
The HAPA Support Program

Annual Report 1992



*REPORT OF ACTIVITIES FOR THE PERIOD
MAY 1, 1991 THROUGH APRIL 30, 1992.*

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THE JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH
INSTITUTE FOR INTERNATIONAL PROGRAMS AND
BUREAU FOR AFRICA, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT.*

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Executive Summary

The HIV/AIDS Prevention in Africa (HAPA) Support Program (HSP), funded by the Bureau for Africa of USAID, carried out its third year of technical support activities to the HAPA project. Technical assistance to PVO HAPA grantees was provided in the form of a final lessons learned/evaluation workshop for field staff; technical assistance for planning and conducting a rapid KABP field survey; the provision of evaluation consultants to projects requesting them; and the development of detailed guidelines for final project evaluations, including guidelines for gathering qualitative data for their projects. Other technical support was provided to the HAPA project by supporting a consultant to complete the initial phase of the Botswana AIDS in the workplace project; by supporting an academic review of the comparative economic impact of AIDS; and by convening the HAPA technical advisory group (TAG).

Technical reports from the projects were monitored, with quarterly reports summarized and disseminated in the *HAPA Update*. Final evaluation reports were reviewed by the HAPA technical advisory group, with comments from the reviews to be compiled, edited and distributed to project staff. HSP published and distributed selected papers from the 1990 Zimbabwe field workshop entitled, *Tradition and Transition*, which included a second printing and Africa-wide distribution by AIDSTECH. The HSP director was guest editor for *AIDS and Society*, in a recent issue focusing on NGO collaboration in HIV/AIDS programs. The program director and assistant were co-authors of an article published in *AIDS CARE* on the role of NGOs in the global response to AIDS.

In addition to the field workshop, HSP staff convened two meetings of the HAPA TAG this reporting year. They participated in seven domestic and international conferences on HIV/AIDS prevention, and made a number of academic presentations on the topic. They continued to review technical and educational documents related to HIV/AIDS prevention, sharing the materials accumulated with a variety of interested persons.

The work plan for the coming year includes the editing and publication of a document reflecting findings of the Uganda field workshop; the production of a comprehensive report on the lessons learned from the HAPA grants program; the production and widespread dissemination of an abbreviated "lessons learned" report from the program; further technical support to the HAPA project as required; and exploration of further approaches to facilitating the involvement of PVOs and NGOs in AIDS activities worldwide.

The financial report indicates that the project spent \$376,167 during the work year covering May 1, 1991 to April 30, 1992, when an estimated \$372,690 in expenditures were projected.

Common Abbreviations

EIL	Experiment in International Living
FHI	Family Health International
HAPA	HIV/AIDS Prevention in Africa
HSP	HAPA Support Program
IFAR	International Forum for AIDS Research
JHU	The Johns Hopkins University
KABP	Knowledge, Attitudes, Beliefs and Practices
NCIH	National Council for International Health
NGO	Non-governmental Organization
PVO	Private Voluntary Organization
STD	Sexually Transmitted Disease
TAG	Technical Advisory Group
TASO	The AIDS Support Organization
USAID	United States Agency for International Development
USIS	United States Information Service
WHO/GPA	World Health Organization/Global Programme on AIDS

I. INTRODUCTION

In May 1989, the Health, Population and Nutrition Division of the A.I.D. Bureau for Africa announced the award of nine HIV/AIDS Prevention in Africa (HAPA) grants for Fiscal Year 1989. The grants funded five private voluntary organizations (PVOs) and one university to add to their existing health or development programs in Africa interventions to assist communities to reduce the spread of HIV infection.

An important focus of the program was to strengthen the capacity of U.S. and African PVOs and other non-governmental organizations (NGOs) to provide high quality, effective, community-based assistance in HIV/AIDS prevention. The HAPA Grants Support Program, based at the Institute for International Programs of The Johns Hopkins University School of Hygiene and Public Health, was funded at that time to assist the HAPA grantees to implement and evaluate appropriate and effective community-based HIV/AIDS prevention strategies. The original scope of work of the Support Program, staffed by the director and one program assistant, focused on the development of guidelines and standards for the PVO HAPA grants projects and on networking and sharing of resources.

The first year of experience with the HAPA Grants Program demonstrated areas of needed support that were not anticipated initially, however, such as the provision of direct technical assistance to PVOs in the development of project strategies, interventions and evaluation. A need was also identified for the HSP to play a broader role in supporting the larger HAPA project, and in assuring and monitoring the quality of the PVO projects. In addition, the HSP was asked to fund an analysis of the relative importance and impact of HIV infection in relation to other infectious diseases in Africa. Appendix A documents the expanded scopes of work for the program.

This report describes the accomplishments of the third year of the HAPA Support Program and outlines a work plan for the coming year.

II. ACCOMPLISHMENTS

A. Technical support to the HAPA project

1. PVO PROJECTS

Technical support for the PVO projects during their concluding year focused on the final evaluation process. The four areas in which support was offered were the implementation of a lessons learned/evaluation field workshop; direct technical assistance in implementing a rapid KABP survey; providing evaluation consultants to individual projects; and developing written evaluation guidelines.

a. Uganda field workshop

The major field activity for HSP during the past year was the Uganda evaluation/lessons learned field workshop. Although not provided for in the HSP budget, funding was successfully sought from Family Health International's AIDSTECH grants program to support the expenses of the workshop. Uganda was selected as a site for this workshop due, in part, to the request of the HAPA projects to visit HIV/AIDS prevention sites in Uganda and share the experience of Ugandans working in HIV/AIDS prevention. The Experiment in International Living was named as a subcontractor in the proposal.

During December 4-6, 1991 a workshop planning meeting between the staff of HSP and selected staff of EIL/Uganda was held in Kampala to formulate objectives for the workshop, to draft a program and to develop and assign specific preparatory responsibilities. The field workshop, entitled "NGOs Respond to HIV/AIDS in Africa: Strategies for Behavior Change," was held in Mukono, Uganda at the Colline Hotel from March 8-14, 1992. The two primary objectives of the meeting were to update skills in project evaluation and to identify lessons learned through project implementation.

Thirty-three full time participants attended the workshop, including staff from the HAPA projects and their government counterparts, staff from invited Ugandan based NGOs working in AIDS prevention, HSP staff, and representatives from FHI and EIL headquarters in the United States. Two persons with AIDS also participated throughout the workshop week. Dialogue on project efforts in HIV/AIDS prevention was further enhanced by field visits to HIV/AIDS prevention sites, both urban and rural, as well as through the integration into the workshop program of dramatic presentations by village community AIDS workers and by members of the drama group from the Post Test Club in Kampala.

Evaluation of the workshop by participants produced very favorable responses, emphasizing the value of exchanges among project personnel working in HIV/AIDS prevention, particularly when such encounters take place in the field setting.

The HSP prepared and issued a detailed report of the workshop following its conclusion (Appendix B). In the upcoming months, selected presentations from the HAPA field workshop will be edited and published.

b. Rapid KABP survey assistance

An important obstacle to assessing project effectiveness as identified by the PVOs has been the major expenditure of time, money and other resources need to carry out field surveys. Technical assistance was offered to HAPA grants projects for their final surveys. In June 1991 the Save the Children/US (SC) HAPA project in Zimbabwe requested technical assistance to conduct a rapid KABP survey as a part of the project's final evaluation. SC had been implementing a training-of-trainers project in two separate impact areas that targeted health workers, village community workers, and village leaders to conduct AIDS education in their communities.

The two primary objectives of the technical assistance were:

- To field test a methodology for assisting PVOs/NGOs to conduct a rapid and affordable KABP survey that would be useful for project evaluation purposes
- To assist SC to determine the extent to which the interventions of their HAPA project had an affect on the knowledge, attitudes, beliefs and practices of the project population

HSP and SC headquarters staff first worked together in the US for one week with survey consultants, in frequent communication with field project staff, to design the 32-item survey questionnaire, develop the sampling method and training plan, and prepare the analysis tables for hand-tabulation. The HSP project director and a survey consultant then traveled to Zimbabwe to assist with the survey planning and implementation.

During the first two days of in-country activity the survey questionnaire was pretested, finalized, translated into the Shona language and retranslated into English. The sampling method was finalized, logistical arrangements were completed, and the training team traveled to the field training site. Supervisors and interviewers were trained over the next three days, and data collection took place over the next 3-4 days. Hand-tabulation of the results was then carried out; during the next week a survey report based on the hand-tabulations was completed and the data entered onto EPI INFO computer package for later in-depth analysis.

A more complete report of the technical assistance provided is in Appendix C.

c. Evaluation consultants

Because of the importance of including skilled and experienced evaluators on the projects' evaluation teams, HSP offered to arrange for or provide the services of evaluation consultants for the final evaluations. Save the Children requested the services of evaluation consultants to serve as team leaders for both their Cameroon and Zimbabwe projects' final evaluations. A list of potential consultants was provided, and SC field and headquarters staff made the final selection of the consultants. In both cases, US-based consultants were selected and utilized.

The Johns Hopkins University HAPA project in Malawi also requested assistance in conducting a final evaluation of their project. Because of the relatively small size of the grant, it was determined that the services of a local consultant would be most appropriate. When the JHU staff in Malawi were not able to identify a locally-based consultant who was available, HSP identified and contracted with a qualified Malawian known to HSP, who conducted the evaluation.

d. Written evaluation guidelines

Since the final evaluations were seen as a critical element in the identification of lessons learned from the HAPA grants, the projects were provided with detailed guidance in the conduct of the evaluations and preparation of the reports. Detailed guidelines and an outline format for the evaluations were distributed to the projects (Appendix D). In addition, a member of the HAPA technical advisory group with anthropological training developed a document that outlined specific approaches to gathering and making use of qualitative data for evaluation (Appendix E) that was distributed along with the final evaluation guidelines.

2. OTHER TECHNICAL SUPPORT

Technical support for non-PVO components of the HAPA project was provided by the provision of a consultant for the Botswana AIDS in the workplace project; subcontracting the preparation of a review paper on the economic impact of AIDS; and consultation with the HAPA technical advisory group.

a. Botswana AIDS in the workplace

In 1991 the East and Southern Africa REDSO AIDS advisor initiated, with the USAID mission in Gaborone, a project for the promotion of AIDS education in the workplace in Botswana. HSP funded the services of a consultant who was involved in the initial stages of the project, Dr. Katele Kalumba, to make a final implementation visit in October, 1991. The final report of his activities will be available in late 1992, following an evaluation of the project.

b. Comparative economic impact review

The HSP worked with selected faculty from The Johns Hopkins School of Hygiene and Public Health to coordinate the preparation of a research review in support of the analytic agenda of ARTS (the Division of Analysis, Research and Technical Support of the Bureau for Africa of USAID). The final document, which was not yet completed at the time of this report, is to consist of three parts: a review of the comparative economic impact of selected diseases (malaria, HIV/AIDS, onchocerciasis, dracunculiasis, and schistosomiasis); a review of applications and implementation of geographic information systems (GIS); and a discussion of the development of a geographic information decision support system, a user-friendly interface for decision makers.

c. HAPA technical advisory group

At the request of the outgoing HAPA project officer, William Lyerly, a meeting of the HAPA TAG was held on November 1, 1991, to solicit input from the TAG as to future directions for the HAPA project and to discuss the ARTS analytic agenda. See section D.2. for a report of the meeting.

B. Management of project reporting

1. ROUTINE REPORT MONITORING

During the current reporting period, the HAPA projects were required to submit quarterly reports and their final evaluation reports to HSP. The exceptions were the EIL/Uganda project and JHU/Malawi project, which did not report directly to the HSP.

Quarterly reports were condensed, edited and disseminated to all of the HAPA grants project staff in the newsletter *HAPA Grants Program Update* (see section C.4.). Information from the quarterly reports was also used on occasion to update A.I.D. staff regarding project activities and outputs.

The final evaluation reports were distributed to TAG members, along with detailed guidelines for their review. TAG members later met to review the reports (see section D.2.); HSP staff then prepared a summary of their review comments for feedback to project staff.

2. PROJECT STATUS SUMMARIES

Below are descriptions of the status of each of the HAPA projects reporting directly to HSP during the past year.

■ Save the Children/Zimbabwe

This project focused on integrating AIDS awareness and prevention activities into an existing child survival program. Training in HIV/AIDS prevention was conducted at many levels, including MOH staff, selected community leaders, headmasters, and village community workers, in addition to families from the impact areas. The project has not yet secured further funding following the HAPA grant.

■ Save the Children/Cameroon

Training over 300 community members as trainers in AIDS education and prevention was the primary activity of this project. Following a relocation of the focus of project activities to the Far North district during the latter half of the project, the primary group targeted for training was district health staff. The multiplier effect was planned into the program as a means of transferring knowledge beyond those who were provided with the original training. HIV/AIDS prevention is being integrated into other USAID mission-funded activities of SC upon the conclusion of the HAPA grant.

■ World Vision/Kenya

AIDS education for high risk groups identified by the project was the main activity of this group. Linkages were made with community leaders from churches, women's

groups, village councilors, commercial sex workers, political leaders, schoolmasters and persons with AIDS to increase community consensus for promoting HIV/AIDS prevention. Health education materials were developed to enhance these educational efforts. The project is currently functioning under a no-cost extension.

■ **World Vision/Zimbabwe**

Project resources were to a large extent directed towards collaboration with the MOH staff at the district level and with the National AIDS Control Program in motivating and educating people to practice HIV/AIDS prevention. During the last months of the project numerous focus group discussions were conducted to develop qualitative data concerning the attitudes of the target population on HIV/AIDS issues. Future funding of HIV/AIDS prevention activities for this project has not been obtained, although many of the activities will continue to be carried out by MOH staff who were trained by the project.

■ **HOPE/Swaziland**

The HOPE/Swaziland project worked in close collaboration with the Family Life Association of Swaziland and the Ministry of Health to initiate broad-based education and counseling interventions for a number of target groups to prevent and control HIV/AIDS infection. Local funding from the USAID mission will be utilized to continue many of the HIV/AIDS prevention activities; the project currently plans to inaugurate a new NGO, The AIDS Support Center, that will exclusively focus on AIDS prevention, support and counseling.

■ **HOPE/Malawi**

The project was developed to provide assistance in HIV/AIDS prevention activities to the Private Hospital Association of Malawi, a consortium of Christian health units in the country. Leaders from the Christian churches as well as from among the Muslim population were trained in HIV/AIDS education and counselling. A close working relationship with the National AIDS Control Program was also established. Additional funding from the local USAID mission will assure continuation of these efforts.

■ **CARE/Rwanda**

Working with a totally rural population, the primary objective of this HAPA project was to incorporate HIV/AIDS education and training activities into an existing water and agroforestry project. Educational materials including flip charts and brochures were also developed. With the conclusion of the HAPA grant, HIV/AIDS prevention activities are being incorporated into the family planning and other activities of CARE/Rwanda.

C. Development and dissemination of written materials

1. *TRADITION AND TRANSITION*

Following the October 1990 HAPA field workshop in Zimbabwe, selected presentations from the workshop were edited and published in June 1991, as a small book entitled *Tradition and Transition*. The response to the initial printing of 400 copies was favorable, necessitating a second printing of 800 copies in November 1991. HSP distributed the document through various channels, such as by responding to written requests and at AIDS-related meetings. Family Health International also sent *Tradition and Transition* in a special mailing in March 1992 to Africa-based recipients of the AIDSTECH materials distribution.

2. *AIDS AND SOCIETY*

The HSP director was the guest editor of the November-December issue of *AIDS and Society*, a journal that reports on social, political and cultural aspects of the AIDS epidemic internationally, with a special focus on Africa (Appendix F). The focus of the issue was the role of NGOs in responding to HIV/AIDS, with special attention placed on mutual collaboration among NGOs and between NGOs and governments. Articles published in this issue ranged from a discussion of the politics of NGOs and governments in Africa to a description of the experience of NGOs in Kenya in forming a consortium for their AIDS work. Also included was a resource section, listing some of the major training and education resources available for AIDS programs, and an analysis of information from the inventory of NGO AIDS activities newly developed by WHO/GPA.

3. *AIDS CARE*

The HSP director and the former program assistant co-authored, with another JHU faculty member, an article entitled "The role of non-governmental organizations in the global response to AIDS," in the October 1991 issue of the British journal *AIDS CARE* (Appendix G). The article highlighted the strengths and constraints of NGOs, and the broad range of contributions that they have made to HIV/AIDS prevention and care.

4. *HAPA GRANTS PROGRAM UPDATE*

Distribution of a newsletter entitled *HAPA Grants Program Update* was continued during the final two quarters of the PVO projects' grants. Distribution included the HAPA grants project staff, PVO headquarters staff, AID missions from HAPA project countries and a limited number of other individuals interested in HIV/AIDS prevention. The purpose of the *Update* was to provide a general report on HAPA business, to publish a listing of upcoming meetings and conferences on HIV/AIDS, to provide news on technical aspects of HIV/AIDS and to share information drawn from the quarterly reports on recent activities undertaken by the HAPA grant projects. Issues of the *Update* were published in May and September of 1991 (Appendix H).

5. AIDS PREVENTION DATA BASE

HSP maintains a file of written materials relevant to international HIV/AIDS prevention projects, including books, articles, educational brochures, posters, training manuals, videos, other visual aids, and miscellaneous other materials. The files are available to anyone wishing to make use of them. During the past year they have been accessed by a variety of JHU students as well as professionals from outside the university, such as the coordinator for the Peace Corps' new AIDS project and the coordinator of a meeting of the International Forum for AIDS Research (IFAR). When particularly relevant materials or articles were found that were not otherwise widely available, they were sent to the HAPA PVO field or headquarters staff.

D. Meetings and presentations

1. EVALUATION/LESSONS LEARNED FIELD WORKSHOP

The major meeting activity for HSP staff was the organization and implementation of the March 1991 field workshop in Uganda. See section II.A. and Appendix B for details of the meeting.

2. HAPA TECHNICAL ADVISORY GROUP MEETINGS

The HAPA technical advisory group is a committee of public health professionals possessing expertise in the areas of international health and HIV/AIDS. The TAG was created by HSP to review the original proposals submitted to the HAPA grants program and to rank the proposals as to their technical merit. The committee has continued to function in an advisory role to the HAPA projects through the regular review of project reports prepared by the field staff. A limited number of other HAPA activities were also brought before the TAG for discussion and guidance. During the current reporting period two meetings of the TAG were held.

a. TAG meeting (November 1, 1991)

A meeting of the TAG was held on November 1, 1991, at the request of the HAPA project officer. The main items of business included a presentation by the HAPA project officer concerning future directions for the HAPA project and Africa Bureau's HIV/AIDS program; reporting from the two USAID Africa regional HIV/AIDS advisors; an update on the recent activities of the HAPA Support Program; a discussion of the guidelines for gathering qualitative data for the final HAPA project evaluations; and an introduction and discussion of the comparative impact review and analysis of HIV/AIDS and other infectious diseases being coordinated for the HSP by Dr. Joan Aron of The Johns Hopkins University.

b. TAG meeting (April 14-15, 1992)

A second meeting of the TAG was convened on April 14-15, 1992 at the Rosslyn Westpark

Hotel in Arlington, Virginia. The specific purpose of this assembly was review of the final evaluation reports submitted by the HAPA grant projects. In addition, during the closing afternoon session PVO headquarter staff from each of the HAPA projects were invited to report to the TAG and AID representatives in attendance the lessons they learned through the implementation of the HAPA grants program. A discussion involving policy issues associated with an HIV/AIDS grants program then followed. A detailed summary of the meeting is in Appendix I.

3. CONFERENCES AND CONFERENCE PRESENTATIONS

HSP was represented at seven international or national conferences on HIV/AIDS prevention during the year.

- **International Forum for AIDS Research (May 22-23, 1991)**

The HSP director was a guest participant in IFAR's fourth meeting, entitled "Behavioral Interventions for the Prevention of Sexual Transmission of HIV." The objectives of the meeting were to consider a model for categorizing behavioral interventions; to share information about current programs and activities; and to foster discussion on whether present strategies are adequate and appropriate. The HSP data base was used by IFAR staff as a resource in preparing briefing materials for the meeting.

- **Planning and Evaluating STD/HIV Prevention Programs (October 7-11, 1991)**

The HSP program assistant took part in a short course on program planning and evaluation related to STDs and HIV prevention, conducted by the Baltimore STD/HIV Prevention Training Center. The purpose of the workshop was to provide knowledge and skills necessary to develop, administer and evaluate a comprehensive HIV prevention program. Workshop instruction focused on problem identification and communication; writing of impact, process and outcome objectives; determination of appropriate solutions; identification of factors which influence HIV related behaviors; and development of a work plan.

- **USAID AIDS Prevention Conference (November 4-5, 1991)**

The HSP director took part in the review of abstracts for the 1991 AIDS Prevention Conference, and both the director and program assistant attended the meeting. Presentations covered a wide range of the HIV/AIDS prevention projects funded by USAID.

- **American Public Health Association (APHA) (November 11-13, 1991)**

The HSP director attended the APHA annual meeting and participated in two sessions on HIV/AIDS. The first was a panel discussion entitled "HIV/AIDS in Developing

Countries: Social Issues for Intervention Programs," which she organized and chaired. Invited speakers represented AIDSTECH (Carol Jaenson), University of California Los Angeles (Gail Wyatt), the Swaziland AIDS Control Program (Rudolph Maziya) and Harvard University (Jonathan Mann). Dr. Mann was unable to attend but sent his paper, which was read by Marc Ostfield of Family Health International. In the second session the HSP director presented a paper jointly authored by the HSP program assistant entitled, "Understanding the Cultural Context of AIDS Prevention."

■ **Society for Women and AIDS in Africa (SWAA) (November 19-22, 1991, Yaounde, Cameroon)**

The HSP program assistant attended the third international workshop on women and AIDS in Africa sponsored by SWAA. The general theme of the workshop was that of barriers to prevention and control associated with women and AIDS. Under this heading were specific topic areas including: AIDS knowledge and attitude barriers, empowerment of women regarding decision making and communication, sexuality and marital factors, socio-economic status of women, traditional and cultural factors, and men's sexual behavior and attitudes towards AIDS. Participants were drawn from over 20 African countries as well as representatives from WHO and a small number of Western based non-governmental organizations involved in HIV/AIDS prevention.

■ **United Nations Development Programme (UNDP) consultation (December 12-15, 1991, Saly-Portugal, Senegal)**

In December 1991 the HSP director attended an informal consultation entitled "Behavior Change: A Central Issue in Responding to the HIV Epidemic." The meeting was facilitated by UNDP, in partnership with the UK NGO AIDS Consortium, the Salvation Army, Save the Children/UK and AIDSTECH. The goal of the consultation was to facilitate communication regarding how community groups working in HIV/AIDS prevention and care are able to facilitate behavior change within their respective communities. NGO representatives from 10 developing countries participated in the meeting.

The meeting sessions consisted of both presentations of the program experience of participants, and participatory sessions in which questions were posed for discussion in small groups. Major questions addressed in both formats were: What is the basis of our shared belief and hope that the epidemic can be overcome? What behavioral and attitudinal changes limit the spread of the epidemic? How do these changes come about? How can community-based organizations assist individuals and communities to change? How do programs expand and develop to assist change? How and why should these changes be documented?

As a result of the consultation, participants developed and circulated a "statement of belief" that affirmed their confidence that behavior change in response to the epidemic was both possible and feasible, and emphasized the need to support this process. The

statement was circulated for additional signatures at the larger Dakar meeting that followed the consultation. A document that attempts to synthesize and summarize the issues and themes from the consultation is forthcoming from UNDP.

As a result of participation in the meeting, the HSP director was identified by the Malaysian participants at the UNDP meeting to take part in a USIS-sponsored teleconference on the effects of HIV/AIDS at the individual, family and community levels, scheduled for May 1992.

■ **Vith International Conference on AIDS in Africa (December 9 - 12, 1991, Dakar, Senegal)**

The HSP director also attended the AIDS in Africa conference in Senegal following the UNDP consultation. The meeting, sponsored annually by WHO/GPA, had as its objectives: to strive for better understanding of the specific characteristics of AIDS in Africa; evaluate the development of HIV/AIDS in Africa; stimulate cooperation and sharing of experiences and scientific information; take stock of prevention and control strategies against the disease; and promote a multi-sectoral approach with collaboration among NGOs and national programs. In addition to the many informative concurrent session presentations, the plenary sessions were relevant to both technical and policy issues. Donald Burke of the USA discussed some of the prospects for vaccine development, expressing hope that a "therapeutic" vaccine might be available within a few years. Peter Piot of Belgium outlined a set of research priorities for the coming few years that emphasized the critical role of research into health services delivery related to HIV/AIDS.

The HSP director presented a poster session describing the rapid KABP survey methodology used in providing technical assistance for the Save the Children/Zimbabwe survey (see section II.A.). There was considerable interest expressed in the comparison of changes in knowledge for project-educated versus non-project-educated respondents, and also in the increase from baseline levels of ever-use of condoms that was reported.

4. ACADEMIC PRESENTATIONS

■ **Centre for Development and Population Activities (CEDPA) (July 29, 1991)**

The HSP director presented a session, "AIDS -- an Update," for a group of developing country participants in a CEDPA course on "Supervision and Evaluation as Management Tools."

■ **Grinnell College lectures (November 25-26, 1991)**

The HSP director was invited to present a Luce Program Lecture on Nations and the Global Environment at Grinnell College on November 25, 1991. The lecture was

entitled, "The Social Ecology of the Global HIV Pandemic." She also lectured for a class on the ecology of HIV/AIDS in Africa during the visit.

■ **The Johns Hopkins University lectures**

Several presentations on HIV/AIDS were made to student groups at The Johns Hopkins University during the past year. These included a lecture on "The Social Context of AIDS in Developing Countries" to students at the undergraduate campus on January 13, 1992; "AIDS Interventions for Women: Aims and Approaches" on February 10 for the course "Women and AIDS: Behavioral Science Perspectives;" "Implementation of AIDS Programs" in a lunch hour student seminar on February 20; and "Public AIDS Policy in the International Arena" on April 21 to School of Hygiene students enrolled in the course "AIDS and Public Policy."

5. OTHER COLLABORATION

a. AIDSCAP

The HSP director was invited to a meeting at Family Health International in North Carolina on October 28, 1991, to participate in a discussion of the organization's plans for their PVO/NGO activities under their new AIDS technical support project, now known as AIDSCAP. FHI requested information on the approaches and content used by the HAPA project in their solicitation of proposals, use of a technical advisory group, development of project reporting requirements, provision of technical assistance, etc. Ongoing discussions have taken place since then, including a follow-up meeting at the AIDSCAP office in Rosslyn, Virginia, to discuss specific plans for FHI's PVO/NGO grants programs.

b. PVO Child Survival Support Program

The HSP director took part in technical reviews of proposals and detailed implementation plans for the JHU PVO Child Survival Support Program. Although the projects were primarily child survival projects, they also included a component of HIV/AIDS education or other prevention activities. Other collaboration between the two programs was ongoing, and included such activities as the sharing of educational materials, information about consultants, meeting information, etc.

c. Additional collaborative activities

HSP staff met regularly with PVO/NGO representatives, staff of other USAID cooperating agencies, students and others wishing to discuss issues and approaches for responding to HIV and AIDS. On November 6, HSP hosted a visit from Dr. Ian Campbell of the Salvation Army Chikankata AIDS project, during which time he made a presentation at the JHU School of Hygiene International Health Department lunchtime seminar.

HSP staff maintained regular contact with the headquarters staff of the HAPA PVOs, including both telephone and occasional personal contact. They also had a close working relationship with the AIDS project staff at the National Council for International Health, regularly taking part in planning, discussions and meetings held by that office. HSP staff were also participants in the monthly AIDS Management Meeting, a program coordination meeting held for all USAID staff and cooperating agencies involved with HIV/AIDS programs.

III. WORK PLAN

A. Support to the PVO projects

The World Vision HAPA grants project in Kenya currently operates under a no-cost extension, and will continue to receive technical support from HSP as needed. They will receive assistance, if requested, for their final evaluation, as well as through comments by the TAG based on review of their final evaluation report. The final evaluation report for the Johns Hopkins/Malawi project will also be reviewed. The EIL/Uganda project is preparing a report on "lessons learned" from their project, which will be included with the other PVO reports in documenting program-wide lessons learned.

HSP plans to maintain contact with the headquarters staff of the HAPA PVOs, as well as some field staff, to continue to provide technical assistance when needed. The HAPA PVOs currently have a number of HIV/AIDS prevention projects in operation, largely as "spin-off" activities of the HAPA PVO grants.

B. Reports and documentation

The HSP plans to prepare a number of summary documents reflecting the lessons learned from the HAPA PVO grants program. The first will be a full report for the Africa Bureau. That report will also be summarized in a more easily readable format for distribution to A.I.D. field missions, PVOs, funders and other interested groups. A third document to be prepared is a report of selected papers from the 1992 field workshop in Uganda, tentatively entitled, "Legacies and Lessons Learned." Finally, other miscellaneous experiences from the HAPA grants program will be documented for possible publication, such as the rapid KABP survey methodology used in Zimbabwe.

C. Dissemination

A priority for the upcoming year's activities will be dissemination of lessons learned from the HAPA grants program to the PVO and funding communities. The documents described above will be distributed as widely as possible within A.I.D. and to outside groups, and presented at appropriate meetings and conferences. In addition, HSP staff will consider

holding a workshop for PVOs, perhaps in conjunction with NCIH, in which the lessons learned are made more usable for the PVO community by means of case studies and exercises (e.g., objective writing and planning an evaluation).

HSP staff will also continue to collaborate with other planned or ongoing PVO/NGO activities, including that of AIDSCAP and the newly organized NGO initiative that is jointly funded by USAID and several European donors.

D. Other activities

HSP will explore with Africa Bureau staff additional ways to provide technical support to the HAPA project and USAID missions, as well as other current or planned PVO and HIV/AIDS activities of USAID. One possible area of collaboration that will be explored further is assisting EIL and the USAID mission in Uganda to document the operating principles, procedures and experiences of TASO and the AIDS Information Center. EIL staff have identified the need to have such a document available for their many visitors who come from other settings in which the establishment of similar HIV/AIDS prevention and support activities is desired.

IV. FINANCIAL REPORT

Actual expenditures for the HAPA Support Program for May 1, 1991 through April 10, 1992, totaled \$376,167. The estimated budget of \$321,408 that was included in the June 1991 revision of the USAID-JHU cooperative agreement covered a 10-month period, making a comparison with actual annual expenditures difficult. To estimate the expenditures that were projected to occur during this funding period, appropriate portions of the 10-month budget were prorated to a 12-month period. The projected budget totaled \$372,690.

Table 1. compares the actual and projected expenditures, by major categories, for the reporting period May 1, 1991 through April 30, 1992. Not shown is a total of \$77 credited to the project, reflecting reimbursements for the cost of mailing individual orders of *Tradition and Transition*.

Total expenditures were within approximately 1% of what was projected. Expenditures within several line items, however, varied more than 10% from what was projected (see Figure 1. for the relative distribution of expenditures by line item).

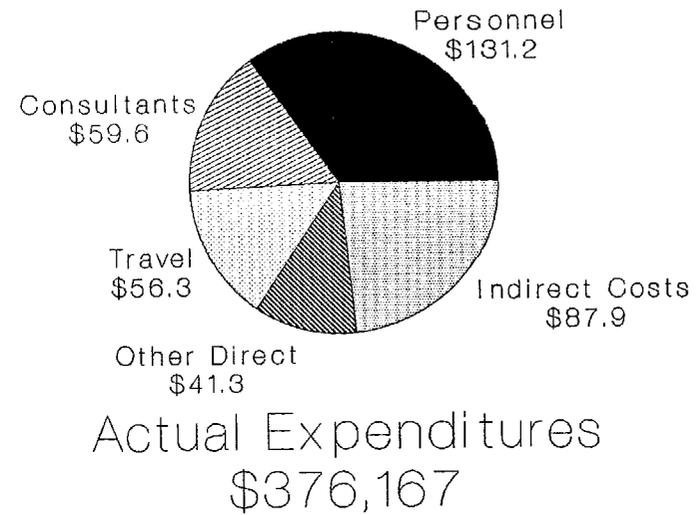
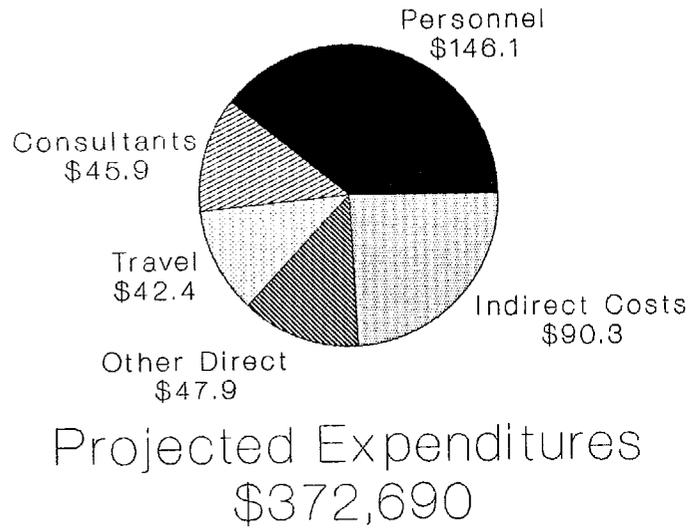
Expenditures for consultants and for travel were considerably higher than what was projected. This was partially the result of consultant services for the Botswana workplace project that were previously performed and travel expenses that were incurred but not billed until this reporting period. Some overspending also was the result of requests from the USAID health officer in Gaborone and the East and Southern REDSO HIV/AIDS advisor to provide support for additional time for the consultant for the Botswana AIDS in the workplace project.

CATEGORY	PROJECTED EXP.	ACTUAL EXP.	DIFFERENCE
Personnel	\$146,104	131,184	(-)14,920
Consultants	45,900	59,634	13,734
Travel	42,421	56,269	13,848
Other Direct	47,916	41,279	(-) 6,637
Indirect Costs	90,349	87,878	(-) 2,471
TOTAL	372,690	376,167	3,477

Table 1.
Comparison of projected and actual expenditures
May 1, 1991 through April 30, 1992

Expenditures for personnel were less than projected, primarily because the economic impact report was still ongoing at the end of the reporting period. Other direct costs were also less than projected, largely because expenses for the Uganda field workshop held in March were covered by outside funds.

FIGURE 1: HAPA Support Program Projected and Actual Expenditures May 1, 1991 to April 30, 1992



in thousand of dollars

APPENDIX A: Expanded Scopes of Work, from modifications #3 and #4 to the Cooperative Agreement

PROGRAM DESCRIPTION
Expanded Technical Assistance Activities
HIV/AIDS Prevention in Africa (HAPA) Grants Support Program

I. BACKGROUND:

In May, 1989, the Health, Population and Nutrition Division of the A.I.D. Bureau for Africa announced the award of nine HIV/AIDS Prevention in Africa (HAPA) grants for Fiscal Year 1989. The grants fund five private voluntary organizations (PVOs) and one university to add components to their existing health or development programs in Africa that will assist communities to reduce the spread of HIV infection. An important focus of the program is to strengthen the capacity of U.S. and African PVOs and NGOs to provide high quality, effective, community-based assistance in this area.

The HAPA Grants Support Program, based at the Institute for International Programs of The John Hopkins report to HAPA Project staff at A.I.D. regarding the status, needs and progress of the funded projects.

However, the HIV/AIDS pandemic is unique in that it is a health problem of major proportions that began less than ten years ago. This has necessitated the HIV/AIDS prevention programs carefully utilize their ongoing experience to identify, during the course of program activities, the best ways to support the development of effective interventions. The first year of experience with the HAPA Grants Program has demonstrated areas of needed support that were not anticipated initially, such as the provision of direct technical assistance in behavioral, anthropologic, and ethnographic methods for assessing community needs and developing appropriate interventions. Increased attention now to assuring and monitoring the quality of the PVO projects will also help lay the groundwork for a project-wide evaluation of the HAPA Project. For these reasons the scope of work of the HAPA Grants Support Program will be expanded.

II. SCOPE OF WORK:

A. Current Scope

The Support Program currently functions in a variety of ways to assist the HAPA grants projects. The Program:

1. -- Assists grantees to identify their technical support needs for the two-year project period, particularly in the areas of baseline studies, project strategies, monitoring and evaluation.
2. -- Identifies resources and means for meeting the technical support needs of the HAPA projects, by such activities as field visits identifying appropriate consultants (from whom PVOs may request direct technical assistance), organizing regional workshops or conferences, providing available written materials, and developing new materials. Maintains a Resource Center of over 250 articles, manuals, and other written and audio-visual materials relevant to HIV/AIDS prevention programs.
3. -- Facilitates communication among HAPA Grantees, to optimize the sharing of resources for HIV/AIDS prevention in Africa and the dissemination of information gained from the HAPA project. Produces a quarterly newsletter, the HAPA Grants Program Update, to share information as to the progress of the projects, and report on current issues and findings in HIV/AIDS prevention.
4. -- Develops guidelines for project reporting, including detailed implementation plans, midterm progress reports and final evaluations, and arranges for technical review of the reports.
5. -- Organizes a technical advisory group (TAG) of individuals having substantial experience with HIV/AIDS prevention, with health programs in Africa, and/or with PVO/NGO health programs. The TAG advises the Program on technical standards for the projects, and reviews reports of project progress.

6. -- Assist the HAPA Grantees and the Africa Bureau to analyze the PVO/NGO experience in HIV/AIDS prevention programming, so that their "lessons learned" are available to assist in guiding future PVO/NGO efforts.

B. Expanded Scope

The HAPA Grants Support Program will assume a broader role in monitoring and assuring the quality of the HAPA grants projects and the other HIV/AIDS prevention activities of the Bureau for Africa. The expanded scope of work will include activities in at least the following areas:

1. -- The Support Program's coordinating role, including field travel, will be strengthened. Regular communication with grantees has been found to be critically important in assuring acceptable technical standards for the projects. This requires increased funding for communications expenses, and for travel to Africa and relevant international meetings (estimated at eight trips), in addition to the domestic travel already budgeted.
2. -- Full funding for a field workshop will be provided to bring together staff from each of the HAPA grants projects for technical training in key areas. Topics to be included might include training for prevention counseling, methods for qualitative assessments of cultural influences on project interventions, KAP survey methodologies for HIV/AIDS projects, and monitoring.
- 3.-- Modest funding will be provided for the Support Program to produce training or other written materials needed by the PVOs. Currently there appears to be a need for materials to guide the PVOs in their baseline studies and in making use of qualitative data to plan their training and educational interventions. Useful materials that result from field and headquarters workshops should be made available in written form.

- 4.-- The involvement of the HAPA Grants Technical Advisory Group (TAG) has been found to be extremely valuable. It will be expanded to include at least one additional TAG meeting, to review the projects' Midterm Progress Reports.
- 5.-- Technical assistance in the expanded Support Program will be directly provided to the PVO projects by external consultants. In particular, technical assistance will be made available in critical areas of the social sciences, to facilitate and assist in evaluating the cultural appropriateness of project interventions. The Support Program can draw on the expertise of anthropologists and others with public health and social science training from The Johns Hopkins School of Hygiene and Public Health, such as staff of the Center for Community-based Health Interventions. In addition, consultants from outside of Johns Hopkins will be used extensively, where appropriate. Africa-based consultants with the necessary skills and training will be emphasized when feasible. Five to eight technical assistance trips are anticipated.
- 6.-- The Support Program will also provide technical assistance in HIV/AIDS prevention outside the PVO community. Funding for consultants included under the expanded scope can be used to provide technical assistance by public health program specialists, anthropologists or other social scientists to support USAID mission-initiated project activities. Three to six consultant visits can be provided. Support Program staff will coordinate closely with USAID mission officers to respond to their needs for assistance in this area.
- 7.-- The monitoring and evaluation component of the Support Program will be further emphasized, utilizing lessons learned during the course of the PVO projects. The Support Program will develop appropriate process and outcome indicators for monitoring and evaluating the effectiveness of the HAPA grants projects that will

also be applicable to other community-based HIV/AIDS prevention programs. They will then utilize the PVO experience to assist in the development of indicators and methodologies that can be used for project-wide evaluation of the HAPA Project's activities.

III. DELIVERABLES:

The Support Program will provide A.I.D. with the following outputs:

1. Written reports of significant Support Program activities including training or other technical materials that are developed, comments from the TAG on the projects' Midterm Progress Reports, and trip reports (in addition to the reporting guidelines, technical reviews of program reports, quarterly program Updates and a final "lessons learned" report provided under the original scope).
2. A full report and evaluation of the field workshop.
3. A consultant report for each technical assistance visit, as well as an evaluation of the effectiveness of each consultation (to be provided by the requesting organization or agency).
4. A set of proposed indicators with which to measure the effectiveness of small-scale HIV/AIDS prevention projects.

IV. EVALUATION CRITERIA:

The effectiveness of the expanded Support Program activities will be assessed according to the following criteria:

1. Timely performance of the activities outlined in the Expanded Scope.
2. Technical quality and usefulness of the Support Program's outputs, as listed above.

3. Perception of the HAPA grantees as to the relevance and effectiveness of services provided under the expanded scope.
4. Demand for and quality of the external technical assistance arranged by the Support Program.
5. Usefulness of the lessons learned regarding monitoring and evaluation of the HAPA Grants projects for other A.I.D. HIV/AIDS prevention activities in Africa.

(End of Attachment)

APPENDIX A2: Final expansion of HSP scope of work

Program Description

As a result of revisions to the Program, the following Program Description is hereby incorporated:

"Expanded Research and Analysis Activities
HIV/AIDS Prevention in Africa (HAPA) Support Program

BACKGROUND

In May, 1989, the Health, Population and Nutrition Division of the A.I.D. Bureau for Africa announced the award of nine HIV/AIDS Prevention in Africa (HAPA) grants for Fiscal Year 1989. The grants fund five private voluntary organizations (PVOs) and one university to add components to their existing health or development programs in Africa that will assist communities to reduce the spread of HIV infection. An important focus of the program is to strengthen the capacity of U.S. and African PVOs and NGOs to provide high quality, effective, community-based assistance in this area.

The HAPA Grants Support Program, based at the Institute for International Programs of The John Hopkins University School of Hygiene and Public Health, originally was developed to assist the HAPA grantees in the development, implementation and evaluation of appropriate and effective community-based HIV/AIDS prevention strategies. Since 1989, technical support has been provided in such areas as quantitative and qualitative baseline studies, technical aspects of intervention strategies, and evaluation. Program staff at John Hopkins report to HAPA Project staff at A.I.D. regarding the status, needs and progress of the funded projects.

In FY90, the program's title became the HAPA Support Program, to reflect a broader role in monitoring and assuring the quality of the HAPA grants projects as well as the HIV/AIDS prevention activities of the Bureau for Africa. The expanded scope of work has included activities in the following areas:

- * The HAPA Support Program now provides technical assistance in HIV/AIDS prevention outside the PVO community. Technical assistance is provided by public health program specialist, anthropologists and other social scientist to support USAID mission-initiated project activities, including a HAPA program and management assessment in January 1991.

- * The involvement of the HAPA Technical Advisory Group (TAG) has been expanded to allow for additional TAG input, including special attention to issues of evaluation of the HAPA project.
- * The monitoring and evaluation component of the HAPA Support program has been further emphasized, utilizing lessons learned during the course of the HAPA project. The Support Program is developing appropriate process and outcome indicators for monitoring and evaluating the effectiveness of the HAPA grants projects that will also be applicable to other community-based HIV/AIDS prevention programs.

As the HAPA project has been amended to authorize only mission-funded activities, this action is to provide funding for an analysis to be carried out under the HAPA Support Program to assist HAPA project management in assessing the relative importance and impact of HIV/AIDS in relation to other infectious diseases in Africa. This information is crucial in providing guidance to USAID Missions so that they may make resource allocation judgements by considering the relative importance of HIV/AIDS in the Mission portfolio.

RATIONALE FOR ANALYSIS COMPONENT OF THE HAPA SUPPORT PROGRAM

The HAPA Support Program already utilizes the expertise and experience of the faculty of the Johns Hopkins University Schools of Medicine and Hygiene in technical assistance, project management, monitoring and evaluation. With the expansion of the HAPA Support Program's scope of work to include the provision of technical assistance to USAID mission-initiated project activities and to HAPA project management, the HAPA Support Program draws strongly on existing connection with researchers at Johns Hopkins in the areas of AIDS, Child survival, and tropical medicine. Faculty from the School of Medicine and Hygiene are especially qualified to further assist the research and analysis component of the HAPA Support Program. Johns Hopkins researchers have developed expertise relevant to the study of the spread of AIDS and other tropical diseases in Africa, and the impact and interrelationship of those diseases in the relationship a to morbidity and mortality.

IN 1989, the JHU Medical Institutions became one of only 11 national Centers for AIDS Research. The Medical Institutions received a five-year, \$3.97 million grant from the National Institute for Allergy and Infectious Diseases to train new

investigators and operate five core projects to support AIDS research. Epidemiologists at the School of Hygiene and Public Health are undertaking studies in Haiti, Brazil, Rwanda, and Malawi (a study partially funded by the HAPA project), while medical anthropologists are exploring the links between individual serostatus, cultural beliefs and socioeconomic factors among women in Uganda.

The Department of Population Dynamics and International Health as well as the Institute for International Programs at the School of Hygiene possess unique capabilities for research in the relationship between AIDS and child survival. Areas of expertise relevant to AIDS prevention include the development of demographic models of child survival (including malaria), and changing patterns of infectious diseases in the developing world. Research on the relative impact of AIDS in Africa will both draw on and have an impact on existing models of morbidity and mortality rates for both children and adults in Africa.

Finally, in the area of tropical diseases, faculty at the School of Hygiene have undertaken relevant studies in the transmission and prevention of malaria, schistosomiasis, and onchocerciasis. In the Department of Immunology and Infectious Diseases, a research project funded by the USAID Bureau for Africa pioneered the use of insecticide-impregnated bednets for malaria control, a project involving both technical innovation and educational intervention. In sum, the field, research, and program experience of Hopkins researchers and staff in AIDS, child survival and tropical medicine are critical to the provision of A.I.D. - relevant research and analytical assistance to the HAPA Support Program.

EXPANDED PROGRAM DESCRIPTION

Under this expanded scope of work, the Support Program will utilize the research and analysis capabilities of The Johns Hopkins University School of Hygiene and Public Health, using existing sources of data, to conduct an investigation of specific cross-sectoral issues related to HIV/AIDS and other infectious disease in Africa such as malaria and onchocerciasis. The research will be conducted by selected faculty and staff of The Johns Hopkins University School of Hygiene and Public Health during the period August 1, 1991 through April 1, 1992.

The primary focus of the research will be: 1) to identify the information that is currently available regarding the distribution and economic impact (primarily focusing on labor

productivity issues) of HIV/AIDS and other infectious diseases of interest in Africa, and 2) using that information, to assess the relationships and relative importance of those conditions on morbidity and mortality in that setting. The comparative impact of specific diseases control programs will be considered, within the limits of available data. The specific disease control programs will be considered, within the limits of available data. The specific research questions to be addressed will be determined in collaboration with Bureau for Africa staff with final concurrence of the Tropical/Infectious Diseases Policy Analyst--HIV/AIDS Advisor.

The specific areas of focus will include, but will not be limited to, the following:

- * To perform an exhaustive review of the literature and other institutional sources of information on the distribution, incidence/prevalence, and economic impact of malaria in Sub-Saharan Africa. This information will be used as the basis for analysis and modeling efforts by JHU/IIP staff and also will be provided to Africa Bureau staff to supplement other sources of malaria-specific information for the in-house Malaria Geographic Information System.
- * The HAPA Support Program provides technical assistance and information to AFR/TR and Missions to assist in making program decisions. As Missions now must use their OYBs to fund in-country HIV/AIDS activities (as a result of the HAPA Amendment), analysis will be conducted by the HAPA Support Program to determine and compare the current and future impacts of morbidity and mortality in Sub-Saharan Africa due to HIV/AIDS and malaria, in terms of labor productivity and other economic and social parameters determined to be appropriate in consultation with the Project Officer. Additionally, if sufficient data is available and time permits within the eight (8) month level-of-effort, similar analyses should be performed also to compare the impacts of onchocerciasis, guinea worm, measles, and diarrheal disease (in that order of priority). These analyses will include the use of modeling, as discussed earlier, for disease specific projections of impact.

The above described analysis shall include a review of the literature and analysis to investigate the changing patterns of infectious diseases (with an emphasis on HIV/AIDS and malaria)

in Sub-Saharan Africa, and the resultant impact on urbanization, migration, and economic performance (paying special attention to issues such as absenteeism and labor productivity).

The HAPA Support Program will provide A.I.D. with the following:

1. An annotated bibliography of sources of available data that are relevant to the research issues addressed in this expanded scope.
2. A comprehensive written report of the background, methods, findings and conclusions of the research, with an oral report to be provided on request. Three completed sets of color [35 mm.] slides corresponding to the graphics, charts and maps presented in the report will be provided.

EVALUATION CRITERIA

The effectiveness of the expanded research and analysis activities will be assessed according to the following criteria:

1. Timely performance of the activities outlined in the Expanded Scope.
2. Technical quality of the HAPA Support Program's outputs, as listed above.
3. Usefulness of the document to A.I.D. staff in targeting activities for the prevention and control of HIV/AIDS, malaria, onchocerciasis and other infectious diseases."

E) Indirect Cost Rates and Fringe Benefits Rate

The fringe benefits rate has been amended by the Negotiated Indirect Cost Rate Agreement, dated June 20, 1991. Delete the existing fringe rate and substitute the following:

<u>"Type</u>	<u>Effective Period</u>	<u>Rate</u>	<u>Locations</u>	<u>Applicable To</u>
Fixed	<u>1/</u>	26.5%	All	<u>2/</u>

- 1/ From 7/01/91 to 06/30/92
2/ Faculty/Staff Employees"

APPENDIX B

Workshop Report
1992 HAPA Field Workshop
March 8-14, 1992
Mukono, Uganda

Prepared by Cynthia E. Mariel

HAPA Support Program
The Johns Hopkins University
Institute for International Programs
April 30, 1992

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Appendix F: Report on Final Evaluation of the HAPA Workshop

Introduction

In July, 1989, the Health, Population and Nutrition Division of the Agency for International Development's Bureau for Africa awarded grants for nine HIV/AIDS Prevention in Africa (HAPA) projects to five non-governmental organizations (NGOs) and one university-based in the United States. An important focus of the HAPA grants was to strengthen the capacity of U.S. and African NGOs and other organizations to provide high quality, effective, community-based assistance in HIV/AIDS prevention. In October 1990, a field-based implementation workshop was organized by the HAPA Support Program (HSP), in collaboration with World Vision/Zimbabwe, to build the skills of project staff in several key interventions that are common to HAPA Grants projects, and to facilitate communication among HAPA Grants project staff about their experiences.

A final evaluation/lessons learned workshop was planned at the end of the two year HAPA grants funding period. Uganda was chosen as the site for this workshop based on requests from the various HAPA project staff attending the Zimbabwe workshop. The Experiment in International Living (EIL) in Uganda agreed to co-sponsor the workshop with the HAPA Support Program; funding for the workshop was sought and awarded by Family Health International. A decision was made to invite both field staff and local counterparts of the HAPA grants projects and staff of selected Ugandan NGOs involved in HIV/AIDS prevention and control. Additional participants would include representatives from other groups in Uganda working on HIV/AIDS prevention such as the National AIDS Commission. A maximum size of forty participants was agreed upon. (See Appendix A for lists of participants and resource persons.)

Active planning for the workshop began in September of 1991, when the HAPA Support Program (HSP) sent out needs assessment forms to project field staff of the nine HAPA projects. In December the HSP staff, workshop facilitator (a Ugandan consultant), workshop coordinator and project staff from EIL/Uganda, met in Kampala, Uganda to plan the conference. They reviewed feedback from the needs assessment form, chose the major topics for the workshop and drafted an outline of the workshop program. (See Appendix B for planning meeting agenda.) Following the planning meeting in Kampala, the program was further developed through continuous communication with EIL/Uganda, consultation with a conference program expert and through the development of objectives and teaching formats for each of the workshop sessions. (See Appendix C for workshop announcement sent to participants and resource persons.)

In-country logistics for the workshop were coordinated by the workshop facilitator and assisted by the workshop team members located in Kampala. They were also responsible for contacting Uganda-based workshop presenters and participants. The HSP office

was responsible for inviting and arranging travel for the HAPA participants from outside Uganda, in addition to inviting those presenters located outside of Uganda. Care was taken to utilize resource persons who would be in Uganda during the time of the workshop in order that no additional travel expenses would be incurred. The HSP staff arrived in Uganda a week before the workshop began to assist with final arrangements.

The workshop took place at the Colline Hotel in Mukono, Uganda which is situated approximately 25 minutes east of the capital, Kampala. This site was selected because of its reasonably priced conference facilities, as well as for its central location which was convenient to proposed field site visits. Sessions were held in a large conference room at the hotel and facilitated by Dr. Jane Mulemwa, a lecturer at Makerere University and a counselor and founding member of The AIDS Support Organization in Kampala. A resource center was arranged in one area of the conference hall where educational materials, reports and other items developed by the various projects were displayed. In addition to the materials brought by participants and organizers, Dr. Elizabeth Marum, AIDS officer with United States Agency for International Development (USAID) mission in Uganda, was able to contribute a new, "hot off the press", AIDS prevention comic book prepared by Uganda's foremost comic strip writer and entitled, "Ekanya Shocked into Sense - Ekanya's Guide to Safer Sex." (See Appendix D for workshop schedule.)

Workshop Activities

I. SUNDAY

A. Welcoming Reception and Introductory Session (6:00 - 8:00 pm)

On Sunday evening a reception was held to welcome participants to the workshop, particularly those from countries outside of Uganda. The community AIDS workers from the nearby village of Seeta-Nazigo, an outreach activity of The AIDS Support Organization (TASO), offered a dramatic beginning to the workshop, both to the setting of Uganda via traditional music and dance and to the issue of AIDS via the focus of their plays. The affect of this drama was to draw together the newly formed group through shared pleasure as well as mutual concern. The introductory session which followed generated an easy exchange of personal and professional information about each of the individual participants attending the workshop.

II. MONDAY

A. Opening Program (9:00 - 10:00 am)

The opening session of the workshop provided an opportunity for representatives from various sectors of the Ugandan government and representatives from sponsoring agencies of the workshop to welcome the conferees and to comment briefly on the issue of AIDS. (See Appendix E for opening program.) A representative of the Mukono District Administrator took the opportunity to greet everyone and to express gratitude for our choice of Mukono as a location for an international conference. He made a strong statement about the seriousness of this disease, AIDS, and the responsibility of the workshop to share our findings with the people of the district. The commitment of the local government was such that a district official attended the workshop throughout the week.

Welcoming statements were then made by Mr. Willy Salmond, country director of the Experiment in International Living/Uganda and Dr. Mary Anne Mercer, director of the HAPA Support Program, Johns Hopkins University, both representing the planning and coordinating organizations for the workshop. In addition, Ms. Carol Jaenson, representing Family Health International, funder of the workshop, contributed brief introductory comments.

[The next several pages of this report contain detailed summaries of most of the presentations given on the first full day of the workshop. Briefer descriptions of other program activities conducted throughout the week are also included in the report. During the upcoming months a small publication containing more complete essays on the workshop sessions will be prepared and available for distribution.]

Comments by Mr. Keith Sherper, Mission Director, USAID/Uganda

The next official to speak was Mr. Keith Sherper, Mission Director of USAID/Uganda. Mr. Sherper underscored the seriousness of the AIDS pandemic and its potential to threaten the fulfillment of USAID's objectives in Africa of promoting economic development and improving the quality of life of African people. Examples were provided specific to Uganda of the success of HAPA funded projects. Mr. Sherper spoke of two very hopeful trends and indications that USAID has identified relating to AIDS prevention in Africa. First, was the documentation of deep cultural traditions which create fertile ground and community receptivity for HIV/AIDS prevention projects and interventions. Secondly, the HAPA grantees demonstrated a high level of creativity, dedication and successful implementation of AIDS prevention projects. Praise for the hard work and dedication of the project staff and counterparts working in AIDS prevention was offered by Mr. Sherper which, he suggested, provided a gift of hope to the clients and communities served by the projects.

Comments by Uganda AIDS Commission Secretariat

Dr. Wilson Kisubi, of the Uganda AIDS Commission Secretariat, outlined the functions and future plans of the Commission. He stressed that a detailed report on this topic will soon be forthcoming.

B. Official Opening (9:40 - 10:00 am)

Dr. Specioza Wandira Kazibwe officially opened the conference in a speech stressing the importance of examining socio-economic and cultural factors that impact HIV transmission and related behavior change in Uganda. The Honorable Minister did not offer solutions in terms of methods to encourage more positive behavior change. Yet, through sharing of cultural information she described many elements which act as barriers to behavior change and/or contribute to the spread of the virus.

Commenting upon feasts during funerals, celebrations when twins are born, and dances which are "so sexual", Dr. Kazibwe identified the need for such activities as a way of balancing the harsh environment in which Ugandans live. But, it is also these cultural practices which may contribute to the spread of HIV.

When addressing polygamy, Dr. Kazibwe spoke of the men's rationale for multiple relationships: "We need a change." But, she countered, who says women do not need a change? In the face of AIDS, she suggested, men and women need to develop mutual trust for one another.

Another cultural belief described in the opening address is the tenet that women must be sexually satisfied. Therefore, if the head of the household is too tired, say from herding cattle miles and miles away, his brothers must fulfill this responsibility attached to sexuality. Further complicating the issue is the taboo which surrounds discussion of sex.

Socio-economic factors are further entrenched in the epidemic of AIDS as some men want only to marry women who have children (thus, increasing the number of available workers) or when women living without a husband exchange sex for food in order to survive.

Many of the Ugandan population are illiterate, so how are the messages concerning AIDS prevention to be received and are they being communicated accurately by community health workers? Problems arise because using a condom is interpreted by many persons to mean abstaining from sex - a key AIDS prevention message. Furthermore, some men consider sexual abstinence to mean not having sex with one's wife. The economic impact of AIDS will be severe because it is the illiterates, the rural populations

composing 90% of Uganda's population who also produce the wealth of the country.

What segments of the population will be targeted and how will prevention messages be absorbed when the social fabric of the people is so fatalistic? Many people say to themselves, "I have survived Idi Amin, so I might as well die having my pleasure." The Minister encouraged those in AIDS prevention to look at social and cultural values and to act to protect the youth. Relevant to protecting young people is the need to look at gender issues and factors as to why girls drop out of school.

In a rhetorical question, Dr. Kazibwe asked, "What is the social fabric of our culture and nation that is stopping people from changing?" She went on to encourage that more research into this issue be conducted by Ugandans and if assistance is needed, the doors of the Ministry of Women and Development, Youth and Culture are open.

C. Keynote Address (10:30 - 11:00 am)

Mrs. Noerine Kaleeba, founder and director of TASO presented in her speech some of the challenges of behavior change related to AIDS. She utilized the music and powerful message of Ugandan artist, Philly Lutaaya, to call the audience together and to remind them of their common purpose. For Mrs. Kaleeba the words of Philly's song, "Alone" voice the reason why she and others have gathered for this workshop.

Mrs. Kaleeba suggested that behavior change associated with AIDS is not simply an examination of sexual behavior, but also includes looking at attitudes towards life, towards self and towards one's neighbors. Through the counseling work of TASO, the perspective has developed that people who have been exposed to HIV are considered to have dual responsibility, that of retaining the quantity of the virus within his or her own circulation and secondly, a responsibility to stay alive. Thus, behavior change needs to include change not only in sexual behavior, but in addition, address other approaches such as eating habits and the attitude in which one views his or herself.

Linked to sexual behavior change is the condom, which Mrs. Kaleeba describes as the technology offering the only chance to continue sexual relationship, for those who have been exposed to the virus. Mrs. Kaleeba pointed out that in Ugandan culture sexual relationship means sexual intercourse. The usefulness of the condom is set against the conflict which arises due to the value Africans place on having children. In addition, consistent use of the condom is necessary for its effectiveness. Yet, for many people geographic distance from condom distribution points as well

as limited condom supplies do not promote consistent condom usage. The potency of the condom is also diminished due to the optimal conditions under which it must be stored in order to prevent spoilage.

Mrs. Kaleeba then posed several questions including the issue of how do we as HIV/AIDS prevention workers communicate with and support clergy and elders who are against condoms. Culture also creates barriers such as how to promote and confirm correct condom usage when cultural practices prohibit a woman from touching a male's organ. Furthermore, counseling is viewed as more conducive to behavior change than mass media messages, yet the counseling process is long and expensive. Who is going to pay? What kind of counseling will be provided - based on Western practices or through training traditional counselors?

Next, the issues common among groups who receive outside funding were addressed. How do we evaluate counseling? How do we find indicators? How do we demonstrate impact? How do we balance the need to do what we are doing as NGOs, acting quickly and without bureaucracy, with the needs of our supporters who want to be given indicators and demonstrated impact? And how do we reconcile the fact that our national AIDS control programs in Africa are structured and formulated from the outside by the World Health Organization in Geneva? Yet, we must keep in mind our need for their financial support? Finally, cooperation with our own governments becomes an issue with NGOs when attempting to complement efforts and activities with those of the government.

D. Statements by members of TASO and the Post Test Club
(11:00 - 11:15 am)

Following Mrs. Kaleeba's presentation two individuals offered comments from the personal perspective of people living positively with AIDS. Margaret, a TASO worker, suggested to the workshop to look for strategies of AIDS prevention taking love as the first priority when addressing behavior change. She also encouraged organizations to use people living positively with AIDS to teach others about prevention.

Chris, a representative from the Post Test Club, spoke of his own personal loss and struggle after he was diagnosed. He was able to find support through TASO and later through the Post Test Club. Chris has now joined other people with HIV/AIDS who visit communities and make presentations concerning HIV/AIDS prevention. The consensus within the group is that it is "our duty to help our fellow friends since it was not our wish that we should acquire this virus."

E. Behavior change: an overview (2:00 - 3:30 pm)

Sister Kay Lawlor from Uganda's Kitovu Hospital began by stating that she had learned a great deal about behavior change through difficulties in changing her own behavior. In addition, experience has taught her that teaching methods on AIDS prevention need to be based in a behavioral approach and not simply an offering of information.

The primary components contributing to behavior were described by Sister Kay and identified to be: 1) habit, 2) comfort, 3) reward and 4) self-selection. It is important to recognize that behavior and choices about behavior are a constant activity on-going since the very beginning of our lives. Sister Kay suggests that self-chosen behavior is a more effective contributor to behavior change than behavior that is imposed from the outside. In addition, theorists believe that behavior which is rewarded will be repeated and behavior that is punished will not. But who decides whether a specific behavior is viewed as reward or punishment is most important. Often another person will attempt to make this decision for an individual. One implication of this problem related to HIV is, for example, that of a woman exposed to the virus who would rather produce a child and die early than live a long life without having a child.

There are several steps to behavior change Sister Kay suggests, including that of first assessing our present behavior honestly, admitting that a problem exists and acknowledging that he or she is part of the problem. Then, in the second step one needs to generate options in order to determine what changes will be sought. Next, one needs to take action. The overall perspective to which Sister Kay adheres is that change is an ongoing process. The only time one can really say failure to change has occurred is when a person stops trying. Sister Kay finished her session with the description of a model on behavior change that she has developed over time and through her experiences including that of HIV/AIDS prevention and care.

F. Peer education model of HIV/AIDS education (4:00 - 5:30 pm)

Mr. Shem Bukombi of EIL/Uganda and Mr. Francis Rwakagiri of the Federation of Uganda Employers (FUE) presented lessons learned during the past three years while implementing HIV/AIDS prevention projects focused on peer education. The philosophy behind the model is that each person who is trained as an educator needs to 1) believe that AIDS exists, 2) accept the fact that they themselves are at risk of becoming infected with HIV and 3) acknowledge that each of us can do something to prevent the transmission of AIDS. Community peer educators and peers to whom the educators had spoken were also present during the session to talk about their experiences and to field questions from participants.

Originally, the program design was one in which EIL would train trainers and then these trainers from the community and work place would train members of their local constituencies to educate others in AIDS prevention. As the project progressed several discoveries were made including knowledge that training a person to become a trainer is a difficult process and that more than one week is needed to effectively train someone. Evaluation of the operational model indicated that the newly trained trainers were not doing what was expected of them within the context of the preconceived peer education model. Secondly, EIL could not effectively conduct follow-up on these trainers.

The peer education program was then modified with the adaptation that EIL, itself, would directly train peer educators during a three day intensive training in AIDS education. Local communities are now utilized to identify potential peer educators who are then trained by EIL. In the work place EIL goes directly into a company to do the training. The peer educators who are trained are expected to talk to their peers. When an outstanding educator is identified, this person is called back for further training.

An erroneous assumption made by EIL within the original peer education model was that trainers/peer educators would initiate talking to their peers in the work place. Conflicting issues arose because worker job descriptions did not include AIDS peer education, the trainer/peer educator was not paid nor was time provided to meet with people and to conduct education sessions. Another lesson learned was that before training workplace trainers, management must first be trained.

From the perspective of project management and budget, it was underscored that the cost effectiveness and level of impact of the peer education model need to be factored into program design and remodeling. Strategies to increase the multiplier effect of the training and to develop institutional capabilities, such as in the workplace, to conduct training of peer educators are issues that require further attention.

In summary, Mr. Bukombi linked the peer education model to behavior change by outlining the peer educator's role as that of establishing normative standards that are generalizable and acceptable to the community. In addition, a peer educator acts as a facilitator for adoption by individuals within the community of behavior based on these normative standards.

II. TUESDAY

A. Introduction to evaluation (8:30 - 10:00 am)

Dr. Mary Anne Mercer presented an introduction to evaluation through identification of the primary ways in which program evaluation can be of benefit to NGOs, discussion of the major obstacles to effective NGO project or program evaluation, and formulation of strategies NGOs can utilize to enhance the evaluation capabilities of their organizations. Early in the session a dramatic role play was acted out by Ms. Cynthia Mariel and Mr. Willy Salmond who were cast as field project management venting their fears and frustrations due to the unexpected arrival of an external evaluator. Following the role play, session participants formed small groups to discuss obstacles to evaluation and to propose possible solutions to these problems. Suggestions made in the small groups were presented to the larger session for feedback and further discussion.

B. HAPA lessons learned #1 (10:30 - 12:30 pm)

Several of the HAPA projects (Save the Children/Cameroon, Care/Rwanda and World Vision/Kenya) were arranged into a panel presentation and discussion, moderated by Ms. Pat Neu from EIL headquarters, to share the lessons learned over the course of their projects. Areas discussed included collaboration with local partners and National AIDS Programs, project experience with counselling, the most and least effective activities of the project and the topic of project sustainability.

C. The role of qualitative methods in program evaluation (2:00 - 5:00 pm)

The afternoon session was conducted by Ms. Carol Jaenson during which time she used lecture, discussion, demonstration and small group activities to share information and to brainstorm about qualitative evaluation. While in small groups, participants were assigned the task of designing interview questions appropriate to a predetermined project. The questions were then critiqued by the whole group and suggestions for revision made.

D. Dinner in Kampala (7:00 - 10:30 pm)

On Tuesday evening an outing to the Fairway Hotel in Kampala was arranged and a reception and buffet dinner served. In addition to the core workshop participants, invited guests included several USAID mission personnel, several representatives from offices of the Uganda government and persons scheduled as workshop speakers who were not resident participants during the workshop week.

III. WEDNESDAY

A. HAPA lessons learned #2 (8:30 - 10:00 am)

A second panel of representatives from HAPA projects was composed of Save the Children/Zimbabwe, Project Hope/Malawi and Project Hope/Swaziland. Monitoring of interventions, experiences working with people with AIDS, work done with special target groups, the most and least effective activities undertaken by the project and issues related to the sustainability of the project were highlighted during their presentations.

B. Report on UNDP consultation on behavior change (10:30 - 11:00 am)

Mr. Dan Wamanya of TASO addressed the workshop providing a brief summary of the United Nations Development Program (UNDP) meeting on behavior change held in Senegal during December 1991 and the "Statement of Belief" generated by the delegates to this meeting.

Special areas of concern associated with AIDS prevention and behavior change included those of community involvement, support for people infected with the virus, utilization of infected people for AIDS education and provision of alternatives to risky behavior. The later will require an in-depth approach to AIDS prevention such as addressing community development issues and those factors related to alleviation of poverty. An additional topic area was that of measurement of behavior change. Due to the lack of progress indicators difficulty arises over quantifying the progress of HIV/AIDS interventions. It was recommended that communities be involved in planning interventions and deciding what information is to be collected during an evaluation. Community participation at every level of project planning, implementation and evaluation was also stressed.

C. Community-based responses to HIV/AIDS: some examples from Uganda (11:00 - 12:30 pm)

In preparation for the afternoon field site visits and as a mechanism to allow each participant to learn about all field trip sites, representatives from The AIDS Information Center (AIC), The AIDS Support Group (TASO) and The Federation of Uganda Employees (FUE) introduced and discussed the work of their projects.

D. Field trips: TASO, AIC and FUE (1:30 - 5:30 pm)

Field trips to HIV/AIDS prevention projects were of significant interest both to Ugandan and non-Ugandan workshop participants. As a result, arrangements were made with four projects to accommodate observers on Wednesday afternoon. Each person was able to select a field trip to one of the four locations named above. The projects included the TASO facility at Mulago Hospital in Kampala,

the AIDS Information Center in Kampala, the TASO community AIDS workers in the village of Seeta-Nazigo and the sugar corporation at Lugazi where FUE has a peer education program.

E. Discussion of field trips (7:15- 8:30 pm)

Following dinner, participants gathered to reflect and share their observations from the field trips.

V. THURSDAY

A. Experiences evaluating a peer education program in Uganda (8:30 - 10:00 am)

Utilizing experiences working with the Federation of Uganda Employees' HIV/AIDS peer education project, researcher Dr. Susan McCombie addressed issues associated with impact evaluation: 1) when to do it, 2) how to do it, 3) when to collect baseline data, 4) what to do with baseline data, 5) monitoring and 6) how to interpret the final results.

B. Evaluation - case studies (10:30 - 12:30 pm)

Representatives from each of the HAPA grants NGOs described approaches to evaluation utilized during their final evaluation and the lessons learned based on these experiences.

C. More community-based programs responding to HIV/AIDS in Uganda (2:00 - 3:30 pm)

The afternoon session allowed both non-Ugandans and Ugandans greater exposure to HIV/AIDS prevention work being undertaken by community-based NGOs in Uganda. Included in this panel were project staff from Nsambya Hospital (Sr. Miriam Duggan), the Uganda Women's Foundation Fund (Mrs. Dolores Nabiyinja), AMREF (Mr. Henry Bagurakayo) and World Vision (Mr. Ham Owori).

D. Intervention Studies of HIV/AIDS Prevention (4:00 - 5:30 pm)

Ms. Liness Mwafulirwa of The Johns Hopkins University/Ministry of Health Project in Malawi (a HAPA grantee), Dr. David Serwadda of the Columbia University/Rakai District Project in Uganda and Dr. Sam Kalibala of the National Sexually Transmitted Disease Control Project in Uganda briefly discussed their respective projects during a session on intervention studies of HIV/AIDS prevention. Objectives, methods, key findings and program implications were reviewed during each presentation.

E. Drama for AIDS Education (6:30 - 7:30 pm)

The evening entertainment was an action-packed drama on AIDS (the dilemma of a king too stubborn to protect himself and his many wives from HIV infection) produced and presented by members of the Post Test Club, an affiliate organization of the AIDS Information Center in Kampala. The drama is one of many activities which the Post Test Club has initiated to provide support to persons who have undertaken testing for HIV and to encourage greater HIV/AIDS education and prevention.

VI. FRIDAY

A. Action plans (8:30 - 11:30 am)

The morning session began with a discussion by participants of the most useful kinds of action plans on which to focus as a concluding activity of the workshop week. A small number of people were interested in developing a list of lessons learned and recommendations for funders of NGO sponsored AIDS projects. The remainder of the participants arranged themselves into small groups to develop recommendations concerning strategies for NGOs relating to behavior change among their target populations.

B. Field trip and lunch at the source of the Nile River and Bujagali Falls (11:30 - 3:00 pm)

For fun, festivity and more out of the conference room exposure to rural Uganda, a brief afternoon outing to the Nile River was arranged following intense lobbying efforts by participants.

C. NGO growth and expansion: challenges to management (3:30 - 4:30 pm)

Mr. Willy Salmond, country director of EIL/Uganda, drew upon his experiences managing an organization which has become increasingly more involved in HIV/AIDS prevention through such projects as TASO, AIC and FUE peer education. Familiar with the growth and expansion of these projects, Mr. Salmond reflected on some of the important issues faced by NGOs as they develop from smaller to larger operations, and posed the question, "Is big so beautiful?"

D. Workshop Evaluation (4:30 - 5:00 pm)

Throughout the workshop week oral and written feedback from participants was sought concerning each day's program. During the final afternoon a written evaluation form was distributed to all participants in which questions regarding an overall assessment of the workshop and recommendations for the future were posed. The report of findings from the final evaluation is found in Appendix F.

E. Workshop closing and awarding of certificates (5:00 - 5:30 pm)

As a final ending to the workshop proceedings, formal recognition was given to organizers of the workshop. In addition, certificates were awarded to all participants in the HAPA field workshop. Souvenir key rings made from fish leather, a new product originating from Lake Victoria, were also given out and imprinted with "HAPA Workshop", the dates and location.

F. Traditional music, dancing and farewell banquet (7:00 pm)

The workshop's "grand finale" was an evening of entertainment by traditional dancers and drummers and a banquet meal of customary Ugandan foods served during the time of feasts and celebrations.

Appendix A

1992 HAPA Field Workshop
Mukono, Uganda, March 8-13, 1992

FULL-TIME PARTICIPANTS, UGANDA-BASED

1. Dr. Ntende, Henry
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2. Mr. Ibanda, Sam Igaga
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4. Mr. Kasozi, Charles
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6. Mr. Owori, Ham
World Vision International
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Kampala
7. Mr. Rwekikomo, Frank
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Kampala
8. Mr. Baitwababo, Chris
AIDS Information Center (AIC)
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Kampala

9. Mrs. Mutyaba, Meryce
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10. Mr. Rwakagiri, Francis
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Kampala
11. Rev. Dr. Tuma, Tom
Uganda AIDS Commission
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Kampala
12. Mr. Bukombi, Shem
AACP/Experiment in International Living
P.O. Box 9007
Kampala
13. Dr. Munyagwa, Rashid
Islamic Medical Association
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Kampala
14. Mr. Onyango, Bernard
Kamwokya Community
c/o Franciscan Sisters
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Kampala
15. Mr. B'Lall, Fred O.
Community AIDS Prevention Foundation
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Kampala
16. Mr. Katamba-Musoke, Ezekias
Ministry of Women and Development, Youth and Culture
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Mukono
17. Mr. William Salmond
Experiment in International Living
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Kampala

PARTICIPANTS FROM OUTSIDE UGANDA

18. Ms. Linile Malunga
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Chimanimani, Zimbabwe
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4. Mr. Henry Bagurakayo
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8. Mrs. Dolores Nabiyinja
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11. Mr. Keith Sherper, Mission Director
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12. Dr. Elizabeth Marum, AIDS Officer
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16. Dr. Mary Anne Mercer
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APPENDIX B

TENTATIVE AGENDA
WORKSHOP PREPLANNING MEETING

Uganda Field Workshop for HAPA Grants Projects
December 4-6, 1991
Experiment in International Living, Kampala, Uganda

Wednesday, December 4

- 2:00 PM Introductions
 Background -- HAPA Grants projects, Zimbabwe workshop,
 etc.
- 2:30 Report on HSP needs assessments for workshop
- 3:00 Finalize agenda for remainder of preplanning meeting
 - topics to be covered
 - time needed (plan a session for Monday?)
- 3:30 Finalize workshop dates, goals, objectives
 - determine invitees - from Uganda, HAPA projects

Thursday, December 5

- 9:00 AM-12:00 noon: - Prioritize topics and methods for sessions
- 1:30 PM-5:00 PM: - Drafting of workshop sessions, determining
 resources needed for each session

Friday, December 6

- 9:00 AM-12:00 noon: - Workshop logistics, e.g.:
 planning week, prior to workshop
 materials: packets of readings, etc.
 coordination of arrivals
 field trips
 finances
 support services (? secretary needed?)
 resource room
 entertainment
 certificates
 final dinner/celebration
 departures
- 1:30 PM-3:00 PM: - Special workshop issues, e.g.:
 preparation of workshop report
 limitation on numbers of participants
 publicity
 post-workshop evaluation
 followup evaluation
- 3:00 PM-5:00 PM - Set timetable of tasks to be carried out,
 and assignment of responsibilities

Appendix C

HAPA Grants Field Workshop March 8-14, 1992 Mukono, Uganda

Introduction

A field workshop focusing on lessons learned in HIV/AIDS prevention in Africa is being organized by the HAPA Support Program of the Institute for International Programs at Johns Hopkins University and the Experiment in International Living/Uganda for selected participants working in HIV/AIDS prevention in Africa. This workshop is being funded through a grant provided by AIDSTECH, a project of Family Health International. Participants will include project staff and counterpart staff of HAPA grants projects and staff of other non-governmental organizations (NGOs) currently working in HIV/AIDS prevention in Uganda.

Goal and Objectives

The goal of the workshop is to enhance the ability of project staff to apply lessons learned and evaluation approaches in the design and implementation of future HIV/AIDS interventions. The following objectives will guide the workshop sessions throughout the conference week.

- * *To identify lessons learned in HIV/AIDS prevention by HAPA grants projects and Uganda based NGOs attending the workshop.*
- * *To identify strategies and indicators for behavior change related to HIV/AIDS prevention in Africa.*
- * *To share ideas and experiences from community based HIV/AIDS interventions in Africa.*
- * *To provide additional training and technical support in evaluation.*

Location

The workshop will be held at the Colline Hotel in Mukono, located approximately 30 minutes east of Kampala, the capitol of Uganda. The dates for the workshop are March 7-14, 1992. Contact numbers for the Colline Hotel are: telephone 256-41-290533 or 256-41-290552 and fax 256-41-242041.

Coordinating Organizations

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APPENDIX D

NGOs Respond to HIV/AIDS in Africa:
Strategies for Behavior Change

WORKSHOP SCHEDULE

Sunday, March 8, 1992

All day	Workshop attendees from within and outside of Uganda arrive during the day.
5:00 - 6:00 pm	Free time
6:00 - 7:00 pm	Reception
7:00 - 8:15 pm	Introductory Session
8:15 pm	Dinner

Monday, March 9, 1992

7:30 - 8:30 am	Breakfast
8:30 - 9:00 am	Free time
9:00 - 10:00 am	Opening Session
10:00 - 10:30 am	Tea break
10:30 - 11:00 am	Keynote Address
11:00 - 11:15 am	Statements by Members of TASO and the Post Test Club
12:30 - 2:00 pm	Lunch
2:00 - 3:30 pm	Behavior Change: An Overview
3:30 - 3:55 pm	Tea break
3:55 - 4:00	Resource Materials Review
4:00 - 5:30 pm	Peer Education Model of HIV/AIDS Education
5:30 - 6:00 pm	Daily evaluation
6:00 - 7:00 pm	Free time
7:00 - 8:15 pm	Dinner

Thursday, March 12, 1992

7:30 - 8:30 am	Breakfast
8:30 - 10:00 am	Evaluation of Peer Education Program in Uganda
10:00 - 10:25 am	Tea break
10:25 - 10:30	Resource Materials Review
10:30 - 12:30 pm	Evaluation - Case Studies
12:30 - 2:00 pm	Lunch
2:00 - 3:30 pm	Community-based Programs responding to HIV/AIDS in Uganda: Nsambya Hospital, Uganda Women's Foundation Fund and World Vision
3:30 - 3:55 pm	Tea break
3:55 - 4:00 pm	Resource Materials Review
4:00 - 5:30 pm	Intervention Studies of HIV/AIDS Prevention: JHU/Malawi, Columbia University/Rakai District Project and the National STD Control Project in Uganda
5:30 - 6:00 pm	Daily evaluation
6:00 - 6:30 pm	Free time
6:30 - 7:30 pm	Drama for AIDS Education
8:00 pm	Dinner

Friday, March 13, 1992

7:30 - 8:30 am	Breakfast
8:30 - 11:30 am	Action Plans
11:30 - 3:00 pm	Field Trip to the Nile River
3:30 - 4:30 pm	NGO Growth and Expansion: Challenges to Management
4:30 - 5:00 pm	Workshop Evaluation
5:00 - 5:30 pm	Workshop Closing and Awarding of Certificates
7:00 pm	Traditional Music, Dancing and Farewell Banquet

APPENDIX E

HAPA Field Workshop
Opening Morning Program

March 9, 1992
Colline Hotel, Mukono Uganda

- 9:00 AM Welcoming Remarks
- Mukono District Administrator
 - Country Director, Experiment in International Living
 - Director, HAPA Support Program
- 9:15 AM Introductory Comments
- AIDS Behavioral Research Officer, Family Health International
 - Mission Director, USAID/Kampala
 - Director General, Uganda AIDS Commission Secretariat
- 9:40 AM Official Opening
- The Minister of Women in Development, Youth and Culture, Dr. Specioza Wandira Kazibwe
- 10:00 AM Tea Break
- 10:30 AM Keynote Address
- Mrs. Noerine Kaleeba, Director, The AIDS Support Organization
 - Statements by Ms. Margaret Nalumansi and Mr. Chris Baitwababo
- 11:15 AM Behavior Change: An Overview
- Sr. Kay Lawlor, Kitovu Hospital

APPENDIX F

Report on Final Evaluation of the HAPA Workshop March 8 - 13, 1992

I. Introduction

The final workshop evaluation forms were dispersed to participants on the last afternoon of the workshop and time was set aside to allow for their completion. Twenty-five evaluations were returned out of 28 full time workshop participants (attendance varied slightly from day to day). Written below is a summary and analysis from these evaluations.

II. Evaluation Questions and Responses

A. Achievement of Workshop Objectives

Objectives for the HAPA field workshop were first identified in the workshop funding proposal and later discussed and further modified during the planning meeting in Uganda. Input from responses on the needs assessment forms which were sent to HAPA projects prior to the Uganda meeting were also taken into account. Written below is a quantifiable summary of responses to the question on achievement of workshop objectives. The numerical scores were assigned in the following manner when rating achievement of workshop objectives: Very good (4 points), Good (3 points), Fair (2 points) and Poor (1 point).

<u>Objective</u>	<u>Mean Score</u>
1. To identify lessons learnt.	3.44
2. To share ideas and experiences.	3.72
3. To identify indicators and strategies for evaluating HIV/AIDS related behavior change.	2.84
4. To provide additional training and technical support in evaluation.	2.76

B. Program Organization and Management

Section B of the evaluation form addressed program organization and management asking for brief comments in the following areas of interest.

(a) What did you like most about the workshop and why?

The most frequently cited comment, one-fourth of all statements made (11 out of 44), was that of appreciating the opportunity to share ideas with other colleagues working in HIV/AIDS prevention.

Secondly, discussion of strategies for behavior change was the aspect of the workshop which participants liked most. Other components of the workshop which received multiple recognition included Dr. Kay Lawlor's presentation on behavior change and the small group work that was part of several program sessions.

(b) What did you like least about the workshop and why?

That which was least appreciated about the workshop was easily identified through responses to this question. The fact of too little time for the whole workshop program was indicated in 16 out of a total of 22 comments. Participants indicated that in general the program was too tight and there was not enough time for presenters, for participants to share experiences, to learn more about evaluation, to ask questions, to comprehend lessons learned, to exhaust various topics of discussion including strategies for behavior change and for relaxing, socializing, and exploring Uganda. In addition, it was pointed out that improvement was needed in time keeping.

(c) Indicate anything new which you have learnt at this workshop.

Of the 31 responses to this question, information on evaluation (7 comments), behavior change (5 comments) and broader understanding of NGO growth and operations (5 comments) were most often stated. Two respondents indicated they did not learn new information, but strengthened the knowledge and understanding that they already possessed.

(d) What other topics would you have like discussed at this workshop?

Although several people expressed full satisfaction with the workshop topic areas, many interesting suggestions were proposed by participants. These included project management, community mobilization and building of relationship within a community, writing of project proposals, development of intra-African strategies, care of AIDS patients, information on the latest research on AIDS, more sharing of ideas among African NGOs and participation in the workshop of program beneficiaries. In addition, 5 people recommended further discussion and strategizing on behavior change.

(e) On the whole, how useful or relevant to you were the topics covered during this workshop?

All evaluators (25 out of 25) indicated that the workshop program was relevant and/or useful. Additional comments such as the following were received.

- o The topics covered during the workshop have been useful to me. I feel encouraged to go back to my organization and implement these ideas.
- o I left the workshop feeling confident about what I am going to do in my organization.
- o The topics are core to my work.

One person indicated that the topics were not directly relevant to his or her work, but very useful to upcoming activities to which he or she might be attached.

C. Other issues

(a) What is your opinion on the overall hotel facilities?

With ratings of excellent (4 points), good (3 points) fair (2 points) and poor (1 point), the mean score for this question was 2.88. No ratings of poor were received and 4 scores of excellent were indicated. In general, there was moderate satisfaction with the hotel facilities.

Due to budget limitations participants were assigned to share rooms with one other person. Yet, from anecdotal information the general consensus was that private accommodations would have been preferred. There were also several verbal comments received pointing out the small size of the hotel rooms.

(b) Please give us your opinion about the 1) field trips and 2) evening activities during the workshop.

All opinions concerning the field trips were favorable (23 out of 23) with 7 comments of excellent. Other adjectives used to describe the field trips were that of useful, exciting, refreshing and educative.

Comments about the evening activities were positive, as well, although requests were made for additional free time and the showing of more films.

(c) Any other comments including recommendations for future workshops of this type.

Once again the lack of time in the workshop program was the key issue mentioned in nearly half of the comments (16 out of 37 references). In addition to improving the workshop's problem of insufficient time for the amount of planned program activities, several people (6) commented on the low level of per diem which was dispersed (approximately \$5/day). Suggestions were made for a per diem amount of \$10-25.00/day be given to participants.

The recommendation most frequently stated by participants regarding the future was the request for additional workshops of this kind. Suggestions were made to have a follow-up workshop, to plan for an annual workshop and to invite more NGOs from other countries to attend such a workshop.

III. Conclusions

Participants in the HAPA workshop were very pleased to have the opportunity to come together to share ideas and experiences related to their work in HIV/AIDS prevention. This feeling was expressed both by Ugandan participants as well as by persons from countries outside of Uganda. Gleaned from discussions at various points in the workshop program, it seemed apparent that for representatives of Ugandan based NGOs the workshop was also a unique occasion for people working in Uganda to gather together and to learn from one another. The need was expressed for the organization of future round tables, including members of the Uganda AIDS Commission, to discuss experiences, lessons learned and problems faced by project implementers.

The general issue of lack of time given the daily program of planned activities needs to be reviewed by the workshop coordinators. The selection of topic areas addressed during the workshop was fully validated through very favorable responses to an inquiry into their relevancy and usefulness. It appears that the underlying problem related to time was that the amount of time available during the workshop week did not match the level of interest in the topic areas. For example, although the objectives referring to sharing of ideas, experiences and lessons learned (Objectives #1 and #2) were well achieved during the workshop, participants continued to express the need for additional dialogue. Another request was that of more time for interaction outside of daily workshop sessions.

The lower achievement scores for Objectives #3 and #4 probably reflect overly ambitious program outputs by the planning team. The discussions on behavior change (Objective #3) - understanding the change process, identifying factors which constrain or promote change, strategizing for impacting behavior change related to HIV/AIDS and identifying associated indicators - were of great interest to participants and more interchange on these issues was sought. Evaluation (Objective #4) was another specific topic area on which people wanted to spend a greater amount of time. From the perspective of the workshop planners, sharing of lessons learned and experiences in HIV/AIDS prevention were the primary purposes of the workshop. Participants, on the other hand, may have held higher expectations for the objectives related to behavior change and evaluation.

People attending the HAPA workshop were stimulated by the small group work which reinforced participatory learning and indigenous

problem solving. Additional ways to incorporate learning modalities based in participatory interaction and problem solving need to be encouraged in future workshops. It is noteworthy that recommendations for holding regular small conferences, similar to the HAPA workshop, were offered by many participants on both the written questionnaire and via verbal feedback.

It appears that one critical role played by the HAPA workshop was that of creating an opportunity for project implementers at various levels to come to better know and understand one another, as well as to become aware of the unique skills and resources each has to offer. This is of particular relevance to current discussions on the involvement of international NGOs and indigenous NGOs in HIV/AIDS prevention.

In summary, the HAPA workshop provided an opportunity for people committed to HIV/AIDS prevention to develop a sense of community and then to explore in an open and respectful environment lessons they have learned, thus far, through their successes, failures and unresolved questions. Like behavior change, the process does not end but rather evolves over time. The HAPA workshop provided the organizational background and setting for this type of growth and development to occur among project headquarter personnel, field staff, policy makers, program beneficiaries and persons infected with the virus.

Responses from Final Written Evaluation of HAPA Workshop
March 8-13, 1992

A. Achievement of workshop objectives: Please indicate the extent to which you think each of the objectives of the workshop was achieved by putting a tick in the appropriate column.

<u>Objective</u>	<u>V. Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
1. To Identify lessons learnt.	13	10	2	0
Mean score: 3.44				
2. To share ideas and experiences.	18	7	0	0
Mean score: 3.72				
3. To identify indicators and strategies for evaluating HIV/AIDS related behavior change.	7	9	7	2
Mean score: 2.84				
4. To provide additional training and technical support in evaluation.	3	14	7	1
Mean score: 2.76				

B.a. What did you like most about the workshop? and why?

The practical sessions were very good.

The keynote address.

Behavior change by Dr. Kay.

Variety of ideas shared among the workshop participants.

Environment was conducive to sharing of experiences.

Freedom to meet new people. Made new friends of Africa family.

Sharing of the NGO/AIDS experience. The breadth and depth of operational experience of NGOs experience in Africa was a rich

feast. I really like the lessons learned and only wish we had more time to work on strategies for behavior change.

The topics of the workshop because they covered most of my particular needs - behavior change, qualitative data gathering, etc.

The way it was organized and the methodologies especially group work. This gave me change to share ideas with other participants.

Dr. Kay and Susan's (McCombie) presentations.

Sharing of experiences and field notes. People were open and willing to give out information.

Accommodation and food.

Good presentations.

The Minister's speech and the keynote address (N. Kaleeba) because it gave us a right picture of where to base our discussions.

We have been very well looked after. The treatment has been good.

We have been well enlightened on strategies to behavioral change.

Materials presented on behavior change, evaluation methods and community-based projects responding to HIV/AIDS. I learnt a lot on how to get my work well done.

I like the behavioral aspects of the workshop as I was hospital based. I did not know about HIV prevention by this aspect.

Identifying indicators and strategies related to behavior change particularly on HIV/AIDS. This opened doors for participants to participate and assist in HIV/AIDS prevention. Group discussions and tasks. They kept our minds really working.

Behavior change and evaluation.

Sharing and experiences between the various NGOs to include HAPA projects and the field visits to the various organizations.

Behavior change because this concerns me personally.

The field trip to TASO Mulago because it helped me to see the reality of what I had heard and read.

Bringing together all those experiences and people being very open in sharing.

Hearing experiences from different countries - their struggles and difficulties especially the prostitute issues.

The time was not enough for certain discussion allowing it was well managed. The idea of incorporating many Ugandan NGOs was good as we were able to share a bit of information.

I have shared ideas/experiences with other project implementers from different parts of Africa and USA.

I like the various presentations especially the opening speech of the Minister and Sr. Kay because it helped me to understand her model of behavior change.

Identifying behavior change strategies - working in groups on 5th day.

Field trips to TASO, etc.

B. b. What did you like least about the workshop and why?

The program was too tight. Presenters did not have enough time and even participants did not finish sharing experiences.

Very packed program which did give room for participants' social needs, etc. e.g. Arrive at 5 pm, start the program. Maybe complete the program and leave at 5 pm.

The short intervals between sessions. Not time to relax the mind.

Perhaps there could have been double sessions carried out at the same time and we could have chosen which to attend, thus allowing more time for particular sessions.

Too small per diem for people who came from other countries.

Evaluation, never was enough time to learn more on project evaluation.

None.

Lecture on evaluation. I expected more discussion.

No comment given.

The program was a bit squeezed. There was no time to relax.

Some sessions did not have enough time for the participants to ask and answer questions. There were still some burning ideas.

Lessons learnt. The speed was too fast to follow since we did not take part in the project implementation.

The per diem was quite low, approximately 5 US\$. At least it should have been approximately 15 US\$ per day.

Some sessions were rushed especially during the presentations.

N/A. Everything was just fine.

HAPA projects fund because we don't have these projects here in Uganda.

None (slash mark).

No comment given.

I do not know what I liked least about the workshop. I guess the lessons were all good for me.

The use of condoms because this is encouraging immorality. The condoms issue should be on a one to one basis. We believe that change can take place. Why condom?

The long hours are tiring and people no longer concentrate.

We did not really exhaust the strategies for behavior change.

No comment given.

Lessons learned because they did not mean much to those who have no HAPA projects.

Spending the whole day up to 7 or 9 pm sometimes was very tiring.

More site visits are required in future.

Time keeping. Rushed topics. Low exhaustion of ideas.

B.c. Indicate anything new which you have learnt at this workshop.

Peer group counselling.

TASO experience.

Organized systematic behavior change.

Qualitative evaluation methods in program evaluation. It helps one to know what people really think about the program and its impact.

No comment given.

The AIC experience and their networking with other NGOs including the Blood Bank of the MOH and their baby the Post Test Club.

Techniques used in gathering data for evaluation.

Slight change after presentation by Susan (McCombie): I am looking forward for her to come to join our group.

Learning more of Uganda.

Evaluation, questionnaire.

Many including evaluation.

Asking for funding for an existing NGO - what trends one has to go through.

Some ways of affecting behavioral change to our communities.

NGO funding sources.

NGO growth and staff development

International response to HIV/AIDS.

Methods of work/action plan of an NGO.

From the keynote address (N. Kaleeba). It was a real challenge.

I learnt about the different NGO programs especially those from other countries in Africa.

NA

Project evaluation especially techniques.

Nothing new but what I already know has been strengthened from the workshop and from other participants experiences.

HAPA project programs.

The way the NGOs in Uganda are able to organize and run through their activities in such an organized manner.

The various approaches in reaching and influencing human behavior.

This was the lessons about evaluations and the issues of the prostitutes.

Trip visit to certain organization was excellent as we have been able to learn a lot of what really is going on.

African cultures that act as barriers to condom use are the same in all countries.

Behavior change is a slow process. It takes time.

The importance of choice/alternative in behavior change. For behavior change to occur one must have alternatives to choose from. Tips in managing growth.

Most was strengthening existing knowledge.

Evaluation techniques and importance.

Growth of NGO.

B.d. What other topics would you have liked discussed at this workshop?

No comment given.

Same or few and spending more time on each topic.

Project management.

Community mobilization.

Building healthy public relationship in the project community.

Identification of operational indicators related to describing and measuring behavior change.

No comment given.

Writing of project proposals for NGOs.

Implementations of EICs geared at changing behavior.

No comment given.

More intra-African strategies.

I think the topic of strategies for behavior change was not exhausted. We need more time for discussions.

Total care of AIDS patients - body, mind, spirit.

Latest information on research findings on AIDS.

That was just satisfactory.

Comparison in NGOs in Africa to find out where we can have a punch and mend.

Nil.

HAPA projects, ACP and AIC, TASO programs.

No comment given.

Community mobilization skills. Participation of program beneficiaries.

Future plan on behavior change. Obstacles to change of behavior and how to improve the strategies.

All covered.

No comment given.

Would have liked to have time to discuss as a group the strategies for behavior change one by one so that we get a good grasp of the indicators and strategies.

Deal more on updated facts on AIDS.

None (slash mark).

B.e. On the whole, how useful or relevant to you were the topics covered during this workshop?

They were very relevant and useful to me. I learned that PWA should be cared for and encouraged to live positively.

Relevant and very useful but covered in a rush all the time.

They are relevant to my HIV/AIDS project implementation.

I found the workshop to be very relevant and operationally useful to NGO/AIDS work.

Very useful especially because I had little to share from my own experiences.

Will help me to integrate the lessons learned into my organization.

Useful.

Good.

Very nice.

The topics covered during the workshop have been useful to me. I feel encouraged to go back to my organization and implement these ideas.

I have left the workshop feeling confident about what I am going to do in my organization.

It was a blessing to attend this workshop: comprehensive and relevant.

Very useful as NGOs work at AIC, TASO, Save the Children.

Although I am not directly involved in any of these programs the topics covered were relevant to my Ministry's programs.

Were relevant because all the topics cover the areas of our operations/concerns.

These were useful to me as my club's objective can be helped much by the topics covered (AIC/PTC).

They were very useful as I am involved in assisting NGOs in selecting strategies relevant to their operations.

The topics covered were useful to me so that I can go back and implement.

Not very relevant to the type of work I do, but very useful since there might be some activities coming up in my country to which I might be attached and I can use the information gained.

The topics are core to my work.

The topics covered were very useful in that I was encouraged as one of the AIDs support organizations to find new ways of improving my service to the nation.

Very useful. I am sure my future project implementation will be better.

Useful.

Very helpful.

Re-examination of strategies for behavior change and evaluating programs.

Ca. What is your opinion on the overall hotel facilities?

Excellent	4
Good	14
Fair	7
Poor	0

Mean score: 2.88

C.b. Please give us your opinion about the : 1. Field trips and
2. Evening activities during the workshop.

Field trips were very good.

Field trips excellent.

Evening activities okay but maybe evenings could have been free.

Field trip was useful because they helped to reinforce the theoretical knowledge gained.

Evening activities were relaxing.

The TASO field visit to the village was of logistical necessity in this area where HIV/AIDS is only beginning to have an impact. The group we visited were committed but quite new to their work in the community.

The evening activities were well executed and the food was fine. It was a good chance to talk with other participants informally.

Okay.

Evening activities were satisfactory. The drama group was excellent

Field trip was refreshing.

I am quite satisfied for all.

Field trips good.

Evening activities good.

Field trips good.

More films for evening activities.

Everything was excellent.

Very educative and entertaining.

From field trips I got basic information in working method and content of response to HIV/AIDS. Better educated.

Field trips excellent.

Evening activities good.

Good.

Oh! no - inexplicable. If all workshop were like this, our input would be developed and sustained. Please next HAPA workshop to be here again.

Field trips.

Evening activities very good. Program was tight.

They were excellent.

Exciting.

Field trips excellent.

Evening activities good.

Field trips were excellent in one way. It was practical way of learning.

Good.

Last night's drama was very good and relevant.

Evening activities good.

Field trips were very exciting and educational.

Necessary. They were rather few.

C.c. Any other comments including recommendations for future workshop of this type.

There is need to have more time.

The per diem was too little.

There is need for a follow-up workshop for the participants.

Please fewer activities that can be dealt with exhaustively.

Give participant half day for shopping and should come earlier for sightseeing and relaxation before the workshop and leave a day later after completion.

Maybe we may need to concentrate on the theme i.e., "strategies for behavior change" in our case. Somewhere on the way we lost the direction.

Better arrangement for per diem and a more meaningful per diem for participants from outside.

This workshop should be held annually in different African countries to update members on new experiences.

More time for behavior change strategies!

In future it will be better not to emphasize that everything will be taken care of in terms of finance because our respective offices end up giving us absolutely nothing. I think that the amount of per diem was very small.

Workshop of this kind should be organized regularly and more foreign NGOs be invited to share more experiences.

Proper timing should be improved to allow more discussion.

Groups are more effective and should be encouraged as a learning method.

Recommend more participatory discussion.

Make more of these workshops for the people concerned so that there is a lot of learning.

Time management should be watched carefully. Some presenters have to rush through their presentations.

They are very necessary.

There is need for a day's relaxing after the conference/workshop to give the participants a bit of free time to do some visiting to different places.

I have enjoyed this workshop very much because this is the first one of this kind I have attended. I have been able to learn from other countries which have participated and even the other NGOs from Uganda. I have got new contacts of people with whom I can refer to in case of any need since all of us are on the very important mission of prevention of HIV/AIDS.

Kindly identify all parties who may be interested and inform them.

Obtain list of NGOs dealing in HIV/AIDS from Uganda AIDS Commission and communicate with them.

Increase per diem to US\$15 per day.

Choice of meals.

Concentrate more on the strategies or theme of the workshop.

If such workshops are organized in Uganda the Ministry of Women in Development, Culture and Youth should be given chance to be represented in the workshop.

Yes. Uganda has more experience in AIDS, more initiative in launching anti AIDS activities and the people (everybody) is very open indeed. This creates good environment for discussing sensitive issues. Thereby making tangible solutions to this enigmatic AIDS problem. So there are more advantages to have most AIDS workshop here than elsewhere and Ugandans should be sent to other countries as consultants. Qualified human resources in Uganda is adequate and if we are to benefit from this (to be cost effective) Ugandans could be called upon for consultancy to other African countries on AIDS community-based activities.

The workshop was generally well conducted and as PWA was delighted to have been a participant. We hope in future we shall be considered. Thanks.

Sharing of rooms should be avoided as we are adults and each one of us have our peculiarities which might not be appreciated by those we are sharing with.

Consider giving us reasonable per diem or out of pocket allowance. Giving us 2.5 US dollars a day is actually not reasonable at all.

No comment given.

The workshop was well organized except that the program was too tight and tiring. Next time try to give participants time to socialize around the area where the workshop takes place.

The workshop should be in a rural community where participants have opportunity of seeing "real" life.

Now we know that the only weapon remaining to fight AIDS is behavior change so future discussion and research should be done so that this can be successful.

None (slash mark).

More time is required or less topics to be covered if the workshop is to be for five days.

Get fewer speakers and allow them enough time to make their presentations. Follow presentations with 10-30 minutes of discussion.

More group work would be desirable.

It is a pity that there won't be any other HAPA workshop. Sharing experiences is very valuable.

None.

A:APPENDG*42892

APPENDIX C: Report of KAPB Survey Technical Assistance

I. BACKGROUND AND OBJECTIVES

The HIV/AIDS Prevention in Africa (HAPA) Support Program (HSP), at The Johns Hopkins University, is funded by the Bureau for Africa of USAID to provide technical support to nine private voluntary organization (PVO) projects for HIV/AIDS prevention. An important area of technical support provided to the projects is assistance with project evaluation.

A major obstacle to assessing project effectiveness as identified by the PVOs has been the major expenditure of time, money and other resources need to carry out their baseline surveys. In June 1991 the HSP provided technical assistance to the Save the Children Federation/US (SCF) HAPA project in Zimbabwe to conduct a rapid KAPB survey as a part of the two-year project's final evaluation. SCF had been implementing a training-of-trainers project in two separate impact areas that targeted health workers, village community workers, and village leaders to conduct AIDS education in their communities.

There were two primary objectives of the technical assistance:

- 1) To field test a methodology for assisting NGOs to conduct a rapid and affordable KAPB survey that would be useful for project evaluation purposes
- 2) To assist SCF to determine the extent to which the interventions of their HAPA project had an affect on the knowledge, attitudes, beliefs and practices of the project population

II. METHODS

HSP and SCF headquarters staff first worked in the US for 5-7 days with survey consultants and project staff to design the 32-item survey questionnaire, develop the sampling method and training plan, and prepare the analysis tables for hand-tabulation. They also served as in-country advisors throughout the survey. Table 1 summarizes the survey preparation and implementation schedule.

During the first two days of in-country activity the survey questionnaire was pretested, finalized, translated into the Shona language and retranslated into English. The 30-cluster sampling method was finalized, modified from that developed for EPI surveys. Logistical arrangements were completed, and the training team traveled to the field training site. Supervisors and interviewers, who were largely drawn from Ministry of Health and project staff, were trained over 3 days: the first day for supervisors alone, and the final 2 days for both supervisors and interviewers. The third day of training consisted of field practice and feedback.

Data collection for 660 respondents in two impact areas then took place over the next 3-4 days, and frequency distributions of the data were hand-tabulated by selected members of the survey teams. At the end of 5 more days, a survey report based on the hand-tabulations had been completed and the data entered onto EPI INFO computer package for later in-depth analysis. Close correspondence was found between the hand-tabulated and computerized frequency distributions

III. RESULTS

The distribution of the sample by age, sex and literacy for 641 respondents is seen in Table 2. Answers to selected questions from the survey were first compared with results from the baseline survey, conducted two years previously. The comparison of baseline and followup survey responses is seen in Figure 1. Substantial and significant increases were seen between the baseline and followup surveys in the proportion stating that they currently used condoms, that faithfulness was a way to prevent AIDS, and that teenagers should be educated about AIDS. Slight decreases were seen in those who believed that there was no cure for AIDS, however, and in those stating that AIDS was a problem in their communities. Nearly all respondents knew that AIDS was usually or always fatal.

In order to assess the likely effects of the actual project interventions, and control for the possibility that the differences were due simply to the passage of time, further analysis was conducted using the computerized data base and EPI INFO survey package. One survey question asked for the respondents' source or sources of information about AIDS. Responses to that question were dichotomized into two groups, those for individuals who had named at least one source that was targetted by SCF for training, and those who had not named a SCF-targetted group (see Table 3). The proportion of respondents who knew the three main modes of HIV transmission was compared for the SCF-educated group and those stating that they had other sources of information (Figure 2). For both men and women, those with SCF sources of information have substantially and significantly higher levels of knowledge than those with other sources. This trend was noted for a number of other knowledge variables, including knowledge of specific prevention methods and of the latency period for HIV infection.

Attitude and practice variables were also compared between the SCF-educated group and those not so educated. Figure 3 shows a set of agree-disagree statements regarding persons with AIDS (PWAs), for which no significant differences between groups were seen. Other attitude and practice variables such as condom use, willingness to tell others if they had AIDS, and also showed no significant differences.

IV. CONCLUSIONS:

Objective #1:

1. A rapid KABP survey can produce, with modest investments of time and other project resources, valid and useful data for the evaluation of PVO HIV/AIDS prevention projects.
2. Hand-tabulation can be used to identify the frequency distribution of variables to provide rapid feedback of survey results that is useful for program purposes. With modest additional effort, hand-tabulation could also be used to analyze data for key questions regarding source of information about AIDS, providing a useful adjunct to pre- and post-project comparisons of survey results.

Objective #2:

3. The SCF HAPA project appeared to be successful in increasing the knowledge of the project population targetted for education about HIV and AIDS, although much of the improvement that was seen between pre-project and post-project survey results was most likely due to the general increase in knowledge that was experienced in Zimbabwe during the study period.
4. SCF-educated respondents did not demonstrate more favorable attitudes or practices related to HIV and AIDS prevention. However, knowledge objectives were more heavily stressed in the SCF curriculum than attitude or behavior change objectives. This finding illustrates the need for HIV/AIDS projects to carefully identify and stress in training the attitudinal and behavioral variables that are crucial to HIV/AIDS prevention.

General conclusion:

5. The rapid KABP survey approach should be considered for use by other NGOs and other small-scale HIV/AIDS prevention projects.

TABLE 1

RAPID SURVEY SCHEDULE				
Days	Week I	Week II	Week III	Week IV
One	Draft Survey Instrument	Finalize & Translate Survey	Data Collection	Write Report
Two	"	Logistics\Training Preparation	"	Write Report
Three	Plan Training	Train Supervisors	"	Data Entry (computer)
Four	Develop Sampling Plan	Train Supervisors and Interviewers	Finish Surveys Start Tabulation	"
Five	Preparation of Analysis Tables	Finish Training (half-day)	Data Tabulation	"

TABLE 2

Demographics of Study Population			
Age Groups (years)	Males n=327 %	Females n=314 %	Total Sample N=641 %
18-20	20.8	15.0	18.1
21-25	22.3	24.2	23.2
26-30	18.3	23.9	21.0
31-35	14.4	13.1	13.7
36-40	10.4	11.8	11.1
41-45	13.8	12.1	12.9
Marital Status			
married	61.5	18.5	74.6
single	37.0	6.7	22.3
widowed	0.6	2.2	1.4
divorced or separated	0.9	2.5	1.7
Literacy			
% Literate	81.8	62.1	72.1

TABLE 3

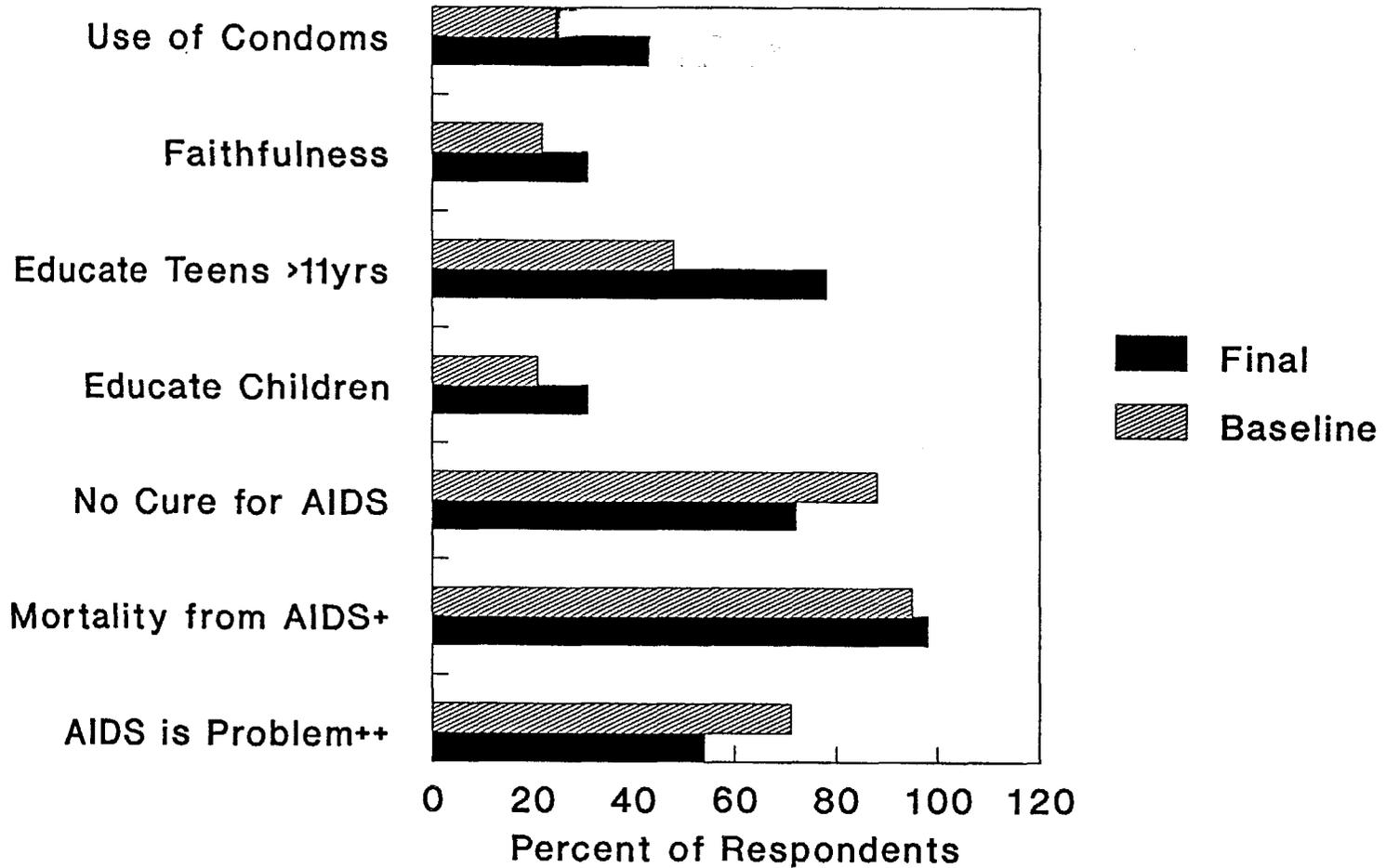
Save the Children Sources of AIDS Information vs. Other Sources of Information	
Save the Children	Others
Village Health Workers Clinic Staff* Community Leaders	Radio\TV Newspapers & Magazines Others

* only in Mutema, not targetted in Mupedzanhamo

FIGURE 1

AIDS KAP INDICATORS

Baseline vs. Final Survey

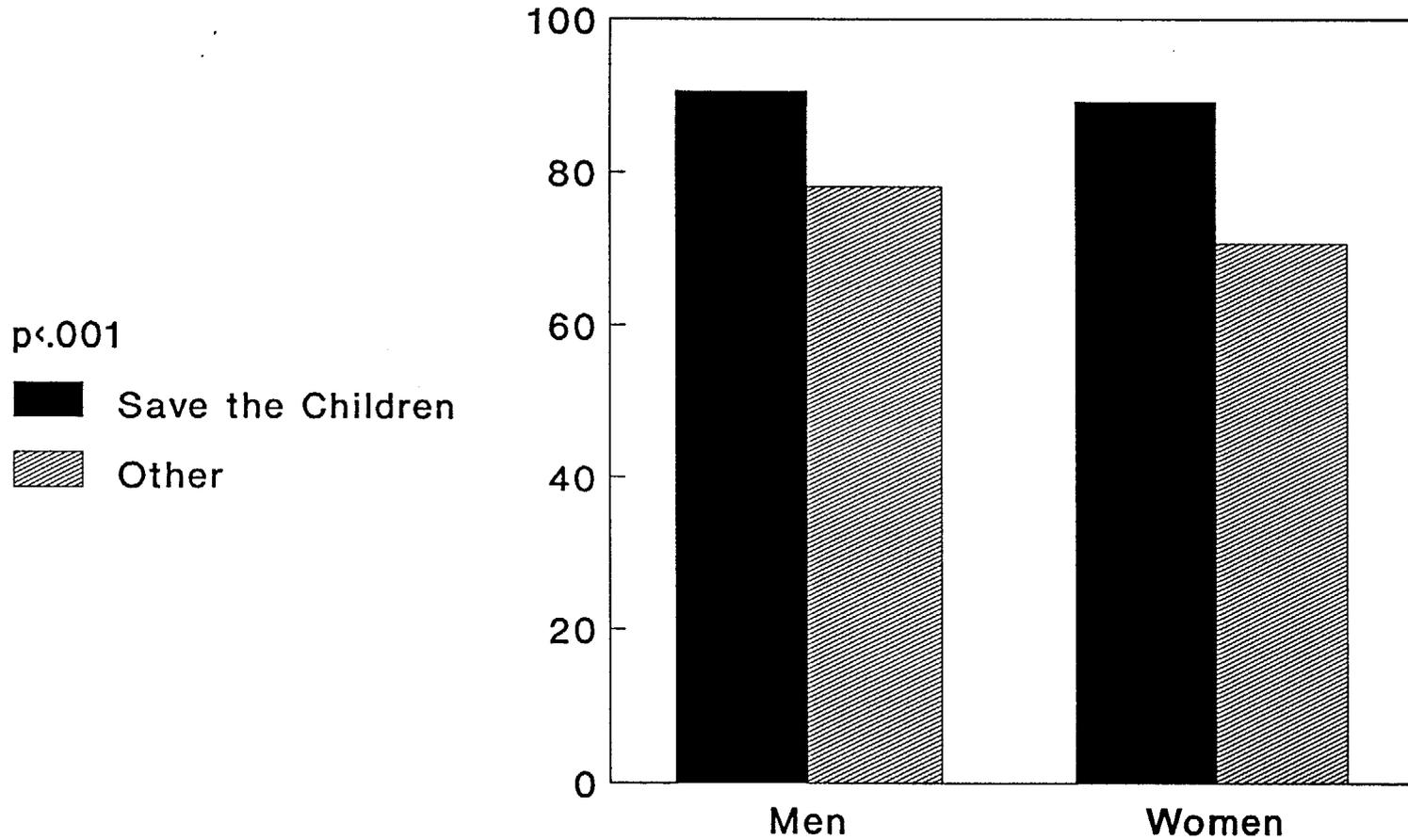


Baseline N=1120 to 1176
Final N=640 to 642

02

FIGURE 2

KNOWLEDGE OF AIDS TRANSMISSION by Source of Information

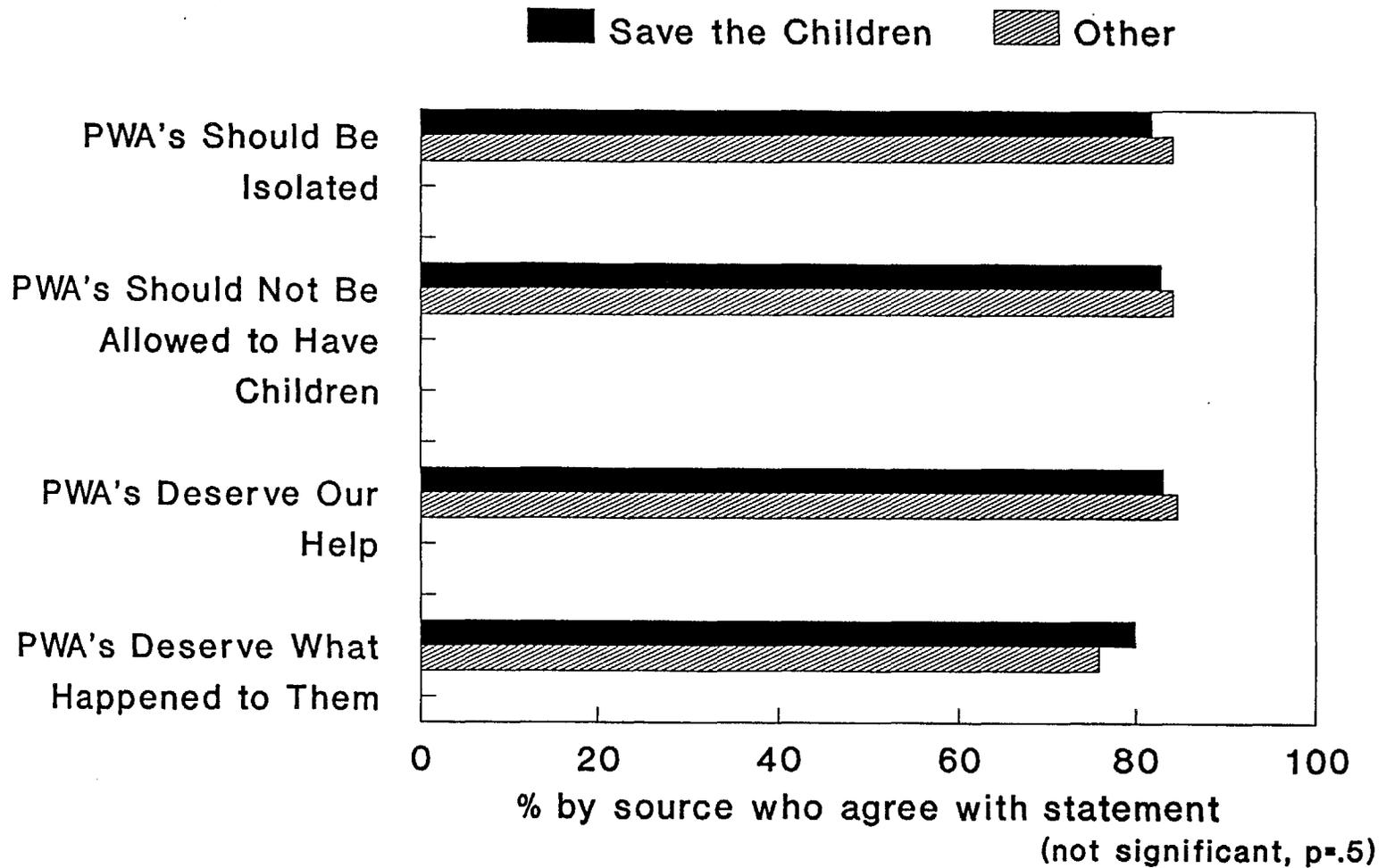


% by source who knew 3 correct
modes of transmission

18

FIGURE 3

ATTITUDES TOWARDS PEOPLE WITH AIDS (PWA'S) BY SOURCE OF INFORMATION



Handwritten mark

HAPA GRANTS PROJECT FINAL EVALUATIONS

APPENDIX D: Overview and General Guidelines

I. Introduction

In May, 1989, the Health, Population and Nutrition Division of the A.I.D. Bureau for Africa announced the award of nine HIV/AIDS Prevention in Africa (HAPA) grants for Fiscal Year 1989. The grants have funded five private voluntary organizations (PVOs) and one university to add components to their existing health or development programs in Africa that will assist communities to reduce the spread of HIV infection. An important focus of the program has been to strengthen the capacity of the PVOs to provide high quality, effective, community-based assistance in this area.

The HAPA grants projects will be completing the implementation of their projects in late 1991 or early 1992; for some, this includes a no-cost extension past the original two year project period. Each project will complete a final evaluation of their project as a part of their grant activities. This document will provide suggestions regarding the purposes, methods and content of the final evaluations, including specific guidelines for the final evaluation report.

II. Purposes of the evaluation

An important purpose of the HAPA grants final evaluations is that of most end-of-project evaluations: to assess the effectiveness of the project's key interventions and approaches. In other words, how well were the stated objectives of the project met?

However, there are a number of reasons why evaluating the end result is not the only reason, and perhaps not the most important one, for conducting the evaluation. The HAPA grants evaluations, like most "final" evaluations, do not mean the end of project activities, but rather the end of a specific funding cycle or funding source. Many, if not most, of the activities carried out by the HAPA grants projects will be continuing after the end of the grant periods. Some will be supported by other sources, such as the USAID mission or other external donors; some will be integrated into Ministry of Health activities; others will be carried out by local collaborating NGOs. Clearly, a purpose of the HAPA grants final evaluations will also be to identify information needed to improve the quality and effectiveness of the project activities that have been, and will continue to be, carried out. This requires a focus on the process of project implementation, in addition to its results. Attachment A, "Monitoring and Evaluation of NGO AIDS Activities," describes in more detail the importance of focusing on the process and quality of project implementation in evaluating HIV/AIDS prevention projects.

The lessons learned from the HAPA grants projects will help to identify the most effective approaches for PVOs to take in future efforts to respond to the HIV epidemic in Africa and elsewhere. This expectation is another reason to focus on the processes that occurred in the development of the HAPA grants projects. Identifying the lessons learned, and sharing those lessons with others involved in HIV/AIDS prevention, will be the focus of an end-of-project workshop that, pending the availability of funding, is tentatively scheduled for early 1992 in Uganda. The HAPA Support Program will also summarize the more important lessons learned in a report for A.I.D. and the rest of the HIV/AIDS prevention community.

III. Evaluation Methods

The HAPA grants final evaluations should be completed before the end of project funding, and the report submitted to USAID within sixty (60) days of the formal end-of-project completion date.

The evaluation should be a team effort; suggestions for the kinds of individuals to be included in the team are discussed in Attachment A. All HAPA grants final evaluations are expected to include on the evaluation team an external consultant who is familiar with HIV/AIDS prevention issues and approaches. By external consultant is meant an individual not directly associated with the project; he or she may be a local national, someone from the region, or from outside Africa. The HAPA Support Program will assist in locating an appropriate consultant, if requested, and will in some cases be able to support the cost of using the consultant.

Each project that completed a baseline survey of the knowledge, attitudes, beliefs and practices (KABP) of their project population is strongly encouraged to conduct a followup survey. To assist the projects to carry out their surveys more rapidly and with a more standardized methodology, the HAPA Support Program will provide or arrange for technical assistance in carrying out the survey to projects requesting it, within the limitations of available funding. A set of written suggestions for planning, implementing and analyzing the surveys will be provided as a part of the technical assistance package. PVO staff should contact the HAPA Support Program office, if they have not already done so, to discuss needs for technical assistance for either the KABP survey or for the final evaluation itself.

In addition to methods that aim to quantify the results of the project's activities, such as the KABP survey, projects are strongly encouraged to consider using more qualitative methods of gathering information for the final evaluation, such as focus group discussions and in-depth interviews. These methods can be

used to gain a deeper understanding of what has occurred during the course of the project, including the perceptions of project staff, target population, and other concerned individuals such as ministry of health officials or community leaders. Focus group discussions can be used to help interpret and deepen understanding of the results of the KABP survey, and identify remaining obstacles to HIV/AIDS prevention efforts.

To assist projects in getting useful qualitative data for the final evaluations, the HAPA Support Program has enlisted the help of selected members of the HAPA Technical Advisory group (TAG). A document entitled "Guidelines for Gathering Qualitative Data for HAPA PVO Grants Project Evaluation" has been prepared by Judith Timyan, an anthropologist who is a member of the HAPA TAG (Attachment B). She was assisted by comments from other TAG members and HAPA Support Program staff. The document outlines some basic guidelines for getting relatively rapid but useful and valid qualitative information for inclusion in the final project evaluation reports. It is still in draft form, since the author and the HAPA Support Program would like to receive feedback from project staff after they have read and field tested the usefulness of the methods and approaches it outlines.

All members of the evaluation team are urged to read the guidelines for qualitative data gathering prior to the final evaluation. The guidelines are designed to be used by persons who have had some training in qualitative methods, although the ideas and approaches included should be useful for any project evaluator. If no one from the evaluation team or project staff has such training, a local consultant can be employed to review the evaluation plans and assist in training key individuals to carry out the qualitative methods described in the report. The reward for a relatively small investment in learning the basics of these methods will be a greatly enhanced understanding of how the project has affected the staff, target populations and others in the project area.

IV. Content of the evaluation

We expect that each project will have a unique set of evaluation questions that they wish to answer. It is impossible for any one document to cover all possible questions that might be of interest in assessing the strengths and constraints of a project, so it is recommended that each project identify a set of key questions on which they will focus the final evaluation. Some major elements will be important for all of the projects to include, however; those key elements will be included in the Evaluation Guidelines.

The evaluation guidelines which follow are meant to be a general guide for those planning, carrying out and documenting the HAPA grants projects' final evaluations. No page length recommendations are given, so projects are free to judge the most appropriate depth to provide in discussing different topics; as a general rule, the body of the final report should be in the range of 20-40 single-spaced pages, however. The guidelines are not meant to provide an exhaustive list of all possible content to be covered; individual projects should follow this basic outline, but add any other areas of project or evaluation emphasis that it does not encompass.

As stated above, the final evaluation report is due sixty (60) days after the project's official completion date. The reports will be reviewed by the HAPA Grants Program's Technical Advisory Group (TAG), with feedback on their comments provided to the projects, as before.

Please send an original (unbound) and 10 copies of the report to:

Mary Anne Mercer
HAPA Support Program
JHU/Institute for International Programs
103 East Mt. Royal Avenue
Baltimore, MD 21202

Please also send 5 bound copies of the report to:

William H. Lyerly, Jr.
HAPA Project Officer
Bureau for Africa, NS 2738B
Agency for International Development
Washington, DC 20523

HAPA GRANTS PROJECT FINAL EVALUATIONS
Detailed Guidelines

Cover Page: Include name of project/PVO, country, formal beginning and ending dates of the project (including no-cost extension, if any), and date submitted.

Report Outline:

i. Contents

ii. Executive Summary

A one- or two-page summary that focuses especially on the recommendations of the evaluation.

I. Introduction

A brief introduction that explains the project setting and the main purposes and approaches of the project, including relationship with the local counterpart organization(s), if any.

II. Evaluation Methodology

Describe the methods of the evaluation in terms of:

A. Purposes of the evaluation, giving the main questions on which the evaluation will focus.

B. The composition of the evaluation team.

C. The methods used, such as major sources of information, means of gathering the information, approaches used in determining the conclusions and recommendations of the team, and how the evaluation results were (or will be) shared with those concerned in the project country. Document separately any KABP surveys or other special activities (e.g., focus group interviews) conducted for the evaluation; these may be included as an appendix.

D. Evaluation schedule and list of informants (can be an appendix).

III. Findings of the Evaluation

A. Design Summarize the project design, and trace and explain any changes made in the design over the course of the project. What were the main strategies of the project? How did the choice of impact areas and target populations affect the implementation of the project? How was the project staffed? How were volunteers utilized? Supervised? How was it intergrated with other local institutions (e.g., local counterparts, NACP, other NGOs)? How was the community involved?

What were the strengths and constraints of the design of the project? Describe the major uses of project funding, and include a budget that summarizes expenditures over the life of the project.

- B. Process Explain how the quality of each major activity undertaken by the project was assured through monitoring of project activities. What do project records show about how well various activities were carried out? Of particular importance are assessment of the quality of training; of the effectiveness of educational sessions; pre-testing of pamphlets or posters, etc. How well were the processes of the project documented? How did staff and target populations assess the quality and relevance of activities?
- C. Outputs What have been the primary outputs or "things done" by the project? How do the outputs compare with what was planned, as stated in project objectives? What explains any shortfalls in achieved outputs? Provide samples of any written or graphic materials developed by the project.
- D. Outcomes What were the planned project outcomes, or effects on the target population, according to the project objectives? How do they compare with the outcomes observed? What explains any shortfalls in observed outcomes? What other effects have been observed, including unanticipated ones on project staff, target populations, others? What have been the effects of the project on PVO staff, and on the organization as a whole (list any other AIDS-related activities that PVO has undertaken, if any, as a result of HAPA grant).
- E. Sustainability What was the original plan to sustain project activities after HAPA funding was completed? What will be the status of the project after this funding cycle? What factors have facilitated or hindered the ability of the project, collaborating groups or the community to sustain project activities?
- F. Staffing and technical assistance Was the staffing plan, as described in part A, adequate? What difficulties or obstacles were encountered? Describe the main sources of technical assistance (TA) and training for project staff (including all sources and all methods, both from consultant or HQ staff visits and written materials). What does staff perceive to be the most useful TA received? What needs for TA remain? Were local sources of TA adequately utilized?

IV. Lessons Learned and Recommendations

- A. For each of the evaluation's areas of focus, describe the lessons learned and state the concrete recommendations for action made by the team.

APPENDIX E:

GUIDELINES FOR GATHERING QUALITATIVE DATA
FOR HAPA PVO GRANTS PROJECT EVALUATION

Compiled by Judith Timyan

June 1991

To reader: Please read and comment on the usefulness of this document for conducting project evaluation. Address all comments to

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GUIDELINES FOR GATHERING QUALITATIVE DATA
FOR HAPA PVO GRANTS PROJECT EVALUATION ¹

I. QUALITATIVE DATA IN PROJECT EVALUATION

Qualitative data are essential to project evaluation. They provide insight into the perceptions and judgments of project implementors; they provide clues for understanding evaluative data from survey questionnaires concerning project impact on beneficiaries.

Two techniques for gathering qualitative data, focus group discussions and individual in-depth interviews, are reviewed here and suggestions made for their use in evaluating the HAPA PVO Grants projects.

The qualitative data for the HAPA project evaluations can be gathered at two different stages. 1) If there is to be a final KAP survey carried out prior to the evaluation team's visit to the project, focus groups and in-depth interviews are effective techniques for understanding the context and rationale for the survey data. 2) During the project evaluation itself qualitative data are routinely gathered from both project staff and project beneficiaries and, although there may be time constraints that prohibit a full-fledged qualitative study at this time, the techniques described here should nevertheless be carefully followed even when the number of interviews are scaled down in number.

The raw data of the KAP surveys are the coded responses to the questions on the questionnaire. The raw data of the focus groups and in-depth interviews are people's statements -- direct quotes expressing observations, judgements, opinions, "known" facts. The qualitative data gathered can be organized around two themes

¹ The following sources provided significant input to the preparation of this document:

Debus, M. Handbook for Excellence in Focus Group Research. HEALTHCOM, Academy for Educational Development, Washington, D.C. (1988).

Guidelines for use of qualitative research methodologies... PATH, Washington, D.C. (1989).

Krueger, R.A. Focus Groups: A Practical Guide for Applied Research. Sage Publications: Newbury Park, CA (1988).

Shedlin, M. Assorted materials for focus group research.

Patton, M.Q. Qualitative Evaluation and Research Methods. Sage Publications: Newbury Park, CA (1990)

- 1) statements about the impact of project activities on project beneficiaries, and
- 2) statements about the systems and functioning of the project itself.

A) How do qualitative data complement quantitative data?

One should not look to qualitative data for the same evaluative power that quantitative data have. Qualitative data are not used to count project outputs or measure percentages of the population that have been affected in a certain way by the project. Results from a properly designed and conducted survey can be projected to the entire population because of the sampling techniques used, the large number of respondents, and the standardized nature of the questionnaire. It would be correct to make a statement like "50% of the married women over 30 reported never having used a condom" when describing the results of a survey, because the data measure responses of individuals within a population in a statistically valid way.

Qualitative data, on the other hand, provide insights into the attitudes, desires, perceptions, prejudices and opinions of individuals within the population, but they cannot validly indicate the extent to which these attitudes and perceptions prevail throughout the communities studied. It would be incorrect to state that "30% of the older married women do not use condoms because they think they will get lost inside of them" based upon statements recorded during focus group discussions or in-depth interviews. It would be correct, however, to state "Various reasons were given by the older married women for not using condoms. Among the more frequently cited was the fear that.....". To sum up, survey results provide data on the numbers (and percentages) of people who hold certain opinions or who report engaging in certain behaviors. Focus group and in-depth interview data provide the reasons for holding certain opinions and for engaging in certain behaviors.

Qualitative data can also usefully complement quantitative data in assessing various program components. For instance, pre- and post-training exam reports are typically used to provide a quantitative measure of the level of achievement of the trainers trained by the program. In-depth interviews or focus group discussions with people trained by the trainer will provide qualitative data on how well the trainer was prepared to the job of training.

B) How generalizable are qualitative data?

Although data from focus groups and in depth interviews are not statistically projectable to the general population, they are not totally ungeneralizable. Qualitative data may be generalizable if care is taken to describe the characteristics of the people who have participated in the discussions or interviews, and there are obvious patterns that have appeared among several focus groups or interviews with the same sub-population. ("Attitudes among young unmarried women living in Marcory range from feelings of invulnerability to feelings of apprehension about the sexual transmission of AIDS. Sources of apprehension were identified as") It would be incorrect to report that "30% of the young unmarried women living in Marcory consider themselves to be invulnerable to the sexual transmission of AIDS" based on qualitative research data.

II. DESIGNING THE QUALITATIVE PORTION OF THE PROJECT EVALUATION.

A) What data and from whom?

Data will be gathered for two purposes:

- 1) to assess the achievement of project objectives
- 2) to assess the process of development and implementation of the project itself.

Both focus group discussions and in depth interviews can be used to gather this data. The following table suggests when to use each of these research techniques.

Examples of what to discuss with whom for qualitative data gathering
in project evaluation

Respondants

Subject matter

Focus group discussions

Program implementors (e.g. trainers,
service providers, educators)

Effectiveness/appropriateness
of training/supervision
Quality, quantity of project materials
(visual aids, training, clinical)
Implementation of project activities
(interfacing with beneficiaries)

Beneficiary groups, for example:

Rural/urban younger/older married women/men
High-risk groups (comm sex workers, migrant
laborers)
Community leaders

Transmission and prevention of AIDS
The care of PWAs
STDs/RTIs
Community participation in AIDS prevention
Acceptability/accessibility of condoms
Testing for STDs/AIDS
Participation in specific project activities
Reaction to educational messages, materials
Sexual practices/frequency of relations
Other practices (injections, scarification,
circumcision, drug use)

In depth interviews

Project decision makers (director, head
of training, head of supervision, etc)

Institutional/organizational capabilities
Training/supervision of staff
Implementation of proj activities

Local health sector decision/policy makers
Key political figures (deputy, mayor, gov-
ernor)

Commitment/support of project
Direct involvement with project
Attitudes re media
Knowledge and attitudes re AIDS (transmission
and prevention)

Key informants among project beneficiary
groups

[Same as above for focus groups]

B) Interviewing for qualitative data gathering

1) What are the possible types of interviews?

Interviews in qualitative research range from the highly structured to the completely unstructured:

* **Highly structured:** the standardized open-ended interview. The key word here is standardized: the exact wording and sequencing of questions is determined in advance and kept constant for each respondent. This increases the comparability of responses, reduces interviewer effects and bias, permits open review of the interview instrument by those making use of the research data, and facilitates the organization of the interview data for analysis.

* **Semi-structured:** the interview using an interview guide. This type of interview allows a freer flow of conversation and discussion than the highly structured interview. An interview guide listing the topics and issues to be raised is drawn up in advance more as a memory device than a questionnaire. The sequence and wording of questions is flexible and depends on the dynamic of the conversation or interview. The interview guide makes data collection more systematic than in the totally unstructured interview described below, and yet, because of the free flow of the conversation, the semi-structured interview enhances the relevance of the questions to the participant and encourages the expression of information and attitudes that were not specifically asked for.

Focus group discussions can also be thought of as semi-structured group interviews.

* **Unstructured:** the informal conversational interview. This is a conversation with one or more people, in which the interviewer has no predetermined list of questions nor specific wording of questions in mind. It is, however, a valid form of data gathering in qualitative research. The interviewer has a general topic in mind, but the questions emerge from the immediate conversational context and are asked in the natural give and take of conversation. This type of "interview" greatly enhances the salience and relevance of the questions and the data. However, it is less systematic and comprehensive as a way of getting information from many people. If the pertinent questions don't arise naturally there are gaps in the data. Organizing and analyzing data from many different informal conversations about the same topic is sometimes difficult.

For the purposes of the HAPA project evaluations, we suggest a combination of

* semi-structured and structured interviews with individuals (both project beneficiaries and project implementors), and

* focus group sessions - semi-structured because an interview guide is used - with groups of project beneficiaries or project implementors.

2) What are the considerations for using in-depth interviews versus focus groups?

In-depth interviews will be held, where appropriate, with

- * key project management personnel
- * key personnel in the Ministry of Health or counterpart NGOs
- * key policy makers
- * key local government personalities
- * key informants² among program implementors (nurses, community health workers, trainer-of-trainers, etc.)
- * key informants among target program beneficiaries (migrant laborers, community leaders, young men).

These interviews may combine the structured and semi-structured approaches: the first phase of the interview to follow a standardized questionnaire listing structured (open-ended) questions that are asked in a standardized manner, and the second phase to follow an interview guide in a less structured manner. For instance, if there is a series of specific questions about the project that you want all of the project nurses to answer, prepare a

² Key informants are individuals (either project implementors or program beneficiaries) who are particularly knowledgeable and articulate and are able to explain events that the evaluator has observed or heard about but not fully understood. Key informants may be interviewed more than once as issues come up that need discussion and where the evaluator needs insight. In fact the evaluator may spend considerable time talking to certain key informants about what is happening in the program. Many such key informant interviews become informal conversations, the questions asked during the interview arising from the immediate conversational context. Keep taking notes, however.

questionnaire for them, remembering to keep the questions open-ended. When these have been answered, take the opportunity to bring up other issues and questions, but in a less rigid manner, using a discussion guide and some of the questioning techniques discussed below.

Focus group discussions are an efficient way to question many people at one time. However, there may be good reasons to choose the in-depth interview with a key informant over a focus group:

* Certain topics that are considered sensitive or personal, like sexual practices, possible exposure to AIDS, negative or controversial views on the project, are best probed in a one-on-one situation. Do not assume, however, that one culture's ideas of what is personal and sensitive coincide with another culture's sensitivities. In many African pastoralist societies, for instance, the most personal, closely guarded knowledge is the number of cows or goats the family has. This would never be discussed in a group, whereas details of sexual practices that might be considered by a non-African to be highly intimate and not appropriate for group discussion might in fact be quite openly discussed in a focus group session.

* Systematic probing about the details of key issues is sometimes more efficient and more to the point in an individual interview with a key informant. For instance

- how a system (public health system, commercial sex system, migrant labor system, youth clubs) functions;
- how a relationship (man-woman, prostitute-client, protector-protected, teacher-student) is formed and how it functions;
- how a sexual contact is negotiated;
- why a specified group of participants reacts to the project in a certain way.

* The group dynamics of focus group discussions tend to bring out commonly held attitudes and perceptions about an issue. Individual opinions or behavior that deviates from the social norm is often easier to elicit during a one-on-one situation.

C) How to design the discussion/interview guide.

The discussion guide³ is a list of topics to be discussed in the focus group session or in-depth interview and serves as a summary statement of the issues and objectives to be covered during the discussion. The guide should be prepared jointly by the people who will be interviewing individuals or moderating group discussions, project management personnel and the evaluation team member in charge of data collection. Preparation of the guide is an exercise that forces both the moderators and those responsible for project evaluation to organize their thoughts and to review their objectives carefully. A loosely constructed guide generally suggests that the subject has not been thought through in sufficient detail to obtain truly valuable results from the focus group.

The discussion guide serves as a memory aid or road map for the moderator during the discussion, but a good moderator must have the flexibility and skill to stay on course and to cover all the objectives of the focus group while still allowing the discussion to flow naturally and spontaneously, and also permitting new issues to be raised if they are relevant to the evaluation objectives.

The guide should not cover too many separate issues. Care should be taken not to include questions on information that "it would be nice to know something about" if it is not specifically relevant to the project evaluation objectives. The order of topics to be introduced is generally from the general to the specific as this makes the flow of discussion easier and creates a framework for later comments on key issues, which may just be brought up naturally by the participants themselves.

The discussion guide should be written as a list of topic areas, rather than specific questions. Probing questions can be listed under each major topic to be brought up. An inexperienced moderator may need a more detailed guide at first, with suggestions for actual wording of questions and probes listed under each topic.

If any educational or training materials are to be presented and discussed by the group, it is important that the moderator understand the communications objectives and strategy of the materials and to incorporate specific issues into the guide relating to each piece of material to be evaluated.

³ Although this section focuses on discussion guides for focus group sessions, most of it is also pertinent to interview guides for in-depth interviews.

A sample topic guide is found in Annex ...

D) How to effectively ask questions and probe answers.

Preparation of the discussion guide includes deciding what questions to ask, how to sequence the questions, how much detail to solicit, and how to word the actual questions. These decisions will affect the quality of the responses which, it is important to repeat, are the qualitative data.

1) What kinds of questions can be used?

It is useful to consider different types of questions that produce different types of data.

* Experience/behavior questions - These are questions about what a person does or has done and are intended to elicit descriptions of experiences, behaviors, actions or activities that would have been observable had the observer been present. "If I followed you through a typical evening, what would I see you doing?" "If I were present when you talk to your teen-age son about AIDS, what would I hear you saying?"

A subcategory of experience/behavior questions are the sensory questions. These questions encourage participants to describe the stimuli to which they are subject (what they hear, see, touch, taste or smell) and to which they react. "What does the counselor say to you when you meet her?" "Describe what I would see and hear if I were at the training session."

* Opinion/value questions - These are questions aimed at the interpretations people make about specific events or issues. Responses reveal what people think about a topic. They reveal people's goals, intentions, desires, and values. The questions typically imply that the person has to reason something out and make a decision. "What is your opinion of....?" "What do you think about...." "What would you like to see happen?"

* Feeling questions - These questions are intended to understand the emotional responses of people to their experiences. Feelings are different from opinions, desires and values because they are typically spontaneous, often not the result of a decision, and sometimes admittedly irrational. It is not always easy to elicit emotions separately from rational interpretations, especially when translating the discussion guide from English or French to an African language, as terms for thought processes and emotional responses are not always directly translatable. For instance, the question "What is your opinion about AIDS testing programs?" might elicit a response "I am afraid of them." In fact, the expressed "fear"

may be reluctance to be tested because the person thinks he risks being contaminated if he is tested, or he thinks his boss will find out that he's been tested and he will lose his job.

On the other hand, the response "I am afraid" to the question "How do you feel about your husband having girlfriends?" probably does reflect a true emotion of fear - fear that he will become infected with HIV.

* Knowledge questions - These questions are used to find out what people consider to be factual information. The important distinction here is that certain things are considered to be known - not opinions, not feelings, but the facts of the case. The goal of these questions is to find out what people know as facts, not what is in fact true. There may be obvious misinformation expressed in response to this type of question, but the focus group session is not the place to correct incorrect knowledge. The recorder and moderator should take note of incorrect knowledge on important issues (like the modes of HIV transmission) and bring them up after the session to correct the misconceptions.

Knowledge about the program under evaluation may consist of reporting on what services are available, who is eligible, what the rules and regulations are about the program, how one enrolls in a training session, etc.

2) What is the suggested sequencing of questions?

It is a good idea to start off the discussion with questions about present behaviors, activities and experiences which require minimal recall and interpretation. Participants will talk descriptively and the moderator will probe to elicit greater detail about the descriptive picture. Once the experience or activity has been described there is a context in which the moderator can ask about interpretations, opinions and feelings. Knowledge and skill questions can be considered threatening and so are easier brought up inside a context. It is helpful to ask them in conjunction with specific questions about program activities and experiences so that there is a concrete context and a good reason to be asking about knowledge and skills.

Questions about the present tend to be easier to respond to than the past. Future oriented questions require a great deal of speculation and responses are less reliable or valuable.

3) What is appropriate wording of questions?

Each major topic of the discussion can be identified with a statement, "I would like to hear what you have to say about your husbands' attitudes towards condoms" or the moderator can launch directly into the first question. The wording of questions is important; they should be open-ended, singular and clear.

* **Open-ended questions** - A truly open-ended question does not imply or suggest a predetermined response. "How satisfied are you with the training program?" is not as open-ended as "How do you feel about the training program?" or "What do you think about the training program?" When probing for more depth and understanding on a response, be wary of the dichotomous response question that may result in a "yes" or "no" answer. For instance, "I'd like you to think of the first time you had sex using a condom. Can you think of something that stands out in your mind?" or "Was this the first time you had heard about AIDS?" can be answered quickly in the affirmative or negative with no additional information offered.

Questions that include a presupposition are useful to get at specific information. "What is the most useful thing you learned at the session?" may provide a richer response than "Do you think you learned anything useful at the session?" They are also helpful in bringing up embarrassing or delicate issues. For instance, in a discussion with young unmarried women the question "How many sexual partners do you have in an average week?" presupposes that it is not surprising to have more than one and that this is not the issue. On the other hand, "Do you have more than one sexual partner?" might be more embarrassing to answer. Be careful of overusing this question technique, or presupposing too much.

* **Singular questions** - The moderator may be tempted to ask a number of related questions at once so that the participants have more than one set of responses to choose from. For instance, "I would like to have your opinion of the messages on the poster. What do you like? What don't you like? What could be improved? What should stay the same? Are the terms used the correct ones?" This tactic should be avoided. It is unnecessary as a device to get people to talk and people often feel confused as to what the moderator wants from them.

* **Clear questions** - Asking singular questions helps with clarity. Another consideration is making sure ahead of time that the language and terminology the moderator uses in the questions is appropriate and well-understood by the local population. For instance, there may be many ways to refer to male and female genitalia and the terms used among people who know each other well might not be appropriate terms to use in a

public forum where an outsider (the moderator) is speaking to local people.

It is important not to collect data that later turns out to be uninterpretable because the analyst is not sure what the participants meant by their responses. To avoid this some repeating may be necessary, "Okay, you have mentioned a number of differences between the public health clinic and the project clinic. Let me ask your opinion about each of the things you mentioned. What do you think about.....?"

Make sure the participants know what entities or people are being referred to when the moderator speaks of key elements such as project components, Ministry of Health components or staff, diseases or symptoms.

Use "why" questions sparingly. They imply that there is a cause and effect relationship, that there is a reason things occur and that those reasons are knowable. It is typically difficult for people to know what is being asked. "Why did you participate in the program?" is less clear than "What was there about the program that attracted you?"

4) What is the importance of probes?

Probing is an important technique for both focus group discussions and in-depth interviews. Once a key question has been asked and a first response has been given, probes are used to dig deeper into the subject by getting respondents to clarify and illuminate what has just been said. They are also useful in a group discussion to encourage more than one person to respond on a given topic. Some useful techniques:

- * remaining silent, thus allowing the respondent to amplify what he/she just said;
- * the mirror technique - restating exactly what the respondent just said in order to see if he/she will add more;
- * repeating the respondent's words as a question to elicit further clarification: "You're reluctant?"
- * using key words from the respondent's answer to form another question: Respondent - "It's frightening." Moderator - "What about it is frightening?"; or R - "I like the color." M - "What is it about the color?" M - "He doesn't like it." R - "How do you know he doesn't like it?"
- * asking about a certain word: "You mentioned something about....", or "I'm not sure I understand what you mean by....";
- * probing feelings, opinions: "What makes you feel that way?/ What makes you think that?"

* asking for an example: "Give me an example of what she would say in that situation."

IV. FOCUS GROUP DISCUSSIONS

The focus group discussion, also called a focus group interview, is a qualitative research technique originally developed by market researchers in the 1950s to gather information about consumer product preference and to gain an understanding of attitudinal factors in consumer behavior. Focus group sessions are used increasingly frequently as a research tool in the development and evaluation of outreach programs where insight into participants' perspectives is important for the design and assessment of program elements.

Focus groups are useful in project evaluation for a number of reasons:

* They are efficient. In one hour information can be gathered from 10 people instead of only one.

* They provide some "quality control" in that the extreme or marginal viewpoint tends to be balanced out by the other participants.

* They tend to highlight the most important issues of the project because the group dynamics will bring these out even if the moderator fails to ask about them.

* It is possible to assess the extent to which there is a consistent, shared view of the project among participants.

* They are typically very enjoyable for the participants.

There are other considerations as well: about focus group discussions:

* Because many of the group participants will want to address a given question or issue, the number of questions or topics that can be raised is limited. With 8 to 10 people in an hour, it is typically possible to ask no more than ten major questions.

* Successful moderating of a focus group requires skill and practice. Strategic planning for the project evaluation should include time, resources and technical assistance for training the moderating team(s).

A) What are the essential components of a focus group session?

- * a well-trained moderator
- * a well-trained note-taker, or recorder;
- * a homogeneous group of 6 to 10 participants representative of the group of interest (e.g. staff trainers, public health nurses, commercial sex workers, migrant laborers, church leaders, young women 18 to 25 years.)
- * a quiet and comfortable meeting site
- * a working tape recorder with a back-up power supply (usually a set of spare batteries), tapes, and a good microphone. The system should have been tested out in that setting prior to the focus group session.
- * a carefully designed focus group interview guide.
- * blackboard and chalk, if needed
- * project materials to be evaluated, if needed
- * refreshments, if appropriate.
- * small gifts for the participants, if appropriate.

B) How to select a focus group moderator.

In selecting persons to be trained as focus group moderators, personality type is an important factor . Persons who are very quiet, pensive, introverted and are reluctant to interact with people usually do not make good moderators. They tend to be ill at ease, and their discomfort is then transferred to the participants.

On the other hand, people who like being around other people and who are good conversationalists usually, with appropriate training, become adept focus group moderators. In fact, personality type may be a better indicator of success than a specific professional training. Those who are accustomed to telling people to do things, e.g. educators, teachers, doctors, nurses, must learn to become listeners before they can be good moderators.

A good moderator must know about the topics to be discussed in the focus group. This does not mean, however, that a background in reproductive health or epidemiology is necessary to lead a focus group session about AIDS. If necessary, details of the subject matter can be learned during

the training sessions. Flexibility is the key in moderator selection. With good trainers, the level and scope of moderator training can be adjusted to meet the realities of each situation.

C) How to select the focus group recorder.

The recorder and moderator work together as a team and should understand and be comfortable with both roles. It is therefore a good idea to train all moderators to both lead and record the focus group session. Some teams may actually trade off so that they function in different roles in successive group sessions. The recorder must learn to listen carefully, be alert, be able to concentrate on all that is said, observe significant body language and other non-verbal communication, be aware generally of how the interview is going, picking up on cues that the moderator may be unaware of because she/he is involved in the discussion. A good memory and the ability to write quickly and use abbreviations and other shorthand symbols are useful skills for a recorder. These skills improve with training and practice.

D) What training is necessary for the moderating team?

It is important that the moderating teams for focus group discussions receive training in focus group techniques, data analysis and reporting. If the focus group discussions are to be conducted during the project evaluation process, they need to be planned for prior to the evaluation. This strategizing includes the identification of someone with focus group experience who can oversee the qualitative data gathering, conduct the training of the moderating teams, and oversee the data analysis. This might be

- * someone on the evaluation team;
- * a locally available social scientist;
- * an external consultant.

Investing in technical assistance for focus group moderator training pays off not only in much better data gathering and analysis for the evaluation objectives but also in lasting expertise in qualitative research. The trained moderating teams will be able to use their skills in many different contexts in future programs.

The amount of time spent in the training of focus group moderators depends on project resources. What is described below represents a typical training schedule for a full-scale

qualitative data gathering effort. Time and resource constraints may require a limitation on the number of teams trained and the number of days spent actually conducting practice sessions with community participants. The key elements of the training process, however, are essential for all contexts: a) background information on focus group discussions; b) observation and practice of a model focus group discussion in the classroom; c) conducting actual focus group discussions in the community; d) follow-up critique/discussion in classroom of performance; e) preliminary analysis of data under supervision of trainer.

Training of focus group moderators should be participatory. The maximum being trained at one time should not exceed 14 (a total of 7 teams), as training organizers must arrange for simultaneous practice focus group sessions on each of several days, and organizing more than seven of these at once becomes difficult.

Classroom training should take no more than two days and includes

- * background information on the focus group session as a research tool;

- * description of the focus group process;

- * discussion of the respective roles of moderator and recorder;

- * how to select participants;

- * how to develop discussion guides;

- * observation of a model focus group session played out by the trainers;

- * practice in focus group session skills within the group through role-playing to give each trainee the chance of playing the roles of moderator, recorder and participant.

The focus group teams (of two each) then spend two or more days conducting actual focus group sessions under the supervision and guidance of the trainers. Some advance organization is necessary for these focus group sessions, although the trainees go through the process of participant selection, the setting up of the site and the actual implementation of the session. If time permits, it is a good idea for each team to conduct at least four sessions so that each person plays each of the two roles at least twice.

Trainees come back to the classroom for follow-up sessions that include analysis of performance and analysis of data. Under the guidance of the trainers/supervisors the trainees performance is analyzed and helpful critiques are given. Trainees gain insight on how to handle difficult situations and how to adapt their techniques.

The teams then go over their notes and the taped sessions to begin to analyze the data. They are guided by the trainers to identify significant statements and expressions of attitudes on the part of session participants. They listen for key terms, phrases; they identify patterns, trends, and themes in the various themes discussed during the session. They learn to pick up the unexpected, unasked for information. They learn to synthesize, to pull out pertinent direct quotes, to present the data in a helpful format.

Analysis and presentation of focus group data requires time, supervised training and much practice.

Moderator training can be accomplished in one week, although two weeks provides more time for carrying out actual focus groups sessions and for the training in analysis.

E) How to select focus group participants.

Focus group discussions with project implementors, Ministry of Health personnel or community leaders may not require sampling decisions because there is little or no choice of participants to be made. Likewise it may not be necessary to apply the same rules about group homogeneity with these groups. Since the subject of these focus group discussions is project processes and systems, rather than beneficiaries' practices and attitudes, such characteristics as marital status and age might be less important to keep constant among the participants. It would be important, however, that discussion participants be at the same level in the project's staff hierarchy.

Focus group sessions with project beneficiaries do require sampling decisions. Here are some guidelines:

- 1) Identify the significant characteristics of the beneficiary population that you would like to have information on. This might be as general as "community women between the ages of 15 and 49", or it may be more specific "truck drivers on the Bujumbura-Kigali route".

- 2) Conduct at least two sessions per major population characteristic, the exact number depending on time, resources, and the complexity of the issues being discussed. For

instance, if age of men in the general community is a major characteristic, two sessions each would be held with young men and older men. If marital status was considered to be an additional important variable among the young men, two sessions each would be held with young unmarried men and young married men. Then, if it were also important to examine the differences between regions or between rural and urban communities, additional group sessions with participants having these same characteristics would be conducted in the different regions or in urban and in rural communities.

3) If patterns are not easily discernible after two sessions with the same segment of the population, or if the first two groups of the same segment produce very different results, then further group sessions may be necessary to explore the differences between the first two groups. At this point, the discussion guide might also be altered to focus even more in-depth on the sections revealing contradictory data. A general rule: when additional sessions fail to yield any new insights and the information is essentially the same as previous groups, it is time to stop.

Once the defining characteristics of the desired focus groups have been established, a selection questionnaire for each can be developed for use in screening participants. The questions should be designed to ensure the presence of the demographic and /or behavioral characteristics required by the sampling design. Use of a questionnaire for the selection process ensures that the interviewer carrying out the selection administers the screening questions in an identical manner. The questionnaire is also useful for obtaining names, addresses and pertinent information on the focus group participants.

In certain contexts, where time constraints are an important limiting factor, filling out individual questionnaires for each participant may not be possible. The selection criteria are nevertheless kept constant and the person carrying out the selection asks the screening questions in an identical manner.

Recruitment can be done at one location, such as a market, a clinic, a church or civic center, or by going house-to-house looking for participants who satisfy the basic characteristics. Some steps to follow when recruiting participants:

- * Explain the nature of the meeting and tell the person why her/his expertise is important.

- * Ask the questions on the questionnaire. If the person meets the criteria for selection, invite her/him to participate.

* In general, do not indicate the specific topic of the focus group session since the invited participant may ask advice from friends and family as to what to say and this might be detrimental to spontaneity during the session. However, be sensitive to local cultural realities and protocol. There may be strong reasons why a married woman, for instance, would not be allowed to participate in a discussion unless her husband knew what was going to be discussed.

* If the person is willing to participate, tell her/him the day, hour and place of the session. Stress the importance of being on time so others are not kept waiting.

* Recruit a few more participants than actually needed to allow for "no-shows".

It is common wisdom that focus group participants should not know one another, the reasoning being that this might inhibit individuals from speaking freely. However, the opposite may hold true in some African contexts, especially in the more traditional rural communities of some cultures, where it is entirely inappropriate to express one's inner thoughts in the presence of strangers. Local conventions and expectations concerning this issue should be investigated prior to selecting the focus group participants.

F) How to select a site for the focus group session.

The session should be conducted in a quiet place large enough to accommodate up to 12 persons (participants, moderator, recorder.) Chairs or mats should be arranged so that there is not a "head table" or "teacher-student" arrangement. A circular seating arrangement usually works best. If the sessions are to be held in the evening, be sure there is adequate lighting.

G) What are the tasks of the moderator and recorder?

The moderator and recorder should not be known to the participants as project staff, nor should they be too closely identified with project staff. This is sometimes difficult to achieve, but it is important that participants feel free to speak frankly and express their feelings and ideas about the project. The moderator and recorder should be of the same sex as the focus group participants and should speak fluently the common language of the group. A solid understanding of the issues to be discussed enables the moderator to ask the right questions to clarify statements made during the session and the note-taker to make relevant observations and choose what is

significant in the discussion.

A good moderator:

- * establishes rapport with the participants in order to gain their confidence and trust. This makes it easier to probe responses and comments made during the discussion.

- * shows flexibility, sensitivity and has a sense of humor.

- * takes care not to act like the expert, not to judge comments made, not to inform or educate participants during the session, not to express personal opinions

- * does not lose control of the conversation.

The moderator's tasks are to:

- * make the group feel comfortable and at ease.

- * introduce the topics for discussion.

- * lead the group and keep it focused on the topic under discussion.

- * actively encourage participation by all group members and intervene if necessary to ensure that one or two persons do not dominate the discussion.

- * move the discussion logically from point to point.

- * keep the discussion from turning into a simple question and answer session, but rather encourage participants to communicate among themselves without the constant intervention of the moderator.

- * take minimal notes, if necessary, on questions to ask or points to raise later on.

A good recorder:

- * observes and listens carefully to all the interactions in the group.

- * remains objective while noting the attitudes and emotions of the participants.

- * is aware of and can interpret non-verbal communication, such as laughter, tone of voice, posture, facial

expression, hand and body movements. These cues are important when they suggest attitudes and emotions relevant to the discussion analysis. Having them on record may help in the after-session analysis.

The tasks of a recorder:

* Collect background information on the participants that is considered important to the research question (if it hasn't been collected during the participant selection interview). This might include such demographic information as age, marital status, number of children, years of schooling, and principal occupation, or more specific information, such as whether or not they had participated in AIDS prevention education sessions.

* Be responsible for the tape recorder and its operation. This includes testing it before the session, making sure there are enough tapes and extra batteries, ensuring that the microphone can pick up voices at all points in the seating arrangement, turning the tape recorder on, turning the cassette over or putting in another tape when the tape has run out, and making sure the power supply is operating properly. After the session, all tapes should be marked immediately with the date, time, place and group identification.

* Have the pages for notes numbered and labeled with the group identification before the session. Take comprehensive notes during the session, which include

- observations of non-verbal behavior and interaction, indicating what elements of the discussion triggered the reaction.

- important terms and language used to talk about the main issues of the discussion.

- any insights that have come as a result of listening and on-the-spot analysis. These will be checked out later during the post-meeting analysis of the session with the moderator.

* Be responsible for the environmental conditions of the session, opening or closing windows, adjusting lighting, dealing with distracting interruptions, unwanted background music or other noise, seating latecomers.

* Take care of logistics, including refreshments.

The moderator and recorder work as a team before, during and after the session. To achieve a good working relationship they must practice together and set up systems of giving feed-back to each other discreetly during the session. They often sit across from each other during the session in order to maintain eye contact and be able to communicate with non-verbal cues. For example, agreed upon signals might be used by the note-taker to suggest that the moderator probe a response or reaction, or that the moderator rephrase a question because there seem to be some confused participants.

H) How to conduct the focus group discussions.

1) Preparation for the discussion

The moderator and recorder should arrive at the site before the participants to make sure the seating is appropriate, the tape recorder is set up and to be on hand to greet the participants and to chat informally. Snacks or drinks may be served at this point if it will help put the participants at ease. This is the time when the recorder collects needed information from the participants (see above.)

After everyone has been seated the moderator welcomes everyone, introduces her/himself and the recorder, explaining the roles of each and why the use of a tape recorder is necessary. Assurance should be given that the information on the tapes will be used by the project staff only and will be kept confidential. It may be appropriate to formally ask permission to use the tape recorder. If someone disagrees, even after extensive explanation, that person may be excused from the session. [If, as seldom occurs, the majority of the participants object to the tape recorder, it should not be used. The role of the note-taker then becomes extremely important.]

2) The discussion

Stage one - The Warm-up.

The moderator reminds the participants why they have been invited to the group, tells them that they are the experts (not the moderator or the recorder), that the project staff and organizers want to learn from them, and that it is important for them to freely express their opinions and ideas. They are told that although the moderator will ask specific questions they should feel free to bring up any other points that are relevant to the general topic under discussion.

The purpose of the warm-up period is to establish the nature of the group process that will take place during the session. Each person has a chance to speak right away thereby overcoming any speech anxiety that some participants may have, an anxiety that tends to mount if speaking is delayed. The moderator establishes him/herself as a safe, non-judgmental interlocutor by asking each person non-threatening, non-delicate questions about him/herself.

The moderator asks each person to give her or his name, by which he or she wants to be addressed during the session. This is an important point as there is frequently a difference in the name given for identification purposes (typically the name on an identification card, or "etat civil" in francophone Africa) and the social identity name. The latter might be Mrs./Mr./Miss X, or a first name, or a nickname, but it is up to the participant to decide how he or she wants to be addressed. The recorder should fill in a previously-prepared seating diagram with each name and give it to the moderator so that participants can be called upon by name during the session. This preliminary name-taking typically adds to a feeling of ease and comfort among the group participants.

Other warm-up questions might concern the distance each had to come to the session, what they would otherwise be doing if they weren't at the session, how often they travel to the capital city. The point is to find questions that are not delicate, that are straightforward, and for which everyone will have a ready answer. This may require some preliminary research and discussion with people who know the community well.⁴

The warm-up period should not last more than 10 minutes. The moderator must use skill and tact in moving the warm-up period into the main body of the session.

Stage Two: Focused discussion

The moderator starts the discussion with the first topic on the discussion guide. Ideally the discussion guide has been prepared to lead the discussion from general topics to more specific, from concrete questions to more abstract. The general to specific, concrete to abstract process is also used on any one topic, as the moderator. Throughout the discussion the moderator uses the guide to check that all items have been

⁴ In some African cultures it is not easy to respond to the question of how long one has been married or how many children one has - questions that are sometimes recommended for warm-up responses.

discussed, keeping in mind that the order in which they are brought up is flexible. If a participant brings up a topic in the normal course of the discussion that was planned for later on in the session, the moderator lets it happen naturally and comes back to topics that have been skipped over in the discussion guide.

Sometimes participants ask for factual information about the topic under discussion (e.g., the project, AIDS, follow-on activities, where to go for health care), or provide what the moderator knows to be incorrect information. The moderator may be tempted to offer the information asked or to correct a misconception. As a general rule this should never be done during the session, as it will change the nature of the session. Participants may stop giving their own ideas and place the moderator in the role of "expert" or provider of information. The moderator should respond to such questions by saying that she/he is there to listen right now and will respond as far as possible to the question after the session is over. It is important, however, for the recorder to record the erroneous information and the questions so that these can be addressed after the session.

Stage Three - Closing the discussion

Ideally, all topics on the discussion guide should be covered during any one session, and ideally the guide has been developed to allow all topics to be discussed adequately in under an hour and a half. It sometimes happens, however, that the discussion goes off on a tangent that seems extremely important for the project evaluation and the moderator chooses to let it happen without breaking the momentum. The hour and a half goes by, people are getting restless or otherwise non-participative, but all the topics have not been covered. It is up to the moderator to decide whether to prolong the discussion or not, sometimes with input from the participants.

The moderator should announce, in an appropriate manner and place in the discussion, that the time is nearly up and that the session is being brought to a close. People who have not spoken much or still have something important to say will thus be alerted.

The moderator should take a few minutes to summarize the main themes that have been discussed and recap the attitudes and feelings on each, stating the consensus of opinion when there is one, significant minority views, the strength of feeling expressed, key group differences ("some of you felt that..., while others of you felt that..."). This will give a last opportunity for participant opinions on the main themes. The moderator's role is to nonjudgmentally identify differences of opinions among participants and to synthesize the findings

of the group.

Before the group breaks up the moderator thanks everyone for a job well done. If there is to be a small gift of appreciation, it is distributed at this time. Once it is clear that the session is over, the moderator may suggest that the questions or issues put on hold during the session be brought up again. Those participants who do not wish to stay and discuss at this point are free to leave, although if important issues have been brought up that need to be addressed the moderator may respond to these before anyone leaves. If there is erroneous information that needs to be corrected, it may be useful to have project health staff present to address these issues.

It is a good idea to keep the tape recorder going as the session breaks up and the participants leave, as important things may be said that were not brought up in front of the whole group.

I) What about the presence of an observer at the focus group discussion?

If it is appropriate and useful for an observer to attend the focus group session (e.g. the research coordinator, someone from project management, a decision/policy maker) her/his presence should be explained by the moderator in an appropriate manner at the beginning of the session. He/she should not participate in the discussion, but should be included in the post-session debriefing.

V. IN-DEPTH INTERVIEWS

Many issues in in-depth interviewing, such as respondent choice, preparation of an interview guide, the use of questions and probes, analysis of data and report writing, are similar to what has been discussed for focus group sessions. There are, however, a few particular considerations.

The qualities cited above for good moderators apply to good interviewers. When people with particular technical or project expertise are to be interviewed, the interviewer should ideally be in the same field or equal in qualification to the respondent, particularly in specialized fields of qualification. Persons trained as moderators may be very appropriate as interviewers.

The interview should be conducted on the respondent's territory, if possible. A quiet, private setting is best. A tape recorder should be used if the respondent does not object.

The interview guide should include questions and topics that can be covered in an hour.

VI. ANALYZING AND REPORTING OF THE QUALITATIVE DATA

Presented here are guidelines for analysis and reporting of focus group and in-depth interview data that should followed when carrying out a full-fledged qualitative study of a project. They would be useful, for instance, when resources permit the collection of a full set of qualitative data prior to the project evaluation mission. The end result of the analysis in that case would be a full report that synthesizes all of the focus group and in-depth interview data into a coherent whole.

If the qualitative data are to be gathered during the evaluation process, however, time constraints may limit the amount of time spent on data analysis, and the subsequent written report. It should be remembered, however, that this may also limit the richness and the scope of the analysis.

A) What is the first step in qualitative data analysis?

An essential first task in analysis of interview and discussion data occurs immediately following the interview or focus group session. In the case of focus groups the moderator and recorder review the session, go over the notes, and listen to the tapes in order to prepare a short written summary of the session. The purpose is to note additional impressions or memories of what occurred during the session, respond to each other's reactions to important points, note important deviations in the sequence of the discussion topics, describe the group mood and the overall dynamics that existed among the participants. These first impressions and immediate reactions are often valuable for later analysis. They are easily lost if not recorded immediately. If the moderating team is to hold another focus group session the same day it is essential that this debriefing meeting take place before the next session. If resources permit, it may be useful to tape these post-session debriefings.

A short summary report should also be made of the in-depth interview, although the interviewer will not have the benefit of another witness to react to impressions and ideas of the interview. These post-session reports should be carefully labeled with the same identification as the tapes of the discussion or interview (i.e. place, date, name of person or group identification).

This first listening of the tapes will also determine whether there is sufficient clarity and volume to be usable for later more detailed analysis. If this is not the case, and the tapes cannot be salvaged, the moderating team or interviewer may want to reconstruct the discussion immediately, as best they can from memory and notes.

B) Who is the analyst?

In most cases there will be one person in charge of the qualitative research for the program evaluation and this person will be the analyst and report writer. This may or may not be one of the focus group moderators. If the analyst has not moderated a group discussion, he/she should have observed a wide range of the discussions. The analyst will work closely with the moderators in analyzing and reporting the data.

C) What is the process of analyzing qualitative data?

Essentially, the three stages of analysis involve

1) raw data (direct quotes of respondents), which are processed into

2) descriptive statements by analyst summarizing issues, ideas, tendencies, consistencies, consensus, which are further processed into

3) interpretation of the data.

Analysis of qualitative data is often daunting. The volume and complexity of the data is less overwhelming if the analyst stays focussed on the intent of the study, in this case, evaluation of a HAPA Project. There will be much more data from the focus groups and interviews than will be used for the project evaluation. The analyst should keep in mind the two questions that are the basis for this evaluation:

"Does this data illuminate the extent to which the HAPA project attained its objectives?"

"Does this data shed light of the process of carrying out the HAPA project?"

Although each analyst may have her/his own techniques, the following guidelines suggest a process that can be adapted to individual situations.

* Make sure you have for each interview or session: tape recordings, short summary reports of each session/interview, demographic information about the participants, discussion/interview guide, and transcripts of the sessions, if available.

* Have a clear outline of topics and questions that the data are to shed light on. The discussion or interview guides will provide some of the detail for this

* Listen again to the tapes of each session, grouping together sessions that deal with the same topics or that involve the same type of participants. The exact statements, or direct quotes, of participants are the raw data of the analysis. Significant statements should be written down as the tapes are listened to. Some analysts prefer using a word processor capture significant quotes as they are listening to the tapes. The statements may be ordered in categories that are relevant to the study (women/men; PWA/others; young, unmarrieds/older, married; rural/urban; program participants/nonparticipants). Data base filing software can be used to sort comments by respondent characteristics.

* Identify the different positions or dimensions that emerged regarding each key topic area, using descriptive statements summarizing participant comments. These statements are summaries of the raw data: brief descriptions of a position taken on an issue; emotions or reactions to an issue; or assessments of the strength of positions taken or reactions expressed. The summary statements can be followed by typical or illuminating quotes.

* It is important to remember not to count or quantify when describing the intensity of the group's feelings or the degree of consensus in the group about a certain attitude or opinion. Qualitative data are an inappropriate source for "percentages of the population that.....".

* The interpretation of qualitative data is the most complex role of the analyst. It builds on the descriptive process by presenting the meaning of the data as opposed to a summary of the data. The post-session summary notes and any notes taken by observers are useful for this step in the analysis. Keeping in mind the final purpose of this research (HAPA project evaluation), look at "the big picture" and identify the constants that emerge regarding each topic area, and interpret them. For instance, people's reluctance to face the AIDS issue, or the amount of power that women have in negotiating a sexual relationship. Identify the divergent opinions and attitudes and attempt to group them into significant categories of responses. For instance, three types

reactions to PWAs might be fear and avoidance; sympathy, tolerance but distance; direct involvement in helping them live their lives.

D) How to incorporate the qualitative data analysis into the project evaluation report.

There are a number of ways that the qualitative data can be included in the evaluation report, depending on the extent of the data, the scope of the analysis, and the amount of time for the report write-up. At a minimum, qualitative data that have been gathered during the evaluation mission can be incorporated directly into the discussion of the appropriate topic. ("According to data gathered during focus group discussions, many of the nurses felt that....." or "The lack of message clarity in the educational materials was also suggested by the reactions of community women to the posters.....").

If time and resources allow for a fuller assessment of the project prior to the evaluation, or if time can be spent doing a full analysis of the qualitative data collected prior or during the evaluation, a separate report can be prepared and attached to the evaluation report as an annex. The following is a suggested format for such a report

- 1) Executive summary
- 2) Purpose of the research - a statement of the objectives
- 3) Methodology and rationale for the design of the research
 - Respondent sampling (key informants, significant population characteristics)
 - Respondent recruitment
 - Location (by zone, area)
 - Research team
- 4) Findings - Analysis of the data from the focus group sessions and the interviews. This generally follows the topics on the discussion and interview guides.
- 5) Conclusions and recommendations

Annexes

- Focus group discussion guides
- In-depth interview guides
- Participant screening questionnaire
- Any project materials evaluated by the participants

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Recasting the Net

Dynamics of International Networking on AIDS

Bob Grose*

Les organisations non gouvernementales (ONG) dont les activités ont trait au HIV reconnaissent que le niveau d'influence qu'elles peuvent exercer sur les agences gouvernementales et les agences de financement, en unissant leur efforts, dépassent de beaucoup l'influence que des groupes individuels peuvent avoir. La coopération pour la dissémination de l'influence et la coopération entre les ONG elles-même d'une part, et entre les ONG et les programmes nationaux pour le SIDA, d'autre part, sont des buts très accessibles pour les réseaux des ONG opérant au niveau international.

Las Organizaciones no Gubernamentales (ONG) concernientes a HIV han encontrado que pueden ejercer un alto grado de influencia en las oficinas gubernamentales y agencias financiadoras y que trabajando juntas pueden de lejos sobrepasar a los grupos individuales que trabajan por su cuenta. La ejecución de metas para la red de la ONG que operan internacionalmente incluye compartir información y generar la colaboración entre las ONG y entre éstas y los programas nacionales de lucha contra el SIDA.

The three musketeers' rallying call, "All for one and one for all" epitomises the spirit of solidarity and mutual action underlying people's desire to join forces to attain common goals. The slogan "Health for All and All for Health" says the same in the context of global health. Both, of course, are as true for organizations as for individuals.

In AIDS, as for many years in other areas of health, non-governmental
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Expanding Partnerships with the Corporate Sector

Shamseh Poonawala and John Novak*

Despite the current AIDS crisis, demands for funds for AIDS prevention programs are exceeding available resources. An uncertain economy and competing priorities for funds are making fundraising for AIDS programs more and more difficult. At the same time, globally NGOs are facing an increase in demand for additional AIDS programs and services, such as community-based care programs, treatments, counseling, and support services. To cope with these challenging times, NGOs have to look for opportunities for collaboration with other organizations, and for expanding partnerships to share the limited resources necessary for implementation of AIDS programs.

Business and industrial corporations have shown a growing interest in HIV/AIDS. Contributions to HIV/AIDS programs from business and industry have been on the increase, but the private sector remains an under-utilized source of potential support.

Working with the Corporate Sector

There are four important approaches to NGO partnerships with the corporate sector. First, corporations may provide direct financial support, often through their associate philanthropic foundation. Corporate monetary contributions to NGOs for AIDS-related activities in the past year have increased; however, there

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Commentary

Official responses to important health and development issues have a familiar ring: develop official agencies with a mandate to study the situation, draw up elaborate plans for how to proceed, and fund outside experts to develop, test and disseminate technologies to address selected manifestations of the problem.

Enter HIV. In the ten years or so since the HIV epidemic was first recognized, it has become clear that the "business as usual" approach will not suffice to slow further spread of the infection, or to cope with devastation that is already apparent. This is true for at least two important reasons.

The first is the scale and momentum of the epidemic. While other health problems such as diarrhea, measles, and malaria continue to kill at relatively constant rates, new HIV infections are accelerating -- a speedy response is vital. There isn't time for business as usual.

A second factor is the social nature of HIV transmission. The virus is spread by private and compelling kinds of human behavior: sexual intercourse; intravenous drug use; the bearing of children -- behaviors deeply rooted in community norms and culture. But health and development bureaucracies, well-known for their distance from social and cultural realities, gravitate towards politically neutral technological solutions, tending to ignore the social basis of health problems.

If the established systems are not suited to the challenge, who is? Enter non-governmental organizations, or NGOs. Acknowledged for their flexibility, mission-oriented NGOs are relatively free from political constraints and have well established community ties. NGOs can be organized quickly when communities see a compelling need, and are intimately familiar with the social environments in which they work.

For all of these reasons, mission-oriented NGOs may be our very best hope in the effort to contain the HIV pandemic. New mechanisms to support the efforts of NGOs working in AIDS prevention and care internationally are currently under discussion, a much-needed and encouraging development. NGOs need access to resources so they may carry out the critical task of empowering communities to respond to the unique challenges of HIV/AIDS. An important first step towards that goal will be to recognize NGOs as vital business partners in responding to the global HIV pandemic.

-MAM

Special issue: This edition of *AIDS & Society* focuses on the role of non-governmental organizations (NGOs) in the global struggle against HIV/AIDS. Our thanks to Mary Anne Mercer, Director of the HIV/AIDS Prevention in Africa Support Program at The Johns Hopkins University Institute for International Programs, who was our guest editor.

Viewpoints and information published in this Bulletin are the responsibility of the authors and not necessarily those of the sponsoring organizations.

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AIDS News Digest

AIDS Conference Rescheduled

Because of U.S. restrictions on the immigration and travel of people infected with HIV, the VIIIth International Conference on AIDS will not be held in Boston, but instead, will be held in Amsterdam, the Netherlands, from July 19-24, 1992. A new call for abstracts and further details will be forthcoming. Contact: Harvard AIDS Institute, 8 Story Street, Cambridge, MA 02138, or telephone Melinda Julien at (617) 495-0478. (Source: Harvard AIDS Institute) □

Indian Blood Banks: An AIDS Depository?

In India, professional blood donors meet over half the demand for blood from hospitals. Over 5 million liters of blood are sold to hospitals each year, and until recently, many pharmaceutical companies purchased blood as well. Dr. Ishwar Gilada, an AIDS specialist at the JJ Hospital in Bombay has been campaigning through the Indian Health Organization for tighter government control of blood products: one of his studies concluded that 80% of Bombay's blood sellers are HIV infected.

Blood screening programs have been launched in eight Indian cities, but doctors still estimate that up to 95% of donated blood is unsafe. (Source: The Lancet, Vol. 338, August 17, 1991, p. 437) □

FHI Lands Grant for HIV/AIDS Prevention and Control

The United States Agency for International Development (USAID) has awarded Family Health International (FHI) a five-year \$168 million grant to assist countries in Africa, Asia and Latin America/Caribbean to expand HIV prevention and control programs. The new project will concentrate on decreasing the number of sexual partners, increasing the demand for and use of condoms, and improving treatment and prevention of sexually transmitted diseases. The project will encourage private sector participation in AIDS programs and will focus its resources in countries chosen on the basis of need, prevalence of HIV, the prevalence of factors facilitating HIV transmission, and national commitment to AIDS prevention. (Source: FHI news release, August 29, 1991) □

AIDS Funding

AIDS Fundraising

AIDS Fundraising, (ed. Michael Seltzer, Foundation Center, 1991) addresses the principles of fundraising for non-profit organizations and the special obstacle facing fundraisers concerned with HIV/AIDS. The 49-page guide, produced by the National Community AIDS Partnership and Funders Concerned About AIDS, presents fundraising principles and offers strategies for AIDS service organizations and prevention programs. It also includes samples of direct mail pieces and an extensive bibliography of general fundraising. Contact: The Foundation Center, 79 Fifth Avenue/16th Street, New York, NY 10003, U.S.A. □

AIDS Funding

AIDS Funding: A Guide to Giving by Foundations & Charitable Organizations (ed. C. Edward Murphy, The Foundation Center, 1991) is intended as a starting point for grant-seekers looking for foundation, corporate and other charitable support for HIV/AIDS services and projects. It contains entries from grant-making foundations, public charities, and corporate giving programs that have shown interest in HIV/AIDS. The 1,446 grants listed represent approximately \$98 million in support of a variety of HIV/AIDS services and projects. In addition, the guide includes an AIDS funding bibliography and directory of the Foundation Center's publications and services. Contact: The Foundation Center, 79 Fifth Avenue/16th Street, New York, NY 10003, U.S.A. □

Letter to the Editor

Dear Editor,

Non-governmental organizations (NGOs) and AIDS Service Organizations (ASOs) have played a critical role in the first decade of the fight against AIDS, but that fact has not been reflected in the support that they have received from government. That must change. Prevention and education campaigns that are not rooted in the community do not work. Treatment and care facilities that do not reflect the needs of the community are not effective.

The issue of government support is not a simple question of funding for NGOs versus funding for government programmes. It is a question of support for community-based responses, whether those responses come from NGOs/ASOs, or from government health ministries working at a local level. Coordination of these efforts is essential, and with the recent creation of the International Council of AIDS Service Organizations (ICASO) and the growth of NGO regional networks, the time is long overdue for governments to recognize the importance of their work and to provide funding. The World Health Organization's Global Programme on AIDS and the National AIDS Control Programmes should be more fully supporting these efforts rather than attempting to do something for which they are fundamentally unsuited.

-- Jon Gates

Coordinator of Interagency Coalition on AIDS and Development,
Canadian Council for International Cooperation (CCIC)

Correction:

Our apologies to Blastus Mwiz-arubi, co-author of "Targetting Truckers in Tanzania," (A&S, April/May 1991) whose name was inadvertently misspelled.

*Politics Amid Prevention***NGOs and HIV/AIDS Prevention in Africa**

Rodger Yeager*

Relationships between governments and non-governmental organizations (NGOs) in Africa tend to be strained at best, and are often adversarial to an extreme. Given the importance of maximizing the contributions of all groups towards the prevention and control of HIV/AIDS, it may be useful to examine the reasons for those tensions, and consider approaches for alleviating them.

An important source of NGO-governmental discord may lie in differing assumptions about the processes involved in making public policy decisions. Development agencies tend to describe their activities in terms of distinctly Western notions. Public policy is seen to be the result of "rational" and "objective" problem solving processes that are only minimally influenced by the personal needs of those who make the decisions. Typically, however, many African governments are organized as corporate-like power systems, in which the ideal of "objective" problem-solving takes a back seat to the personal survival and advancement requirements of national leaders.

This situation often causes potentially "rational" policy interventions to be rejected, ignored, or neglected by those who control access to society's resources. Many governments have, for example, demonstrated a considerable reluctance to accept the risks of either placing HIV/AIDS high on the public agenda, or allowing others, including NGOs, to do the job for them. Specifically, behavioral intervention, such as promoting condom use, may be seen as politically dangerous for national leaders. In these policy settings, such important but sensitive activities might better be conducted by NGOs than by governments.

The experience of NGOs in response to national disasters provides an interesting contrast to their current role in responding to HIV/AIDS. Disaster relief is an example of an acute societal need in which the role of NGOs has been well established. Providing emergency aid during a drought, however, is an inherently less political undertaking than attempting to control the spread of HIV/AIDS. Droughts are singular events, whereas diseases represent complex and slower-acting processes. Events require a less sustained commitment, and because of their emergency nature, also allow national rulers a narrower opportunity to weigh political options. When NGOs attempt to conduct HIV/AIDS programs as they would carry out a disaster relief effort, they are likely to encounter bureaucratic obstacles of a radically different nature.

International donors as well as national ruling elites are prone to mistrust proposals to delegate significant autonomy to locally-based or foreign NGOs, perhaps especially

for work in controversial areas like HIV/AIDS prevention. The problem is closely associated with accountability mandates and the unwillingness of leaders to share power. At root, most NGOs are private, mission-oriented interest groups. Donors and national elite, however, perceive NGOs as programmatic supplements or at worst, as threats to their authority, and seek either to co-opt them or control their influence.

With this constraint in mind, NGOs can influence government heads and their financial supporters by encouraging them to view the entire range of HIV/AIDS issues from the perspectives of their enlightened self-interest -- most immediately in the contexts of political stabilization

and economic growth. NGOs communicate the positive effects of timely behavioral interventions and the negative consequences of inaction. NGOs should also attempt to identify elements of information-gathering, policy-making, and financial frameworks which are compatible with their own organizational missions, working within those structures whenever possible. They must also resist a tendency, common among NGOs operating in emer-

gency situations, to define their missions in terms of highly visible and highly specialized crisis management. In effect, NGOs must learn to identify which issues are critical to their missions and mandates and which are not, and to emphasize approaches that are compatible with the political realities of the settings in which they work.

Whatever the actual prevalence and demographics of HIV/AIDS within individual countries, NGOs should recognize that national policy-makers will themselves define the problem and specify the desired nature and scope of action. Behavioral interventions are most likely to be implemented if those in charge sense that they "own" (and can, to some extent, control) them. When this happens, rulers become more willing to commit to the effort as part of normal government responsibilities. If they are willing to be cast as supporting actors in this process, NGOs will find their most productive and sustainable niches.

The basic political challenge in managing Africa's HIV/AIDS pandemic will be to convert what can currently be characterized as power relations into problem-solving relations. For NGOs, the key to assisting in this transformation will be to recognize the nature of government decision-making processes, avoid characterizing HIV/AIDS as a one-time crisis, emphasize the positive socio-economic and political ramifications of prompt action, and strive to function within frameworks that both NGOs and national policy-makers deem appropriate. □

The basic political challenge in managing Africa's HIV/AIDS pandemic will be to convert what can currently be characterized as power relations into problem-solving relations.

Finding a Way to Respond AIDS Orphans

The National Council of International Health (NCIH) distributed a report in March 1991 entitled "Children Orphaned by AIDS: A Call for Action for NGOs and Donors," by Shamseh Poonawala and Rachel Cantor (1). This report provides a broad perspective on the AIDS orphan problem, and specific recommendations on the role of NGOs and the role of donor agencies. The following article draws extensively on that report.

Global disasters, such as war, famine, natural disasters, epidemics, and diseases, have historically claimed large numbers of lives, particularly in developing countries, usually either the very young or very old, or at most one parent. As a result, relatively few orphans have been left behind, and in most countries, these orphans could usually be cared for by their extended families. The current problem of AIDS, however, while killing some of the very young, primarily attacks their parents, leaving large numbers of orphans in need of care.

The Global Programme on AIDS (GPA) of the World Health Organization (WHO) predicts that worldwide by the year 2000 up to 10 million children will have contracted HIV, and another 10 million uninfected children under the age of 10 will be orphaned due to AIDS as their parents die from the disease (2). Models need to be developed for coping with this disastrous consequence of AIDS on children. Already, indigenous and international NGOs have begun providing direct services in areas heavily affected by HIV/AIDS. For example, World Vision/Uganda, through a program funded by the World Bank, (the Program for Alleviation of Poverty and Social Costs of Adjustments) works with orphans in a number of the most affected districts in Uganda. The project aims to assist orphans and their foster families by reinforcing community-based mechanisms for their support and by distributing limited material and financial resources. Yet the problems caused by children orphaned by AIDS are so large in scope and so unprecedented and complex in nature, that current facilities, infrastructures, resources, and NGO efforts are not enough.

NGOs, because of their technical expertise and traditional associations with local organizations, are often in ideal positions to assist overburdened governments, communities and families in developing strategies to meet this crisis. However, NGOs require the support of bilateral and multilateral donor agencies to implement such strategies. NCIH has identified broad guidelines for meeting this challenge and has defined them in terms of NGO and donor agency roles. The guidelines outlined below do not suggest that NGOs and donors take it upon themselves to implement the vast array of needed services and policy reforms. Instead, the guidelines are provided as suggestions of a variety of ways an organization can be involved in this difficult issue.

GUIDELINES FOR RESPONSE:

NGOs can:

- Pursue multi-sectoral solutions and increase information exchange and program coordination;
- Make appropriate balances between short-term assistance and long-term sustainable solutions;
- Give high priority to the maintenance of a child's sense of identity and his ties with family, clan and community;
- Involve local communities in all phases of project planning, implementation and evaluation;
- Provide women with counseling on the risk of perinatal transmission and make efforts to empower women to make their own reproductive choices;
- Ensure that there is no discrimination due to HIV infection by including all orphans identified in an area in an assistance program;
- Be advocates for human rights and social change.

Donors can:

- Encourage the pursuit of multi-sectoral solutions;
- Increase funding available to NGOs and improve the means of disbursing these funds;
- Support the efforts of NGOs by facilitating information exchange, funding and conducting research, offering strategic guidance and taking responsibility for program coordination;
- Ensure the sustainability of projects designed to assist children orphaned by AIDS;
- See that an improved legal, social, and economic status for women and children is pursued.

AIDS has raised issues that society has always been reluctant to discuss, such as discrimination, the status of women, and human sexuality. Collaboration has not been sufficiently emphasized. But now is the time for NGOs to forget their differences and work together. Now is the time for bilateral and multilateral agencies to assume responsibility for supporting the NGO response. Donors should take this opportunity to show their commitment to international partnerships with NGOs. The reward for this coordination and collaboration will be the prevention of thousands of infant deaths and improved lives for the millions orphaned.

Compiled by Sally Scott with information from Rachel Cantor and Elizabeth Levine.

1. For copies of the report, contact Shamseh Poonawala, Project Manager, AIDS Coordinator, at NCIH, 1701 K Street, N.W., Suite 600, Washington, DC 20006, U.S.A.

2. World Health Organization. WHO Press Release WHO/49, 25/9/90. □

Latin America and the Caribbean NGOs Working in AIDS

Pamela Hartigan*

Note: The contents of this article represent the views of its author and not necessarily those of the Pan American Health Organization.

AIDS is a relatively new phenomenon in Latin America and the Caribbean, the first cases emerging less than a decade ago. Almost immediately, however, community-based responses to the disease surfaced, beginning in Brazil where the epidemic spread rapidly. Most of these responses were catalyzed by individuals who had lost loved ones to AIDS. Initially, most of these groups were formed by individuals who themselves felt marginalized by societal norms that stigmatized their personal sexual preferences and behaviors. Many of these groups voiced frustration with non-existent or top-down governmental programs, expensive and ineffective AIDS education campaigns, and continued ostracism by the very national programs that were created to respond to the epidemic.

At first, AIDS service organizations (ASOs) were few in number, motivated primarily by visions of a world without discrimination towards sexual preference, but since the early 1980s, Latin America and the Caribbean have witnessed a mushrooming of NGO responses to AIDS. Mexico, for example, reports a total of 92 NGOs working in AIDS education, prevention and care (Figueroa, 1990). The current estimate for NGOs in the region is about 500. Analysis of the NGO response to AIDS provides insights into the features of different types of organizations that comprise the NGO universe, and helps us to understand the types of NGOs which might best tackle AIDS prevention and care. In the region, NGOs working in AIDS are engaged in one or more of the following functions: (1) education for prevention; (2) advocacy in support of specific AIDS-related policies in institutions that are responsible for providing health care services; (3) provision of services for persons with HIV infection and AIDS and their families; (4) networking for mutual exchange of experiences and joint formulation of policies and programs.

In addition, many NGOs working in AIDS address specific groups, i.e. male homosexuals; lesbians; heterosexual men and/or women; teenagers; street children; persons with HIV infection; prisoners; intravenous drug users; and so on.

Faced with a myriad of groups with differing objectives and capacities, it is important for development-oriented and/or donor organizations to be aware of characteristics and trends in the NGO response to AIDS and other health problems. The following observations concern the recent experience of NGOs working in AIDS in Latin America and the Caribbean.

1. Health promotion programs are intended to improve the living conditions of the people for whom they

are designed. Particularly in AIDS, prevention programs emphasize the maintenance or modification of particular behaviors which can only be affected when the pressure to change comes from within the individual or community and is not perceived to be imposed from without. This pressure from within is often generated by key individuals at the helm of NGOs who galvanize members to action. To date, NGOs offer a significant but underutilized potential to involve people in the formulation, execution and evaluation of health-related activities, including AIDS.

2. Donors often exercise inordinate influence on NGOs by directing support to certain activities, to the exclusion of others that may be more consistent with the goals of particular NGOs. Indigenous NGOs often act as barometers of community needs; that is, because they operate at the grassroots level, they are the first to be aware of changing health patterns and accompanying needs. For example, a number of NGOs in Latin America and the Caribbean are attempting to respond to the increasing demand for care for AIDS patients. However, they have found few donors willing to consider proposals to fund home-based care and/or hospice services. NGOs who wish to respond to this need find themselves pushing education and prevention proposals instead, thus compromising their desire to respond to the growing need for care of seropositive individuals and people with AIDS.

3. Persons with AIDS (PWAs), and NGOs which include PWAs, have unique contributions to make in planning and executing education, prevention and care programs. Ironically, the fact that they carry the deadly virus becomes their strongest asset, for they best know what educational efforts have a chance of driving home a message of prevention and are living proof that there is life after HIV infection.

4. In Latin America, and to a lesser extent in the Caribbean, much has been done through the media to debunk the image of AIDS as a "gay male disease," but the general public has yet to consider AIDS a serious threat to the heterosexual population. To date, almost all NGOs working in AIDS in Latin American countries were formed by homosexual men working with other gays and with commercial sex workers. There is an acute need to integrate non-gay concerns into the activities targeted by NGOs working in AIDS prevention and education, or run the risk of bypassing all other social groups which are sexually active and also at risk. These other groups tend to consider themselves socially, economically and behaviorally immune to HIV, partially because they do not identify with what they view as "core" or "high-risk groups." They tend, consequently, to be seriously misinformed. One way to reach these other groups is through NGOs that have been traditionally viewed as advocates of maternal-child health,

(continued page 7)

NGOs Working in AIDS (from page 6)

women, and youth organizations. These NGOs may have more experience executing effective community outreach among more "socially acceptable" groups.

5. The influx of funding gives rise to a special type of NGO which acts more like a business in the "development racket." AIDS is no exception. Unlike the mission-oriented NGOs which are motivated to work in AIDS (or other development issues) for primarily humanitarian reasons, these market-driven service contractors, although legally identified as not-for-profit, sell health services they know the market wants. Market-driven NGOs assess the availability of funds and tailor their commitments to coincide with shifting donor interests. One year it might be AIDS, the next year the environment, the next, child survival. Track record is critical in discerning these types of NGOs, and the success of an AIDS intervention may depend on the dynamics which motivate the mission-oriented as opposed to the market-driven NGO.

6. Donor emphasis on including NGOs in development projects can backfire as governments, seeking to tap funds directed to the not-for-profit entities, create GONGOs (government-organized NGOs) that compete for funding with indigenous mission-oriented NGOs. As donors push National AIDS Programs (NAPs) towards including NGOs in Medium Term Plans, NAPs can create GONGOs to work in AIDS education and prevention. Moreover, some NAPs select NGOs for their steering committees based on the degree of control they are able to have in these NGOs' activities, co-opting these already-existing NGOs by continuously funding them so long as they unquestioningly execute governmental programs.

7. While NGOs might have difficulties working with governments, they often have as much difficulty working with one another. This has been also true with AIDS, as groups vie for limited resources, often duplicating one another's efforts within the same geographical area. Emerging networks have been one way of diffusing the competition and duplication, as NGOs realize that joining forces with one another provides more leverage in influencing public policy, greater access to opportunities and a more equitable distribution of benefits. Regional and sub-regional networks are rapidly being formed by NGOs to pool scarce organizational know-how and share experiences and knowledge.

Strong arguments have been made as to the importance of NGO participation in AIDS policy formulation and program execution. However, caution must be taken that "participation" of NGOs does not turn into a way of making sure that the NGOs go along with the plans of the planners. Moreover, NGO participation does not lessen the responsibility of governments for the health needs of citizens with HIV infection and AIDS. In short, NGOs, governments, and donors have differing strengths which can shore up one another. In the context of AIDS, there is a clear case for a division of labor which makes maximum use of their differing strengths.

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News Briefs

□ **Australia:** A study of AIDS risk behaviors among South Australian prisoners found 42% of prisoners engaged in risk behaviors while incarcerated. Thirty-six percent of prisoners injected drugs intravenously, and 60% of those who did shared needles. In addition, 12% of prisoners engaged in anal intercourse. (Source: AIDS, Vol. 5, pp. 845)

□ **Germany:** In a recent interview, Federal Health Minister Gerde Hasselfeldt asserted that if German physicians did not undergo test for HIV infection voluntarily, the Government would have to consider stricter regulations. (Source: The Lancet, Vol. 338, August 10, 1991, p. 375)

□ **Great Britain:** The Fifth International Conference for People with HIV/AIDS met in London on 11-15 September 1991. About 600 people from over 50 countries took part in this largest-ever international gathering of people with HIV/AIDS. It represented an important step forward in the development of this potentially authoritative and important network. (Source: Shamseh Poonawala, NCIH)

□ **India:** Many private nursing homes and clinics in India are offering "rewarding gifts" to poor people willing to sell their kidneys for transplant, and the demand for those organs is high. AIDS specialists are concerned about the possibility of HIV transmission through infected donors. (Source: The Lancet, Vol. 335, June 22, 1991)

□ **Nicaragua:** The end of war has meant the beginnings of a new AIDS concern in Nicaragua, a nation that had many fewer AIDS cases (8 as of August 1990) than its neighbors, Honduras and El Salvador. With the return of ex-guerillas and refugees from camps in Honduras, 47 Nicaraguans have been found to be seropositive. Well over half of these are heterosexual. (Source: The Lancet, Vol. 337, April 20, 1991, pp. 967-968)

Dynamics of Networking (from page 1)

organizations (NGOs) have been consulting with each other to keep up to date with new information, to learn from each other's experiences, and to share information about funding sources. They have worked together to influence policies, programmes or actions of other groups or institutions. NGOs have found that the degree of influence that they can exert by working together can far exceed that of individual agencies working alone. They are able to influence government offices, funding agencies, information providers, and other NGOs or networks.

Informal networking among AIDS NGOs began with individuals, and more organized national and cross-national efforts soon developed. Examples of new multi-country networks of NGOs in developing countries include the Southern Africa Network of AIDS Service Organizations (SANASO) and the Latin American Network of Community-Based ASOs/NGOs (LANCOBAN). A global network exists for people with HIV/AIDS, increasingly focused on the International Steering Committee of People with HIV/AIDS. A Latin American group of persons with HIV/AIDS met for the first time in Bogota in December 1990. In the north, EuroCASO links NGOs working on AIDS in Europe; networking with nascent groups in Central and Eastern Europe is a growing part of its activities. Networks of church-based NGOs, with long histories in health promotion and care worldwide, are now increasingly involved in a response to AIDS.

The International Council of AIDS Service Organizations (ICASO), originally proposed in 1989 at the First International Meeting of AIDS Service Organizations, is becoming a point of reference for regional networks such as LANCOBAN and SANASO. ICASO is also a focus for the development of new regional networks among indigenous NGOs working on AIDS in North and West Africa, Asia, the Caribbean and the Pacific. ICASO is beginning to appear as a potential force on the world stage: regionally driven, providing basic information and advocacy in support of the practical and policy actions of community-based groups.

Another group of internationally-oriented NGO AIDS networks brings together the longer-established development NGOs that build AIDS components into their existing programmes -- for example, in primary health care or provision of basic health or educational services. These networks exist in the home countries of NGOs that work internationally. At least six such networks have been formed: in Canada, France, Denmark, the Netherlands,

Norway, the United Kingdom and the United States. Of these, the Canadian, U.K. and U.S. coalitions are the most active. In addition, the development NGOs in the Australian Council For Overseas Aid (ACFOA) are increasing their AIDS activities in a new alliance with the Australian Federation of AIDS Organizations (AFAO), which works with community-based organizations in Asia and the Pacific, as well as in Australia.

The hardships facing NGO networks are amplified when they operate internationally. The most obvious reason, of course, is that it is difficult to communicate over

long distances, especially for NGOs lacking communications budgets, equipment or skills. Other important potential constraints or operational difficulties include: conflicting ideologies and interests, especially in members' non-AIDS-specific agendas; difficulty in reaching agreement on achievable goals and activities; maintaining the independence of network members; and the sustainability of networks run by volunteers.

Networks may go through phases that reflect members' interests, changing priorities, or quality of leadership. Differences and disagreements among organizations may become stronger than the common goals that originally held them together; networks may weaken or dissolve as a result. This transience need not be interpreted negatively: networks do form and fade away, membership does rise and fall, objectives do evolve.

What general conclusions can we draw from the experience of national and international NGO networks to date? The first is the need for **flexibility**: members will put more effort into a network when it has potential for meeting their needs. It is important to allow for a change in network priorities as members' own priorities change.

Second, public bodies need to express their **recognition** of effective or potentially effective networks. This is vital for morale and is a cornerstone of cooperation. The networks, too, find cooperation easier when they recognise the strengths and limitations of public bodies, including national AIDS programmes.

Third, it is vitally important that networks set **achievable objectives**, avoiding the temptation to satisfy all the aspirations of all the members. This implies a need to set initial goals and then whittle them down to what can readily be achieved. Grandiose plans are less likely to find support, especially with potential donors; members are also more likely to lose interest when they realize their goals are unattainable.

ACHIEVABLE GOALS FOR NETWORKS OPERATING INTERNATIONALLY:

- **Sharing information on technical aspects of AIDS, programme and policy activities, and fundraising.**
- **Taking joint action to raise public awareness, influence public policy, obtain recognition for member organizations' work, and generating collaboration among NGOs and between NGOs and public bodies such as national AIDS programmes.**

Expanding Partnerships (from page 1)

is much competition for the corporate philanthropic dollar. Secondly, NGOs can receive noncash contributions from the corporate sector in the form of "gifts-in-kind."

An area of great potential growth for NGO funding, and one with the possibility of receiving sustainable, long-term corporate support, is the provision of AIDS education and prevention services and condom distribution programs to employees and their dependents. Finally, NGOs can also encourage companies to implement AIDS program initiatives that benefit the community at large.

Motivating Corporations to Philanthropy

The key to approaching the corporate sector is to understand corporate motivation. According to Paul Ross, Manager of AIDS Programs, Digital Corporation, "The difference between corporations and foundations is that corporate contributors often align themselves with the interests of their customers."

Many companies are socially conscious and are interested in their employees' welfare. AIDS has hit hardest in the most economically productive age group: young to middle-aged adults in the work force. The loss of skilled workers because of AIDS, increasing employee absenteeism, and the cost of training new staff provide economic incentives for companies to protect their employees.

NGOs can improve corporate visibility in the community by publicizing corporate contributions for AIDS programs at the community level. These contributions can be made either in cash, staff time or local materials. Also, many multinational companies operating abroad make profits in local currency which must be reinvested locally. NGOs can convince companies to invest some of this money in HIV prevention activities. NGOs must demonstrate imaginative approaches and effective uses of resources in ways which will benefit their constituencies and society at large.

Advantages and Limitations

There are several advantages to working with the corporate sector. Companies are less bureaucratic than public agencies, so programs can be established with little delay. Working together NGOs and private companies can reach people in dispersed communities. For example in Zimbabwe, by working with the commercial farming sector, the AIDSTECH AIDS prevention program has access to nearly 1.25 million agricultural workers and dependents through 8 regional branches and 73 grassroots farmers' associations. Worksites are an effective arena for educators to reach the same audiences repeatedly with a consistent message, and NGOs establishing fee-for-service worksite programs are assured of sustained funding.

Unfortunately, there are also limitations to NGO/corporate sector partnerships. Often, financial contributions from the corporate sector are short-term, one-time grants. NGOs can approach the corporate sector to fund discrete projects such as AIDS education workshops, or to donate material resources, such as medical supplies for the

home care of persons with AIDS. When distributing commercial products, NGOs must ensure that controls are in place to prevent the products from being sold for profit.

A primary concern of industrial corporations is efficient production. NGOs should avoid implementation of new projects during the busiest season of the production cycle, and should ensure that implementation does not interfere with business. For example, education sessions for workers must start and end on time so as not to keep the employees from completing their work.

Strategies of Approach

1. First and foremost, NGOs must prove their credibility. NGOs can gain support from governments by establishing relationships with the National AIDS Program and complementing its efforts. A letter of support from the NAP can assist in opening doors in the corporate sector. Building up the prestige of the NGO's board of directors is another way to establish credibility. A board including key members of the community is vital to establishing links with the corporate sector.

2. NGOs must develop contacts that will provide access to senior management of corporations. Cold calling or formal letters to management are not effective. NGOs should take a personalized approach. Influential board members can provide an introduction to senior corporate decision-makers. NGOs can also host networking receptions to promote the health benefits and cost savings of AIDS prevention and education programs to individual companies. The Family Health Trust (FHT), an NGO established in Zambia, mounted a deliberate program to reach the corporate sector. A reception was held targeting upper level management of large companies including the banks in Lusaka. The video, "It's not Easy" was shown and the corporate executives were informed of the impact of AIDS on their staffs and their profits. FHT convinced the managers of the importance of investing in AIDS education as a means of preventing employee absenteeism and high turnover rates. As a result of that program, Barclays Bank provided funds to cover the cost of operating a vehicle for the home-based care AIDS project, Zambia Airways provided airline tickets for staff training overseas, and a local textile company donated blankets for the orphans program.

3. When soliciting from the corporate sector, NGOs must organize a team to make presentations to senior management representatives. Successful solicitation requires that the team possess program knowledge and expertise as well as good business sense. NGOs should ensure that the AIDS project manager is present to answer any technical questions, but the presentation itself should be led by the business representative.

4. Too often, NGOs approach a potential donor with a list of "what you can do for us." A more effective approach is to make clear "what we can do for you." If an NGO knows a corporation's key constituencies, the demographics of its employees, and the nature of the company's

*The Kenya Experience***The Benefits of a Consortium Approach**

Tina Wiseman*

There are now many examples of successful and innovative AIDS projects that have been initiated and implemented by NGOs worldwide. This has resulted in an increasing awareness of the valuable contributions NGOs may make and, in the case of Kenya, has led to government requests for greater NGO participation in the AIDS program. However, little is known about the problems that NGOs may face in responding to such a request. In Kenya, an NGO consortium was formed in 1990. The following discussion of this consortium's formation may offer useful insights into both the problems and possible solutions. Although this example comes from Kenya, the issues raised could be of importance in any country.

During the first meeting of the consortium, major problems of concern to NGOs were clarified and summarized as follows:

- The degree of NGO involvement in the National AIDS Program design had been limited and had resulted in a feeling that they were being deliberately excluded from the program. The Medium Term Plan for AIDS control made no specific statement about the role that NGOs could play, nor did it make provision for their future involvement.

- Government efforts to coordinate the program were perceived in a negative sense as a form of "control" and with a reluctant attitude towards NGO involvement.

- Communication channels with government and amongst NGOs were limited to those few NGOs which had initiated activities early on in the program or those who had been invited to become members of the various AIDS committees. However, they had no obligation to share information with the wider NGO community and there were no formal channels through which this could have been done.

- Awareness of funding availability was also limited, and many NGOs were not actively participating in the AIDS program apparently because they were not familiar with the possible sources of funding.

- Accountability and reporting mechanisms were of increasing concern to both government and implementors as the programs became more complex. The disparate reporting requirements of government and funding agencies made the situation even more difficult.

- Duplication of efforts and "black holes" of non-activity were highlighted as issues needing more attention; the former was not regarded as problematic per se if resulting from deliberate action, while the latter was a cause for concern.

- A lack of information sharing and official "control" of information had resulted in many NGOs feeling unsure of the procedures required for participation in the AIDS program. They had also been unable to benefit from the

experience of the participating NGOs.

- Many NGOs felt that support and recognition of their efforts were important, particularly in terms of sustainability of the overall program.

- Skills sharing and joint implementation of projects had not been evident and this was felt to be a waste of valuable resources.

In looking at the impact of the consortium on the above issues, certain benefits can be identified. No attempt has been made to prioritize these and therefore no inference should be drawn from the order in which they appear below. During its first meeting, the members of the consortium elected a number of NGO representatives to sit as members of the various AIDS committees and act as a conduit for the flow of information to and from those committees. At subsequent meetings of consortium, these representatives were then able to share valuable insights into the priorities, problems, and general status of the AIDS program. At the same time, a representative from the AIDS Programme Secretariat was invited to attend consortium meetings, ensuring a regular dialogue with government. Previous misunderstandings were clarified and procedures necessary for participation in the AIDS program were explained. The positive and supportive attitude on the part of government towards the participation of the NGO representatives on the AIDS committees is worthy of mention here.

Information was also collected from the NGO participants concerning their present and planned AIDS related activities. Information was given verbally and in a questionnaire, the results of which were subsequently circulated to participants in report form. It was apparent that not all interested NGOs would be able to attend all the meetings of the consortium, so considerable effort was put into compiling a comprehensive mailing list. The degree of information and skills sharing that resulted was remarkable. In one case, an NGO carrying out AIDS education with urban slum dwellers felt that they could not produce the needed materials for educating non-literate adults. Another NGO which had already produced a cartoon style magazine for children offered to collaborate in producing the materials. In another case, an AIDS support group offered advice and practical assistance to NGOs unfamiliar with the needs of people affected by HIV and AIDS.

This sharing of information also led to a recognition of the valuable contributions made by many NGOs to the AIDS program in Kenya. The resulting psychological benefit to the participants was an unforeseen but extremely valuable outcome of the meetings. One would expect that this aspect of the consortium will become more important with time, as the numbers of AIDS cases continue to increase and implementors face possibly growing criticism

Alliances for AIDS Prevention NGOs and Government Agencies

Much of the AIDS prevention work of NGOs focuses on relatively small target populations. The strength of many NGOs lies in their ability to work effectively within defined geographical limits, or with groups having special characteristics, such as health providers, sex workers, or traditional healers. However, another important role for some NGOs can be the catalyzing of national efforts in AIDS prevention. Three NGOs currently involved in cooperative AIDS projects at a national level are Africare in Nigeria, World Vision International in Uganda, and Project HOPE in Swaziland.

Africare has been providing technical, material, and financial assistance to Nigeria's national AIDS prevention program. In concert with CEDPA (the Center for Development and Population Activities, based in Washington, DC) Africare co-sponsored a 1988 national policy workshop conducted by the Federal Government of Nigeria to update senior policy makers and technical staff on the AIDS pandemic, present to them the national AIDS strategy, and facilitate the development of regional strategies for the four health zones into which Nigerian states are organized for the purpose of coordinating federal and state-level programs. The workshop itself and various follow-up programs were undertaken in concert with Nigeria's Federal and State Ministries of Health, its national and state Expert Advisory Committees on AIDS, and the World Health Organization.

World Vision International is involved in a collaborative effort with the Government of Uganda to undertake the AIDS orphan component of the PAPSCA program

(Programme for the Alleviation of Poverty and Social Costs of Adjustments). The three year programme is to be carried out in the Masaka and Rakai districts, which are among the areas most devastated by AIDS. The programme tries to ensure a proper home environment for children orphaned by AIDS, and provides additional funds for schooling or vocational development. In addition, the NGO has undertaken a baseline survey of orphans and foster parents as a means of monitoring and evaluating intervention efforts.

In Swaziland, Project HOPE collaborates with a national NGO, the Family Life Association of Swaziland (FLAS), to carry out education and training in AIDS prevention and counseling for clinic workers nationwide. The HOPE/FLAS project also works with other national groups, such as the adult literacy organization SEBENTA, the organization of traditional healers, and several local businesses, to train staff in HIV/AIDS prevention. They have been successful in using local print and broadcast media to draw attention to their activities, and expect to expand their training and mass media efforts in the near future.

Whether NGOs act as catalysts for national AIDS prevention efforts, or participate in collaborative programs with state or federal agencies, when NGOs and governments can work together, AIDS efforts can be more efficient, and often are less costly as well.

Compiled by Bridget Mazur with information from Alan Alemian (Africare), Mary Anne Mercer (HOPE/FLAS Project), and R.M. Namuli Nyonyintono (World Vision International). □

Benefits of a Consortium Approach (from page 10)

of their efforts.

A staff member from the WHO/GPA team in Geneva attended a specially convened meeting of the consortium to inform participants of funding availability. Over 40 NGOs were represented at the meeting, and it is worth noting that the meeting would have been far more difficult to arrange had the consortium not already been in existence.

Increasing availability of information enabled the AIDS Programme staff to coordinate activities more effectively. NGOs were able to make much more informed decisions regarding their planned activities, taking into account possible areas of duplication and "black holes" of non-activity. The greater the number of implementors, the more important these issues become.

Without a doubt, the motivation for forming a consortium came from the need for more information among NGOs. Prior to the formation of the consortium, there had been other meetings for NGOs but these had not been continued on any regular basis and had therefore been of limited value. From its inception, the consortium had acknowledged the need for regular meetings in order

to establish permanent communication mechanisms and was supported in this aim by the AIDS Programme Secretariat and WHO/GPA staff. The meetings were facilitated and chaired by UNICEF Kenya at the request of the NGO community.

During 1990, three meetings of the consortium were held and the high level of attendance suggested a degree of commitment that was surprising in NGOs coping with already busy schedules. Participants expressed the desire for meetings to continue because they valued the personal contacts that they had been able to make. The opportunity to meet and discuss issues face to face was acknowledged as being one of the most useful aspects of the consortium. In concluding, it would be fair to say that the existence of the consortium rapidly opened up new possibilities for information exchange that enabled many more NGOs to become actively involved in the AIDS program. This process would probably have happened anyway, but it would have taken much more time, a luxury we can ill afford in implementing AIDS control programs. □

ICASO: A Model for an NGO Unified Response Against AIDS

Rita Arauz and Juan Jacobo Hernandez-Chavez*

The International Council of AIDS Service Organizations (ICASO) was founded in 1989 with the support of the World Health Organization's Global Programme on AIDS. The most recent meeting of ICASO's Council of Representatives took place this past June during the VII International Conference on AIDS in Florence, Italy. As an international consortium of AIDS service organizations (ASOs), ICASO's intent is to deal with AIDS from a broader perspective which includes advocacy for the contribution of voluntary community organizations in prevention, access to care, support services, education and human rights advocacy.

At the Florence meeting, the Council of Representatives overwhelmingly endorsed the need for a strong organization that will be able to carry out the mission of ICASO. This mission was defined as the promotion of non-governmental organizations (NGOs) and in particular, community-based AIDS service organizations (ASOs) as vehicles for appropriate and effective responses to HIV/AIDS. Particular emphasis was placed on resource-poor communities and affected groups.

ICASO is further guided by eleven formally established principles. These include: the right of equal access to AIDS prevention; the rights of persons with HIV to be free of discrimination; ASO solidarity and autonomy; promotion of partnership with governmental and international AIDS service providers and funders of AIDS activities; and respect for the diversity of approaches and treatments consistent with ICASO's basic beliefs.

The development and expansion of a base for ICASO's

operation is becoming firmly rooted as regional ASO networks are beginning to convene, giving additional substance to the construction of the umbrella organization. Europe, Africa and Latin America and the Caribbean have already held formal regional conferences and are searching for models and approaches to networking and advocacy, trying to exchange training activities and financial assistance.

Concerned community leaders from each global region have completed the next steps in this advocacy organization to represent the needs of the heavily burdened and under-funded HIV/AIDS community groups. ICASO intends to keep attention focused upon the flood of infections and the difficulty of accessing needed resources, particularly within poorer communities and in the developing nations of the world.

The importance of this approach lies in the fact that the constituents of ICASO are all NGOs dealing directly with individuals, families, communities and affected groups on AIDS issues. NGOs, as community-based, mission-oriented groups, are frequently more effective than governmental organizations which tend to be constrained by religious and/or political persuasions. As such, NGOs are crucial to public education about AIDS, a role which the World Health Organization's Global Programme on AIDS has come to acknowledge. ICASO will continue to build its global base of support as a response against AIDS drawing from the expertise and flexibility of NGOs operating in communities throughout the world. □

Expanding Partnerships (from page 9)

business, they can design an AIDS program to benefit the company.

5. NGOs must be familiar with the corporations' funding cycle and funding pattern.

6. NGOs can interest companies in AIDS prevention programs by starting small and demonstrating past successes. It is extremely important to develop a model and demonstrate its effectiveness before attempting to replicate it on a larger scale. Project Hope, a U.S. based NGO, established a child survival and AIDS prevention program with tea and coffee estates in Malawi by initially approaching one major company. A base-line survey was conducted at the company to illustrate the benefits of such programs for the estates. Success of the program generated interest among the other estate owners, and as of September 1991, Project Hope was working with 39 of 43 estates in Malawi.

7. Corporations, like all donor organizations, prefer to fund programs that build on partnership. Proposals showing NGO collaboration may be more favorably received. Also, corporations may more readily provide funds to

match grants from other sources.

8. Lastly, NGOs must be equipped to quickly respond to any corporate inquiry.

Summary

Corporations have become increasingly supportive of preventive health and family support programs which benefit employees and their families. Many communities already offer programs in family planning, maternal/child health, and daycare services. Where possible, NGOs should look to the organizers of these programs and learn from their experiences in promoting and implementing these preventive health care programs.

The successful promotion of AIDS education and prevention programs to the corporate sector will also require the development and refinement of new, specialized approaches and strategies. Here we, as NGOs, are just beginning to learn what works and doesn't work; as we continue to share the results of our promotional campaigns, we will continue to develop a more effective and efficient corporate sector strategy. □

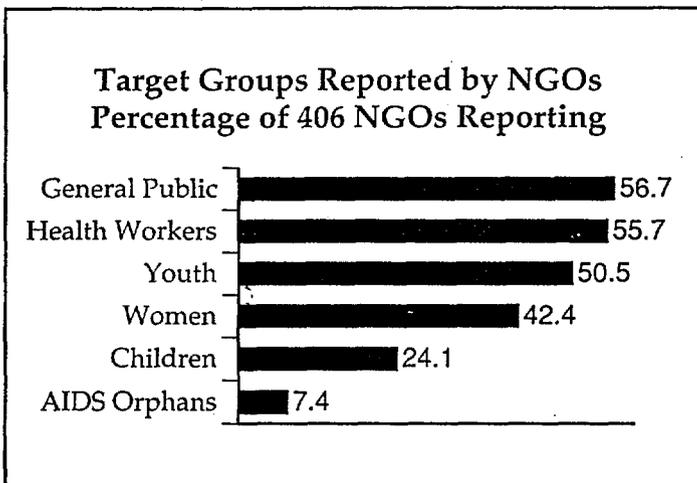
*authors' biographies, back page

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NGO Inventory Reveals Trends in AIDS Care and Prevention

Inventory of Nongovernmental Organizations Working on AIDS in Countries that Receive Developmental Cooperation or Assistance, a directory designed to facilitate networking between NGOs in the developing world, has been released. Now in its second edition, the inventory includes information on over 400 NGOs in 77 countries.

The information provided includes the main AIDS-related activities carried out by individual NGOs, funding sources, and organizations to which financial support is provided. For ease of use, the directory is cross-referenced by four categories: type of organization, countries where the NGOs operate, main AIDS-related activities, and target groups.



Of the 406 NGOs responding to the directory questionnaire, more than half reported AIDS work based in Africa. Uganda was the most-mentioned African nation with 74 NGOs in service. Mexico and Brazil also had significant amounts of AIDS-related NGO activity; each was named by 30 or more NGOs.

AIDS Networks

International Council Proposed

As plans move forward for ICASO, (see article page 12) another proposition is circulating among international NGOs concerned indirectly with AIDS: to bring together a group of international NGOs to form a Council of World Organizations Concerned About AIDS, or CWOCAA.

The CWOCAA would be distinct from ICASO in that the member organizations would be international, not national in scope. In addition, the primary concern of these groups would not be AIDS, but would relate to AIDS. It would include, for instance, such organizations as the League of the Red Cross and Red Crescent Societies, and the International Council of Nurses to name but a few.

The value of the CWOCAA would result from the unique ability of the Council to bring together organiza-

AIDS-Related Activities Listed by NGOs

n=406 NGOs Reporting

72.7%	Provide Education/Info for Specific Groups
55.2%	Provide Education/Info for the General Public
51.5%	Offer AIDS Counseling
43.4%	Are Involved in Community Development
42.4%	Provide Primary Health Care
33.0%	Conduct Counselor Training
26.1%	Offer Family Planning Services
25.6%	Supervise Home Care for AIDS Patients
22.9%	Offer Sexually Transmitted Disease Program
20.7%	Conduct Research
18.2%	Perform Blood Testing for Prevention or Care
7.6%	Offer Drug Abuse Counseling

Of all NGOs responding, 28% classified themselves as national NGOs; 25% described themselves as international NGOs, and 14% described themselves as religious organizations.

Eighty of the 406 NGOs geared some portion of their program toward commercial sex workers, and 75 reported targeting homosexuals. Forty-one of the 406 offered services to IV Drug Users. Migrant workers and transport drivers were mentioned by nearly 10% of the organizations reporting, which reflects a rising concern for those groups. Only 3 NGOs had programs aimed at teachers and traditional healers.

The inventory was prepared on behalf of the World Health Organization Global Programme on AIDS by the United Nations Non-Governmental Liason Service. An electronic version of the directory has been prepared for computer use, and abbreviated versions of the document will be available in French and Spanish later this year. Contact: Bob Grose, WHO/GPA, Avenue Appia, CH-1211, Geneva 27, Switzerland. □

tions with resources and expertise in areas other than HIV-related illness, knowledge, and skills essential in the global fight against AIDS. CWOCAA could deliberate and catalyze action on particular aspects of global AIDS, including: human rights; maternal and child health; social and economic development; etc. At the same time, CWOCAA could serve to represent the diverse international NGO community in deliberative forums called by governments or the United Nations and its specialized agencies.

International NGO representatives interested in learning more about the proposed CWOCAA and how they can become involved in its planning and development should contact: George Worthington, Worthington Associates Worldwide, 3D 345 West 21st Street, New York, NY 10011-3059, U.S.A. Tel/FAX (212) 243-5883. □

AIDS Publications

Laboratory HIV Testing Guide

HIV Testing and Quality Control is a resource guide for laboratory program managers, national program managers, laboratory trainees, and others concerned with the prevention and control of HIV/AIDS. Authors Constantine, Watts, and Callahan have taught HIV testing workshops in developing countries for over three years, and developed insight into laboratory problems. The 180-page guide provides laboratory managers and supervisors with background needed to manage an effective and efficient HIV testing program in the developed or in the developing world. Special features include explanations of the principles and interpretation of HIV screening and confirmatory tests, quality assurance guidelines, and standards for laboratory safety. The book is available within the continental U.S. for \$2.00 per copy (\$10 per copy elsewhere). Spanish and French editions will soon be available. Contact: HIV Testing Guide, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709, U.S.A. □

African Field Reports

Tradition and Transition, a collection of papers from the 1990 HIV/AIDS Prevention in Africa (HAPA) Grants field workshop in Zimbabwe is available for \$2.00/copy to addresses within the U.S., and \$5.00/copy elsewhere. Papers focus on the cultural context of AIDS prevention and care, religious and social traditions influencing sexual behavior, and the cultural barriers facing women living in an AIDS pandemic. Broad programmatic issues facing NGOs are also discussed. Contact: The HAPA Support Program, The JHU Institute for International Programs, 103 East Mount Royal Ave., Baltimore, MD 21202, U.S.A. □

AIDS and Women: The Politics of Survival

The International Journal of Health Services (Vol. 21, No. 1, 1991) recently featured a special section on Women and AIDS. Kathryn Caravano's piece, "More than Mothers and Whores: Redefining the AIDS Prevention Needs of Women," addresses issues of inequality from a global perspective, and asserts the need for women to have control over their own sexuality. "Women and AIDS in Zimbabwe: The Making of an Epidemic," by Mary Bassett and Marvellous Mhloyi examines how the intersection of traditional culture with the colonial legacy and present-day political economy has influenced family structure and the social position of women. A final article, "Human Immunodeficiency Virus and Migrant Labor in South Africa," by Karen Jochelson, Monyaola Mothibeli, and Jean-Patrick Leger investigates the impact of South Africa's migrant labor systems on heterosexual relationships and assesses the implications for HIV transmission. □

Special Section: The Threat of AIDS

The March/April issue of The Courier: Africa-Caribbean-Pacific-European Community featured a dossier on AIDS, including an interview with Michael Merson, Director of the World Health Organization's Global Programme on AIDS. In addition, it included articles on the social implications of the AIDS pandemic, AIDS and women, and AIDS orphans. Contact: The ACP-EEC Courier, Berlaymont 5/2, 200, rue de la Loi, 1049 Brussels, Belgium. □

New AIDS Quarterly

The World Health Organization's Global Programme on AIDS (WHO/GPA) is now publishing French and English versions of a quarterly newsletter, Global AIDS News, outlining GPA's efforts in curtailing the pandemic. □

Guide to Films on AIDS

Seeing Through AIDS: A Guide to Over 70 of the Best Films and Videos on AIDS and AIDS-Related Issues (2nd edition), a 40-page guide, is now available for \$6.50 from Alternative Media Information Center, 121 Fulton Street, 5th Floor, New York, NY 10038, U.S.A. □

Treatment Directory

The HIV/AIDS Treatment Directory is available for a yearly subscription of U.S. \$44.00 (\$60.00 outside of the U.S.). The guide includes updates on HIV infection treatments and clinical trials, indices, and glossaries of all sites of NIAID AIDS Clinical Trials Group Centers, plus reviews of emerging topics in clinical management and research. Contact: AmFAR Treatment Directory, 6020 North Lindbergh Boulevard, St. Louis, MO 63042, U.S.A. □

Special issue: AIDS Prevention

Family Health International Network's special issue on AIDS prevention features strategies for behavior change, intervention models, and evaluation strategies for AIDS interventions. Contact: Debbie Wade, FHI, Box 13950, Research Triangle Park, NC 27709, U.S.A. □

Dynamics of Networking (from page 8)

The networks of NGOs working locally and internationally on HIV/AIDS have tremendous potential power and authority. Ultimately, their impact will result from improving community-level action in prevention or care. The networks mentioned above work to strengthen local action at the same time as operating strategically and globally to support it. An objective of the World Health Organization's Global AIDS Strategy is to unify and coordinate the international and national effort. Building, strengthening and linking local, national and international NGO networks is a central element in achieving this goal. □

Resources for Training in HIV/AIDS Prevention

Compiled by Sally J. Scott*

Books and Manuals

The Handbook for AIDS Prevention in Africa

Publications Assistant, AIDS Prevention Handbook, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709 U.S.A. Phone: (919) 544-7040, Telex: 579442, Cable: FAMHEALTH, Fax: (919) 544-7261.

- Each chapter, written by a team of experts, gives precise information on subjects ranging from HIV testing to evaluation. (1990)

Training of Trainers for AIDS Education

Save the Children, Health Unit, 54 Wilton Road, Westport, CT 06880, U.S.A. Phone: (203) 221-4000.

- A wide-ranging manual developed by Save the Children U.S.A. to be adapted to the local context and serve as a curriculum and guide for training trainers in AIDS prevention education. (1991)

Love and AIDS

The Community AIDS Information and Support Centre, P.O. Box 1477, Johannesburg 2000, The Republic of South Africa. Phone: (011) 725-6740, Fax: (011) 403-1069.

- A comic book which tells, in a frank and entertaining style, the story of four urban black South Africans and their response to the AIDS threat. (1990)

Tools for Program Evaluation

Sharon Weir, at the Family Health International address. (see above)

- Compiled to assist AIDSTECH staff who develop and monitor programs, by describing evaluation strategies, methods, models and examples that can be adapted to specific programs. (1990)

Training in AIDS Counselling: A Manual for Use by Trainers

Centre for Development and Population Activities (CEDPA), Project HOPE and the Family Life Association of Swaziland. Order copies through: Marjorie Souder, Ph.D., Project HOPE, Health Sciences Education Center, Millwood, VA 22646, U.S.A. Phone: (703) 837-2100.

- Developed for use in training HIV/AIDS counselors in Swaziland, this manual offers a thorough step-by-step guide to the training process, with extensive use of handouts, case studies, and role-playing exercises. (1991)

You Can Help Crush AIDS

Pied Crow's Environment Special Magazine, CARE-Kenya, P.O. Box 43864, Nairobi, Kenya. Also available through: Zoe Kopp, Deputy Director PHC Unit, CARE, 600 First Avenue, New York, NY 10016, U.S.A.

- A colorful and amusing comic book which illustrates how the HIV virus is and is not spread, and includes additional information for discussion and ideas for teachers and AIDS educators. (1988)

Preventing a Crisis: AIDS and Family Planning Work

Gill Gordon and Tony Klouda, The AIDS Prevention Unit, International Planned Parenthood Federation, P.O. Box 759, Inner Circle, Regent's Park, London NW1 4LQ, U.K. Phone: 01-486-0741, Telex: 919573, Cable: IP-EPEE LONDON.

- An extremely readable book originally written for the staff of family planning organizations; includes specific information and graphics which many other types of non-governmental organizations are certain to find relevant. (1988)

Videos

Born in Africa

12300 Coppola Drive, Potomac, MD 20854, U.S.A.

- This powerful video tells the story of Ugandan singer Philly Lutuya, a superstar who discussed his AIDS diagnosis publicly and despite stigma and illness traveled extensively to educate Ugandans about HIV/AIDS.

It's Not Easy

AIDSCOM, c/o Academy for Educational Development, 1255-23rd Street N.W., Washington, DC 20037, U.S.A. Phone: (202) 862-1900, Fax: (202) 862-1947.

- NGOs working in Africa are finding that this drama (filmed in Uganda) depicting two urban middle-income couples facing and overcoming the stigma and fear of AIDS is an effective tool in both training and educational sessions.

TASO - Living Positively and Counselling

TALC (Teaching AIDS at Low Cost), P.O. Box 49, St. Albans, Hertfordshire AL1 4AX, U.K. Phone: 0727-53869, Fax: 0727-46852. Telex: 266020 CORALP G Ref. TALC.

- Using a mix of documentary and educational styles, this video presents the work of The AIDS Service Organization, a Ugandan NGO that counsels and cares for PWAs and their families.

Taking Drugs Seriously

The Atlantic Project, 20 Fir Road, Waterloo, Merseyside L22 4QL, England.

- A film by Allan Parry about the radical drugs and AIDS strategy in Liverpool, England, intended for educators, health professionals, and policymakers. □

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Authors' Biographies

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Rodger Yeager, Ph.D, is Professor of Political Science and Adjunct Professor of African History at West Virginia University. Currently researching policy aspects of environmental conservation, he has worked in Africa for the past 25 years.

Conference Calendar

Second International Workshop on HIV Risk Reduction. Thirty day workshop at Israel's Hebrew University. Contact: Dr. Ronny Shtarkshall, Hebrew University, School of Public Health, P.O.B. 1172, Jerusalem, 91010 Israel. Tel. (972/2) 447-110.	Oct. 29- Nov. 27 1991	Jerusalem, Israel
Second Annual AIDS Prevention Conference. Contact: AIDSCOM, 1255 23rd Street, NW, Washington, DC, 22037, U.S.A.	Nov. 4-5 1991	Rosslyn, VA U.S.A.
Responsible Sexology, Annual Meeting of the Society for the Scientific Study of Sex. Contact: Howard Ruppel, Jr., Executive Director, S.S.S.S., P.O. Box 208, Mount Vernon, IA, 52314, U.S.A. Tel. (319) 895-8407.	Nov. 7-10 1991	New Orleans, LA, U.S.A.
American Public Health Association, 119th Annual Meeting; World Federation of Public Health 6th International Congress. Contact: Meeting Registrar, 1015 15th Street, NW, Washington, DC 20005, U.S.A.	Nov. 10-14 1991	Atlanta, GA U.S.A.
Nursing in HIV/AIDS Care -- The Challenge of the Nineties. The Second European Conference for Nurses in AIDS Care. Contact: Conference Organizers, Tel. (31/0) 20 6793411.	Nov. 19-22 1991	Noordwij- -kerhout, Netherlands
American Anthropological Association, Annual Meeting. Contact: Douglas Feldman, University of Miami, R-669, P. O. Box 016609, Miami, FL 33101, U.S.A. Tel. (305) 547-6559.	Nov. 20-24 1991	Chicago, IL U.S.A.
VI International Conference on AIDS in Africa. Contact: Management and Communication International (MCI), PB Box 4000, Dakar, Senegal. Tel. (221) 24 24 00; FAX (221) 24 04 63.	Dec. 9-12 1991	Dakar, Senegal
Third International Conference on the Reduction of Drug-Related Harm. Contact: Conference Administrator, P. O. Box 529, South Melbourne, Victoria 3205, Australia. Tel. (61/3) 690-6000; FAX (61/3) 690-3271.	Mar. 23-26 1992	Melbourne, Australia
Sexuality: New Visions. Annual Guelph Conference on Sexuality. Contact: Division of Continuing Education, University of Guelph, Guelph, Ontario N1G 2W1, Canada. Tel. (519) 767-5000; FAX (519) 767-0758.	June 15-17 1992	Guelph, Ont. Canada
VIII International Conference on AIDS. Contact: Harvard AIDS Institute, 8 Story Street, Cambridge, MA 02138, U.S.A. Tel. (617) 495-0478.	June 19-24 1992	Amsterdam, Netherlands
Second International Conference on AIDS and Street Youth, a Satellite Conference of the XXth International Conference of Pediatrics. Contact: HIV Adolescent Studies Group, 722 W. 168th St., Box 29, New York, NY 10032, U.S.A. Tel. (212) 740-7323. Or: Barow de Lucena 32, Botafogo, Rio de Janeiro, Brazil 22260. Tel. (55/21) 266-0048.	Sept. 4-5 1992	Rio de Janeiro, Brazil

The role of non-governmental organizations in the global response to AIDS

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Introduction

As the epidemic of HIV infection and AIDS continues to expand to all corners of the globe, it is clear that every sector of society must respond. AIDS has ceased to be a concern just of health authorities; the potential impact of AIDS makes it a challenge in economic, political, social, and religious spheres as well.

Among the organizations responding to the crisis, non-governmental organizations (NGOs) are emerging as a powerful force in the effort to contain the epidemic. From 'street kids' in Zambia and prostitutes in Brazil to gay men in India, diverse groups at risk of HIV infection have been reached by NGOs in a wide variety of innovative programmes.

Who are NGOs?

The term 'non-governmental organizations' applies to diverse organizations that "work together outside of government to address a need, advance a cause or defend an interest" (Brodhead & O'Malley, 1989). The World Bank uses a somewhat narrower definition of NGOs as "private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment or undertake community development" (World Bank, 1988). Neither of these definitions is helpful in identifying the place of NGOs vis-a-vis other sectors of society, however.

Brown and Korten, in a paper prepared for the World Bank, further differentiate non-governmental groups into the commercial and voluntary sectors. The voluntary sector is seen as a distinct class of organizations that are held together by common beliefs and shared values, rather than by political imperatives (government) or economic incentives (the commercial sector). This article will focus on the voluntary subgroup of NGOs, particularly those involved in health and development activities in developing countries. They include locally-based groups as well as international organizations having local offices in project countries. Many are single-focus, narrowly targeted organizations while others attempt to meet broader needs in mainstream communities. All, however, are characterized by their dedication to a set of shared social values that guides their organizational mission (Brown & Korten, 1989).

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NGOs and AIDS

How have NGOs been involved with AIDS up to now? In areas of the industrialized world most hard-hit by AIDS, NGOs helped set trends now institutionalized within AIDS prevention: advocacy for persons with AIDS (PWAs), targeting educational materials to specific groups, improved access to experimental drug trials and health care and peer education. In the developing world, the NGO response to AIDS emerged somewhat more slowly, reflecting both a lack of resources and experience and a widespread reluctance to recognize publicly or acknowledge the threat. As the epidemic has progressed, however, both well-established and newly organized NGOs have been among the first to respond, promoting the need for persons with AIDS and HIV to have access to counselling, support and health care. They have mobilized impressive efforts for training, education and other supportive services at times when official declarations denied even the existence of the problem (Morna & PANOS, 1991; Haslegrave, 1988; Liskin, 1989).

The importance of NGOs in the national AIDS control programmes of developing countries has also evolved over time. When the World Health Organization's Global Programme on AIDS (GPA) first began to assist countries to draw up national plans for AIDS control, NGOs were not regularly consulted for official input into the plans, and were rarely represented on national AIDS committees. Over time, GPA has developed extensive links with a wide range of NGOs, and now supports their efforts to combat AIDS at global, national and local levels (Grose, 1989). A 1989 resolution of the World Health Assembly supported the importance of NGOs in the global strategy for the prevention and control of AIDS, acknowledging that "their commitment and versatility, and their knowledge and experience . . . can make a special impact on individuals and society regarding AIDS and the needs of HIV-infected people and those with AIDS" (World Health Organization/Global Program on AIDS, 1989).

Success stories

There is a growing list of successful NGO projects for AIDS prevention and care that are providing critically needed services in many different settings. A few examples are:

TASO—Uganda. TASO (The AIDS Support Organization) was organized in response to the urgent need in Uganda for medical, emotional and practical support for people with HIV infection or AIDS and their immediate families. Many trained volunteers who themselves are infected with HIV or have lost a family member to AIDS carry out counselling and supportive home visits. The family focus is critical to TASO's ability to catalyze support for PWAs at the community level. In addition to counselling people with AIDS and HIV infection, TASO assists their families with material and medical support, such as food, oral rehydration salts, and home care kits containing soap, antiseptic cream and rubber gloves (Oomey, 1989; Kaleeba, 1989).

Bombay Dost—India. In response to violence against the gay community and a lack of information about AIDS and other STDs, the newsletter 'Bombay Dost' was started to reach out to people with alternate sexuality in the city of Bombay. The first issue had a print run of 1,250 but the readership expanded as the issue was photocopied and passed on widely. The founding editor of 'Bombay Dost' plans to expand from the newsletter to set up a whole network of support services for the gay community: a meeting house, access to health

professionals who can offer testing and counselling referrals, and networking with male street prostitutes (Bombay's New Newsletter, 1991).

Prostitutes Association—Brazil. With the help of a community organizer, the women of Vila Mimosza—Brazil's oldest red-light district—have formed the 340-member Rio de Janeiro Prostitutes Association (APRJ). To fight STDs and AIDS, APRJ has worked out two groundbreaking agreements with local medical institutions. A Rio state hospital provides Vila Mimosza with free monthly medical check-ups, and BEMFAM, Brazil's largest private family planning agency, provides the APRJ with 180,000 condoms a month. Every week, APRJ holds two-hour meetings where Vila Mimosza women talk about AIDS and other health-related topics, and address the poor self-image that plagues many prostitutes (Kepp, 1990).

Family Life Association—Swaziland. Project HOPE, an international NGO, is collaborating with a local NGO, the Family Life Association of Swaziland (FLAS), in a dynamic AIDS awareness and prevention programme. HOPE/FLAS staff are developing training programmes and educational materials for different groups—non-literate adults, out-of-school youth, staff of FLAS family planning clinics, and traditional healers. The project has also pioneered the training of 60 HIV/AIDS counsellors in Swaziland, and catalyzed the development of a nationwide network of regional counselling support groups (Project HOPE, 1990).

EMPOWER—Thailand. EMPOWER (Education Means Protection Of Women Engaged in Recreation) offers support, assistance and access to education for women workers in Patpong, the entertainment district of Bangkok, Thailand. A drop-in centre provides referrals and health counselling on sexually transmitted diseases, nutrition, exercise, safe drug use and family planning. EMPOWER helps women in the entertainment industry build their self-confidence and develop a language for discussing safe sex with customers, while women who want to find alternative employment can enroll in continuing education programmes or skills training classes (Deadly serious humor for the "Go-Go Girls", 1989).

Copperbelt Health Education Project—Zambia. The Copperbelt Health Education Project (CHEP) in Zambia offers 'street kids' a five-day course in survival skills that responds to both their immediate and longer-term concerns: finding job training, running a small business, staying within the law, avoiding drug and alcohol abuse, and preventing STDs and AIDS. CHEP shows workshop participants AIDS prevention videos, and provides them with condoms. In addition to their work with street kids, CHEP produces effective materials on STDs and AIDS in English and Zambian languages, and runs training workshops for health workers and community leaders. CHEP has even reached a national audience through dramatic television plays followed by commentary and discussion (Zambia's Crash Course in Survival, 1991).

NGO Consortium—Kenya. NGOs are also learning how to organize themselves to increase their influence at the country level. Last year in Kenya, a growing awareness of the AIDS crisis prompted NGOs to form a national consortium of organizations working in HIV/AIDS prevention and care. The formation of the consortium helped ensure a regular dialogue between NGOs and the AIDS Programme Secretariat; the government supported the participation of NGO representatives on national AIDS committees. The degree of

information and skills sharing between NGOs was remarkable, and led to a recognition of the valuable contributions made by many NGOs to the AIDS programme in Kenya (Wiseman, 1991).

NGO strengths and constraints

In identifying the most effective future roles for NGOs in HIV/AIDS prevention and care, it is important to recognize their strengths and limitations. While not all NGOs share the same strengths, most have special abilities:

- To implement programmes quickly, address controversial issues and devise innovative solutions. Because NGOs are smaller, have more flexible administrative systems, and less cumbersome bureaucracies than governmental organizations, they can devise and carry out programmes faster. NGOs typically do not face the political constraints that hinder governmental AIDS prevention efforts. This makes it potentially easier for some NGOs to be more open about such sensitive subjects as sexuality and condom use.
- To reach the community more easily and effectively. Often created and staffed by community members, NGOs have more credibility with and understanding of the communities they serve. Thus NGOs are more likely to attract community participation in HIV/AIDS prevention and care efforts, and are more likely to recognize what will be appropriate and effective for their constituencies. This 'inside track' on communities provides the potential for transforming community attitudes, beliefs and behaviours *from within*—a badly needed approach in AIDS prevention.
- To reach the poorest and most marginalized groups, based on their strong commitment to serving those in greatest need. Because they are willing to involve those individuals in the development of programmes, they can often reach groups such as prostitutes or intravenous drug users who are outside the mainstream of society and may be suspicious of public institutions.
- To mobilize local resources and talent, thus providing services at lower cost than groups coming from outside the community. Volunteers provide the energy and resources to staff many NGOs, and even paid staff often work at lower salaries because of personal commitment to the goals of the organization.

There are, however, a number of constraints shared by many NGOs that must be considered when identifying the best ways that NGOs can contribute to HIV/AIDS prevention and care:

- The administrative systems of many newer and smaller NGOs are not designed for large-scale or complex budgeting or technical reporting. This leaves many NGOs, particularly indigenous groups, at a disadvantage in competing for AIDS-related funding from large international donors. Similarly, the smaller scale of many NGOs limits their in-house technical capacity for complex projects. This sometimes leads to deficiencies in their ability to meet the requirements of outside funders for fiscal and programme reporting, including evaluation of project efforts.
- Since many NGOs operate largely with volunteer or modestly paid staff, the likelihood of attrition due to 'burn-out' is also great. Heavy turnover of staff can make it difficult for small organizations to maintain consistent, high-quality activities. Burn-out is most frequent when the work involves emotionally demanding activities, such as working with persons with HIV infection and AIDS.

- NGOs in many settings have tended to work in isolation, reluctant to collaborate either with each other or with the government. This leads to limited sustainability of many NGO projects, which despite their links with the community often do not focus on developing local capacities to carry on without NGO or other external support. In addition, the ability of NGO projects that may be highly successful at a small scale to effectively 'scale-up' is largely undemonstrated. Often the early success of a project is found to be related to unique characteristics of the community or of the NGO (e.g., an unusually charismatic leader), and may not be replicable on a larger scale.

Conclusions and recommendations

Clearly there is enormous potential for NGOs to play a major role in the effort to combat HIV and AIDS. Based on experience with a limited number of encouraging examples to date, we suggest the following approaches to supporting the role of NGOs in a global response to the challenges of HIV/AIDS in its second decade.

1. Explicitly include NGOs in the design, implementation and review of national AIDS programme plans, as recommended by the Global Programme on AIDS of the World Health Organization.
2. Support the efforts of AIDS-related NGOs to form national and regional consortia, in order to strengthen their abilities to collaborate with each other and with their respective national AIDS control programmes.
3. Consider making available seed money and technical assistance designed to strengthen the administrative and organizational capacities of AIDS-related NGOs, especially in areas where the need is great (e.g., Africa). Research is needed as to the best ways that this can be accomplished; it may require funding projects for longer periods than the traditional two- to three-year time frame.
4. Fund larger and more established NGOs to work with newer organizations as mentors, to strengthen the capacity of small, indigenous NGOs. This could enable fledgling groups to gain more quickly the needed organizational skills.
5. Recognize and support the special strengths of NGOs when selecting projects for funding, and in developing reporting guidelines. NGOs should be funded to do what they do best, which is rarely research-oriented, complex, or large-scale projects. They should be encouraged to build on their special strengths, such as their abilities to respond in an integrated fashion to the felt needs of the community. In the area of HIV and AIDS, this requires recognition of NGOs' desire to provide support and care to persons with AIDS, as an integral part of their prevention activities.
6. Actively encourage NGOs to develop links with local universities for technical expertise and training which can substantially add to their technical capacities.
7. Further evaluate collaborative relationships between international and indigenous (also identified as Northern and Southern) NGOs (Fowler, 1990). Does the 'partnership' approach of WHO/GPA's NGO grants show evidence of meeting its

- goals? What kinds of links are the most likely to succeed? What is the potential for application of positive NGO experiences from the South to the North?
8. When providing external funding for an NGO project, emphasize the importance of full-time, paid key staff members to maintain project continuity. NGOs need to maintain a balance between paid and volunteer staff (Crane & Carswell, 1990).
 9. Consider the potential value of technical assistance in key aspects of NGO programme interventions, when developing or funding projects. Of great importance is the need for the assistance to be provided by consultants or staff who have experience in working successfully with NGOs, and who appreciate their strengths and constraints. Often minimal assistance early in the project life will prevent the needless expenditure of misguided energy, and will assist NGO projects to do what they do best—meeting the needs of the people they serve.

One of the most important lessons learned to date in HIV/AIDS prevention and care is the need to adopt multiple approaches and involve diverse organizations in bringing about attitudinal and behavioural change at the community level. Past experience with child survival, family planning and other health and development programmes has shown the importance of active community involvement in sustaining gains made. With their flexibility, diversity and base in the community, NGOs must be accepted as equal partners with governments and donors alike in the global effort to mount an effective response to AIDS in the years to come.

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HAPA GRANTS PROGRAM UPDATE

Vol.2, No.2 May 1991



In this mailing:
A South African comic,
Love and AIDS

- 1) seropositive but symptom-free
- 2) generalized lymphadenopathy
- 3) symptomatic disease
- 4) death

In most cases, a straightforward transition from one stage to the next was not observed. Often people with HIV disease moved back and forth between stages 2 and 3. While the expected time from infection or seroconversion to death is difficult to estimate from the data, it is clear that the rate of progression from asymptomatic infection to overt disease is considerably more rapid than reported from other studies.

Several theories --none yet proven-- are offered to explain why the rates of progression differ for this group of African women. 1) As this is the first large study of women anywhere, gender itself could be an important determinant of disease progression. 2) Genetic or environmental factors unique to Africans could account for the more rapid rate. 3) The high rates of sexually transmitted diseases among prostitutes could stimulate more rapid disease progression. 4) In addition, with 80% rates of seropositivity among the study population, it is likely that the women are being reinfected with HIV on many occasions, which could affect the progression of the disease.

Quarterly Reports

Save the Children Cameroon

Activities for the quarter included training of trainers (TOT), follow-up visits, and refresher courses for 1st generation trainers. In the two project areas, approximately 3470 people have been reached with AIDS message and many of the 1st generation trainers have trained their colleagues as trainers to assist them.

In a 3-day TOT, the divisional Chief Medical Officer helped facilitate the workshop, especially more technical sessions dealing with the epidemiology of the disease and the scope of the problem in Cameroon. Participants --who must have been expecting the doctor to refute some of the horrors they had been hearing about AIDS-- were visibly shocked when the doctor only confirmed them. At the onset, participants seemed reluctant and hesitant about Save the Children's (SC) participatory training methodology, but all agreed by the end of the workshop that this approach was more effective than the didactic method of training. All participants developed 3-month action plans and were given monthly reporting forms.

Four one-day refresher courses provided an opportunity for the trainers to meet as a group and share potential solutions. Some of the experiences reported by the trainers include:

- > Most people contacted were conscious of the danger posed by AIDS and wished to see an end to it.
- > In spite of the danger, most people abhorred the idea of using condoms. People believed using condoms would reduce the pleasure and satisfactions they expect from sex and would even make them permanently sterile.
- > Some women accuse their husbands of being unfaithful if the man proposes using a condom.
- > Most men don't realize the health implications of their actions on their families. This is particularly true with regard to mother-to-child transmission.
- > Women are reluctant to participate in condom demonstrations.

"Most men don't realize the health implications of their actions on their families...particularly with regard to mother-to-child transmission."

Participants in the refresher courses discussed possible solutions to these problems, including: conducting separate condom discussion and demonstrations for men and women; meeting with com-

munity leaders privately before a public information session to discuss the agenda and get their support; planning sessions to coincide with other community development activities so as to reduce transportation problems; and, concentrating on the training of 2nd generation trainers so as to reduce the workload on 1st generation trainers.

In addition to organizing refresher courses, project staff made follow-up visits to 1st and 2nd generation trainers. Staff noted the trainers' level of progress on action plans and learned what problems trainers are encountering in training others. To evaluate the effectiveness of the training given to trainers, SC staff asked them questions which assess their understanding of the materials presented to them, and, in the case of 1st generation trainers, their experiences in training others. Trainers and staff together evaluated the effectiveness of the AIDS messages being promoted and revised them if necessary, and also gleaned lessons learned which could help project staff better prepare for future workshops.

In follow-up visits to Ntui, one project area, several problems were identified. First, most of the trained trainers could not name the 3 main modes of AIDS transmission. The trainers often did not mention mother-to-child transmission, and their understanding of certain other facts was tentative. Many trainers were behind in their action plans, due to increased agricultural demands, and most had not written their activities

printers. This represents unprecedented speed in the start-to-finish process for development of new literacy materials, and confirms the importance attributed to HIV/AIDS prevention by Sabenta.

-> Love and AIDS comic book

HOPE/FLAS has ordered 500 copies of the comic book "Love and AIDS" from the Johannesburg City Health Department, after pre-testing it for appropriateness and popularity in Swaziland. [Photocopies of the comic book are enclosed in Update mailings to project staff.] When the comic books arrive they will be distributed to the seven youth groups/organizations which had representatives educated by HOPE in STDs and AIDS. Meanwhile negotiations are underway between HOPE/FLAS and the Johannesburg City Health Department for rights to translate the comic book into Siswati and to produce it in Swaziland.

-> Counselling

In June 1990, HOPE/FLAS trained the first group of HIV/AIDS counselors in Swaziland. In December 1990 a follow-up workshop was organized, during which regional counselling support groups were formed. Recently these support groups were officially introduced to the regional health management teams. In addition, lists of the trained counsellors have been distributed to the major medical institutions for establishing a referral system for HIV/AIDS counselling.

The National AIDS Programme (NAP) has requested the part-time secondment of the HOPE/FLAS counselling officer to serve as interim national counselling coordinator, until such time as funding can be found and the position officially established. This will result in the NAP assuming responsibility and funding for the continuation and expansion of counseling activities developed by HOPE/FLAS.



BAMBALA -- Female figure with child

"Community leaders have an important role to play in supporting the efforts of the village community workers and farm health workers in planning and monitoring progress of activities"

As the project heads into its final months, sustainability is a critical issue. In all three impact areas, health coordinators have started having monthly meetings with the village community workers and farm health workers to identify problems and constraints during the phaseover period, and to deal with them before the end of the project. At a February meeting SC and MOH staff produced a calendar of events outlining the handover of staff and assets.

In January 1991, the project coordinator Linile Malunga visited the SC home office in Westport, Connecticut. Ms. Malunga received an in-depth orientation to SC -- its history, organization, systems, and approach to development-- as well as to individual departments. Ms. Malunga gave valuable feedback on the AIDS curriculum that is still undergoing development. The visit to Westport gave Ms. Malunga an opportunity to address pending issues in depth and learn what resources exist at the home office that she can tap into. Home office staff had an opportunity to better understand programs in the field. Ms. Malunga

reports that the orientation "makes the people in Westport real, as opposed to talking on the telephone to a person you do not know. This gives the Coordinator a sense of who to talk or write to if she needs certain information or advice."

While in the U.S., Ms. Malunga also traveled to Baltimore to meet with HAPA Support Program and Child Survival Support Program staff, and to Washington, D.C. for meetings with the USAID Child Survival project officer and HAPA project officer.



BAKONGO -- Female figure with child

World Vision Zimbabwe

World Vision participated strongly in National AIDS week activities, from 24 to 30 November 1990. The theme for the week was "A national effort will stop the spread of AIDS and will create understanding and compassion for people with AIDS." Highlights from the week of activities:

- > All church ministers were requested to preach sermons on AIDS during Sunday services. National AIDS Council messages and leaflets were distributed to church ministers.
- > Trained anti-AIDS motivators carried out house-to-house campaigns in the two high-density suburbs in Marondera urban area. Market women were also reached by the campaign.
- > The AIDS videos "Born in Africa" and "African Perspective" were shown to factory workers, beer hall and hotel clients, college and school children, and members of a women's church group. The videos were followed by question and answer sessions, condom demonstrations, and condom distribution. A total of 6,500 condoms and 3,000 leaflets were distributed during the week.

After National AIDS week, the organizing committee met to discuss and evaluate the activities. They decided

that there is a need to stress the common modes of transmission, and also how AIDS is not spread. The question of whether mosquitoes spread AIDS was raised by nearly all the groups reached during the campaign. The video "Born in Africa" made an impact on all those who were shown it, and demand for more videos was expressed.

"The question of whether mosquitoes spread AIDS was raised by nearly all the groups reached during the campaign."

In the town of Marondera, the seat of WV's project area, World AIDS Day was commemorated with a marching procession, speeches, choir singing, poems, and traditional dance. The mayor of Marondera district emphasized the crucial role played by women in development, and that women have key roles in preventing HIV infection and in caring for HIV-infected people and people with AIDS.

Project plans for FY91 were mapped out by the MOH district nursing officer and WV IEC, counselling and evaluation officers. The annual plans for AIDS activities of the rural health centre staff were incorporated into the District plans. Targets for planned activities are still to be decided upon. The IEC officer also attended the Zimbabwe AIDS Network (ZAN) steering committee meeting in

3) **Condom dispensers can become part of corporate culture.** The company was very supportive, but initially was not optimistic. Minutes after the first motivation seminar, 12,000 condoms were distributed.

4) **A successful program will be asked to consult with other organizations** interested in learning from the program.

Ms. Cole expressed reservations about claiming a direct association between condom distribution and use, suggesting that the association would probably be greater if the project were selling the condoms. Also, she noted that sustainability requires a better condom distribution system. Currently, condoms are being distributed via AMREF and the national AIDS program. The system works, but is not currently sustainable. An effort to involve district medical officers has not yet been successful.



Evaluation of a KAP Study

Susan Toole, CARE

Background

The CARE/Rwanda HAPA grants project carried out a baseline survey to identify target population and community groups, and to assess condom use in project area. The KAP process took an unexpectedly long six months. KAP findings included the following: 65% of respondents knew several facts about AIDS, while only half had ever seen a condom, and only 7.2% had ever used a

condom. While people feared AIDS, only 65% felt at risk. Most people had negative attitudes towards condoms, but a very compassionate attitude towards PWAs. Of people claiming to practice protective behaviors, only 7.8% are monogamous, and only 6.6% use condoms.

Lessons learnt

1) **Collaboration.** Work closely with groups who have already implemented similar baseline surveys. In this example, the NACP survey was adapted, by eliminating of questions which had received the same response from 98% or more of respondents, and by adding questions about attitudes towards condoms and AIDS protection.

2) **Resources.** Significant survey pre-testing time and accompanying resources are required. The project was aided by the survey experience of the NACP, but the CARE survey still had to be pretested and turned out to be more expensive than expected.

3) **Remuneration.** People were reluctant to sit for one hour without remuneration of some kind. Respondents appreciate it when some form of exchange is made. During focus group discussions, a bottle of banana beer was given to respondents.

4) **Data validation.** It is necessary to validate data entry. The project used CDC Epi-Info package software which was found to be very useful. However, data entry hadn't been validated and

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AIDS ACTION AHRTAG

1 London Bridge Street
London SE1 9SG, U.K.

Quarterly/English, French, Portugese,
Spanish

International newsletter for information
exchange on AIDS prevention and
control, with a report from WHO Global
Programme on AIDS in each issue.
Regularly features new resources.

**HEALTH TECHNOLOGY
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Program for Appropriate
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4 Nickerson Street
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Quarterly/English

Each issue focusses on one specific topic
(such as eye care, nutrition, safe birth,
etc.) giving detailed practical advice on
diagnosis and management. The
newsletter is written with appropriate
and community health participation in
mind, and includes a materials list for
further study.

IPPF MEDICAL BULLETIN

International Planned
Parenthood Federation
Regent's College, Inner Circle
Regent's Park, London NW1
U.K.

Bi-monthly/English, French, Spanish

Up-to-date information on clinical
aspects and developments in the field of
family planning practice. General
discussion of population and fertility
issues.

NETWORK

Family Health International
Research Triangle Park, NC 27709
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Quarterly/English, French, Spanish

A quarterly newsletter on family
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and lists of FHI publications.

POPULATION REPORTS

Population Information Program
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Provides comprehensive and up-to-date
reviews of important issues in population
and family planning, with occasional
issues in general health topics.



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Subscription Newsletters**ADULT EDUCATION AND DEVELOPMENT**

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quarterly/English

Subscription: US \$5.00 a year.

This is a 'how-to' newsletter treating a different topic of interest in each issue. Topics have included: breastfeeding, animal husbandry, land conservation, pesticides, participatory education, appropriate technology, health and nutrition, dental health, community-based health care, visual aids, women and development, agriculture, associations and co-ops.



NSAPO-NSAPO -- Female figure

HAPA GRANTS PROGRAM UPDATE

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AIDS



What is AIDS?

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more of the funds are to be allocated to subprojects, most of them in 15 priority countries, which international PVOs will be eligible to receive. For more information contact FHI, P.O. Box 13950, Research Triangle Park, NC 27709, USA.

Field Trip Report

Mary Anne Mercer, HSP Director, traveled to Zimbabwe in June with consultant Martha Holley and the HAPA coordinator for Save the Children/US, Nicola Gates. The purpose of the trip was to assist the Zimbabwe Save the Children Federation (SCF) staff to conduct a followup knowledge, attitudes, behaviors and practice (KABP) survey, as a part of their final evaluation.

After several days in the US with survey preparations, the team spent 2 days in Harare with SCF/Zimbabwe HAPA coordinator Linile Malunga making logistical arrangements. They then traveled to the Mutema field site, accompanied by Ellen Tagwireyi, World Vision/Zimbabwe HAPA coordinator, who assisted SCF with every stage of the survey. Training of the 30 interviewers and eight supervisors was conducted over three days, and data collection took another three days. The survey data were immediately hand-tabulated, after which the survey report was drafted. Data were entered into the EPI INFO computer package for later in-depth analysis.

All told, three weeks of in-country effort were required, including one week of intensive effort by the full survey team. Preliminary analysis of the data shows a high level of reliability of the two tabulation methods, and the information provided should prove to be very useful for both evaluation and future programming of HIV/AIDS prevention efforts in Zimbabwe.

Staff Changes

Sally Scott, program assistant with the HSP office during the past two years, recently left HSP in order to pursue further academic training. Her replacement, Cynthia Mariel, joined the staff in



HAPA BUSINESS

Workshop Funded

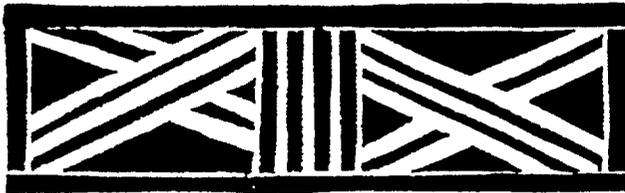
The HAPA Support Program (HSP) is very pleased to announce that funding was recently received from AIDSTECH for a workshop to be held in Uganda in early 1992. This workshop will be coordinated by the HSP office and the Experiment in International Living HAPA grant project in Uganda. The purposes of the workshop, which will be held at the end of the 2-year HAPA grants projects, are primarily that of evaluation and development of lessons learned by NGOs involved in HIV/AIDS prevention and control in Africa. Invitees will include HAPA grant recipients who are continuing AIDS prevention work beyond the two year HAPA grant funding period. Resource persons for the workshop will be drawn largely from Uganda. More information about this workshop will be sent out to the HAPA projects in the near future.

Special News Report

Family Health International (FHI) was recently awarded a \$168 million grant from AID to assist countries worldwide to expand AIDS prevention and control activities. The new 5-year AIDS Technical Support Project is the largest provided by any government for international AIDS work. Of special interest to PVOs is that \$50 million or

mid-August. Below are reflections Sally had upon leaving this office. We wish her the very best and thank her for the many fine contributions she made to the HSP office!

The past two years have taught me a huge amount about the difficult challenge of responding to HIV/AIDS, and the resources NGOs bring to the task. While the work is often sobering, I found the time spent with field and headquarters staff filled with energy and hope. Thank you for your willingness to share what you are learning. Though I am leaving this job, I plan to stay in Baltimore and to keep in touch with the HAPA Support Program and NGO work in Africa. This September I am starting a doctorate in anthropology and development at the Johns Hopkins School of Advanced International Studies. In three years, I hope to return to Africa for field work on my dissertation, possibly on community-level responses to AIDS in Africa. I hope we meet again in the course of work or study.



TECHNICAL UPDATE

[The following pieces, which address casual transmission of HIV and the current research into the AIDS drug KEMRON, were both compiled by the Bureau of Hygiene and Tropical Diseases in London, for WorldAIDS, May 1991, p. 6. The third item is a summary of an article which appeared in Nature on August 15, 1991.

Study Rules Out Casual Spread

A recently published study offers further conclusive evidence that people who were and are the families and close household contacts of people with HIV and AIDS are not vulnerable to HIV infection through ordinary human contact.

According to Friedland and colleagues the risk of acquiring HIV outside the well-established transmission modes of blood, sex and perinatal events was so remote that it was "too low to measure."

Household contacts of 90 people with AIDS were enrolled in the US study between 1984 and 1987. None of the 206 adults and children tested positive for HIV despite close and prolonged intimate contact, including sharing toothbrushes, eating utensils, bed linen and toilet/bathing facilities with an adult with AIDS for periods from six months to more than five years. Personal interaction included kissing, bathing and sharing a bed with people with AIDS. Sexual partners and infants born to HIV-positive women were excluded, as well as adults with other risk behavior (injecting drug use, for example).

However, there is still widespread concern about possible HIV transmission through close, but non-sexual contact with people with the virus.

Misconceptions appear greatest among people who know how the virus is transmitted but lack knowledge about how HIV is not transmitted. Studies have documented that people who can correctly identify how the virus is transmitted, also simultaneously --and wrongly-- believe that HIV is transmitted by use of public toilets, attendance at school with a student who has the virus, the sharing of a drinking glass, etc.

According to the researchers, the reason for continuing public anxiety and misconceptions include (1) inadequate, contradictory or confusing public health messages; (2) fear of a fatal illness; (3) lack of understanding that the presence of HIV in body fluids such as tears and saliva does not mean that that fluid is important in transmission; (4) stigmatizing attitudes towards populations identified with the virus; (5) the understandable desire for absolute certainty of absence of risk.

Surveys demonstrate that those who understand how the virus is and is not transmitted are more tolerant, less discriminatory and less punitive toward people with AIDS and their families. Friedland and colleagues believe public health messages must also emphasize how HIV is not

transmitted and that public policy should reflect that close personal contact with a person with AIDS carries no risk of transmission.

Science Looks at KEMRON

In July 1990 President Moi of Kenya announced the launch of the drug KEMRON, describing its registration and clinical use as a bold and practical move. KEMRON was developed by the Kenya Medical Research Institute (KEMRI) with the help of the U.S. and Japanese companies Amarillo Cell Culture Co. and Hayashibara Biochemical Laboratories. KEMRON is a preparation of nine different forms of alpha interferon, which is active only at low dosages. It is administered orally as a lozenge which is sucked slowly, apparently allowing the interferons to penetrate membranes in the mouth, which stimulates the body's immune system -- as demonstrated by an increase in the number of T-cells.

World Health Organization (WHO) studies in five African countries have confirmed that KEMRON stimulates T-cell activity, but the investigators question whether small doses can dramatically reverse the symptoms of AIDS, as claimed by KEMRI scientists. The drug is now sold for 74 Kenya shillings (US \$3) a tablet and is available only in provincial and designated private hospitals. A course of treatment lasts eight months and costs 13,000 shillings (US \$500).

Other clinical trials of alpha interferons in New York, Los Angeles and Amsterdam have been small and inconclusive. In an attempt to obtain some reliable data, the Community Research Initiative in Toronto, in collaboration with Canada's Health and Welfare Department, is conducting a large, randomized trial with KEMRON (from the same Japanese supplier as in the Kenyan studies) in some 150 HIV-infected patients with T-cell counts below 700mm. One patient group receives a placebo, another 50 units of KEMRON, and the third 100 units.

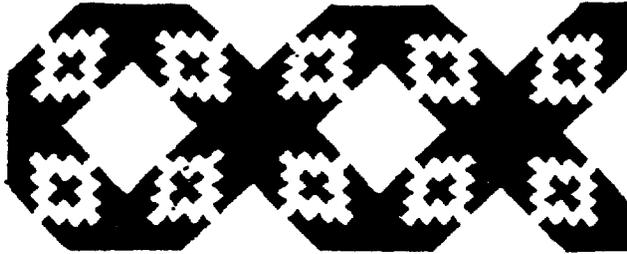
In Zimbabwe clinical trials with KEMRON in AIDS patients have been suspended because of problems concerning availability of the drug. The

early results indicated that KEMRON increased T-cell counts in recipients of the drug, although six of the 29 patients died in a double-blind trial (where neither doctors nor patients knew who received the drug or the placebo). The drug did not slow the progress of disease or demonstrate a clearance of antibodies to HIV in the blood of patients who took part in the trials, as had been reported in the Kenyan studies.

WHO has expressed concern that now that KEMRON is on sale in Kenya, labels have been falsely attached to bottles containing aspirin or other products and sold at high prices. Another concern is that the drug has been viewed as a cure, and this misperception is undermining health education messages which emphasize the importance of safer sex to prevent HIV transmission.

Mathematical Models of AIDS in Africa

An article in the August 15 edition of *Nature*, entitled "The spread of HIV-1 in Africa: sexual contact patterns and the predicted demographic impact of AIDS," reviews mathematical models of the spread of the epidemic in Africa. Given the lack of detailed studies on patterns of sexual contact, it is difficult to make precise predictions about the likely demographic impact of AIDS in any one country. Despite these uncertainties, the authors argue that -- in the absence of major changes in behavior, or the development of an effective treatment or vaccine -- AIDS could reverse population growth in the worst-hit countries in Africa over a few or many decades. The mathematical models also indicate that timing is critical in slowing the spread of infection. Changes in behavior or treatment to slow infection which are introduced earlier on in the course of the epidemic have a disproportionately greater effect than similar changes introduced later. Therefore, the authors argue, even when levels of HIV infection are low in the general population and AIDS is not the leading cause of mortality in countries afflicted by many other serious diseases, significant resources should be directed towards inducing behavioral change to try to prevent a widely disseminated and lethal epidemic in 10-20 years.



QUARTERLY REPORTS

WORLD VISION Zimbabwe

World Vision (WV) Zimbabwe, describing AIDS intervention activities for the early months of 1991, reported several interactions of potential interest to other HAPA projects. In particular, information, education and communications workshops were conducted for the following groups: health care workers, police officers and their spouses, WV Zimbabwe workers, and teachers attending a schoolmasters' workshop.

WV Zimbabwe also participated in a meeting of the Zimbabwe AIDS Network Steering Committee which is comprised of organizations working in the country on AIDS related issues. During this meeting AIDS health facilitators were selected from the 60 involved NGOs and agencies to help establish community home-based AIDS support services. The support services will serve as focal points for AIDS prevention within the communities. Two interesting aspects of this committee's work are that of organizing community AIDS services focused on the home, and that of coalition building among organizations working on HIV disease within a single country.

The HAPA project coordinator participated in a meeting organized by Canadian CIDA concerning women in development. A women's small project fund was proposed during the meeting which aims to strengthen relationships among village leaders, government, and other NGOs in order to meet the needs of women, and to help them with activities which will promote their economic and social well-being. Once again, as discussed in the HAPA workshop in Zimbabwe last October, there

exists an intricate connection between the needs and issues related to women and development, and similar economic and power issues faced by women in relationship to HIV disease.

Visitors to HAPA project WV Zimbabwe sites during this quarter included staff from the local USAID mission and the U.S. embassy, as well as two consultants participating in the HAPA Program and Management Assessment.

As reported by the Minister of Health, there were 5,996 cases of AIDS and 11,500 people infected with HIV in Zimbabwe as of December 1990.

WORLD VISION Kenya

Second quarter (FY91) activities undertaken by World Vision (WV) Kenya were diverse and represented education, training and support to various target groups including church leaders, traditional birth attendants, youths, persons with AIDS, persons with STDs, orphans and community health workers. Project staff conducted AIDS awareness seminars, held training of trainer workshops, offered counseling, distributed condoms and AIDS literature, undertook community outreach and organized meetings with government agencies, universities and other NGOs sharing common interests.

Project outreach efforts were strongest in terms of number of people reached among the designated categories of youths, women of childbearing age, antenatal mothers, factory workers and pregnant mothers. In addition, WV Kenya also coordinated the visit of a representative from the local USAID Health and Population office, during which time meetings were held with drug addicts and with traditional birth attendants on AIDS education and prevention.

A constraint identified by the WV Kenya project was that people have to walk long distances between villages in the Ruiru District, one of the areas where WV is focusing on AIDS prevention and control. Inadequate material support provided to orphans and persons with AIDS was the other major constraint indicated by the project.

SAVE THE CHILDREN Cameroon

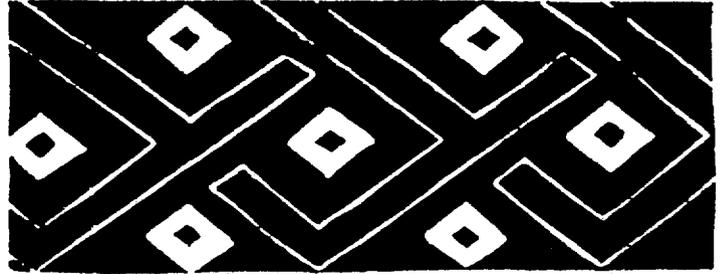
Save the Children (SCF) Cameroon summarized their HAPA project activities for the second quarter as being concentrated on follow-up visits with AIDS education and prevention trainers. A total of 53 trained trainers and 150 second generation trainers were contacted. Most of these visits were supervisory in nature -- to provide support to trainers, to evaluate progress-to-date on current work plans, to assess trainers AIDS knowledge, attitudes and practices, to distribute training materials and supplies, and to develop future work plans.

Problematic issues discussed by trainers during these visits ranged from the constant challenge of people holding the erroneous opinion that AIDS is a disease that attacks only city dwellers, to the underutilization of health workers trained in AIDS prevention who are based at community medical centers. Health worker contacts are reduced, in part, because a smaller number of people are visiting the medical centers. Because health centers currently lack supplies of medicines, few people are now seeking out such facilities. As a result, AIDS prevention resource people who work at these sites have fewer opportunities to meet with people and carry out health education activities.

Erroneous beliefs, more commonly held by rural people, are another barrier to AIDS prevention work in Cameroon. Included among these beliefs are incorrect statements such as AIDS has a cure, and that preventive actions such as drinking a salt solution or taking antibiotics prior to sexual intercourse have the same effect as that of using condoms.

A further challenge faced in Cameroon by the project staff was a limited awareness about AIDS and/or its low priority for government district heads. Yet, SCF Cameroon has found it to be increasingly productive to work with divisional medical officers (DMOs) who have, in the past, participated in a provincial AIDS seminar. Information, education and communication activities were then organized by the SCF project to coordinate with various DMOs' district AIDS prevention plans that were catalyzed by the

seminar. As a result, interest by the DMOs in the AIDS prevention work of SCF Cameroon has risen. On two separate occasions, it was reported that two DMOs even paid participants' transport to and from a training workshop being offered in their divisions.

*PROJECT HOPE/FLAS -- Swaziland*

Project HOPE/FLAS (the Family Life Association of Swaziland) continued working with its initial target groups, and also initiated programs with church groups and private businesses seeking assistance in HIV/AIDS prevention. The project followed up on last year's training of 60 counselors with continued assistance for regional counseling support groups. HOPE/FLAS staff also established contact with other AIDS-related organizations in Southern and Eastern Africa through conferences and study visits to other projects.

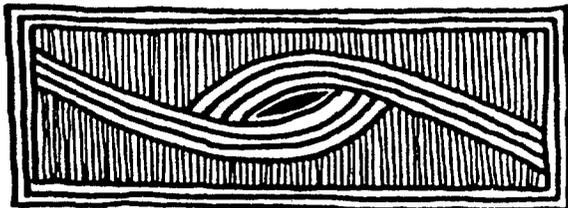
A total of 135 traditional healers attended HOPE/FLAS training courses in HIV/AIDS prevention; during the courses IEC materials were distributed which the project had developed and translated into the local language, siSwati. Another HOPE/FLAS target group, Sabenta adult literacy instructors, continued to call on the technical assistance of the project education officer to finalize production of HIV/AIDS adult literacy booklets developed during a February writers' workshop.

The project counseling officer served as a key person on a panel in a workshop sponsored by the Trans World Radio to discuss HIV/AIDS and the role of the Christian Broadcasting Network.

Radio broadcasters from several African countries participated in the workshop. Private businesses -- including ranch, forestry and railway enterprises -- have also sought the HOPE/FLAS assistance in setting up training in AIDS prevention for employees and their families. It is encouraging to hear that the management of one company has agreed to meet all training costs and to release staff from their duties for training purposes.

The regional counseling support groups established by HOPE/FLAS in 1990 continue to meet with one another, to identify and address problems. Members of the support groups faced many sensitive and difficult situations: health staff's fear of caring for HIV positive clients; a lack of confidentiality for HIV positive patients; a lack of sufficient pre-test counseling for patients, particularly tuberculosis patients who are starting to be routinely screened for HIV. In each case, the support groups worked with HOPE/FLAS staff to develop educational talks and one-day workshops to help health staff care for HIV-infected patients with more understanding and compassion.

HOPE/FLAS staff strengthened contacts with NGOs outside of Swaziland through conferences and study visits. The project education officer attended the Southern Africa Network of AIDS Service Organizations (SANASO), and the project coordinator traveled to Johannesburg (South Africa), where she identified potential trainers in AIDS counseling from a local AIDS center, and visited the City Health Department HIV/AIDS Programme and the Township AIDS Project (TAP). A study trip to Uganda was planned for early July, to identify activities and services which could be adapted to Swaziland, especially walk-in HIV/AIDS counseling and testing services, home-based care, and activities supported by the private sector.



PROJECT HOPE -- Malawi

In a busy three-month stretch, Project HOPE developed and distributed training and educational materials, extended technical assistance in information management to its counterpart PHAM (the Private Hospital Association of Malawi), and trained religious, youth and women's guild leaders in AIDS prevention.

Project HOPE helped the PHAM AIDS coordinator to review and revise training curricula for PHAM health workers, and also printed and distributed 5,000 additional copies of an AIDS fact book in English and Chichewa. To assist church leaders in HIV/AIDS education, counseling, and training, HOPE reviewed, revised and distributed 400 copies of the booklet "AIDS: A Christian Response".

Since one objective of the HOPE project is to institutionalize the capability for HIV/AIDS education and counseling within PHAM by the end of the project, HOPE provided technical assistance to its counterpart in administration, supervision, and evaluation. This assistance included developing a monitoring and supervisory checklist for a PHAM primary health care project which includes an HIV/AIDS component.

In addition, the PHAM AIDS coordinator visited the AIDS Support Organization (TASO) in Uganda. Based on this visit, she recommended the consideration of: 1) day centers where people with AIDS come together to make friends, share experiences, and counsel each other; 2) home-based care services, with a church leader included in the counseling team; 3) an AIDS information centers where people can walk in freely to learn about the disease and related services.

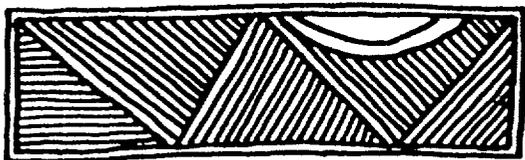
Project HOPE conducted training sessions for ministers, priests and nuns, and distributed ample copies of IEC materials to participants for distribution to their congregations and their communities. Pre-and-post test score comparison data indicated increased knowledge of HIV/AIDS after workshop participation. In addition to church-oriented trainings, Project HOPE provided basic HIV/AIDS information to 432 Muslim Mulaloims. Feedback from two Muslim

Association AIDS Coordinators indicates that HIV/AIDS education is now included in all Friday evening prayers in three mosques, and performance of circumcisions at home using a single razor blade is being reduced.

The project encountered some constraints in the implementation of project activities:

→ As trained church leaders have limited time to organize and conduct second-level trainings within their congregations and communities, these trainings may be shortened from 3 days to 2 days.

→ At both the regional and district levels, there are not enough resource persons to assist in monitoring and supervising project activities.



QUESTIONS AND ANSWERS

[A new feature of the Update introduced in this issue is a question and answer column featuring questions that are commonly asked of AIDS prevention field staff and/or are questions about which field staff desire more information. Please note that the replies to these questions are prepared over 3400 miles (5500 kms) from those posing the questions. Thus, your adaptation of these answers to the needs of your immediate environment is highly recommended. Please send us your questions for future issues of the Update.]

Q: Do mosquitos pass on AIDS (HIV disease)?

A: The answer is simple - No, as indicated both by experiments and experience.

From a scientific perspective there are two potential pathways by which a mosquito (a blood-sucking insect) could spread disease: biologically and mechanically. Biological transmission occurs when an insect consumes blood infected with

virus, the virus is replicated inside the insect, and then is passed into the insect's salivary glands. When the insect is feeding (sucking blood), saliva from the insect may be secreted to keep the blood from coagulating. As a result of the insect's saliva secretion, there is a possibility of disease transmission. This, in fact, is the way yellow fever, dengue and encephalitis are passed from human being, via mosquito, to human being.

Biological transmission of AIDS is impossible because there is no evidence that HIV replicates inside insects. Experiments have been conducted in which insect cells were cultured with HIV and in which insects were artificially fed with high concentrations of HIV-infected blood. The results have demonstrated that the AIDS virus does not multiply in insects. Thus, without replication of the virus within the mosquito there is no possibility of biological transmission of HIV.

The second potential pathway for mosquitos to transmit HIV is that of mechanical transmission. This could theoretically occur if a mosquito, when feeding on an infected person, was temporarily interrupted and then flew onto another person. In theory, a tiny portion of the infected blood carried by the mosquito could be injected into the second person.

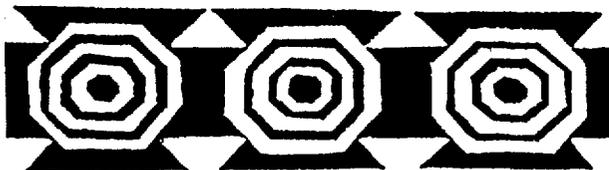
The above transmission does not occur because the volume of blood involved is much too small - far less than on the tip of a needle. It is reported that the probability of an infectious dose of HIV being present through mechanical transmission is that of one in 10 million. In contrast, the probability of infection from needle stick injuries is about one in 300 due to the higher volume of blood. Therefore, mechanical transmission of HIV by mosquitos is dismissed due to the minimal amount of virus potentially carried in the mouth parts of mosquitos.

If mosquitos were the transmitters of HIV disease, then all age groups in mosquito ridden areas would be equally infected with the disease. This hypothesis is not correct as illustrated by the fact that particular age groups (children 5-15 years and adults 45 years and older), are statistically least infected by HIV disease, even when dwelling in areas heavily infiltrated by mosquitos.

Confusion over the question of mosquitos transmitting HIV disease often arises because of the clearly established and well recognized association between mosquitos and malaria. "If malaria is carried by mosquitos, then mosquitos probably carry HIV as well," is a commonly held idea. This assumption is erroneous. Unlike HIV, malaria is not a virus but an infectious disease caused by the presence of a microscopic, parasitic protozoa (single-celled animal). Because the malaria protozoa, known as a plasmodium, is replicated in the stomach of the mosquito after the insect has fed on an infected person, the disease is then carried by the mosquito from one person to another. Again, the difference between malaria and HIV disease in relationship to mosquitos is not only the phenomenon itself (HIV disease is caused by a virus and malaria is caused by a protozoa), but the fact that the malaria protozoa replicates in the mosquito whereas the HIV does not.

The above explanations are based in biological science. Naturally, it will be important to translate this information into concepts which can be identified and easily grasped by the people with whom one is working. Please forward to us any suggestions you might have on how to answer the above question in a way that is understandable within an African culture and context. Your ideas would certainly be helpful to other project staff and AIDS prevention workers.

(Information to answer this question was drawn from Booth, W. *Science*, 1987, July 24, 237(4813), pp 355-356., Burton, F. *Medical Journal of Australia*, 1989, 151 (9), 539-540., and Miike, L. *Do Insects Transmit AIDS?*, 1987. Office of Technology Assessment. U.S. Congress.)



Q: What are the prospects for an AIDS vaccine?

A: While testing of vaccines has begun, it is difficult to predict when a vaccine will be ready.

There are currently 13 vaccines in various stages of human testing around the world, including 6 which are being used in HIV positive volunteers in an attempt to produce an effective immune response against the virus. The overall goal is to use a substance which resembles all or part of HIV and which the human immune system will sense as foreign and thus, attack. It is hoped that the products generated by this immune response would also be effective against HIV in the bloodstream and HIV-infected cells of people who are already HIV positive. In order for vaccine to be useful in this population, the immune response to the vaccine will have to be stronger than that which already occurs in the great majority of people immediately following HIV infection.

The substances used in the various vaccines are produced by one of the following methods. The whole virus can be killed or inactivated; the Salk HIV vaccine uses this *whole killed virus* approach. Alternatively, small portions of the virus, including part of its outer coat (envelope), or portions of its inner (core) proteins, can be produced by genetic engineering technology. These are called the *subunit* vaccines. Another approach, using *synthetic peptides*, is also being tested; these are similar to subunit vaccines, but are smaller and produced using different techniques. (A peptide is simply a small part of a protein.) Finally, some researchers are inserting the gene for one or more of these proteins into different microbes (viruses, yeasts, bacteria, etc.) which then produce the protein. When these microbes, known as vectors, are injected into people, they make the HIV proteins which they were genetically engineered to produce. This approach is known as the *recombinant vector vaccine*.

Combinations of these, and other methods of vaccine production, are currently being tested. According to Daniel Bolognesi, M.D., one of the leaders in HIV vaccine research from Duke University, several vaccines should be ready to enter large-scale human trials for testing of effectiveness in the next three years. [This summary is taken from *AIDS Treatment News*, Issue Number 130, July 12, 1991. For subscription information, contact John S. James, P.O. Box 411256, San Francisco, CA 94141.]

UPCOMING CONFERENCES

Educational Interventions to Reduce the Risk of HIV Infection Among Youth and Hard to Reach Groups: Second International Workshop.

October 29-November 27, 1991 in Jerusalem, Israel.

- Contact: Ronny Shtarksell, The Hebrew University and Hadassah, School of Public Health and Community Medicine, P.O. Box 1172, Israel.

Second Annual AIDS Prevention Conference sponsored by USAID. November 4-5, 1991 in Rosslyn, Virginia.

- Contact: AIDSCOM, 1255 23rd Street, N.W., Washington, D.C. 20037 USA.

Third International Workshop on Women and AIDS in Africa. November 19-22, 1991 in Yaounde, Cameroon.

- Contact: Mrs. Rose Mimbange, c/o AIDS Control Program, Ministry of Health, B.P. 155, Yaounde, Cameroon. Phone: (237) 22-20-23, 22-29-20, 23-14-43/ Telex: OMS YDE 8573KN, 8565KN/ Fax: (237) 22-37-98

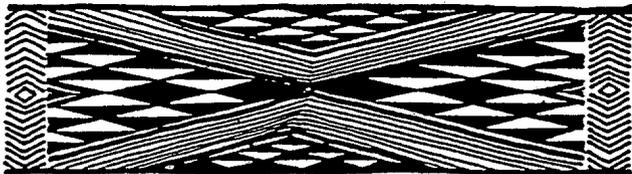
The World Conference on Philanthropy. December 5-8, 1991 at Doral Resort, Miami, Florida. Program will explore opportunities for partnerships between and among groups such as NGOs, foundations, corporations, individuals, and governments to increase possibilities for effective, inclusive philanthropy.

- Contact: The World Congress on Philanthropy Educational Foundation, 901 King Street, Alexandria, Virginia 22314 USA.

The Sixth International Conference on AIDS in Africa. December 16-19, 1991, Dakar, Senegal.

- Contact: Scientific Secretariat, Laboratoire de Bacteriologie-Virologie (HALD), Avenue Pasteur, B.P. 3001, Dakar, Senegal.

This issue of the HAPA Grants Program Update was produced by Mary Anne Mercer, Dr.P.H., Sally J. Scott, M.A. and Cynthia E. Mariel at the office of the HAPA Support Program, The Johns Hopkins University Institute of International Programs, 103 East Mount Royal Avenue, Baltimore, MD 21202. Phone: (301) 659-4104.



APPENDIX I

**Report of the HAPA Technical Advisory Group Meeting
Review of HAPA Grants Final Evaluations**

April 14 and 15, 1992

**The HIV/AIDS Prevention in Africa (HAPA) Support Program
The Johns Hopkins University School of Hygiene and Public Health
Institute for International Programs
Baltimore, Maryland**

I. Introduction

On April 14 and 15, 1992 the HIV/AIDS Prevention in Africa (HAPA) Support Program (HSP) convened a meeting of the HAPA Technical Advisory Group (TAG) with the specific purpose of reviewing the final evaluation reports submitted by the HAPA grant PVO projects. The meeting was held at the Rosslyn Westpark Hotel in Arlington, Virginia.

The morning session began with introductions by those in attendance and welcoming remarks by Mary Anne Mercer, director of the HAPA Support Program. Appendix A lists the meeting participants.

II. Comments by A.I.D. representatives

A briefing by representatives from the Bureau for Africa of the U.S. Agency for International Development (A.I.D.) was the first item of business (see Appendix B for the meeting agenda). Connie Collins, HAPA Project Officer, provided an introduction to the reorganization of the Africa Bureau and offered an update on the AIDSCAP initiative concerning the selection of priority countries as primary targets for AIDS prevention activities. In addition, reference was made to the status of the continuing resolution within the legislative process of Congress through which funding for the agency is determined.

William Lyerly, also of the Africa Bureau, followed-up on Collins' overview with further explanation of the Bureau's reorganization. An organizational chart outlining the new structure is attached as Appendix C.

III. Review of HAPA projects final evaluation reports

The remainder of the first day was spent in review of the final evaluation reports of the HAPA Grants projects. Prior to the meeting, each member of the TAG received copies of final evaluation reports for 6 HAPA grants projects, and an annual report from a seventh project which had not yet completed the period of its no-cost extension.

Each member served as primary reviewer of one report and secondary reviewer of another (reviewers' guidelines and score sheet are in Appendix D). The review of each individual report was followed by a general discussion of the project. A summary of the TAG's comments regarding strengths, concerns and recommendations/lessons learned for each project will be sent to their respective PVO headquarters.

IV. Summary presentation of the EIL project in Uganda

On the morning of the second day, Dace Stone provided a summary of the workplace peer education component of the Experiment in International Living/Uganda (EIL) project. EIL/Uganda was the recipient of a HAPA grant that was channeled through the local A.I.D. mission, and so has not provided routine reports to the HSP.

Stone described the relationship between EIL and the Federation of Uganda Employees (FUE), which involved worksite HIV/AIDS prevention activities. Referring to the recent expansion of HIV/AIDS prevention within EIL, she advised that PVOs and NGOs start small, by first developing and defining a model and then later reshaping the model based on careful evaluations of project effectiveness. She stressed the importance during this process of identifying needs and constraints in the local infrastructure such as condom availability, abundance of human resources possessing specific technical skills such as counselling, and determining adequate staffing needs for personnel with primary HIV/AIDS prevention responsibilities. A cautionary comment was made regarding project expansion, as the demand for services may lead projects to exceed their original project intent and, perhaps, project capabilities.

Another point emphasized was the importance of insuring routine followup of training, job performance, availability of commodities, etc. Promotion of consistent health messages was also stressed, with identification of key messages as an important first step. Assuring that these key messages are being communicated by persons trained by the project, i.e. peer educators, during all their presentations, may be very important to project effectiveness. An additional lesson arising out of the collaboration of EIL and FUE is the importance of work site managers. Management needs to be called upon to provide incentives to enhance a peer educator initiative, as well as to develop project sustainability.

V. Lessons learned from the HAPA grants program

Project Level

The TAG discussed the general lessons learned and recommendations from the evaluation reviews regarding PVO HIV/AIDS projects. The elements considered were project design and staffing, training, supervision/monitoring and evaluation. The following is a summary of the TAG's conclusions:

A. Project design and staffing

1. It is critical that new projects limit the number of different groups in their target population, and justify why the organization has selected a particular population for their project. It is also important to limit impact areas initially to one or at most two geographically separate sites.

2. Projects should emphasize the careful development of project **objectives and indicators**, with technical assistance if necessary. Objectives should include both outputs and outcomes, as well as, in some cases, overall impact. The adaptation or use of appropriate existing indicators is encouraged; an example given was the indicators used by UNICEF, which focuses on interventions for youth: number of unwanted teenage pregnancies; rates of teen syphilis, and HIV seroprevalence in 15 to 19 year old. The evaluation should be designed to include key indicators of all major objectives.
3. At this early stage in knowledge of how best to respond to the HIV epidemic, projects must regularly monitor and assess the need for **changes in project design**. Modifications that respond to new information (such as new government policies or information related to local epidemiology of HIV infection) is appropriate, and should be explained in project documentation as a part of the process of identifying lessons learned.
4. The ability to identify and respond to **serendipitous findings** arising during the lifetime of the project are key strengths of PVOs and NGOs; the documentation of these findings or insights is important.
5. When PVOs work in **collaboration with indigenous NGOs**, awareness of the limitations of their respective institutional capacities is important. The possibility of success is enhanced by the recognition that truly collaborative relationships take time and need to be carefully monitored for obstacles to their success.
6. The eventual **integration** of HIV/AIDS services into primary health care or other development activities rather than maintaining vertical programs is, in general, desirable, although there are advantages and disadvantages to each approach. To facilitate integration it is important that HIV/AIDS prevention projects build liaisons locally with existing health programs such as child survival, family planning, water and sanitation, etc.
7. The roles and workloads of **multi-purpose workers** should be carefully considered before assigning them duties as HIV/AIDS educators. It is important to assess the capacity of each level of worker before adding the demanding and potentially controversial problems of HIV/AIDS into their existing workloads. An added consideration is that relatively more intensive training is needed for HIV/AIDS education as compared to many other areas of health education.
8. Caution should be exercised when projects receive pressure for **expansion or extension of services** before early activities have been evaluated. Expansion or extension of services should be undertaken only after careful examination of pilot efforts demonstrates that they are effective and that the project has the capability to replicate them or add new components without compromising the quality of services.

9. Plans for staffing a new HIV/AIDS project should take into account current and projected staff workloads and the time needed to initiate new activities. Until projects are well established, a bare minimum of one full-time, well qualified coordinator and adequate support staff are essential.
10. As with other kinds of health and development efforts, approaches to sustainability of HIV/AIDS projects must be built into their initial design. Progress in working towards sustainability should be monitored along with progress in achieving other project activities.

B. Training

1. Including training as a project activity is a decision to be made based on feedback from an initial needs assessment, with training content based on the findings of that assessment. If indeed training is carried out, evaluation of the training curriculum and follow-up monitoring of those trained need to take place.
2. Training objectives should be carefully defined. Two important questions related to training that must be addressed are, "What are the trainees being prepared to do?" and "How can we be sure that they are able to do it after training?" The use of curricula and materials developed by other HIV/AIDS prevention projects, instead of developing all new materials, may be useful.
3. Indicators for measuring achievement of training objectives need to be a part of the training curriculum, along with methods for measuring them.
4. When training is geared towards preparing individuals to spend substantial time in the training of others, a systematic methodology for monitoring this planned "multiplier effect" needs to be designed into the project, tested, evaluated and redesigned based on feedback. Although many projects make reference to training of trainers (TOT), in reality many are actually training educators, who provide education and information rather than training others.
5. Regular refresher training needs to be a standard component of training programs.
6. Expectations regarding length of training, such as what can be accomplished during a three day training course, should be realistic. Three days is a very limited time period and project planners should not expect significant skill and knowledge attainment during such a brief interaction, particularly for the new and deeply personal topics that must be included in training to deal with HIV/AIDS. As far as possible, the time to be spent in training should be flexible, based on the rate of learning and skills acquisition that is occurring during the training.

C. Monitoring and supervision

1. A simple and useful **information system** for collecting, analyzing and using data that track project activities is an extremely important component of a successful project. A workable information system should be a high priority for any new project, and should be designed with technical assistance if needed.
2. **Supervision** in and from the field needs to be an on-going project activity; by definition, all persons who receive "training" also need the benefit of regular supervision.
3. If **condom promotion** is part of a project's approach, it should regularly monitor the availability and accessibility of condoms, and integrate that information into project strategies and approaches.
4. **Materials development** may be an appropriate objective for PVO projects where relevant and useful materials are not already available in sufficient quantity. Projects should take care to provide appropriate levels of expertise and resources for this effort, as the materials often may be requested for wider distribution. Pre-testing of materials is absolutely necessary to ensure their effectiveness. Monitoring the distribution and evaluating the effectiveness of the materials produced should be an integral part of materials development.
5. A mechanism for **monitoring the quality and effectiveness of educational activities** needs to be developed when community or other group education sessions are included in a project's approach.
6. Correct identification of the nature of interventions related to **support of individuals and families** is important, in order to avoid confusion and unrealistic portrayal of project scope. Projects may list as an activity HIV/AIDS "counselling," when education and information sharing are more apt descriptions. Support for people with AIDS and their families can be an important function that does not necessarily need to include formal counseling, particularly if referral sources for counseling are available.

D. Project Evaluation

1. **Composition of the evaluation team** is very important; PVOs benefit when appropriately skilled persons with a variety of viewpoints and expertise are involved. The presence of well-qualified external consultants is perhaps most important for the midterm evaluation, when there is still time to identify problems and make mid-course corrections. Whether or not project staff are formally members of the evaluation team, their involvement in the process of internal evaluation is critical to the usefulness of the evaluation, and serves to generate project ownership of the evaluation findings.

2. **Midterm evaluations** can be very important to the process of identifying and fine-tuning effective approaches to project implementation. For both midterm and final evaluations, sufficient time must be allowed for a full review, including time for field visits where project operations can be observed and target populations interviewed.
3. **Appropriate evaluation designs** may vary substantially based on the type of interventions employed, the capabilities and needs of the PVO, the needs and level of involvement of beneficiaries, and the needs of donors. A mix of qualitative and quantitative methods should be included in gathering data for an evaluation.
4. When formally-defined approaches such as **surveys or in-depth interviews** are used, projects should assure that staff are adequately trained in their execution, analysis, and the use of results. Technical assistance for the training of project staff in these methods can be extremely valuable.
5. Many PVO projects planning to collect quantitative data could make an important contribution to knowledge of HIV/AIDS prevention by considering the use of a **quasi-experimental evaluation design**. This might include the use of a comparison group or area, in which pre- and post-project data are gathered but the HIV/AIDS intervention is not implemented. In other cases a modified case/control approach, designed to assess attributability of changes to project interventions, may yield useful results. At a minimum, comparable pre- and post-project data should be collected in an effort to assess the possible effectiveness of interventions.

VI. Reporting by PVO headquarters staff

On the last afternoon of the TAG meeting, participants included PVO headquarters staff from World Vision, CARE, Project HOPE, Save the Children and the Experiment in International Living. The goals of their participation were to assist the entire group in gaining further insight into institutional lessons learned through the HAPA grants program, including future needs of PVOs, and to hear the current status of the PVO's HIV/AIDS programming. Each representative was given time to report on these topics. A summary of their comments is provided below.

A. Save the Children (SC)

Nicola Gates reported on SC's experience with projects in Cameroon and Zimbabwe. Some of her major points were:

1. It was a valuable experience for SC to have more than one HAPA project so as to compare and contrast lessons learned.

2. It was important for SC to integrate AIDS activities as much as possible into existing programs, as opposed to creating a vertical structure that is likely to be less sustainable.
3. A two year funding mechanism is too short, particularly for programs that are trying to affect attitudinal and behavioral change.
4. PVOs were encouraged to try to get mission support for the HAPA grants projects at the conclusion of the two year grants; however, SC experience with mission support has been disappointing. If mission support is expected, there needs to be a system in which A.I.D./Washington provides the missions with a directive, mandate or perhaps a separate funding mechanism designated for support of PVOs.
5. The training of trainers (TOT) methodology used by projects to diffuse AIDS messages, when supervision is adequate, can be a very efficient and cost effective way to reach relatively large numbers of people, especially in areas where access to mass media campaigns is limited.
6. At the community level, educational methods which are participatory and entertain through dancing, singing, or drama are useful approaches to AIDS education. Because of the serious nature of AIDS subject matter, less threatening ways of teaching people are potentially more appealing.
7. HIV/AIDS educational campaigns have indicated that people possess the capacity to remember the correct modes of HIV transmission; however, misconceptions concerning transmission of HIV are difficult to change. This is also true regarding attitudes involving assumptions and reactions towards people with the virus.
8. Central funding for PVO headquarters within HIV/AIDS prevention programs serves a crucial function and needs to continue. Funding for headquarters involvement is utilized to promote sharing of information and recent research findings with the field offices, to provide technical assistance, to support headquarters staff and general networking as well as to inform the field of new funding opportunities. SC does not otherwise have the private monies to fund these activities at the headquarter's level.

SC's current AIDS programming includes on-going HIV/AIDS activities in the Cameroon project (from other funding); an AmFar-funded project in the Gambia; a partnership in a PACT/PCI project in Indonesia; and AIDS activities in a child survival project in Nepal. SC in Mali and Ethiopia also hope to start projects soon.

B. World Vision (WV)

Milton Amayun presented written and verbal reports on the history and current status of WV's involvement in AIDS programming. Appendix E gives the current status of WV's many HIV/AIDS activities. Some of WV's lessons learned are:

1. PVOs need to start with a corporate policy to define and delineate their specific areas of commitment to AIDS programs. This will provide field, technical and fund-raising staff a framework for their work and frees them from internal debates on the importance of AIDS and its order of priority in resource allocation. An institutional commitment is particularly important given that AIDS prevention does not have the fund-raising appeal of child survival and other kinds of health and development work.
2. USAID's HAPA PVO grants program was painfully short; there was no opportunity to evaluate impact. In WV's child survival programs, six years has been identified as the optimum length of time to demonstrate impact in the African context. In a few countries with particularly weak health infrastructures, that period might be up to ten years. Because AIDS prevention programs were new when the HAPA program was introduced, a longer time frame would have been desirable to ensure momentum of activities.
3. The integration of AIDS with child survival and other health activities could have been given more emphasis. Although the initial proposal guidelines strongly urged this process, and child survival programs started asking for AIDS statistics for the annual reports, the linkage seems to be stalled at present.
4. The focus of HAPA was the sexually active age group. As the epidemiology of AIDS unfolded in Africa, the numbers of children and mothers infected with HIV became more significant. In some countries, AIDS has been demonstrated to have reversed gains in child survival. Infants and children would be important target groups if there is a "HAPA Phase II."
5. The evaluation of impact of WV HAPA projects has been difficult for two reasons, including the short time frame and the relatively undeveloped state of HIV/AIDS evaluation. In order not to lose the very important lessons learned from the evaluations done on HAPA projects, this issue should be given special focus in the writing of the final report on HAPA.
6. The turnover of staff, both on the PVOs' side as well as USAID's, has had a negative impact on programming.

C. CARE

Zoe Kopp presented CARE's experience with the Rwanda HAPA project, as well as with the 20% of their HAPA grant that went to support a regional technical office in Kenya. Her comments were:

1. The HAPA funding clearly had an important "multiplying effect" for CARE. One of CARE's first activities was a meeting of staff from 6 African countries in Uganda to begin developing an AIDS strategy for CARE. All but 1 of the countries in

attendance now have AIDS projects. The strategy developed has been found to be very helpful.

2. One of the very valuable outputs from funding the regional technical office in Nairobi has been the development of our intra-organizational newsletter, AIDS Focus. This document provides information about the status of the epidemic, of AIDS programming generally and CARE's particularly. It is now distributed to all CARE offices worldwide.
3. The Rwanda cross visit, in which staff from four other countries visited the Rwanda project, proved to be very useful and served as a kind of "mini evaluation"; as a result of this activity, projects were started in Togo and Haiti.
4. Evaluation guidelines and assistance from the HAPA Support Program have been very helpful, especially with regard to qualitative research methods and sustainability. The evaluation workshop recently held in Uganda was very helpful for CARE's evaluation planning, particularly the chance to hear first-hand about the evaluation of a Ugandan project.
3. The availability of central funds to support activities at headquarters level is crucial to CARE's ability to set up and carry out AIDS programs.
4. Two years was a very short time for an AIDS project -- not enough time to implement a new program and demonstrate impact. Now that the "seed money" is finished, funds for continuation of the work are difficult to find.
5. Some project-level lessons were: it is difficult to change people's beliefs (e.g. AIDS can be transmitted through mosquito bites); condom distribution systems can be extremely important once awareness is raised; availability of testing and counseling must be considered if the demand for those services is stimulated by the project; and providing AIDS education for all CARE staff is very important, because they are seen by the community as authorities on all issues.

CARE has seven AIDS projects currently in operation and a number of other efforts pending. Activities from the HAPA project in Rwanda will be contained within the family planning program there. CARE also recently received a large grant from the Nairobi USAID mission to carry out an AIDS prevention project in Kenya.

D. Project HOPE

Marjorie Souder reported on lessons from Project HOPE's HAPA grants projects in Malawi and Swaziland.

1. Strong links with indigenous organizations need to be developed for sustained effectiveness of programs. Because of the difficult tasks involved in HIV/AIDS

prevention, highly capable project coordinators are extremely important factors in project success.

2. Indigenous people need to be in control and have real responsibility for input into programs, including decision making about selection of intervention messages and materials.
3. In addition to meeting project objectives, there is a great need for flexibility in determining project approaches and strategies. Projects need to look at the needs and wants of the country, and move accordingly in that direction.
4. Mutually beneficial collaboration for AIDS interventions with local counterparts having other priority functions may be difficult to sustain. In both Swaziland and Malawi we are finding that a number of local organizations are interested in part-time collaboration, without committing full-time efforts to AIDS. We are exploring the possibility of setting up a separate NGO in Swaziland that devotes full-time efforts to AIDS education and support.
5. Training of counsellors in a country with neither previous experience of counseling nor an acknowledged need for it is unlikely to be effective without substantial additional inputs. Institutional support for the importance of the role of counselors is necessary for a counseling program to succeed.
6. There is a growing expectation that the leadership in Africa on HIV/AIDS prevention is going to be guided more and more by professionally trained African women.

Both the HAPA grants projects in Swaziland and Malawi are continuing with local USAID mission funding.

E. Experiment in International Living

Patricia Neu reported that the EIL HAPA project in Uganda, a comprehensive effort that began in 1988 and involves both governmental and nongovernmental sectors, was funded for 3 more years by the Kampala mission for a total of \$12 million.

Some of the lessons learned or recommendations that Ms. Neu reported from the EIL Uganda project are:

1. The way in which assistance to NGOs is designed will influence the extent to which local constituencies are built that can effectively confront the HIV pandemic. Decentralization of decision making within HIV/AIDS prevention programs can be effective; funding at the local level can work well with technical assistance coordinated at the national level.

2. Incremental project funding, beginning with small grants appropriate to the institutional absorption capacity, is an important mechanism to build local capacity.
3. The peer education model appears to transmit information effectively at the cognitive level. In Uganda, people know about AIDS, how it is transmitted and are more sympathetic towards people with AIDS. But despite well-conducted programs, such as that for peer educators in the workplace and in the nonformal sector, there is still little evidence of important, widespread changes in risk behavior. More efforts are needed that focus specifically on the process of behavior change at the individual level. Risk analysis techniques, being developed by AIC, TASO, FUE and EIL counseling programs, are a first effort in this direction.
4. It is important to look at the diversity of local institutions and identify what each can bring to the process of HIV/AIDS prevention and the supportive role these institutions can play regarding reinforcement of normative sexual behavior.
5. There is some evidence, being investigated further by a CDC team, that knowledge of serostatus has an important motivational role in bringing about behavior change. This may be true for both HIV positive and HIV negative individuals.
6. The distinction between assistance for prevention and care is becoming less clear within HIV/AIDS efforts at the field level. The same blurring of distinctions is also becoming apparent between government and NGO efforts, with an increasingly evident need for a close partnership between the two groups.

VII. Lessons learned at the PVO grants program level

During the final discussion of the day, both PVO staff and TAG members discussed several policy issues related to the implementation of a grants program. The general topic areas related to technical assistance for PVO projects, miscellaneous issues related to reporting and duration of the project, functions of a technical advisory group, and management of a grants program/support program.

A. Technical assistance

The TAG reviewers cited problems common to many of the HAPA projects which may have been avoided if the project had sought technical assistance (TA) at crucial points, and if the recommendations generated through TA were then incorporated into the project design and implementation. Some of the frequently noted problems included:

- overly ambitious or otherwise inappropriate objectives,
- lack of supervisory efforts to match training activities, and
- inadequate monitoring of the quality of services.

The need for technical assistance is difficult to anticipate, but is often needed at least at the time of preparation of the detailed implementation plans (DIP), during/after the mid-term assessment and for the final evaluation. PVOs generally felt that more TA was needed than was anticipated for the HAPA grants, and that building generous levels of TA into a grant would be wise. They also noted that experienced field staff will be aware of the value of TA, and will request it when needed.

The PVOs expressed general satisfaction with the quality of technical assistance they received, stressing that when appropriate persons were available locally or regionally they tended to be much more cost-effective than internationally-based consultants. They also noted that it was useful to have access to other groups' experience of specific consultants for HIV/AIDS projects, so as to judge their appropriateness for additional assignments.

The question was raised as to how the new approaches of AIDSCAP can be used to provide TA for PVO projects. It was pointed out that the AIDSCOM TA provided to the HAPA grants projects was funded by a HAPA buy-in, not through the A.I.D. missions. The major difference between this previous method and A.I.D.'s new approach is that the missions themselves will need to support any future TA, as there are no remaining core HAPA funds that can be used to buy-in to AIDSCAP.

It was pointed out that PVO headquarters staff themselves serve as technical advisors to field projects, with the extent of their involvement depending on the availability of time and travel money as well as organizational relationship between the headquarters and the field. Experienced field managers, it was suggested by one PVO, are knowledgeable about when to call upon headquarters for assistance.

The discussion of technical assistance included the issue of support for PVO headquarters as an integral part of field project planning and implementation for HIV/AIDS prevention projects. The competitive grants program that AIDSCAP is planning was discussed, and concern was expressed by PVO representatives that it be of sufficient size and scope to allow for further development and maintenance of headquarters expertise. The AIDSCAP representative stressed the commitment of AIDSCAP to maintaining a strong role for international PVOs in their project. Another concern raised was the maintenance of a strong PVO headquarters role in relation to the field-level funding mechanisms of the new AIDSCAP initiative, which will work with existing NGOs and PVOs in priority countries.

It was suggested that PVOs discuss with local A.I.D. missions the need for headquarters as well as field office funding for country projects. There was much skepticism voiced by several members of the PVO community and TAG as to whether that proposal was, indeed, a viable solution to the problem. Concerns were expressed that, based on past experience, mission support for PVO headquarters was not likely to occur. The current A.I.D. approach to funding for PVOs at the mission level by-passes, for the most part, direct engagement with PVO headquarters. There was concern that this approach would not take optimum advantage of the accumulated expertise PVO headquarters have developed in HIV/AIDS

prevention. Without support for the activities of PVO headquarters, there is limited opportunity for cross-fertilization and application of lessons learned from one HIV/AIDS prevention project to other field projects. A.I.D. representatives reiterated the importance of communicating these concerns to A.I.D. missions, as it is the individual missions who are increasingly the decision makers regarding PVO/AIDS funding.

A lengthy discussion ensued of policy changes at A.I.D. related to decentralization of project funding, and the need for PVOs to adapt to these changes.

B. Life of the project

The next discussion topic focused on recommendations concerning project duration and reporting requirements. The first consideration was the amount of time needed to satisfactorily plan, implement and demonstrate effectiveness of a new HIV/AIDS project. The consensus by the PVO representatives was that three years be allotted initially for grants, with the possibility of extensions of two or three years.

PVO staff recommended that an on-going mechanism be developed to promote sharing of information, materials and networking among HIV/AIDS prevention projects locally and/or regionally situated. Field workshops, including one planned earlier than mid-term, were considered to be very worthwhile mechanisms for sharing experience and networking.

Project reporting was seen as a valuable means of tracking progress. Both TAG and PVO staff thought that the quarterly reports might be used for the sharing of materials, data collection instruments, curricula and other documents developed during the project. These were seen as more useful than quantifying project outputs and listing activities. There was consensus that the mid-term evaluation should be heavily emphasized, as it might help to identify problems at an early enough stage that appropriate changes could be made.

C. Functions and management of a grants program

PVOs considered the coordinating functions of a support program to be beneficial to their projects. It was helpful for both field and headquarters staff to have feedback provided by the TAG on project reports. Field visits by support program staff, preferably very early in the project, are also very important. It was thought that it would also be very useful if TAG members were able to visit a field project at least once.

Sharing of experiences among HIV/AIDS prevention projects through workshops and cross-visits were seen to be highly supportive and useful exchanges. Because in the field of HIV/AIDS prevention the knowledge base changes so quickly, interactions such as these provided an opportunity for updating information and being introduced to new ideas and approaches. Encouraging field visits to other prevention projects early on in the planning/implementation process was thought to be an effective means for avoiding common mistakes, and of facilitating replication of effective efforts previously developed and tested

by another project. The mutual exchange of staff as evaluation consultants between the World Vision and Save the Children staff in Zimbabwe was mentioned as a satisfactory example of country-level PVO collaboration.

Sharing of KAP instruments and materials developed by various HIV/AIDS projects were identified as additional interests of PVOs that support offices such as HSP might provide to the field.

The newsletter produced by the HSP was found to be useful, particularly following the mid-term HAPA field workshop. Personal contact and familiarity with the other HAPA projects generated during the workshop lent a "new face" to information shared in the newsletter. A recommendation was made to further enhance the newsletter as a tool for communicating among HIV/AIDS projects.

D. Technical advisory group (TAG) functions

The contributions of the TAG were seen as very valuable by both the TAG members and by PVO staff. Their functions were identified as helping to establish technical standards and guidelines; reviewing routine reports; and serving as general advisors and trouble-shooters. It was also suggested that in some cases TAG members might be available to serve as members of project evaluation teams.

The interdisciplinary nature of the TAG was seen as beneficial, contributing to its ability to understand the field perspective and also providing personal/professional satisfaction for TAG members. TAG members appreciated the attempt to maintain continuity in the reports that they reviewed. To facilitate the possibility that TAG members would be available to assist PVO projects, it was recommended that projects continue to be assigned based on their location in countries to which TAG members anticipated field travel.

The former A.I.D. HAPA project officer expressed his gratitude for the support and advice of the TAG over the period of the HAPA project. Mutual thanks between PVO and HSP staff were expressed, and the meeting was adjourned.

APPENDIX A

Participants in the HAPA Technical Advisory Group Meeting April 14-15, 1992

A. HAPA Support Program staff

Mary Anne Mercer, director
Cynthia Mariel, program assistant

B. Technical Advisory Group members

Laurie Liskin, Johns Hopkins University
Henry Mosley, Johns Hopkins University
Kathy Parker, Centers for Disease Control
Michele Shedlin, Sociomedical Resources, Inc.
David Sokal, AIDSTECH
Dace Stone, AIDSCOM
Dory Storms, Johns Hopkins University
Judith Timyan, PSI

C. Invited guests

William Lyerly, USAID
Constance Collins, USAID
Jaime Henriquez, USAID
Vicky Kunkle, USAID
John Paul Clark, USAID
Erin Soto, USAID
Mary Lyn Field, AIDSCAP
Shamseh Poonawala, NCIH

D. PVO representatives

Zoe Kopp, CARE
Pat Neu, Experiment in International Living
Marjorie Souder, Project HOPE
Nicola Gates, Save the Children
Milton Amayun, World Vision

** Participation in the meeting varied, with attendance by the HAPA Support Program and TAG constant. The PVO representatives attended only the afternoon session of April 15.

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APPENDIX B

HAPA GRANTS PROJECTS
FINAL EVALUATION REVIEW TAG MEETING

Schedule

Tuesday, April 14, 1992

Primary Secondary
Reviewer: Reviewer:

9:00 AM Introductions, opening comments
9:30 Review: CARE/Rwanda
10:15 Break
10:30 World Vision/Kenya
11:15 HOPE/Malawi

12:00 noon - Lunch (on your own)

1:30 PM Project HOPE/Swaziland
2:15 Save the Children/Cameroon
3:00 Break
3:15 Save the Children/Zimbabwe
4:00 World Vision/Zimbabwe
4:45 Discussion and adjourn

Wednesday, April 15, 1992

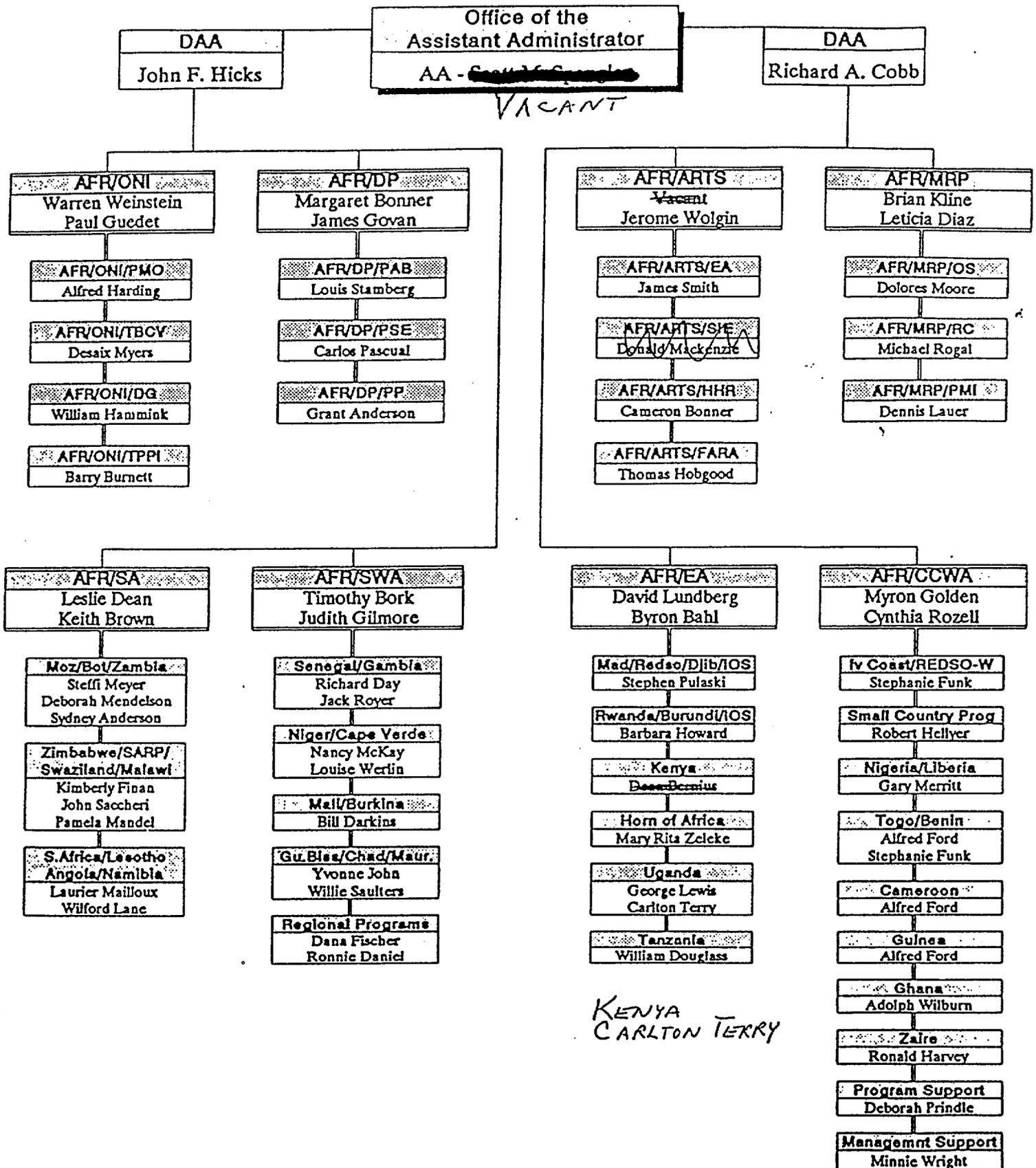
9:00 AM EIL/Uganda summary
9:30 JHU/Malawi summary
10:00 Break
10:30 TAG discussion of lessons learned/recommendations

11:30 AM - Lunch in the Vantage Point (HAPA PVO headquarters staff join the meeting)

1:00 PM Presentations by HAPA PVOs re: lessons learned, plans for future HIV/AIDS activities (15 minutes each)
2:30 Break
3:00 Group discussion of recommendations for PVOs and funders re: future HIV/AIDS activities
4:00 Next steps: recommendations to Bureau for Africa and USAID regarding future PVO involvement in HIV/AIDS
5:00 Adjourn

APPENDIX C

BUREAU FOR AFRICA



KENYA
CARLTON TERRY

APPENDIX D

HIV/AIDS PREVENTION IN AFRICA (HAPA) GRANTS PROGRAM FINAL EVALUATION REVIEW GUIDELINES

INFORMATION FOR REVIEWERS

The final evaluation for the HAPA grants projects is an opportunity for PVO staff to review their project experience for the entire funding period of the grant, to identify project accomplishments and lessons learned, and to make recommendations for future activities of a similar nature. Technical review of the final evaluation reports provides an opportunity for the Technical Advisory Group to identify strengths and weaknesses of the projects, compare the experiences and lessons learned that have been identified by project staff, and to make recommendations to PVOs and their funders regarding key issues for future HIV/AIDS activities. Following the technical reviews, the PVOs will be provided written summaries of the TAG's comments on their reports. Most of the PVO headquarters staff will also be present on the last afternoon of the TAG meeting, during which time they will be able to discuss with the TAG their own concerns, lessons learned and recommendations.

Please review the "Overview and General Guidelines" and "Detailed Guidelines" for the final evaluations that were provided to project staff. As stated in the guidelines, it was not necessary for the PVOs to follow the evaluation outline exactly as given, so as to allow each evaluation team to emphasize the special problems, strengths and approaches of each project as they found it appropriate. However, all of the information included in the guidelines should be provided at some point in the report.

The written review consists of two parts. The scoring sheet, Part A, asks that for each major heading given in the guidelines, you assign a number score for each topic listed. Narrative comments specific to the overall effectiveness of the project are requested in Part B. We would like you to pay particular attention to identifying the lessons that have been learned as a result of the project experience, both from the project's own documentation and from your own insights or additional information. Finally, please include any recommendations you might have for the PVOs and for A.I.D. or other donors regarding future PVO/NGO AIDS projects.

Each TAG member will serve as primary reviewer for one report, and as secondary reviewer for another (see the review schedule individual review assignments). The primary reviewer will provide a brief summary of the project, and each reviewer will then present his/her assessment of the strengths, weaknesses, and lessons learned/recommendations, to be followed by a general discussion.

HAPA GRANTS PROJECT FINAL EVALUATIONS Overview and General Guidelines

I. Introduction

In May, 1989, the Health, Population and Nutrition Division of the A.I.D. Bureau for Africa announced the award of nine HIV/AIDS Prevention in Africa (HAPA) grants for Fiscal Year 1989. The grants have funded five private voluntary organizations (PVOs) and one university to add components to their existing health or development programs in Africa that will assist communities to reduce the spread of HIV infection. An important focus of the program has been to strengthen the capacity of the PVOs to provide high quality, effective, community-based assistance in this area.

The HAPA grants projects will be completing the implementation of their projects in late 1991 or early 1992; for some, this includes a no-cost extension past the original two year project period. Each project will complete a final evaluation of their project as a part of their grant activities. This document will provide suggestions regarding the purposes, methods and content of the final evaluations, including specific guidelines for the final evaluation report.

II. Purposes of the evaluation

An important purpose of the HAPA grants final evaluations is that of most end-of-project evaluations: to assess the effectiveness of the project's key interventions and approaches. In other words, how well were the stated objectives of the project met?

However, there are a number of reasons why evaluating the end result is not the only reason, and perhaps not the most important one, for conducting the evaluation. The HAPA grants evaluations, like most "final" evaluations, do not mean the end of project activities, but rather the end of a specific funding cycle or funding source. Many, if not most, of the activities carried out by the HAPA grants projects will be continuing after the end of the grant periods. Some will be supported by other sources, such as the USAID mission or other external donors; some will be integrated into Ministry of Health activities; others will be carried out by local collaborating NGOs. Clearly, a purpose of the HAPA grants final evaluations will also be to identify information needed to improve the quality and effectiveness of the project activities that have been, and will continue to be, carried out. This requires a focus on the process of project implementation, in addition to its results. Attachment A, "Monitoring and Evaluation of NGO AIDS Activities," describes in more detail the importance of focusing on the process and quality of project implementation in evaluating HIV/AIDS prevention projects.

The lessons learned from the HAPA grants projects will help to identify the most effective approaches for PVOs to take in future efforts to respond to the HIV epidemic in Africa and elsewhere. This expectation is another reason to focus on the processes that occurred in the development of the HAPA grants projects. Identifying the lessons learned, and sharing those lessons with others involved in HIV/AIDS prevention, will be the focus of an end-of-project workshop that, pending the availability of funding, is tentatively scheduled for early 1992 in Uganda. The HAPA Support Program will also summarize the more important lessons learned in a report for A.I.D. and the rest of the HIV/AIDS prevention community.

III. Evaluation Methods

The HAPA grants final evaluations should be completed before the end of project funding, and the report submitted to USAID within sixty (60) days of the formal end-of-project completion date.

The evaluation should be a team effort; suggestions for the kinds of individuals to be included in the team are discussed in Attachment A. All HAPA grants final evaluations are expected to include on the evaluation team an external consultant who is familiar with HIV/AIDS prevention issues and approaches. By external consultant is meant an individual not directly associated with the project; he or she may be a local national, someone from the region, or from outside Africa. The HAPA Support Program will assist in locating an appropriate consultant, if requested, and will in some cases be able to support the cost of using the consultant.

Each project that completed a baseline survey of the knowledge, attitudes, beliefs and practices (KABP) of their project population is strongly encouraged to conduct a followup survey. To assist the projects to carry out their surveys more rapidly and with a more standardized methodology, the HAPA Support Program will provide or arrange for technical assistance in carrying out the survey to projects requesting it, within the limitations of available funding. A set of written suggestions for planning, implementing and analyzing the surveys will be provided as a part of the technical assistance package. PVO staff should contact the HAPA Support Program office, if they have not already done so, to discuss needs for technical assistance for either the KABP survey or for the final evaluation itself.

In addition to methods that aim to quantify the results of the project's activities, such as the KABP survey, projects are strongly encouraged to consider using more qualitative methods of gathering information for the final evaluation, such as focus group discussions and in-depth interviews. These methods can be

used to gain a deeper understanding of what has occurred during the course of the project, including the perceptions of project staff, target population, and other concerned individuals such as ministry of health officials or community leaders. Focus group discussions can be used to help interpret and deepen understanding of the results of the KABP survey, and identify remaining obstacles to HIV/AIDS prevention efforts.

To assist projects in getting useful qualitative data for the final evaluations, the HAPA Support Program has enlisted the help of selected members of the HAPA Technical Advisory group (TAG). A document entitled "Guidelines for Gathering Qualitative Data for HAPA PVO Grants Project Evaluation" has been prepared by Judith Timyan, an anthropologist who is a member of the HAPA TAG (Attachment B). She was assisted by comments from other TAG members and HAPA Support Program staff. The document outlines some basic guidelines for getting relatively rapid but useful and valid qualitative information for inclusion in the final project evaluation reports. It is still in draft form, since the author and the HAPA Support Program would like to receive feedback from project staff after they have read and field tested the usefulness of the methods and approaches it outlines.

All members of the evaluation team are urged to read the guidelines for qualitative data gathering prior to the final evaluation. The guidelines are designed to be used by persons who have had some training in qualitative methods, although the ideas and approaches included should be useful for any project evaluator. If no one from the evaluation team or project staff has such training, a local consultant can be employed to review the evaluation plans and assist in training key individuals to carry out the qualitative methods described in the report. The reward for a relatively small investment in learning the basics of these methods will be a greatly enhanced understanding of how the project has affected the staff, target populations and others in the project area.

IV. Content of the evaluation

We expect that each project will have a unique set of evaluation questions that they wish to answer. It is impossible for any one document to cover all possible questions that might be of interest in assessing the strengths and constraints of a project, so it is recommended that each project identify a set of key questions on which they will focus the final evaluation. Some major elements will be important for all of the projects to include, however; those key elements will be included in the Evaluation Guidelines.

The evaluation guidelines which follow are meant to be a general

guide for those planning, carrying out and documenting the HAPA grants projects' final evaluations. No page length recommendations are given, so projects are free to judge the most appropriate depth to provide in discussing different topics; as a general rule, the body of the final report should be in the range of 20-40 single-spaced pages, however. The guidelines are not meant to provide an exhaustive list of all possible content to be covered; individual projects should follow this basic outline, but add any other areas of project or evaluation emphasis that it does not encompass.

As stated above, the final evaluation report is due sixty (60) days after the project's official completion date. The reports will be reviewed by the HAPA Grants Program's Technical Advisory Group (TAG), with feedback on their comments provided to the projects, as before.

Please send an original (unbound) and 10 copies of the report to:

Mary Anne Mercer
HAPA Support Program
JHU/Institute for International Programs
103 East Mt. Royal Avenue
Baltimore, MD 21202

Please also send 5 bound copies of the report to:

William H. Lyerly, Jr.
HAPA Project Officer
Bureau for Africa, NS 2738B
Agency for International Development
Washington, DC 20523

HAPA GRANTS PROJECT FINAL EVALUATIONS
Detailed Guidelines

Cover Page: Include name of project/PVO, country, formal beginning and ending dates of the project (including no-cost extension, if any), and date submitted.

Report Outline:

i. Contents

ii. Executive Summary

A one- or two-page summary that focuses especially on the recommendations of the evaluation.

I. Introduction

A brief introduction that explains the project setting and the main purposes and approaches of the project, including relationship with the local counterpart organization(s), if any.

II. Evaluation Methodology

Describe the methods of the evaluation in terms of:

A. Purposes of the evaluation, giving the main questions on which the evaluation will focus.

B. The composition of the evaluation team.

C. The methods used, such as major sources of information, means of gathering the information, approaches used in determining the conclusions and recommendations of the team, and how the evaluation results were (or will be) shared with those concerned in the project country. Document separately any KABP surveys or other special activities (e.g., focus group interviews) conducted for the evaluation; these may be included as an appendix.

D. Evaluation schedule and list of informants (can be an appendix).

III. Findings of the Evaluation

A. Design Summarize the project design, and trace and explain any changes made in the design over the course of the project. What were the main strategies of the project? How did the choice of impact areas and target populations affect the implementation of the project? How was the project staffed? How were volunteers utilized? Supervised? How was it intergrated with other local institutions (e.g., local counterparts, NACP, other NGOs)? How was the community involved?

What were the strengths and constraints of the design of the project? Describe the major uses of project funding, and include a budget that summarizes expenditures over the life of the project.

- B. Process Explain how the quality of each major activity undertaken by the project was assured through monitoring of project activities. What do project records show about how well various activities were carried out? Of particular importance are assessment of the quality of training; of the effectiveness of educational sessions; pre-testing of pamphlets or posters, etc. How well were the processes of the project documented? How did staff and target populations assess the quality and relevance of activities?
- C. Outputs What have been the primary outputs or "things done" by the project? How do the outputs compare with what was planned, as stated in project objectives? What explains any shortfalls in achieved outputs? Provide samples of any written or graphic materials developed by the project.
- D. Outcomes What were the planned project outcomes, or effects on the target population, according to the project objectives? How do they compare with the outcomes observed? What explains any shortfalls in observed outcomes? What other effects have been observed, including unanticipated ones on project staff, target populations, others? What have been the effects of the project on PVO staff, and on the organization as a whole (list any other AIDS-related activities that PVO has undertaken, if any, as a result of HAPA grant).
- E. Sustainability What was the original plan to sustain project activities after HAPA funding was completed? What will be the status of the project after this funding cycle? What factors have facilitated or hindered the ability of the project, collaborating groups or the community to sustain project activities?
- F. Staffing and technical assistance Was the staffing plan, as described in part A, adequate? What difficulties or obstacles were encountered? Describe the main sources of technical assistance (TA) and training for project staff (including all sources and all methods, both from consultant or HQ staff visits and written materials). What does staff perceive to be the most useful TA received? What needs for TA remain? Were local sources of TA adequately utilized?

IV. Lessons Learned and Recommendations

- A. For each of the evaluation's areas of focus, describe the lessons learned and state the concrete recommendations for action made by the team.

HIV/AIDS PREVENTION IN AFRICA (HAPA) GRANTS PROGRAM
FINAL EVALUATION REVIEW SCORE SHEET - Part A

Country/PVO _____ Reviewer _____

Please assign a numerical rating for each of the topics given below, using the following scale: NA=not applicable, 0=topic not addressed, 1=topic inadequately addressed, and 2=topic adequately addressed.

In some cases you may find that the report responds to the request for information on an item, but that the project's activities in that area were inadequate. Both adequate documentation and a technically acceptable response to the question are required if the item is to merit a score of "2."

i. Executive Summary

Is there an executive summary? Does it reflect the major points contained in the report? _____

I. Introduction

Is adequate background provided as to the setting, purposes and approaches of the project? _____

II. Evaluation Methodology

A. Are the purposes of the evaluation stated? Are important focus areas for the evaluation identified? _____

B. Was the composition of the evaluation team appropriate? _____

C. Were the methods used to gather and analyze information adequate and appropriate? Were the evaluation results shared with concerned groups? _____

Were any KABP surveys or other special activities (e.g., focus group interviews) executed and documented appropriately? _____

D. Was the time frame for the evaluation adequate, and did it include field visits? Did the selection of informants include a broad representation of those concerned with the project, including the target population? _____

III. Findings of the Evaluation

- A. Design Are the overall design and strategies of the project clearly described, and appropriate to the setting? Were timely modifications made in the design if indicated? _____

Did the project successfully collaborate with at least one other local institution (e.g., local counterparts, NACP, other NGOs)? _____

Was there active involvement of the community in the project? _____

Is a budget included that summarizes expenditures over the life of the project? Were expenditures reasonable, given the overall focus of the project? _____

B. Process

Is an effective system described for monitoring of the quality of project activities (e.g., the quality of training, the effectiveness of educational sessions or materials produced, etc.)? _____

Were project management and staffing issues appropriately addressed by the project (see also section F)? _____

C. Outputs

Are the outputs of the project documented? _____

How do the outputs compared with what was planned, as stated in project objectives? Are any shortfalls in achieved outputs adequately explained? _____

D. Outcomes

Are the planned project outcome objectives, or effects on the target population, given? Were appropriate indicators used? _____

Was it possible for the project to measure end-of-project levels of key outcome indicators? How do they compare with the levels that the project planned to achieve? Are any shortfalls in observed outcomes explained? _____

Are the longer-range effects of the project on the community and on the PVO itself documented? Did the project appear to have any important lasting effects at the community level? Did spin-off activities or projects result from the HAPA-initiated activities? _____

E. Sustainability

Is the current status of the activities carried out under the HAPA grant described? Are project activities continuing? Are factors that facilitated or hindered the sustainability of the project identified? _____

F. Staffing and technical assistance

Were difficulties or obstacles related to staffing and supervision of staff recognized and described? Were appropriate steps taken to overcome them? _____

Are appropriate sources of technical assistance (TA) and training for project staff described? Were local sources of TA utilized? _____

IV. Lessons Learned and Recommendations

A. Are important lessons learned identified and concrete recommendations for action made for each of the evaluation's areas of focus? _____

TOTAL SCORE: _____ (maximum possible total=44)

* * * * *

Overall Impression (circle one):

- 1. Excellent project; final evaluation indicates all major activities were very well planned, implemented, and sustained.
- 2. Very good project; final evaluation indicates that it was well planned and implemented but with some important constraints (e.g., not sustainable, not adequately evaluated, etc.).
- 3. Good project; some weak areas in design or execution that would need modification if it were to be replicated.
- 4. Fair project; would need substantial modification if replicated.
- 5. Poor project; technically inadequate planning and implementation.

HIV/AIDS PREVENTION IN AFRICA (HAPA) GRANTS PROGRAM
FINAL EVALUATION REVIEW SUMMARY - Part B

Country/PVO _____ Reviewer _____

Please record your impressions of the major strengths and weaknesses of the project. Then provide your summary of the lessons learned from the project, as well as any recommendations you would have for both the PVO/NGO community and for future funders of PVO/NGO AIDS projects, based on this project experience. Please consider the following key areas, and any others you find important: design; staffing and management; monitoring and evaluation; technical quality, appropriateness and effectiveness of interventions; community involvement; collaboration with local institutions; and sustainability.

STRENGTHS

Country/PVO _____ Reviewer _____

WEAKNESSES

Country/PVO _____ Reviewer _____

LESSONS LEARNED/RECOMMENDATIONS

HAPA Grants Final Evaluation Review

Lessons Learned in World Vision's AIDS Prevention Program

by

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Introduction

World Vision began to recognize the importance of AIDS as a factor in international development in 1985. At that time, we did not know as much of the disease's character, evolution and potential impact on health systems. What was clear, however, was that this new disease was a killer and medical science had no known cure for it.

Africa was the first area of World Vision's worldwide work where the disease took its toll. Unfortunately, data was not readily obtainable and tracking was difficult because countries were not open to epidemiological studies. Governments feared the new disease's potential impact on commerce and tourism. It was only after years of pressure and international recognition that AIDS was a pandemic sparing no region of the world that genuine openness began to take place. There are a few exceptions here, notably Uganda, Kenya, Tanzania and Zimbabwe; these were the countries where World Vision's work in AIDS prevention is most advanced.

In the last seven years, it is interesting to note that the progression of World Vision's AIDS program has expanded to other geographical areas, has led the organization to rediscover its old strengths and into many new areas of involvement.

From Policy to Action

Africa was the first region where World Vision mandated the development of an AIDS prevention program. In 1987, each office in Africa was asked to develop strategies that integrated AIDS prevention with Primary Health Care activities. The response was not uniformly vigorous throughout the 21 field offices, and the interest was initially a function of a country's AIDS caseload at that time. Simultaneously, a fairly comprehensive AIDS policy was adopted at the international level of the organization. This policy covered issues such as standards of project implementation, safety of employees, discrimination against HIV+ individuals, resource allocation and integration with other health activities.

In 1988, USAID's Africa Bureau invited US-based PVOs to develop proposals for AIDS prevention in Africa. World Vision submitted proposals for Zimbabwe and Kenya, both of which were approved with funding for two years, starting October 1, 1989. Technical support was provided by Johns Hopkins University.

Since then, World Vision's specific AIDS projects have multiplied in number and expanded in scope. Today, all regions within the World Vision partnership* have some involvement in AIDS programs, as the attached table shows.

*Partnership is the term used for the network of 94 WV offices worldwide.

KEY GEOGRAPHIC AREAS OF WV'S AIDS INVOLVEMENT

Africa

1. Uganda - Assistance to AIDS orphans; collaboration with other NGOs in counselling and advocacy; material assistance to the sick and their families
2. Kenya - AIDS prevention programs in several urban, peri-urban and rural communities
3. Zimbabwe - province-wide AIDS prevention programs
4. Tanzania - district-wide AIDS prevention program
5. Chad - region-wide AIDS prevention program
6. Zambia - collaboration with local partners in counselling and AIDS prevention

In addition, the following field offices are developing their country-specific AIDS prevention programs: Ethiopia, Ghana, Malawi, Mozambique, Zaire and Zambia.

All WV offices in Africa were asked to integrate AIDS prevention with PHC activities in 1987.

Asia

1. Thailand - AIDS prevention programs in rural and urban locations targetting fishermen and commercial sex workers
2. India - Research on AIDS and adolescent girls in a Bombay slum
3. Vietnam - province-wide AIDS prevention program based in Danang

WV offices in Burma and Cambodia are currently studying the possibility of AIDS prevention programs.

Latin America

1. Brazil - AIDS prevention in collaboration with an NGO associated with the Catholic church.
2. Haiti - AIDS education and counselling as part of a Child Survival strategy.

Others

1. Romania - Assistance to AIDS Orphans

The Role of PVO Headquarters

World Vision's headquarters in California has an International Health Programs Department which provides technical support to field activities overseas and ensures that technical and financial reporting, as well as other obligations are met. Detailed Implementation Plans; quarterly narrative and financial reports; midterm, annual and final reports; and other internal reports for fund-raising were prepared as a collaborative effort between field and headquarters staff. Headquarters staff also act as liaison between the field office on one hand and Johns Hopkins and USAID on the other. This was very necessary in the beginning when the processing of the cooperative agreement was not completed until the final days of FY 88: 89.

The series of technical meetings for headquarters staff set up by Mary Anne Mercer of JHU and her staff were very helpful and had great impact on the quality of our program. The discussions on what constituted appropriate interventions, objectives and corresponding indicators provided us guidance in the writing of our Detailed Implementation Plan. The workshops on evaluation gave us alternatives to some WHO recommendations (e.g., program indicators and survey questionnaires) which we felt were impractical or not applicable. The technical meeting in Harare where field staff from the different HAPA projects met to discuss their experiences after the first year was enlightening, encouraging and fun.

Probably the most significant role of headquarters staff is the identification of lessons learned which needed interpretation and dissemination throughout the WV partnership. To assist field and support offices interested in AIDS programs, headquarters staff provided sample DIPs, format reports which could be adapted to donor and local MOH requirements. This helped raise corporate interest and ability to write proposals and implement AIDS programs.

Lessons Learned at Headquarters

After almost three years now of the HAPA program, we are able to identify the following lessons learned relevant to headquarters:

1. PVOs need to start with a corporate policy to define and delineate their specific areas of commitment to AIDS programs. This will provide field, technical and fund-raising staff a framework for their work and frees them from internal debates on the importance of AIDS and its order of priority in resource allocation.
2. USAID's HAPA PVO grants program has been painfully short. There is no opportunity to evaluate impact on the reduction of disease transmission. In our Child survival programs, we have identified six years as the optimum length of time to demonstrate impact in the African context. In a few countries with specially weak health infrastructures, that period could be up to ten years. Because AIDS prevention programs were new when the HAPA program was introduced, a longer time frame would have been desirable to ensure momentum of activities.
3. The integration of AIDS with Child Survival and other health activities could have been given more emphasis. Although the initial proposal process strongly urged this process, and Child Survival program started asking AIDS statistics for the annual reports, the other USAID HAPA requirements that followed did not place adequate emphasis on it.

4. The focus of HAPA was the sexually active age group. As the epidemiology of AIDS unfolded in Africa, the numbers of children and mothers infected with HIV became more significant. In some countries, AIDS has been demonstrated to have reversed gains in Child Survival. Infants and children could have been added as a target for a HAPA Phase II.
5. The evaluation of impact of our program has been difficult due to two reasons. First, the time frame has been very short and the science of AIDS evaluation is new. In order not to lose the very important lessons learned from the evaluations done on HAPA projects, this issue should be given special focus in the writing of the final report on HAPA.
6. Programming has been negatively impacted by the turnover of staff, both on the PVOs' side as well as USAID's. The only constant figure has been Mary Anne Mercer whose work must have been a challenge at times.

Current Status of WV's HAPA projects

WV's Zimbabwe HAPA project has now been completed and a final report has been submitted. The Marondera District Health Office now has an AIDS Education unit that continues activities. WV Zimbabwe has full confidence in the ability of the DHO staff to maintain the program. Potential constraints include logistics for the team to reach the peripheral villages of the district.

WV's Kenya HAPA project continues with leftover funding from the project's second year of implementation. World Vision UK also has committed additional funding to keep the project going for another two years. Two impact communities have been dropped by the project. Ruiru, a peri-urban community has a full-blown AIDS education program run by the Ministry of Health of Kenya. AIDS prevention activities in Loitokitok is now integrated into the ongoing Child Survival project. The project's current focus now and for the next two years will be Kibera and Korogocho, two slum areas of Nairobi.