appropriate and effective. Participants of educational sessions interviewed described the materials as clear and helpful in understanding messages.

Finally, observations indicated that the community leaders did serve as resources to their community groups. The community leaders interviewed reported that community members often came to them with questions about HIV/AIDS and/or for condoms outside of the educational sessions.

4.3.3. Weaknesses/Areas for Improvement

Observations from the educational sessions included several areas which might be improved. These were:

There were no guidelines provided to extensionists or AIDS educators regarding the composition of the audience regarding sex or age. The project did not give any consideration to women and men separately. The methodology developed by the project was intended for a mixed group of men and women.

The session was too long and too many messages were given.

Too much emphasis was placed on HIV/AIDS transmission through scarification and injections relative to sexual transmission.

The question of mosquito transmission was frequently raised indicating that it should be included in the educational session itself.

The methodology didn't vary. The session was presented the same way each time without emphasis on particular messages for certain groups.

5. TRAINING PROCESS, OUTPUTS AND OUTCOMES

5.1. Training Process

As with the IEC component, technical assistance from PATH/AIDSCOM was important in the development of the training component. In both of the visits previously cited in the IEC section, the consultant provided assistance in training AETPP staff to train community leaders.

The initial strategy was to train CARE extensionists who would, in turn, train leaders of local community groups and members of CCDFP to be AIDS educators. After the completion of a three-day training, local leaders were expected to hold one educational session per month for members of their association. The CCDFP members were also expected to hold AIDS education sessions although no targets were established. This training of educators approach was an important part of the strategy to sustain the diffusion of AIDS information after the end of the project.

It is not clear how or if the project assessed the effectiveness of the training it provided to community leaders. In the training design, there was no provision for retraining or follow-up training sessions for community leaders and supervision was minimal. After achieving the initial target of 60 trained community leaders in the first few months of the project, the strategy was not assessed for effectiveness before its expansion.

During the first year, the project trained approximately 300 leaders and 42 members of the Pedagogic Councils to serve as AIDS educators in three communes. In addition the community leader group, initially limited to leaders of existing associations, was expanded to include local administrative leaders such as sector counsellors, cellule leaders, and ONAPO extension workers. This was done in order to reach people who were not members of community associations.

However, by expanding the group of leaders, the project found itself with a large number of community leaders to supervise. It should be noted that these leaders had little formal training and required close follow-up and supervision. By 1991, with project expansion into new communes, the number of community leaders trained had risen to over 1,000. Thus the project staff were no longer able to supervise these volunteers effectively.

In an attempt to increase coverage and decrease supervision, in March 1991, AETPP changed its strategy of training community leaders. The project selected the most motivated and effective community leaders who had been trained by the project to act as project community AIDS educators. These community AIDS educators (three per commune in the original three communes) conducted four education sessions per week with a small remuneration of FRW 400 per week of service (\$2.50 USD). The CARE extensionists provided on-the-job training and support to the community AIDS educators on a weekly or bi-weekly basis. By focusing on a small group of community AIDS educators, the project sought to increase the quality of communication skills of the community educators and intensify education activities in the project area.

5.2. Training Outputs

As described earlier, CARE extensionists trained three levels of AIDS educators in the project area. They were: 1) the leaders of community organizations, 2) the 9 community AIDS educators, and 3) the 72 members of the Pedagogic Council and CCDFP.

The training for the community leaders and the Pedagogic Council members of the CCDFP was a three-day course. It covered the topics of basic AIDS education, attitudes towards AIDS, basic communication skills, and use of education materials. The trained community leaders were expected to conduct one education session for their respective groups per month.

NUMBER OF PEOPLE TRAINED IN AIDS EDUCATION TECHNIQUES

Target Group	Muhura	Murambi	Gituza	Giti	Ngarama	Total Number Trained	Total Target Group	Percent of Target Group Trn
Community AIDS Educators	3	3	3	0	0	9	9	100%
Community Leaders	287	383	132	16	183	1,001	60*	1668%
CCDFP Pedag. Council	15	13	14	15	15	72	75	96%

* target for year 1

5.3. Training Outcomes

5.3.1. Strengths/Positive Outcomes

CARE extensionists and community AIDS educators demonstrate a high level of knowledge of AIDS and good training and communication skills. They are comfortable with the topic, respond readily and correctly to questions and solicit active participation in the educational sessions. They also report serving as local resources for people who come to them outside of sessions with questions.

The quality of the training appears to have been good. The educational materials appear to have been appropriate and facilitated the educational sessions.

The target groups for the staff-level training and numbers trained were appropriate. Representatives from other organizations involved in AIDS prevention activities were included in training events and this can be viewed as an added benefit. Much of this training was successful, particularly sessions on the KAP surveys, focus group discussion and the production of materials and IEC skills for extensionists.

While there were some shortcomings in implementation, the training strategy which focused on the multiple role of the CARE extensionists was good.

The project was able to select 9 leaders and with some additional training and close supervision, prepared them to be effective AIDS educators. While this did involve some remuneration, the cost was low and the training effective.

5.3.2. Weaknesses/Areas for Improvement

The quantitative results indicate the number of community leaders trained by the project far exceeds the established target for year 1. An assessment of this result should take into account the following factors: the lack of year 2 targets and the shift in project strategy based on the judgement of project management that the community leaders were not effective in assuring a high coverage of the target population with IEC activities.

Perhaps the largest problem encountered by the project was the training of a large number of community leaders without the ability to offer adequate follow-up. Due to the shortness of the training, it was more of an orientation than a training of trainers. Leaders were not given educational support materials to assist and motivate them in carrying out educational sessions. It was not clear if the leaders which had received the three-day training were able to serve as resources to the community in AIDS education or as AIDS educators as originally envisioned.

The evaluation was not able to assess the training process, but the change in project strategy indicates that the three-day sessions were not adequate to transform community leaders into AIDS educators.

The major shortcoming of the staff training seems to be indicated by the fact that the CARE extensionists were not able to effectively train community leaders to become AIDS educators. This is not necessarily a critique of the training, but of the overall training strategy and the limited time devoted to the training of extensionists in extension education and training of trainers. A more appropriate approach would have involved an initial training of the project extensionists for one to two weeks, several months in the field doing AIDS education, supervision, and an additional two to three week TOT course which would include supervised field training. The lack of training on monitoring and evaluation can also be seen as weakness.

6. COUNSELLING

6.1. Counselling Process

As noted in the preceding Section 3, the counselling objective appears too ambitious for the short project time frame and required a completely different approach from the IEC and training activities previously undertaken by the project. A major constraint to establishing effective counselling services was the lack of adequate testing sites in the project area. At the time of the evaluation, only two rural hospitals and one health center had the capability to draw, store and send blood to Kigali for HIV testing.

Clearly this lack of testing facilities had implications for the counselling activities carried out by the project. Only two hospital staff could be appropriately trained to provide pre and post test counselling.

Apparently in response to recommendations from the HAPA DIP review, the project attempted to establish a community-based counselling system in conjunction with training health personnel. However, this system remained in the discussion stage, although CARE extensionists and several representatives from other local organizations working with AIDS received training in counselling.

Technical assistance was provided in two instances to the project through PATH/AIDSOM. During three weeks in September 1990, an HIV/AIDS counselling workshop was held for project staff and other organizations. A training curriculum was developed and counselling guides drafted. In April 1991 a TOT workshop was held for project extensionists in order to permit them to train social workers and medical assistants in counselling techniques.

The evaluation team felt the extensionists were not the correct persons to either provide counselling or train others. As test results are confidential and provided through the health system, extensionists had no opportunity to practice counselling skills in the field.

6.2. Counselling Outputs

With assistance from PATH/AIDSOM, the project achieved the following outputs during the second year of the project:

1. Trained AETPP staff in basic counselling techniques during a five-day course.
2. Trained AETPP staff, two CIDC/NACP counterparts, one MOH social worker in the project area, two staff from the Presbyterian Church and one staff from the Red Cross in a four-day course in the training of counsellors.
3. Developed counselling guides to be used in training and counselling sessions as aide memoirs (See Example, Appendix F).

6.3. Counselling Outcomes

Probably the most significant outcome of AETPP in terms of counselling is the advancement of the discussion regarding community counselling in the project area. Prior to AETPP, there was little mention of counselling services to rural areas. Through project activities, local authorities and MOH staff have been involved in discussions regarding the constraints associated with provision of counselling services through the MOH structure and issues of confidentiality. The project has also served to underline the need for testing services in rural areas.

In light of the problems posed by establishing a community counselling system, AETPP made a good choice of working with the local health center staff to provide training in counselling. The effectiveness of this training could be increased by collaboration in training with local groups providing counselling in Kigali.

The guides developed by the project for counselling were shared with the Red Cross and CIDC and may be adapted by other groups in Rwanda undertaking counselling activities.

7. COLLABORATION AND PARTICIPATION

One of AETPP's strong points has been its participative collaboration at the national and regional levels with the NACP, MOH and local authorities.

During the project, staff collaborated fully with the NACP and made an effort to follow the strategies and priorities of NACP. As a result, much useful information has been gained at the national level from AETPP.

AETPP also made an effort to include representatives from other organizations in its training activities. For example, staff from other NGOs and the NACP participated in the counselling training as well as the cross-visit.

At the regional level, MOH personnel and local authorities are well informed of AETPP's activities. Extensionists developed schedules with CCDFP and are often supported in social mobilization by the commune authorities.

At the health facility level, flip charts and brochures were distributed to those staff responsible for doing health education and were used in health education sessions. However, health staff were not trained in their use through project activities.

The project also established a coordination committee, made up of AETPP staff, the NACP, the Bourgmestre, and the Prefectural MOH Director. While the role of the committee is not clearly defined in project documents, it was intended to serve as an advisory body in the planning and implementation of project activities. However, it was felt that the coordination committee served more as a sounding board for decisions already taken by the project, than providing advice to the project in actually formulating project plans. The composition of the group was too large and the meetings too infrequent to provide effective input into project activities. The coordination committee met three times during the project period at six month intervals. Selected members from the coordination committee also met to plan the final evaluation of the project.

At the commune level, local authorities thought official contact with the project to be irregular and infrequent. Although they had frequent contact with the extensionists, they felt visits from project management to be insufficient.

Collaboration with the members of CCDFP posed a problem throughout the life of the project. With demands on their time and resources from the many different activities on-going in the commune, it was difficult to establish on-going supervision for leaders trained through AETPP.

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8. PROJECT MANAGEMENT AND TECHNICAL SUPPORT

8.1. AETPP Staffing

Overall, the project made good use of local resources. The initial staffing plan appears to have been well designed and adequate to carry out project activities as initially designed. The six extensionists were locally recruited and served as the core field staff.

According to project management, the recruitment process did not result in an appropriate selection of extensionists. Because of pressure to staff the project quickly, a thorough interview process with the checking of references was not carried out. The extensionists recruited included several who were not fully committed to project work and did not integrate well in their roles in the community.

CARE staff received substantial training in extension and HIV/AIDS prevention (see Appendix G).

In the first year, the number of volunteers to supervisory staff was adequate. It was felt to be an appropriate role for extensionists to serve as supervisors and trainers for community leaders. However, with the expansion of the number of trained community leaders and the move into additional communes, the extensionists were overloaded.

In all, over 1,000 community leaders were trained. This is a number far beyond any estimated targets. With the minimal training they had received, they required an intensive follow-up which the extensionists could not provide. The ratio between supervisory staff and trained community leaders was not calculated and roles were not clearly defined.

The change in strategy, to use paid community AIDS educators is of questionable appropriateness. It called for a major change in the staffing plan of the project which is not documented in project records. The payment for AIDS education activities clearly limits the sustainability of those activities, even if the payment only represented a minimal sum. However, through these community AIDS educators the project was able to reach a larger percentage of the population in a short time period.

The basing of the Project Coordinator in Kigali handicapped implementation of activities. As AETPP was a rural-based project, the Coordinator could not provide adequate field supervision and contact with local counterparts. Supervisory visits by the Project Coordinator were carried out twice a week. The visits included meetings with extensionists, local authorities and the observation of training and educational sessions. The war and project activities such as staff training interrupted this pattern and resulted in periods where little field support was provided.

As staff were new and trained for a relatively short period of time, the supervision of training and IEC sessions was key. Subsequent problems as identified through strategy changes indicate that supervision was inadequate.

8.2. Technical Assistance

8.2.1. CARE Technical Assistance

CARE institutional technical assistance was provided to the project periodically during the life of the project. These visits were:

DATE	VISITOR	OBJECTIVE
July 1989	RTA/PHC East Africa	AETPP Start-up and Staffing
August 1989	Deputy Director, PHC Unit	Initial Baseline Assistance
August 1990	RTA/PHC East Africa	Mid-term Progress Report
March 1991	RTA/PHC East Africa	Preparation for Final Evaluation
June 1991	RTA/PHC West Africa	Cross-Visit
August 1991	RTA/PHC West Africa	Final Evaluation

It should be noted that there was a period of one year, August 1989 to 1990, when the project was not visited by CARE technical support. The project, however did have considerable outside technical assistance during that period. NACP provided assistance for carrying out the baseline, and the PATH/AIDSCOM consultant provided almost four months of technical assistance during this period. The Project Advisor met with the RTA/PHC East Africa in January 1990 to review the DIP report.

8.2.2. Outside Technical Assistance

As discussed earlier, the project used PATH/AIDSCOM technical assistance to a great extent. In total, this consultant visited the project four times for three to four week periods. These visits included:

DATES	OBJECTIVES
Nov/Dec 1989	Adult education techniques and focus groups methodology
Mar/Apr 1990	Training curriculum and materials development
Sept/Oct 1990	Counselling curriculum development
Apr/May 1991	TOT in counselling

This technical assistance provided the project with good training basics and assisted greatly in the development of educational materials. The CARE extensionists interviewed commented positively on the training they had received.

However, the evaluation noted that the same technical assistance was not appropriate for the counselling component which required different skills and most importantly, experience in counselling. CIDC counsellors, trained in Canada, were invited and participated in the training on a part-time basis but did not feel themselves to be well-versed in issues of concern to rural populations. Perhaps more experienced outside technical assistance could have been found for this component, as AETPP was the first organization to broach the subject of counselling in rural areas of Rwanda.

Local technical assistance was provided by the NACP in basic AIDS education, KABP survey interview techniques for the baseline and follow-up surveys. This assistance was judged to have been useful by project staff.

8.2.3. Remaining Needs For Technical Assistance

Several possible areas could be supported by technical assistance. These include:

The planning and analysis of KABP for the control group.

The design of a possible follow-on project.

8.3. Information System

The project generated a substantial amount of information on its activities. This information included trimesterly monitoring reports prepared by the Project Advisor and Project Coordinator, consultant reports on training activities, and baseline documents. A monitoring system was established to track IEC activities and the performance of community leaders (see Appendix C for a list of project documents).

However, the AETPP information system was identified as the weakest element in project management. Notably, the staff had received no technical assistance or training on the design and implementation of the monitoring and evaluation system.

Overall, it was felt that the existing information system was not adequately rigorous for a pilot project. Major weaknesses were identified as followed:

The lack of a control group for the baseline and follow-up KABP surveys presented a major obstacle in evaluating the effectiveness of project interventions. In Rwanda, knowledge levels are high regarding AIDS and information is widely dispersed through the radio. A control group would have permitted attribution of knowledge increases to project activities.

The monitoring system was not closely supervised. Monthly activity reports from extensionists were not well kept, tracked or analyzed. The evaluators were unable to verify records or supervision carried out by the extensionists.

There was a critical lack of a mechanism to provide feedback on the effectiveness of leader training. As a result, the project management was unable to make informed decisions regarding changes in strategy.

Ruptures in stocks of IEC supplies were frequent. The information system was not adequate in tracking needs.

8.4. Use of Funding

The CARE Rwanda mission did a good job of managing the control and reporting on project expenditures. The monthly reports and yearly expenditures by major category were readily accessible for review by the evaluators.

The project expenditures correlate closely to budgeted amounts per major category (see Appendix H for a comparison of annual project budgets and actual expenditures).

Major budget items included national staff (28% of total), international staff (17%), vehicles and maintenance (15%), local materials and equipment (6%) and consultants (9%). A significant percentage of total expenditures (10%) were spent on training of the Project Coordinator and project extensionists.

The majority of the PATH/AIDSCOM technical assistance was funded out the local USAID mission. The project paid \$17,200 to PATH/AIDSCOM for one consultancy (3% of total project expenditures).

CARE Rwanda raised US \$160,450 or 37% of the total project funds as a match to the HAPA grant of US \$270,432 to the project. The funds were donated by the following agencies: Overseas Development Administration, CARE Britain, CARE US and Shering Plough.

9. SUSTAINABILITY

Sustainability is one of CARE's programming principles and received much attention in the project documentation and in the AETPP's coordination committee meetings.

The project strategy to promote the sustainability of the project benefits was to train community leaders on HIV/AIDS transmission and prevention who would then act as resource persons in their respective groups. Selected community leaders, health personnel and members of the CCDFP were trained to enable them to integrate HIV/AIDS messages into their regular training and education activities.

It has been recognized that the current level of intensity of the education activities in the communes is not only unnecessary in the future, but also not a desirable use of resources. The project reached 24% of the target population directly through IEC sessions on HIV/AIDS prevention and a much larger percentage through its educational materials such as brochures. Information on HIV/AIDS has now been widely diffused in the project area, based on the high level of knowledge and positive attitudes toward HIV/AIDS prevention measured in the repeat KABP study. According to the KABP study results, over 90% of the population can identify the three major routes of infection and associated preventive measures. By having trained key leaders within community organizations, the project has established resource persons who can reinforce basic knowledge and positive attitudes among their constituents towards HIV/AIDS prevention.

During the project coordination committee meetings, counterparts and the bourgmestres of the communes in the project area agreed that the CCDFP should be the coordinating body for on-going AIDS education activities in each commune. The actual supervision and follow-up of CCDFP agents in supporting AIDS education activities would be the responsibility of the Prefectural Health Department. In 1990, all of the Prefectural Health Departments received vehicles and annual budgets for AIDS education activities from the NACP and were mandated to include the supervision of AIDS activities in their normal supervision work. The supervision strategy, however, was not adequately designed or implemented.

CARE will continue to support AIDS education and training in the project area under the auspices of its new health education program. The HIV/AIDS activities will focus on the next phase of HIV/AIDS control which will seek to reinforce the current level of knowledge on HIV/AIDS transmission and ensure the availability of condoms in the project areas.

10. ORGANIZATIONAL IMPACT FOR CARE

AETPP was CARE's first major HIV/AIDS prevention project. AETPP has allowed CARE the opportunity to gain field experience in AIDS programming. Other activities carried out in collaboration with AETPP include:

1. AIDS Education Activities for CARE Rwanda Staff. Staff in CARE Rwanda and other missions in Africa have received information and training on AIDS prevention. Mission-level AIDS Coordinators have been appointed and condom distribution initiated. AETPP educational materials have been distributed to french-speaking CARE missions in Africa.
2. CARE African HIV/AIDS Information and Planning Meeting in Kampala, Uganda, August 1989. Seven representatives of CARE's six high priority missions in Africa attended. These were: Ethiopia, Kenya, Mali, Rwanda, Swaziland and Uganda. The Regional Technical Advisors for PHC and Extension, Education and Communication along with the Deputy director of the PHC Unit, New York, facilitated the meeting. The primary purpose of the meeting was to begin a dialogue among missions in Africa concerning HIV/AIDS and develop a strategy and framework for CARE's HIV/AIDS efforts. (See CARE African HIV/AIDS Information and Planning Meeting Report, August 1989)
3. CARE AIDS Education and Training Pilot Project Cross-Visit in Kigali, Rwanda, June 1991. Four CARE staff from Cameroon, Haiti, Mali and Togo along with four representatives from local Rwandan organizations visited AETPP during a five day period. The AETPP Project Advisor and Coordinator served as resource persons for the cross-visit. The visit was facilitated by the RTA/PHC for West Africa. The objectives for the cross-visit were to enable participants to become familiar with AETPP and to facilitate AIDS project development in their respective countries. (See AETPP Cross-Visit Report, June 1991)

AETPP's experience in AIDS programming has contributed greatly to CARE's organizational development. In addition to AETPP, four AIDS prevention projects have been developed and begun implementation, one project is seeking funding, two projects are in development and a regional AIDS study is currently underway.

11. LESSONS LEARNED

AETPP was one of the first HIV/AIDS prevention projects to be implemented in rural Africa. Major lessons learned include:

1. Pilot AIDS IEC projects in rural areas require a careful assessment of constraints during the planning process. For example, the reliability of condom distribution mechanisms and the availability of blood testing services should both be carefully examined and the project role clearly defined.
2. Successful IEC programs can be established in rural areas. The project did not encounter the anticipated resistance at the local level from conservative attitudes. Local authorities and community members enthusiastically supported and participated in IEC activities.
3. In rural areas, special attention should be given to the identification of high risk individuals and settings which are likely to serve as foci for HIV transmission. Appropriate IEC activities need to be targeted to these groups.
4. The results of the baseline KABP surveys and focus group discussions are extremely useful in the development and adaptation of messages and IEC materials. The involvement of the NACP and other local organizations facilitates this process.
5. AIDS IEC projects in rural areas require a supply of condoms to distribute in educational sessions since most participants have never seen or used one.
6. A pilot project should test and evaluate variations in the content and number of messages in a single session, the number of sessions used to transmit basic information, visual aides and the composition in age, sex and marital status of session participants.
7. The training of community AIDS educators requires a longer period of time than three days. In order to provide basic AIDS education sessions, leaders require intensive supervision and periodic retraining sessions throughout the life of the project. As a result, only a limited number can be trained in a project of short duration.
8. The recruitment, training and supervision of AIDS counsellors is substantially more complex and requires a higher level of professional expertise than that required for community-based AIDS educators.
9. Blood testing services must be locally available or established in a AIDS project which includes counselling.
10. Collaboration during training events with a variety of organizations such as NACP, the Red Cross and others can contribute to the effectiveness of project activities and help to widely disseminate information.

11. IEC projects should, whenever possible, work with other agencies (public or private) to assure a sufficient supply of condoms to distribution points in the project area.
12. Pilot projects require data from control groups in order to measure the outcomes and impacts of interventions on the target population.
13. Indicators for a pilot IEC project should focus on measures such as changes in knowledge, attitudes and reported behavior. Increased demand for condoms is also a good indicator. Other measures should focus on the variety and quality of educational sessions, training materials and the participation of local institutions. Impact indicators such as STD rates are less useful during the first few years of this type of project.
14. The strategy for sustainability should be carefully planned and reviewed early in the implementation cycle. Institutions expected to assume a role in sustaining activities should be involved in early stages of planning implementation. Actions to overcome obstacles and constraints should begin as early as possible and alternative plans developed if necessary.
15. Incentives for those who function as unpaid community AIDS educators should include educational support materials for IEC activities and periodic rewards to serve as encouragement.
16. The cross visit is an effective mechanism for the dissemination of project information to other countries. CARE staff can contribute useful suggestions to strengthen the project and obtain the information they need to design and/or modify AIDS projects in their countries.

12. RECOMMENDATIONS

12.1. For CARE International in Rwanda AIDS Programming

12.1.1. Recommendations for AETPP through February 1992

1. KABP survey should be carried out in a control area. The results should be compared and a final report written.
2. The information system should be reviewed and monitoring information verified.
3. The education materials (flip chart and brochures) should be revised based on information from the extensionists and AIDS educators.
4. Feedback sessions on the final evaluation should be held for Bourgmestres, leaders and community members. This should be combined with a discussion on the planned next steps for AIDS activities.
5. Training in counselling should be arranged with CIDC for the two hospital staff persons involved in HIV testing.
6. An activity plan for integration of activities should be developed with MCH and Water Systems staff. ↓

12.1.2. Recommendations for Future AIDS Activities

IEC

1. As a high level of basic understanding of HIV/AIDS transmission and prevention has been achieved in the project area, IEC activities which reinforce perception of risk of the population and encourage associated behavioral change should be supported. Messages should focus on attitudes towards high-risk behaviors and condoms, perceptions and sources of risk, communication with partners about AIDS, testing for high risk couples, orientation toward health services for testing and counselling, access and proper use of condoms, and attitudes toward infected persons in the community.
2. Messages should be integrated into the MOH clinic-based health education system in the project area.
3. The identification and targeting of high risk groups with a specific IEC program, which is either integrated or separate from the current projects, should be considered.
4. Methods, such as mini-surveys and systematic informal interviews, to monitor the extent to which the target population understands and accepts the HIV/AIDS messages promoted by projects should be considered and applied.

Training

1. The CARE Rwanda Mission should consider the development of a new project which supports the training of health personnel in counselling techniques and increasing the access of the population.
2. Persons at condom distribution points should be trained in tracking the number of condoms distributed in the area and the most effective and appropriate distribution points should be identified.
3. Education sessions for CARE staff at the Kigali and field offices on HIV/AIDS subjects should be conducted on a semi- or trimesterly basis.

Counselling

1. The use of CIDC expertise and training curriculum for the training of health personnel in the project area in counselling techniques should be considered. Priority should be given to establishing counselling services where clients already have access to testing services in the project zones.

Collaboration/Participation

1. The communal authorities should be oriented fully to project strategies; the Communes should be encouraged to hold trimesterly Coordination Meetings for all CARE Projects in each Commune.
2. Local authorities should be involved at the design stage. They should address issues such as the organization of field activities and collaboration with local institutions.
3. As NACP has authority over NGO AIDS education projects, procedures and time periods for decision-making on key activities should be established jointly and respected by both parties.

Management/Administration

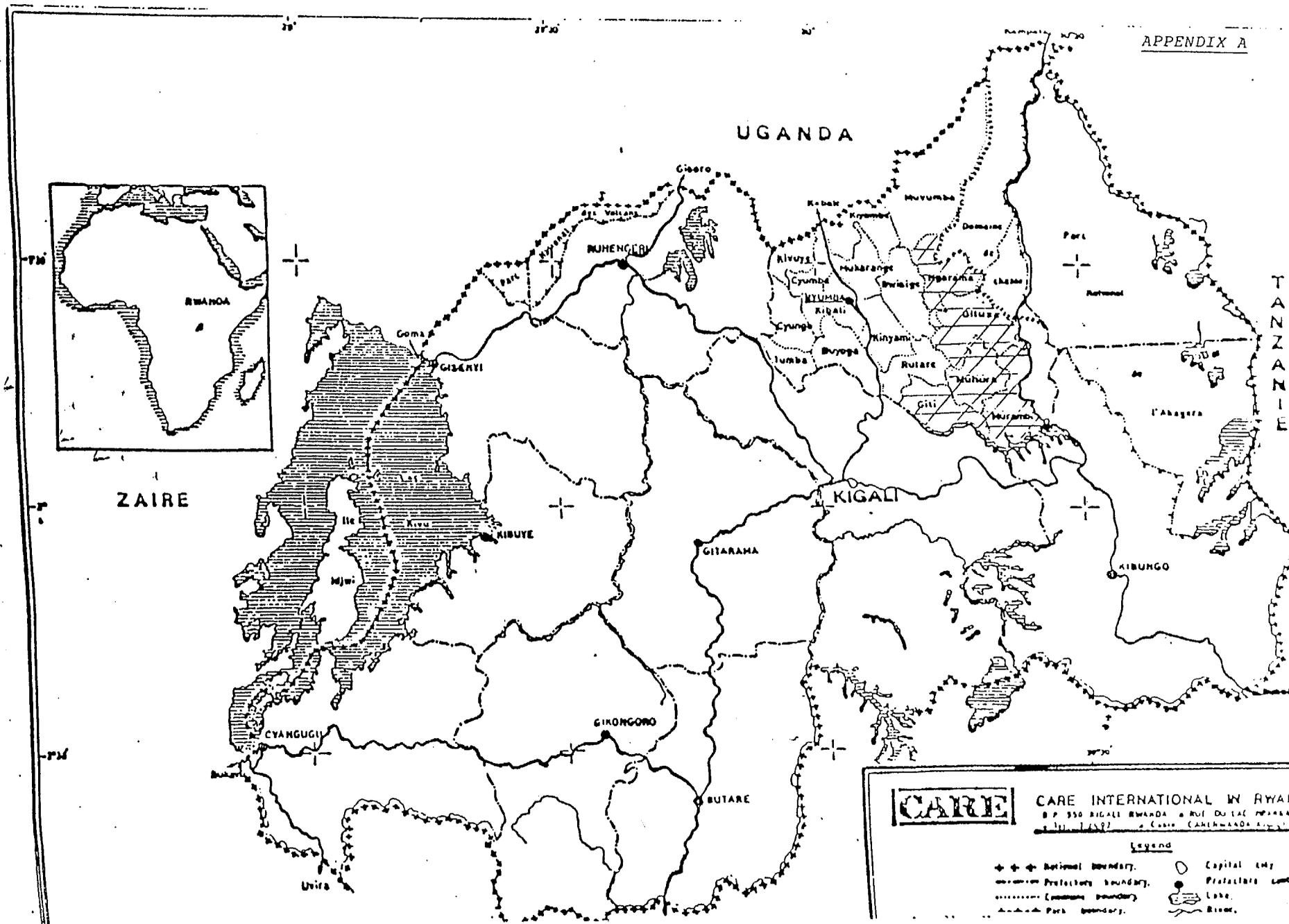
1. The projects should consider investing more time into the recruitment process for key project staff like the project extensionists. The projects should consider offering training with pre- and post-tests to determine the levels of motivation and capacities for learning among candidates.
2. Information collection requirements should be linked directly to project indicators and targets.
3. A system and schedule of supervision for all staff and project activities should be designed during the early stage of implementation. It should incorporate check lists and other data collection instruments to guide and standardize the supervision of staff and reporting.
4. A clear definition of the roles of each staff member should be written early in the project and periodically assessed and modified. This should take into account factors such as the number of community educators to be supervised, the frequency of visits, data to be collected and other tasks.

Sustainability

1. A phase-over period should be built into project plan to allow time for the transfer of responsibilities and roles to project counterparts before the project ends.

LIST OF APPENDICES

- A. Map of project area.
- B. List of persons contacted during project evaluation.
- C. List of project documents reviewed.
- D. Report on preliminary findings of repeat KABP survey.
- E. Final Evaluation Schedule.
- F. Technical guides for counselling.
- G. Project staff and counterpart development.
- H. Financial analysis (1989-91).



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Legend

- National boundary.
- - - Prefecture boundary.
- Common boundary.
- - - - Park boundary.
- Capital city.
- Prefecture center.
- ☪ Lake.
- ~ River.

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APPENDIX B: LIST OF PERSONS CONTACTED DURING AETPP EVALUATION

Muhura Commune

NDAYISHIBYE François, Bourgmestre Muhura Commune

RUHUMULIZA Aloys, Chargé des Affaires Sociales et Culturelles,
Assistant au Bourgmestre

TWAHIRWA Pierre, Animateur AETPP, Muhura Commune

MUKAMUYANGO Alvera, Leader/Formateur

NSABIMANA Evaniste, Leader/Formateur

Angela, Chef de groupement

Christophe, Chef de groupement

Giti Commune

MUKAGACINYA Eugeine, Service de Seropositives, Centre de Sante de
Rwesero, Giti Commune

Murambi Commune

NIKUZE Affissa, Animatrice AETPP, Murambi Commune

BIZIMUNGU Dr. Deo, Physician, Hopital Kiziguro

NUMUKOBWA Felicitee, Assistante Sociale, Hopital Kiziguro

MUKAGAKUBA Jeanne d'Arc, Leader/Formateur, Murambi Commune

IYAKAREMYE Fidele, Leader/Formateur, Murambi Commune

GATETE Jean-Baptiste, Bourgmestre, Murambi Commune

Gituza Commune

MUJAWINGOMA Monique, Assistante du Bourgmestre, Assistant Sociale

MUKANKINDI Beatrice, Animatrice AETPP, Gituza Commune

GATSINZI François-Xavier, Responsable de Centre de Sante
Groupement Communautaire

Kigali

GRUNDMANN Chris and NZAHABWANGAMUNGU Patrice, HPNO, USAID/Rwanda

MUKANDEKEZA Irene, Directrice du Counselling CIDC/PNLS

NYABYENDE Venantie, Coordinatrice de Projet, PPESS

APPENDIX C: LIST OF DOCUMENTS REVIEWED

1. HAPA Grants Projects: Technical Review of FY89 HAPA Proposals, CARE Rwanda
2. Technical Assistance Report, CARE Rwanda, East Africa Technical Advisor for PHC, Update on AIDS Education and Training Pilot Project, July 11-14, 1989
3. Detailed Implementation Plan, Southeast Byumba Integrated AIDS Education and Training Pilot Project, CARE International, June 1989
4. HAPA Grants Projects: Review of Detailed Implementation Plan for CARE Rwanda, May 1990
5. Midterm Progress Report, Southeast Byumba Integrated AIDS Education and Training Pilot Project, CARE International, August 1990
6. HAPA Grants Projects, Review of Midterm Progress Report for CARE Rwanda
7. Technical Assistance Report, CARE Rwanda, East Africa Technical Advisor for Primary Health Care, March 1991
8. HAPA Grants Projects Final Evaluations- Overview and General Guidelines
9. AETPP Project Implementation and Monitoring Reports
June 1989
July -Oct 1989
Nov 1989- Feb 1990
Mar- June 1990
July- Oct 1990
Nov 1990- Feb 1991
March- June 1991
10. Rapport de Visite, Martha Campbell, Juillet 1991
11. Compte-Rendu, Reunion du Comite D'Evaluation, PPESS, Avril 1991
12. Rapport sur l'Enquete Controle CAP pour l'Evaluation Finale du PPESS, 1991
13. CARE AETPP Cross Visit Report, RTA/PHC West Africa, June 1991
14. Trip Report, Morales, Nov 22- Dec 18, 1989, PATH, AIDSCOM
15. Trip Report, Morales, Sept 7- Oct 1, 1990, PATH, AIDSCOM
16. Trip Report, Morales, Apr 2- May 1, 1991, PATH, AIDSCOM
17. Rapport de la Formation sur la Production du Material Educatif Sur le SIDA, Du 5 Mars au 5 Avril 1990, AETPP, CARE Rwanda
18. Rapport de la Formation des Leaders Communautaires, 7-13 Fevrier 1991, AETPP, CARE Rwanda
19. Report on CARE's First African HIV/AIDS Information and Planning Meeting, Kampala, Uganda, RTAT East Africa, August 1989

V. EXECUTION:

V.1. Les enquêteurs

Pour réaliser cette enquête, 12 enquêteurs ont été recrutés de l'Ecole Sociale de Byumba, côté filles et du Groupe Scolaire de Byumba, côté garçons. Ils étaient de formation sociale et pédagogique. Au niveau de chaque commune se trouvaient 4 enquêteurs, dont 2 hommes et 2 femmes. Chaque enquêteur a interrogé au moins 62 personnes pendant une période de 7 jours. Les animateurs du Projet ont servi de facilitateurs quant au déroulement des travaux de cette enquête en participant à la formation des enquêteurs, dans les déplacements des enquêteurs et leur orientation dans les secteurs pour interviewer les personnes identifiées.

V.2. Formation.

Les enquêteurs ont suivi une formation sur les connaissances générales sur le SIDA et les techniques d'enquête par le Coordinateur du Service IEC au PNLS. Cette formation a eu lieu à MUHURA du 11 au 13 juillet 1991. Tous les 12 enquêteurs recrutés et les 4 animateurs du Projet ont suivi la formation.

V.3. Programme

- le 11/7/1991: Formation sur les connaissances générales sur le SIDA
- le 12/7/1991: Prétest du questionnaire
- le 13/7/1991: - Discussion sur les résultats du Prétest
 - Retouche du questionnaire
 - Répartition des rôles aux animateurs et enquêteurs
 - Elaboration de la fiche des quotas journalières par enquêteur.

Après le prétest, les aménagements ont été apportés au questionnaire par les agents formés et le formateur. L'enquête débuta le 16 /7 pour terminer le 22/7/1991.

A la fin de la journée, les questionnaires étaient ramassés et revus par les animateurs assistés d'un agent de CARE, chef de projet Santé Maternelle et Planification Familiale et d'un agent de l'IEC au PNLS.

VI. RESULTATS

Le traitement et l'analyse des données a été assuré par CARE International, utilisant les logiciels de EPIINFO. La phase d'analyse nous permettra de comparer les résultats de cette enquête à ceux de l'enquête CAP au début du projet afin de mesurer l'impact méthodologique du Projet sur les connaissances, les attitudes et les comportements de la population. Ces données constituent donc un outil de base à l'évaluation finale du Projet PPESS.

VI.1. La population enquêtée

L'enquête CAP a visé la population des trois communes pré-citées qui ont accueilli le Projet Pilote de Sensibilisation et d'Education sur le SIDA depuis juillet 1989. Parmi les 743 personnes enquêtées il y avait une division égale entre les hommes et les femmes. Le groupe visé est situé dans la tranche d'âge de 15 à 49 ans, âge des sexuellement actifs. 48% étaient des célibataires, 50% étaient des mariés, 1% étaient des veufs et 1% des séparés et divorcés. 60% de la population enquêtée sont des jeunes situés entre 15 et 25 ans. 11% de la population enquêtée sont situés dans la tranche d'âge de 26 à 30 ans, 21% dans la tranche d'âge de 31 à 40 ans, et 8% dans la tranche d'âge de 41 à 50 ans. 89% de la population enquêtée sont des cultivateurs, 3% sont des commerçants, 2.4% sont des agents de l'Etat, 1% sont des chômeurs, 2.8% sont des étudiants et 1.8% sont de diverses professions (domestiques, chauffeurs, etc...)

En ce qui concerne le niveau d'éducation, 62% sont du niveau de l'école primaire, 3% sont du niveau de l'école secondaire, 0.1% sont du niveau universitaire. 11% n'ont pas terminé l'école primaire et 13% n'ont pas fait des études. 11% ont fait le CERAI.

VI.2. Connaissances sur le SIDA

Parmi les maladies les plus préoccupantes, le paludisme et le SIDA sont cités au premier plan par les enquêtés à 82% pour le paludisme et 94% pour le SIDA. 90% de la population enquêtée affirme que le SIDA est une maladie causée par un VIRUS. 96% affirment qu'il n'y a pas de médicament. Parmi ceux qui tentent d'en trouver un ne parlent en fait que de la prévention (ex: abstinence).

Les enquêtés distinguent très bien les vrais modes de transmission des modes de non-transmission. La transmission mère-enfant et par les seringues ont été cités respectivement à 98% et 99%.

"Etes-vous de ceux qui affirment que le SIDA s'attrape par:

- piqûres des moustiques	17%
- latrines	20%
- serrer la main	7%
.	.
- seringues des magendu	98%
- transmission mère-enfant	98%
- objets tranchants	96%
- approcher le malade du SIDA	11%

Quant à la question d'affirmer qu'une personne ayant le virus du SIDA dans son corps peut vivre longtemps sans se sentir malade ou vivre en bonne santé mais transmettre le virus: 91% de enquêtés comprennent qu'une personne apparemment en bonne santé mais infectée au VIH peut transmettre le virus. Cependant, un pourcentage relativement bas (62%) ne comprend pas encore assez bien qu'on peut avoir le virus dans son corps et vivre longtemps sans se sentir malade.

97% affirment qu'on ne reconnaît un séropositif que s'il passe le TEST de sang. Cependant, un pourcentage relativement élevé (64%) prétend reconnaître le séropositif par les symptômes. Ce qui n'est pas acceptable.

La population enquêtée connaît bien les modes de protection. A cette observation les réponses sont enregistrées comme suit:

On se protège en: - ayant des relations sexuelles qu'avec son partenaire régulier 52%

- en gardant la virginité 91%
- évitant de fréquenter les prostituées 99%
- utilisant les préservatifs 97%
- évitant les injections des Magendu 97%
- évitant d'être transfusé 40%
- ne sait pas 2%

Par ailleurs les soupçons subsistent quant à la transfusion et les dons de sang. 25 à 40% croient encore qu'on peut attraper le VIH/SIDA par la voie de transfusion sanguine ou par le fait de donner du sang.

Les injections des Magendu sont condamnées par la population et constituent incontestablement une voie de transmission du VIH. Ainsi 94% affirment éviter ce genre d'injection est un des moyens efficace de protection au VIH/SIDA.

Le préservatif est considéré par 98% des enquêtés comme un moyen efficace de protection contre le VIH/SIDA et savent où s'en procurer. Les gens sont informés de points d'approvisionnement de préservatifs instaurés par le Projet. Les réponses fournies à la question sur ces centres d'approvisionnement oscillent dans ce sens:

La population ayant besoin de préservatif sait très bien où s'en procurer:

- centre de santé 95%
- CCDFP 84%
- PPESS 90%
- ONAPO 93%
- Bars 5%
- Encadreur de la jeunesse 82%
- animateur de santé 90%

La communication sur le SIDA est très intense. 86% de la population enquêtée affirme entretenir des conversations avec les autres sur le SIDA dans leur milieu. Cependant 68% seulement croient qu'ils sont suffisamment informés et les besoins exprimés en information touchent divers domaines:

- transmission du VIH 98%
- Cause du SIDA 97%
- comment se protéger 97%
- comment traiter le SIDA 98%
- conseil du médecin 99%
- prise en charge du malade de SIDA 98%

Malgré les résultats enregistrés prouvant le degré élevé de connaissances de la population enquêtée et que relativement elle semble informée, le SIDA reste quand même un problème tellement inquiétant que la population ne parvient pas à faire confiance en la connaissance qu'elle possède, ce qui explique le besoin poussé enregistré en information sur le SIDA. 24% seulement des enquêtés n'expriment aucun besoin d'être informé.

VI.3. ATTITUDES

Comme constaté plus haut, la population enquêtée a tellement peur du SIDA qu'elle le place au deuxième plan parmi les maladies les plus inquiétantes. Dans la société certains groupes sont plus à haut risques d'autres. 98% affirment que les prostitués et les vagabonds sexuels sont plus à haut risque que les autres. Cependant d'autres facteurs tels que la fréquentation des Magendu et l'exode rural vers les villes prédisposent à la notion du haut risque. La fréquentation des Magendu est citée à 96%, la vie citadine à 75% et l'exode rural est citée de 67 à 70%.

En ce qui concerne le risque personnel, le SIDA reste considéré comme une affaire des autres et concerne moins l'individu soi-même. Ainsi, 75% affirment qu'il est possible pour quelqu'un de leur cellule d'attraper le VIH/SIDA, 75% affirment qu'il est possible pour un membre de leur famille de l'attraper et 56% admettent qu'ils peuvent attraper le VIH/SIDA. En considération de l'état civil, il n'y a pas de différence dans la perception de risque.

La population (95%) comprend bien la nécessité pour un séropositif de ne plus faire des enfants et d'utiliser le préservatif (93%) pour ne pas transmettre le virus et l'importance de se faire soigner (91%) pour des maladies opportunistes afin de pouvoir prolonger sa vie.

78% à 79% affirment qu'il ne faut pas faire de relations sexuelles. Ceci est difficile à analyser vu qu'on ne précise pas s'il s'agit de relations sexuelles protégées ou non.

- 18% de la population enquêtée affirment que s'ils étaient infectés au VIH, ils se suicideraient. Cette considération mérite plus d'attention est sensibiliser la population sur le sens d'une vie positive et productive même étant infectée.

5% garde une mauvaise attitude d'infecter les autres. Ceci est un sentiment farouche de ceux n'acceptent pas de mourrir seuls.

Pour la personne infectée, 90% de la population enquêtée est pour une sa prise en charge et la contribution de la société entière par le biais de l'Etat serait appréciée. Ceci confirme les résultats de l'enquête exploratoire où la famille est prête à prendre en charge le séropositif et à lui rendre visite s'il était hospitalisé.

Un faible pourcentage (20 à 24%) sont pour l'abandon ou l'isolement.

Les attitudes et croyances sur les préservatifs sont relativement négatives malgré que les connaissances sur leur importance soient assez bonnes. La population enquêtée dit ceci sur les préservatifs:

- | | |
|--|-----|
| - les préservatifs rendent les rapport sexuels moins agréables | 39% |
| - le préservatif s'impose en cas de rapports avec un partenaire non régulier | 96% |
| - le préservatif peut rester dans le vagin de la femme | 53% |
| - utiliser le préservatif est une offense pour l'époux ou le partenaire régulier | 60% |
| - utilisés correctement, les préservatifs peuvent prévenir les MSTs et le SIDA | 98% |

- les préservatifs s'imposent quand l'un des partenaires est infecté 98%
- les préservatifs sont empoisonnés 5%
- les préservatifs peuvent causer les maladies 9%
- les préservatifs rendent les hommes stériles 16%

36% des enquêtés affirment que les hommes devraient être responsables de la protection contre le SIDA. 11% affirment que les femmes devraient l'être. 52% affirment ce sont les deux qui devraient l'être.

VI.4. PRATIQUES ET COMPORTEMENTS

Dans ce CAP contrôle, les questions posées portent sur le comportement adopté pour s'assurer de la prévention .

98% affirment qu'on se protège en utilisant le préservatif, en évitant le vagabondage sexuel (97%), en gardant la virginité (93%), en évitant les injections des Magendu (98%) et en ayant des relations sexuelles qu'avec son partenaire régulier (46%).

Concernant l'utilisation du préservatif, 51% disent qu'ils ont utilisé le préservatif au cours de cette dernière année. 44% disent qu'ils l'ont utilisé au cours de ce dernier mois. Par rapport au CAP exploratoire, il y a un accroissement du nombre des utilisateurs des préservatifs et qui sont favorable à leur usage continu. En effet, 87% de ceux qui l'ont utilisé au cours de ce dernier mois affirment qu'ils vont continuer à l'utiliser.

APPENDIX E: AIDS EDUCATION AND TRAINING PILOT PROJECT (AETPP)

FINAL EVALUATION TEAM SCHEDULE

Wed. 11 Sept.	Thurs. 12 Sept.	Friday 13 Sept	Sat. 14 Sept.	Sunday 15 Sept.
Evaluation Team Meeting	Evaluation Team Meeting	Field Work:		Documentation Review
		* Muhura * Murambi	* Muhura * Murambi * Gitu	
Kigali	Kigali			Kigali

4

Mon. 16 Sept.	Tues. 17 Sept.	Wed. 18 Sept.	Thurs. 19 Sept	Fri. 20 Sept.
Field Work:	Evaluation Team Meeting	Report-writing	Report-writing	Debriefing on evaluation findings and recommendations
* Gituza	Synthesis and Recommendations			(CARE; NACP; USAID; UNICEF; Red Cross)
Interviews in Kigali	Kigali	Kigali	Kigali	Kigali

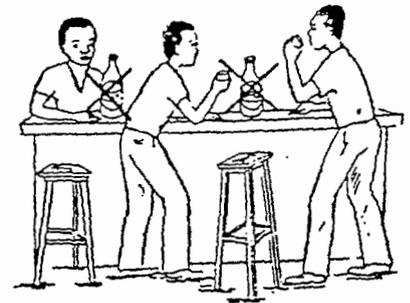
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CONSEILS AUX INFECTES AUX VIH/SIDA

Toute personne qui n'est pas gravement malade avec les symptômes du SIDA peut continuer à travailler et être membre productif de la communauté. Il est très important de mettre l'accent sur le suivi des conseils suivants:

- 1) .Eviter de prendre des boissons alcoolisées.

Eviter de prendre des médicaments non prescrits par le médecin. Consulter celui-ci chaque fois que vous tombez malade.



- 2) .Adoptez un régime alimentaire riche et équilibré.

Une bonne alimentation doit inclure des aliments constructifs d'origine animale (comme de la viande, le poisson, les oeufs) et des aliments constructifs d'origine végétale (comme le soja, le petit pois, les haricots); des aliments énergétiques et calorifiques (comme du maïs, la pâte, le pain et les lipides); les aliments protecteurs comme les fruits et les légumes verts sont aussi conseillés.

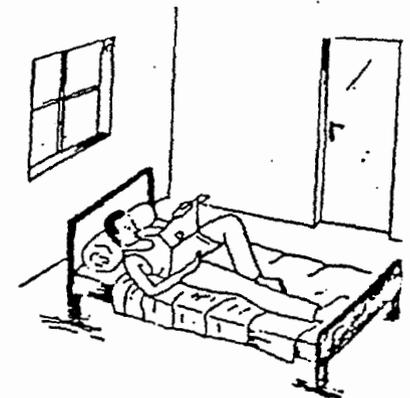


- 3) .Eviter des travaux pénibles; faites des exercices modérés.

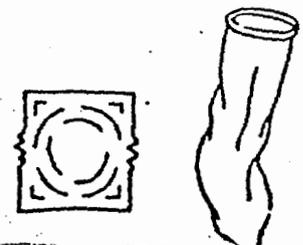
- 4) .Reposez-vous suffisamment.

.Réduire la tension.

- 5) .Evitez de vous énerver; restez toujours en bonne humeur.



- 6) .Evitez des relations sexuelles non protégées. Gardez-vous de vous réinfecter et d'infecter les autres; utilisez des préservatifs dans toutes vos relations sexuelles.



LISTE DE CONTROLE - COUNSELLING DU POST-TEST

Résultats positifs

1. Etablir le rapport
 - . Souhaiter la bienvenue au client;
 - . Lui poser les questions sur le test pour s'assurer qu'il comprend ce que veut dire le "Résultat Positif"
 - . Lui assurer la confidentialité des résultats.
2. Donner les résultats
 - . Utiliser un langage neutre.
3. Etre disponible au client
 - . Observer son état émotionnel et son langage non-verbal;
 - . Vérifier les sentiments du client et y répondre d'une manière appropriée;
 - . Ne pas être compatissant;
 - . Ne pas juger le client;
 - . Etre disponible à répondre à toute question;
 - . Identifier les ressources dans la communauté.
4. Donner des conseils
 - . Suivi médical: se faire soigner chaque fois qu'on est malade;
 - . Alimentation riche, pas d'alcool, repos suffisant, exercices modérés...
5. Proposer le retour
 - . Encourager le client à venir vous voir.

Résultats Négatifs

1. Cfr résultats positifs No1
2. Donner les résultats
 - . Utiliser un langage neutre;
 - . Expliquer ce que veut dire le "Résultat Négatif":
 - ne veut pas dire nécessairement qu'on a le VIH, le test pouvant avoir lieu pendant la période de "séroconversion" (période entre le début de l'infection et le moment où les anticorps se montrent dans le sang).
 - . Lui demander s'il des questions pour y répondre efficacement.

LISTE DE CONTROLE - COUNSELLING POUR LA PREVENTION

1. Expliquer le but du counselling pour la prévention
Il a pour but d'aider le client:
 - . à prendre une décision appropriée à sa situation;
 - . à donner les informations correctes visant à diminuer l'incidence du VIH;
 - . à mettre en pratique des conseils.

2. Poser des questions afin d'évaluer les connaissances du client:
 - . Qu'est ce que le VIH ?
 - . Quels sont les modes de transmission ?
 - . Quels sont les modes de prévention ?
 - . Quels sont les conseils à donner ?

3. Evaluer des comportements à hauts risques
Demander au client;
 - . s'il a eu des rapports sexuels dans un temps donné
 - . s'il a eu des rapports sexuels avec ou sans préservatifs
 - . le nombre de partenaires sexuels
 - . s'il n'a jamais eu des maladies sexuellement transmissibles (MST)
 - . s'il n'a pas fréquenté les Magendu
 - . s'il a reçu la transfusion sanguine avant 1985

4. Demander au client de résumer ses risques et l'aider à les évaluer

5. Résumer ce que le client vient de dire et l'orienter vers la réduction de ses risques

6. Demander au client d'identifier des comportements à adopter pour diminuer des risques

7. Aider le client à établir un plan d'action afin de se rassurer qu'il va adopter une nouvelle pratique

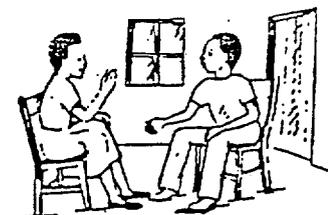
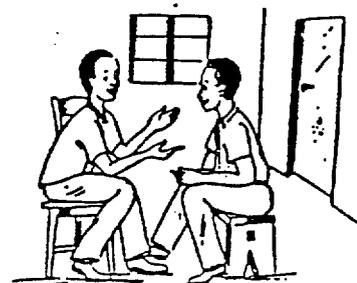
8. Retour: encourager le client à revenir vous voir en cas de besoin.



COMMENT ETRE UN CONSEILLER EFFICACE

Avant d'aborder ces conseils, prenez d'abord quelques minutes de vous rappeler sur ce qu'une personne a fait pour vous aider avec quelque chose afin de mieux comprendre comment être un bon conseiller. C'était peut être ce qu'il a dit ou bien la façon dans laquelle il ou elle a écouté ou a montré son intérêt.

- . Ecouter soigneusement le client et le mettre à l'aise pour lui permettre de s'exprimer librement
- . Poser au client des questions simples et ouvertes afin de recueillir plus de renseignements sur sa situation
- . Mettre le client dans un endroit tranquille et privé, lui rassurer la confidentialité
- . Faire de l'humour et sourire au client quand cela est approprié
- . Paraphraser les idées du client, faire un signe de tête et l'encourager dans ce qu'il dit de positif
- . Etre convaincant et essayer de montrer au client ce qui peut lui être bénéfique
- . Penser comme vos auditeurs en utilisant leurs mots, leurs dessins, leurs histoires et leur musique .
- . Etre claire et honnête en clarifiant les mythes et les idées fausses, tout en ne promettant pas des services qu'on n'est pas à même d'offrir
- . Utiliser simultanément plusieurs moyens d'éducation et ne pas se contredire pour mieux renforcer la propagation du message.

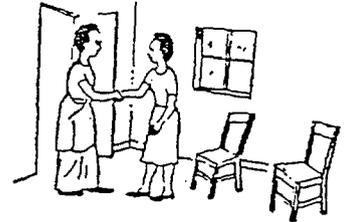


B E R C E R

Le mot "BERCER" vous permettra de vous souvenir d'un processus qui peut vous aider à conseiller vos clients sur le VIH/SIDA ou d'autres sujets de la vie courante.

B ienvenue:

- . Saluer le client et demander ce que vous pouvez faire pour lui
- . Le mettre à l'aise en disant que sa visite sera confidentielle.

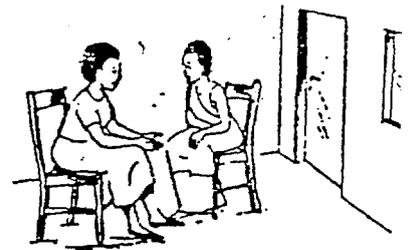


E ntretien

- . Poser au client des questions simples et brèves pour exposer ses besoins, ses souhaits et ses connaissances sur le VIH/SIDA

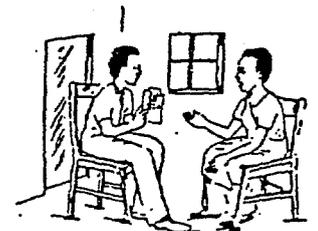
R enseignements:

- . Donner au client des renseignements relatifs au VIH/SIDA et corriger les mythes du client
- . Aider le client à estimer ses risques personnels d'infection au VIH.



C hoix:

- . Aider le client à identifier des comportements alternatifs (à moindre risque au VIH, comme la fidélité conjugale, l'abstinence, l'utilisation des préservatifs...)
- . Aider le client à choisir un plan de comportement sain
- . Vérifier s'il a un plan précis: "Quel plan allez-vous prendre"



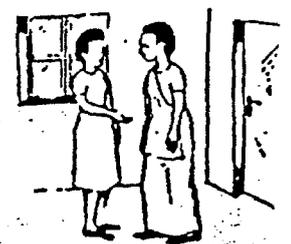
E xplication:

- . Selon le plan du client, aider le à trouver comment l'exécuter.
- . S'il a des informations supplémentaires donnez-les lui. (ex: s'il a décidé d'utiliser des préservatifs, montrer lui le pénis en bois et l'utilisation correcte)
- . Vérifier s'il a bien compris l'explication en lui demandant de démontrer ce qu'il appris.



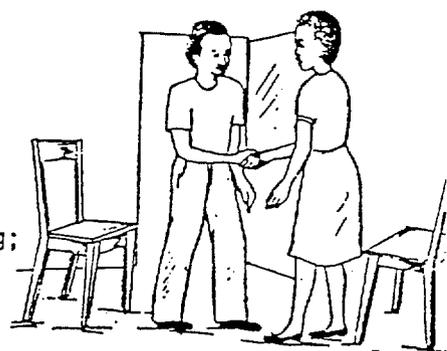
R etour:

- . Encourager le client de revenir vous voir
- . Demander s'il a des questions et s'il continue à employer son plan
- . S'il a des problèmes, aidez-le à identifier des solutions possibles et à modifier son plan
- . Encourager le à continuer des comportements sains (sans risques d'infection au VIH)



LISTE DE CONTROLE - COUNSELLING DU PRE-TEST

1. Etablir le rapport: - Bienvenue
- Demander s'il y a des questions.
2. Faire sortir les connaissances sur l'infection au VIH et le système immunitaire: (- modes de transmission)
(- modes de prévention)
3. Expliquer la procédure du test de sang
 - . On va prélever une petite quantité de sang;
 - . Donner le délai de temps pour avoir le résultat;
 - . Expliquer comment il va avoir le résultat;
 - . Résultat positif veut dire qu'on est infecté au VIH et qu'on peut le transmettre aux autres;
 - . Résultat négatif veut dire qu'on est pas nécessairement infecté, mais qu'on peut aussi être infecté quand les anticorps ne sont pas encore détectables.
4. Réviser/Evaluer la réduction des risques
 - . Poser des questions pour aider et encourager le client à mieux adopter les comportements sans risques.
ex: - La fidélité conjugale
- L'abstinence
- Utilisation des préservatifs
5. Préparer le client à recevoir le résultat
 - . Poser des questions comme:
 - Quels sont vos sentiments ?
 - Comment vous sentez-vous en attendant vos résultats ?
 - Comment pensez-vous que votre communauté va recevoir votre plan ?
 - Comment projeteriez-vous votre plan d'action ?
 - a) Changement des comportements de supports
 - b) Ressources dans la communauté
 - c) Ressources de supports dans la famille
- 6.. Retour
 - . Vérifier s'il y a des questions
 - . Encourager le client de revenir vous voir s'il a des questions



APPENDIX G: AETPP PROJECT STAFF AND COUNTERPART DEVELOPMENT

AETPP/PNLS/ONG STAFF	SUBJECT	TRAINERS	DATES
Project Coordinator Extensionists (6)	Basic AIDS Education	PNLS	20-23 Novembre, 1989
Project Coordinator Extensionists (6)	Group education and focus group discussion techniques	AIDSCOM/PATH	25 November- 18 December, 1989
Extensionists (6)	KAP survey interview techniques	PNLS	3-5 January, 1990
Project Coordinator Extensionists (6) PNLS Officers (2)	Development of training curriculum and education materials	AIDSCOM/PATH	26 February- 6 April, 1990
Project Coordinator	English language training	Kent College, U.K.	6 weeks July 1990 3 weeks July 1991
Project Coordinator	Computer operations training	Local firm in Kigali	1 week 1990
Project Coordinator Extensionists (6) Red Cross (1) Protestant Church 2 CIDC/PNLS (2) Social Worker-Health Center Giti (1)	Training in counselling techniques and development of a training curriculum	AIDSCOM/PATH	10-28 September, 1990
Project Coordinator	Workshop for NGOs involved in the control of HIV/AIDS	HAPA Support Programme. Workshop held in Harrare, Zimbwe.	October 1990
Project Coordinator Extensionists (5) CIDC/PNLS (2) Protestant Church 2 Action Accord (1)	TOT in counselling techniques and development of counselling materials	AIDSCOM/PATH	4-24 April, 1991

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APPENDIX H: FINANCIAL ANALYSIS OF AETPP: July 1989 - June 1991 (US \$)

	YEAR ONE: FY 90		YEAR TWO: FY 91		YEAR THREE: FY 92		TOTAL EXPEND	TOTAL BUDGET	TOTAL EXPEND	TOTAL BUDGET	TOTAL	TOTAL*
	USAID	CARE	USAID	CARE	USAID	CARE	YEARS 1-3 USAID	YEARS 1-3 USAID	YEARS 1-3 CARE	YEARS 1-3 CARE	EXPENDED USAID/CARE	
A. PROCUREMENT												
1. Equipment	4,381	6,106										
Vehicle 4x4	1,755	12,254	2,805		700							
Motorbike (6)		10,385										
Office equipment	220	4,048	6,067	1,421	482							
2. Office Supplies	2,766	552	1,610		1,365							
3. Services	0	2,000	208	4,513	5,000	5,730						
4. Consultants												
Local	1,526											
External	1,346	17,200	2,545			12,500						
SUBTOTAL PROCUREMENT	11,994	52,545	13,235	5,934	7,547	18,230	32,776	14,900	76,709	75,300	109,485	90,200
B. EVALUATION												
1. Consultants			175		9,088	5,000						
2. Other					0	4,000						
SUBTOTAL EVALUATION	0	0	175	0	9,088	9,000	9,263	14,500	9,000	5,300	18,263	19,800
C. PERSONNEL (list each key position and number of person months (p/m)).												
1. Health personnel/Administrative:	42,470	0	18,602	24,197	13,796	5,635						
a. Coordinator: 30 p/m												
b. Extension Workers (18 p/m x 5; and 14 p/m x 1)												
c. Secretary: 24 p/m												
d. Driver 24 p/m												
2. Other: Project Advisor (15 p/m)	30,610	0	36,206	0	3,423	0						
SUBTOTAL PERSONNEL	73,080	0	54,808	24,197	17,219	5,635	145,107	135,146	29,832	0	174,939	115,000

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