# ARUMERU: Project and Evaluation

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**Précis**

Arumeru is a "classic" HIV/AIDS prevention project in the best sense of the word. Prevention is the chief intervention and largely relies on counselling and education activities carried out by community volunteers. Dependence on volunteers, when combined with fervent community acceptance and participation, gives the Arumeru Project a high probability that it will be sustainable. Strong governmental approval of the project's performance adds to the likelihood that HIV/AIDS prevention measures will continue after World Vision funding stops.

Arumeru is more than prevention, however. The project also engaged communities in ways to care for AIDS orphans and people living with AIDS (PLWA). While not the main thrust of the Arumeru Project, care became an important intervention, as did ways to improve people's livelihoods. Enterprise development grew out of a concern that poor women have few assets to sell except their bodies, a risky endeavour where HIV is epidemic. Loans to start businesses were also extended to youth in an effort to turn "loitering" into something more productive.

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## Summary

The Arumeru HIV/AIDS Prevention and Control Project (Arumeru Project) began in October 1995 and serves about 211,837 people living in four divisions, Poli, King'ori, Mbuguni and Moshono. This report describes the findings of an evaluation of the Arumeru Project conducted in September 1999. The purpose of the evaluation was to review progress against the Project objectives and assess the impact to date. The evaluation would also seek to understand the process by which achievements have been attained, draw conclusions and identify recommendations for enhancement of future performance.

An evaluation team of 25 people, included the major stakeholders, such as Project staff, Project committee members, community representatives and counsellors, district and central government representatives and World Vision staff conducted the evaluation. The evaluation process was used as an opportunity to build the capacity of a variety of Project stakeholders in evaluation methodologies. Through the use of participatory processes, the stakeholders gained experience in all aspects of evaluation including developing key evaluation questions, interviewing techniques and data analysis.

The evaluation revealed that the Arumeru Project had a significant impact on HIV/AIDS awareness in the Project areas.

- In the Poli Division, although the level of awareness about HIV was already high before the current Project began, the depth of understanding about HIV transmission and risk of infection has increased significantly during the period of Project implementation.
- The length of time that the Arumeru Project took place in a community affects the knowledge of HIV. Comparing data from Poli Division with other Arumeru Project areas revealed higher levels of HIV/AIDS knowledge in Poli than King'ori. The major difference between the two divisions was that the Project had been implemented for longer time in Poli than King'ori.

Through the stimulus of regular seminars and other information sessions, HIV was firmly on the agenda of the community from villages to local governments. Community members identified a number of changes in behaviour that occurred since the Project began. These included reduction in alcohol consumption in bars and reduction in adultery.

There was a high level of community ownership of the Arumeru Project as indicated by the significant participation of community members in Project activities and the dedication of Community Counsellors who conduct HIV education seminars. Overall, the evaluation team rated the Arumeru Project high in terms of sustainability because it:

- Was socially viable as its theory, content, such as HIV education curriculum, and methods were congruent with the local mainstream understanding and culture.
- Was also in line with government strategies and policies, such as encouraging industrious attitudes and practices.
- Worked through government structures. The Arumeru Project was more difficult than conventional projects to tell where the Project began and ended as it formed an integrated, seamless web of HIV prevention and care with its partners, government, village leaders, religious leaders and the community in general.

The evaluation team made a number of recommendations pertaining to the continuation and coverage of the Project; the approaches used by the Project; and specific HIV prevention and care strategies. Key recommendations that relate to Project planning in the future are:

*Project continuation and coverage*

1. Project partners did an excellent job in raising awareness about HIV in the Arumeru District. HIV was firmly on the agenda in the communities. Nevertheless, the epidemic remains and continues to expand. Given that the Arumeru Project is the major response to HIV/AIDS in Arumeru District, it is imperative that it be continued.
2. The Arumeru Project area should be expanded to include Mukulat and Enaboishu divisions and Mirerani mining village.

*Project approach*

1. The Arumeru Project supported an approach that targeted some of the associated causes of HIV, such as loitering and alcoholism. Perhaps this assistance is best done through community development. It is important that this strategy not only continues but that it be expanded to include issues not currently addressed. Examples include women's marginalised position, negotiated safe sex or abstinence, and the socio-economic programs that address wider contextual factors.

2. There is a need for constant dialogue between religious leaders and other Project partners in order to derive a common stand on the use of condom as one of the main measures in the prevention and control of HIV/AIDS. The project approach to HIV prevention should include vigorous promotion of condom use as one of the methods for preventing infection.

*HIV/AIDS education*

The evaluation team recommended that the Arumeru Project adopt a peer education approach to instruct various community members about HIV. This allows for better opportunities to teach skills for behaviour change and will require the identification and training of a range of educators such as young men and women.

*Community counsellors and trainer-of-trainers*

The evaluation team recommended that the Arumeru Project expand the role of Community Counsellor from HIV educators to Primary Health Care Volunteers. This will require additional training for them, but it will address an area of expanding need by providing home-based care close to where people live.

*Care and support for people living with AIDS (PLWA)*

1. To reduce the fear and stigma associated with HIV/AIDS and change community attitudes about PLWHA, the Project should develop new HIV/AIDS education messages which do not promote fear of people infected with the virus.
2. The project should take a leadership role in showing that PLWHA are employable, even when their HIV status is known to the employer, by employing the PLWHA community educators who have been volunteers for a number of years.

# Introduction

## HIV/AIDS in Arumeru

The Arusha region where the project is located identified the first case of AIDS in 1986. Since then the epidemic has spread quickly, as has happened in other parts of the country. By the end of 1998, nearly 4,000 AIDS cases had been reported to the National AIDS Control Program (NACP). However, only people who attend the formal health care centres are included in the number of reported cases. It is widely recognised that the majority of patients are not treated in hospitals. The NACP estimates that 12,000 people have developed AIDS in Arusha region since the epidemic began in 1986. An estimated 120,000 people are infected with the virus but do not yet have AIDS. Of the eight districts in Arusha region, Arumeru has the second highest number of HIV/AIDS cases. Over half (54%) of the people with HIV/AIDS are women.

Information from non-governmental organisations (NGOs) in Arusha region indicated that 730 children were orphaned by the epidemic. Arumeru district had nearly 200 orphans.

## Responses to the epidemic in the Arumeru District

The responsibility for co-ordinating the HIV/AIDS response at the district level rests with the District AIDS Control Co-ordinator (DACC). In reality, there has been little funding from the government for HIV/AIDS prevention and care activities in Arumeru District. The Arumeru DACC estimated that in 1999, only15% of spending on AIDS prevention activities was provided by the government. The remainder of the funding for HIV/AIDS activities was done through NGOs and churches: 65% by World Vision through the Arumeru Project, 15% by the Evangelical Lutheran Church of Tanzania (ELCT), and 10% by Oxfam.

## The Arumeru HIV/AIDS Project

*Background and coverage.* The Arumeru Project began in October 1995. It was an expansion of the former Nkoaranga HIV/AIDS Prevention and Control Project that was implemented in Poli Division from 1990 to 1995. Community members from three other divisions in the Arumeru district, King'ori, Mbuguni and Moshono, invited World Vision Tanzania to include them in the HIV/AIDS prevention program underway in Poli Division. The total population served by the project was 211,837 (1988 census) and consisted of 83,038 men, 86,427 women and 42,366 children. The area covered was 1,654 square kilometres, consisting of 85 villages in the 23 wards of the four divisions.

*Summary of project objectives and activities.* The overall goal of the project was to support the development of the Arumeru District communities by reduction of the spread of HIV/AIDS within the program area. The main purpose of the project was to control the spread of HIV/AIDS epidemic in the project area by expanding the activities of the former Nkoaranga HIV/AIDS Prevention and Control Project into King'ori, Mbuguni, and Moshono divisions. The specific objective was to

ensure that by 2000, 70% of the target population would be informed about HIV/AIDS.

The basic approach of the Arumeru Project is to facilitate discussion in communities about the risk of HIV infection. During this process, the community members also identified prevalent risk behaviours, and defined strategies to change them.

Activities conducted to realise the Arumeru Project objectives and purpose include:

- Situation analysis to assess the level of HIV/AIDS knowledge in the project area and identify the training needs of communities.
- Provision of information and education about HIV/AIDS through communication media such as seminars, films, radio, posters, song and drama.
- Provision of counselling, home-based care and pastoral care to people living with HIV/AIDS, orphans, widows and others affected by HIV/AIDS by a cadre of Community Counsellors trained by the project.
- Provision of income generation opportunities for young people and others vulnerable to HIV/AIDS.

*The Arumeru project structure: Project partners*. The Arumeru Project is implemented by WV Tanzania in close collaboration with the Arumeru District Government. Besides the Ministry of Health, the project also works with the ministries of Education, Community Development, and Agriculture. Other project partners include religious organisations, community leaders, traditional leaders and traditional birth attendants, other NGOs and several community-based organisations (CBOs).

The Ministry of Community Development, Women Affairs and Children provides community development (CD) workers who facilitate mobilisation of community groups to implement the project activities. Specifically, the CD workers assist with community meetings, group formation and training in income generation activities. The Ministry of Education provides teachers for HIV/AIDS awareness in schools.

*Project Committees.* There are three committees, established at the district, ward and village levels that guide the implementation of the Arumeru Project.

- Arumeru Executive Committee: The executive (district) committee has 21 members and includes representatives from each Project Division, District Commissioner's Office, District Director's Office, District Medical Office, four religious leaders, a representative from the District AIDS Co-ordination Office and the District Officers of the four project divisions. The committee meets quarterly to review project progress and plan strategies for mobilisation and supporting the ward and village committees.
- Ward Project Committee: The Ward Project Committee is comprised of representatives from each project village, the Ward Executive Officer, health officer, education officer (who are government employees) and representatives of religious bodies in the ward.

  The committee is the formal mechanism for the representatives of the community (the Arumeru Project "beneficiaries") and the government staff of the ward. The committee forms a link between the Arumeru Project Executive Committee and the village committee.

  The main activities that have been implemented by this committee include:

  - Conducting HIV/AIDS awareness raising seminars and meetings in all project villages;
  - Planning for project sustainability - whereby each of the committee members has pledged to contribute 700 Tshillings (for men) and 500 Tshillings (for women) to the sustainability of the project.
  - Planning the formation of community groups for enterprise development activities and recreation clubs such as football clubs for youth.
- Village Project Committee. The Village Project committee is composed of 21 members who are drawn from different community groups. These include the village chairman, village executive officer (a government employee), representatives from each of the sub-villages, head teachers of village primary schools, retired government officials living in the village, religious and traditional leaders in the village and HIV/AIDS trainers and counsellors. The village committee usually meets monthly but other meetings can be scheduled when the need arises.

  The main role of the village committee is to implement and monitor the project activities. Specific activities conducted by village committees include:

  - Formation of community groups for income generation and recreation activities;
  - Mobilising the community to participate in HIV awareness raising workshops and seminars;

- Contributing to the Arumeru HIV/AIDS fund;
- Supporting village HIV/AIDS TOTs and Community Counsellors with food and transport;
- Supporting people infected and affected by HIV/AIDS with food, clothing and counselling;
- Reviewing the project progress reports from the sub-villages;
- Identifying possible new HIV/AIDS cases in the village; and
- Planning for the project activities.

## Evaluation Process and Methods

### Aims and objectives of the evaluation

The purpose of the evaluation was to review progress against the project objectives and assess the impact to date. The evaluation would also sought to understand the process by which achievements have been attained, draw conclusions and identify recommendations for enhancement of future performance.

The evaluation was an opportunity to build the capacity of Arumeru Project stakeholders in the evaluation process. Through the use of participatory processes, the stakeholders gained experience in all aspects of evaluation including developing key evaluation questions, interviewing techniques, and data analysis.

### Evaluation process

The evaluation team of 25 people, included the major stakeholders such as Arumeru Project staff, Project committee members, community representatives and counsellors, district and central government representatives and World Vision personnel. The team worked together to:

- Formulate key evaluation questions;
- Develop question guides and a questionnaire;
- Identify types of informants;
- Develop a sampling plan;
- Gather information;
- Code qualitative information; and
- Undertake preliminary analysis of the data.

### Planning the evaluation

*Developing a shared understanding of the project and evaluation.* The planning process began with the team sharing their understanding of the project and of evaluation by answering the questions:

"What does the Arumeru HIV/AIDS Project mean to you?"

"What does evaluation mean to you?"

Participants wrote down the answers to each question. These were collected, mixed together and read out aloud.

The responses to the first question, "What does the Arumeru HIV/AIDS Project mean to you?" revealed that many of the participants regarded the project as an important part of the life of the community. The closeness of some community members to the project is indicated by the following answer:

> It is not a project because it is part of us, part of our community.

Although the levels of education varied significantly among those participating in planning the evaluation, there was consistency in the answers to the second question. Most of the participants understood evaluation to be a process of assessing what has been done and learning from the process to improve future action.

*Defining the terms of reference.* As the funding and implementing agency of the Arumeru project, World Vision devised terms of reference (TOR) for the evaluation. As other project stakeholders had not had an opportunity to contribute to the TOR, the evaluation team considered it important to determine what these stakeholders wanted from the evaluation process. They were asked to write three things that they would like to know about the Arumeru by filling in the blank in the following sentence:

*I would really like to know* _____ *about the project.*

The list of questions that the participants wanted to ask about the Arumeru Project was compared with the terms of reference provided by the implementing and funding agencies. A final list of key evaluation questions was then written.

*Developing evaluation questions and selecting appropriate data collection methods.* Once the list of key evaluation questions was finalised, the team divided into several groups to discuss and write more specific queries for each key evaluation question. The evaluation team also identified the types of informants and the methods used for collecting information to answer the questions. Data collection methods included key informant interviews, focus group discussions, document reviews and community survey.

Finally, the following data collection instruments were developed:

- Questionnaire for collecting quantitative data from about knowledge, attitudes, behaviours and practices among the community;
- Focus group question guides to collect qualitative data from community leaders, religious leaders, community members, counsellors and TOTs;
- Other question guides for key informant interviews.

The participatory approach enabled the project partners to own the evaluation exercise and to build capacity in such skills as formulating questionnaires, gathering information through interviews and focus group discussions and analysing data. The participatory approach also helped the project partners to discuss and accept failures as well as successes.

*Sampling*. Based on the time available for conducting the field research, the evaluation team decided to visit eight villages where the Arumeru Project was implemented and two in the neighbouring divisions of Mukulat in Arusha Region that were not part of the project. To ensure that the team visited and gathered data from a spread of Arumeru Project sites, two villages were randomly selected from each of the four project division areas. In each village, 20 adults were randomly selected for the knowledge, attitudes, beliefs and practices survey.

## Field data collection procedure

Some 16 of the 24 evaluation team members made visits to villages to collect information. The group was divided into two teams of eight people. Each team was assigned two divisions. During two days of field visits, each team covered the two villages in one division per day. The members of each evaluation team were assigned tasks before visits to the villages as follows:

- Four team members would administer the community survey to 20 randomly selected community;
- Two team members would conduct a focus group discussion with village leaders;
- Two team members would conduct individual interviews or group discussions with selected community members including religious leaders, traditional birth attendants (TBAs), women and young people.

Visits to each village proceeded more or less as described below.

*Welcome and Introductions.* In each village the team was met by a large crowd (up to 250) of community members. After introductions of the evaluation team members and explanations of the purpose of the visit, two members of the evaluation team would conduct a focus group discussion with village leaders.

*The community survey*. Community survey questionnaires were administered to approximately 20 people, with equal representation of men and women.

*Focus group discussions.* Focus group discussions (FGD) were conducted with women, men, village leaders, young people and trainer-of-trainers (TOTs)/ Community Counsellors.

### *Meetings with TOTs and Community Counsellors*

The Project Co-ordinator arranged for 40 Community Counsellors to meet with the evaluation team for half a day. After a general group meeting, five two-person teams of evaluation team members conducted focus group discussions with groups of counsellors (eight per group).

### *Review of project records and reports*

Arumeru Project reports and other records were examined in order to extract some indicators for answering key evaluation questions. The reports examined included those from the village committee (monthly), the ward and executive committees (quarterly), and the project report to World Vision (quarterly).

### *Data entry and analysis*

The evaluation team manually analysed the qualitative data from the focus group discussions and interviews by categorising the information, identifying variables and summarising findings.

A meeting of the larger evaluation team included all the members who participated in the initial evaluation planning. The session was held to report the initial findings of the evaluation and obtain comments. A preliminary list of recommendations was generated from this meeting and presented to senior WVT staff on the final day of the evaluation.

The data from the community survey were entered for computer analysis using FileMaker Pro and imported into SPSS for analysis. Cleaning and double checking of all entered data were carried out to eliminate possible data entry errors. The data was analysed in three stages: computation of simple frequencies, cross tabulations and statistical significance analysis.

## Limitations of the evaluation

- Due to limitations of time and difficulties in getting to more remote parts of the project area, the Evaluation Team visited only 8 out of the 85 villages involved in the Arumeru Project.
- Using the participatory approach meant active involvement of the staff, committees and volunteers of the project in the process and thus a potential decrease in objectivity.
- As in all studies on sexual behaviour, there was a possibility of inaccuracy of respondents concerning their sexual behaviour. In addition, the respondents may have biased their responses towards what the Arumeru Project promotes.
- Cost effectiveness analysis was not conducted because there were no data available about the costs associated with HIV/AIDS in Arumeru.

## Arumeru project activities and coverage

Covered in this are the main activities undertaken by the Arumeru Project. The evaluation team also outlined the extent of achievements of outputs and identified constraints in implementing key activities.

## Community education activities

Conducting seminars was the major strategy used to increase awareness about HIV/AIDS among the people in the project area. At these seminars HIV/AIDS information was communicated through drama, video, song, poetry and other media. The seminars were conducted in a variety of settings including bars, restaurants and guesthouses. In each community TOTs and Community Counsellors were responsible for organising the HIV/AIDS education sessions.

In 1998, 328 seminars were conducted in the four Project Divisions. Out of the 31,845 people who attended these seminars, 56% were female and 44% male. The average number of participants per seminar was nearly 100. The seminars appeared to be most popular in Poli Division where an average of 147 people (63% female) attended each seminar. The highest number of seminars were conducted in King'ori, with an average attendance of 67. The reasons for the difference in attendance of seminars between the political divisions were not immediately clear. The quality of TOTs/Community Counsellors could be one factor. The popularity of the seminars in Poli also could be due to the fact that the Arumeru Project was implemented there for the longest period; thus the TOTs/Community Counsellors were more experienced.

The large number of people attending the seminars (averaging 99 per seminar) suggest that these were broad awareness raising sessions which would not encourage discussions about intimate sexual behaviour change strategies. These sort of activities aim to increase knowledge about HIV/AIDS and may not necessarily lead to changes in the behaviours which put individuals and their partners at risk of infection.

Informing young people about the dangers of HIV/AIDS has been a primary aim of the Arumeru Project's education activities. By training school teachers as TOTs, the project has enabled them to speak knowledgeably about HIV/AIDS to students. Consequently, the HIV/AIDS education through schools has improved significantly. Young people are also actively involved in educating each other and other members of the community about HIV/AIDS.

Religious leaders play an important role in creating awareness about HIV/AIDS in members of their religious organisations. They also provide spiritual counselling to the people infected by the virus.

Some religious leaders report that their involvement in the Arumeru Project has changed their attitude to PLWHA. They stated that they no longer regard PLWHA as sinners but as community members who need spiritual and material care from them.

## Project coverage

*Level of awareness about project activities.* Overall, the focus group discussions showed a good level of community awareness of the Arumeru Project. The project was perceived as being open to and focussed on the whole community apart from certain groups of people who were not able to attend the seminars.

Although the level of awareness of the Arumeru Project was high, the knowledge of the community about the range of different activities and services provided by the project was less impressive. The majority of FGDs mentioned only education as a project activity. However, in some focus groups discussions (FGD), respondents named the main project activities as HIV education, care of orphans and care of people living with HIV/AIDS (PLWHA).

*"Reach" of the project.* As most projects, it appears that there was variation in quantity and quality of Arumeru Project activities across villages. There was some

evidence, for example, that the project was not well known and had a relatively smaller "reach" in Sekei, than Ambureni and Usa-River. According to one key informant interview, *Sekei leadership is uncooperative*.

All discussion groups indicated that the Arumeru Project had broad community coverage. In response to the question, "Who benefits?", group members usually replied *community*. One or more members of the Usa-River focus group said *the beneficiaries of the project are the village members, AIDS patients and those who have not yet got the disease.* A discussion group in King'ori said *community, school pupils*.

The question, "Who is the Arumeru Project reaching?", was not only a question of who had participated in the project or not. Among other things, it also involved distinguishing between high and low involvement in the project activities. As expected, there was a wide variation in community involvement in the project's HIV/AIDS education activities. Of the five members of the King'ori women's FGD, for example, one had attended two seminars, one had attended three seminars, two had attended six seminars and one had attended eight seminars. Seven of 15 women from one of the Ngurodoto discussion groups attended one seminar, two were present at two seminars, one had attended six seminars and one went to eight training sessions.

A common response to the question, "Who is the Arumeru Project not reaching?" was *those not attending seminars*. Examples given by the Ngudoroto and King'ori women's FGD of the types of people not attending seminars included:

- Those who were doing business, morning till evening,
- Long-distance truck drivers, and
- Older people who with limited mobility.

Answers to the question, "Who is not benefiting?" included *those who had heard but were not following the project's teaching.*

### *Care and support for people living with AIDS (PLWA) and their families*

Although HIV/AIDS education for the community as a whole was the primary focus of the Arumeru Project, there was some emphasis on providing care and support for people living with HIV/AIDS and their families. In particular, meeting the needs of children orphaned by the epidemic was a priority for the project.

It was clear that only a fraction of people with HIV/AIDS in Arumeru were known to the Arumeru Project and received home-based care. At the close of 1997, there were an estimated 2,628 people with AIDS in Arumeru. Yet the number of hospital-based counselling (HBC) clients was 84. There were several reasons for this large difference between apparent need for care and support and access to services. One reason was that because very few people had been tested for HIV, it was likely that only a small portion (approximately 25%) of those infected with HIV were aware of their status. A second reason was that due to the stigma and discrimination associated with AIDS, people who knew that they were infected were often reluctant to tell anyone outside their immediate families. Project data from seven revealed that between 60% and 75% of families of PLWHAs were reluctant to accept assistance from Community Counsellors and TOTs.

It is possible the HBC services provided by the project may not be required by all PLWHAs. Information from the Community Counsellors suggested that most PLWHAs were cared for by their families in the home. This is supported by data from the community survey which found that despite the stigma attached to AIDS, between 85% and 100% of respondents in King'ori and Poli indicated their willingness to care for a family member with AIDS. It is clear that families and communities have accepted the responsibility to care for people infected and affected by the virus. Yet the silence surrounding the disease continues.

The limited information available on numbers of orphans needing and receiving care suggested that the silence associated with AIDS may be broken on the death of the person with AIDS. There were about 192 children orphaned by AIDS in Arumeru in 1999. Over 180 orphans received support from the project in 1999. Providing care for children orphaned by the epidemic enabled them to remain in their community and helped to reduce the impact of AIDS on families.

### *Income generation (IGS) and recreation activities*

In recognition of the shortage of employment opportunities in the Arumeru District, particularly for women and young people, the Arumeru Project supported a pilot program in Poli to assist groups to establish income generation initiatives. The project contributed Tshillings 800,000 (US$ 1,176) to a credit facility from which groups of 15 people are provided with loans for their businesses. Loan repayments are

returned to the credit facility. By September 1999 Tsh500,000 (US$ 735) was disbursed to 17 groups.

The success of this pilot IGA program is only anecdotal at the moment. Some respondents stated that the IGA program has increased their income levels. Others mentioned that they are able to buy more food for their families. Some women noted that their dependence on male partners has decreased because they are now able to earn some income.

There were problems with the pilot IGA program, some of which were common to micro-enterprise development projects in general. Some of the groups who received loans lacked business skills, including marketing and bookkeeping skills and were not successful in their chosen venture. Many of the groups engaged in similar ventures and thus competed against each other. This reduced profits and business viability.

Despite the constraints mentioned above, the pilot IGA scheme was very popular with communities, in particular women. Continuing or expanding the IGA program will require sustained effort to provide the skills needed by groups to manage the initiatives and diversify the micro-enterprise activities.

#### *Community counsellors/trainer-of-trainers (TOTs)*

Community Counsellors/TOTs were the backbone of the project. They provided much of the HIV/AIDS education in their villages and provided counselling and care for PLWHA. About 55% of Community Counsellors were male (160 of 287). The mean age of the female counsellors was 36 years. For male counsellors, it was 40. On average, Community Counsellors stayed with the project for about four years.

It appears that many counsellors donate an extraordinary amount of time to the Arumeru Project. In one focus group all 11 counsellors estimated that they worked (as counsellors) between one and two days per week on average. Based on other evaluations undertaken by the evaluators, a realistic expectation of volunteer labour per month could be in the vicinity of a couple of hours. An average in the Arumeru Project could well be between four days and eight days per month, if this focus group was typical. There was evidence of varying coverage and impact between villages and this may or may not relate to quality and quantity of Community Counsellors' activities in the villages. However, estimating labour volunteered per month required further research and, of course, generalisations from one focus group of counsellors to the "population" of counsellors were an inappropriate use of FGD data.

## Project Impact

Discussed in this section is the impact of the Arumeru Project on HIV/AIDS knowledge, beliefs, practices and perceptions of risk. The evaluation team examined behaviour change that was influenced by the approach adopted by the project. In particular, indicators of change were identified and defined by the communities. The evaluation team took a close look at attitudes to condom use in the community, and the role of the project in shaping opinions regarding condoms. Also included is an assessment of the support and care for people living with HIV in the communities.

### Knowledge about HIV/AIDS

The evaluation team used information from the community survey as well as focus group discussions (FGD) and in-depth interviews to assess the impact of the project on HIV/AIDS knowledge and attitudes. There were four main ways in which the evaluation team conducted the impact assessment:

- Using the data from the community survey, changes in knowledge across time were examined in the in Poli Division
- Differences between two Arumeru Project areas were scrutinised.
- Data in Arumeru Project areas was compared with information in Mukulat, a division in Arumeru District where the project was not implemented
- Differences in HIV/AIDS knowledge between men and women were analysed.
- Information from FGDs and in-depth interviews were used to determine how the community perceived their risk and vulnerability to HIV/AIDS.

*Comparison across time.* The expressed objective of the project was "to ensure that by 2000, 70% of the target population would be informed about HIV/AIDS." In 1991, a study was conducted in Poli Division to determine HIV/AIDS related knowledge, attitudes, and beliefs. This baseline data provided the evaluation team with an opportunity to determine whether there were any changes in knowledge about HIV/AIDS in Poli since the Arumeru HIV/AIDS Project began.

Knowledge of HIV/AIDS, in terms of the proportion of people who had heard of AIDS, although already high, increased from 89% in 1991 to 100% in the 1999

survey. More important than the modest increase in knowledge was a deepening understanding about the biological ways in which the virus spreads. For example, the proportion of respondents who knew that HIV could spread through sexual intercourse increased from 31% in 1991 to 94% in 1999. Knowledge about the use of condoms to protect against AIDS also significantly increased. In 1991, half the respondents in Poli knew that condoms could be used to prevent infection with HIV. By 1999, more than 90% stated that they knew about the protection given by condoms.

The 1999 survey revealed that there were significant gaps in knowledge and understanding in Poli respondents about HIV/AIDS. For example, only 18.2% of women and 5.9% of men stated that HIV could be transmitted from an infected mother to her unborn child. At the same time there were some misconceptions about risk of infection. More than a quarter of respondents in Poli sited sharing toothbrushes as a risk of HIV transmission.

Perception of risk to HIV infection and attitudes to people infected with the virus also changed between 1991 and 1999. In 1991, AIDS was considered a major threat to the community by eight of ten respondents, compared to 100% of respondents in 1999. The change in willingness to look after a family member with AIDS was even more dramatic, increasing from roughly one-third of respondents in 1991 to 94% in 1999. It is likely that the increased understanding that HIV cannot be spread through casual contact, such as touching or sharing food and clothing with PLWHA, served to reduce fear in the community and increased willingness to care for infected family members. This was a significant achievement of the project and an important step in reducing the stigma and discrimination of PLWHA. Discussions with Community Counsellors and Arumeru Project staff supported the data of the survey. People with HIV/AIDS were cared for by family members, often with little or no support from the wider community. This was because families are often unwilling to disclose the presence of HIV in their home.

*Comparison between Arumeru Project areas.* The survey results revealed some interesting differences between HIV/AIDS knowledge, attitudes and beliefs in the different Arumeru Project areas. In comparing the KAB survey of respondents in Poli with those from King'ori, the evaluation team found that knowledge about HIV/AIDS was higher in Poli. With regards to knowledge and use of condoms, 100% of male respondents in both divisions stated that they had *ever heard* of a condom. However, more than half of Poli respondents had *ever used* a condom compared to one-third of male respondents in King'ori. There were also differences in knowledge about transmission of HIV/AIDS. Some 94% of Poli male respondents knew that HIV could spread sexually, compared to 66% in King'ori.

The difference in HIV/AIDS knowledge between Poli and King'ori respondents could be attributed to the fact that the Arumeru Project was implemented for a longer time in Poli than in King'ori. Therefore, Poli residents were exposed to HIV/AIDS information for three to four years longer than people in King'ori were. There could also be differences in the quality of HIV/AIDS information provided in the two divisions, although the evaluation team had no information to support this conclusion. Certainly attendance at seminars in 1998 were lowest in King'ori and highest in Poli. The evaluation team recommended that the Arumeru Project assess the quality of seminars, other HIV/AIDS education activities and the effectiveness of Community Counsellors and TOTs across the four divisions and ensure consistent high quality performance.

*Comparison between Arumeru Project and non-Project area.* The community survey allowed the evaluation team to compare HIV/AIDS knowledge in the Arumeru Project area to that in Mukulat, a neighbouring division where the project has not been implemented. Comparing the data from Mukulat with that from the project divisions was very revealing. The level of knowledge and understanding about HIV/AIDS in Mukulat was considerably lower than the Arumeru Project divisions. Only one in ten respondents from Mukulat knew that HIV could be transmitted through sexual intercourse, compared with 95% and 67% in Poli and King'ori respectively.

There were several anomalies in the responses to the community survey on HIV/AIDS knowledge and attitudes in Mukulat. For example, although over 53% of respondents stated that they know how HIV was transmitted, only 10% could nominate a specific transmission route, namely sexual transmission. Secondly, more than 40% stated that condoms could protect against AIDS, although only 10% knew that HIV could be transmitted sexually. The inconsistencies in the HIV/AIDS knowledge in Mukulat suggested that although some messages about the epidemic got through to the community, there was little understanding of the information. This was probably because there was no

opportunity for the community in Mukulat to discuss the information that they herd about HIV and have their misconceptions corrected.

*Comparison between HIV/AIDS knowledge of men and women.* A person's gender (what it means to be male or female) is one of the most powerful determinants of individual risk to HIV/AIDS. In most societies, gender determines how and what men and women are expected to know about sexual matters and sexual behaviour. The evaluation team compared the responses given in the community survey by women to those given by men to determine whether there were any differences.

In the Arumeru Project areas, the levels of HIV/AIDS knowledge of men and women were similar in many respects, although there were some notable differences. With regards to knowledge about how HIV is spread, three times as many women than men knew that HIV could be transmitted from an infected mother to her child. There were also differences in reported condom use and knowledge about where to obtain condoms. Women were less likely than men to have ever seen or used a condom.

The most significant difference between men and women in the Arumeru Project areas was in the perception of risk to HIV/AIDS. Twice as many women (54%) than men (22.6%) considered that they "had a moderate to good chance of catching AIDS." The survey data was supported by information from FGDs with women. The disturbing aspect of the higher perception of risk in women was that they recognised that they were exposed to HIV infection because of their husbands' behaviours rather than their own. Women knew that their husbands had sexual relations with other women, and that these relations were unlikely to be protected. During a FGD with women from Mikungani, a village situated about three to five kilometres from the Mirerani mining settlement, eight out of 10 women stated that their husbands travelled to Mirerani frequently. When asked about what went on in Mirerani, the women stated that:

> *Some of them go to work in the mines or sell (gem) stones. In the evenings they go to the bars and drink a lot. Sometimes they don't come home for two or three days. We know they are sleeping with other women there. We have seen those women. They ["those women"] only go to Mirerani to get men. That is how those women get their money — by sleeping with our husbands.*

At the same time women stated that they do not use condoms with their husbands and were afraid to suggest the use of condoms for fear of triggering a violent response. The following quote from the Mikungani women's FGD captured the feeling of helplessness and fatalism that led many women to believe they had a moderate to good chance of "catching AIDS".

> *The men don't like to use condoms. They beat their wives if the women ask them to use a condom. So women just leave it to God.*

The difference in levels of HIV/AIDS knowledge between men and women was more marked in Mukulat than in the Arumeru Project areas. The most striking difference was in the knowledge about reported use of condoms. While 90% of men in Mukulat knew about condoms, only two-thirds of women heard of condoms. An even smaller proportion of women (16%) had ever seen a condom, compared with 57% of men.

*Impact of Arumeru Project on beliefs and perceptions.* Information about the effect of the Arumeru Project on knowledge about HIV/AIDS was enhanced by the focus group discussions (FGDs) and interviews. When asked, "What have you learned about HIV from the project?", most groups gave similar responses, exemplified by the following quotations from FGD with women in different villages:

> *They [the community] have learned how to change their risk behaviours by avoiding promiscuity, reducing alcohol indulgence and the use of condoms in case someone fails to behave.*
>
> *I have learned about prevention: to be faithful to your partner, reduce alcohol and loitering, reduce drug use, respect God's rules.*
>
> *We have learned how to take care of AIDS patients, give high protein diets, not to infect them. Project taught the community, instead of loitering, to do small IGAs (income generating activities) such as planting maize.*

In response to the question, "What is the key message of the project?", one member of the Ngurodoto FGD suggested that it was:

> *For those who are already married, stick to one partner. For unmarried, wait until you get your partner. For those who can avoid prostitution, project says it is better to stop prostitution. Those who can't avoid prostitution, use condoms.*

King'ori village religious leaders summarised the Arumeru Project's teaching as:

- To reduce things that encourage adultery, such as drunkenness, wearing mini skirts, loitering and videos that show sex.

- Avoid bad customs, such as female genital mutilation and wife inheritance.
- Close down bars and reduce alcoholism.
- Take care of HIV/AIDS victims.

In general, it appears from the FGDs that communities learned from the Arumeru Project — or had their pre-existing views reinforced — that the main contributing causes of HIV were adultery, promiscuity, drunkenness or alcohol consumption and prostitution. The responses of different discussion groups were very consistent. While these transmission risks were mentioned in-group interviews, the overall impression was that the Arumeru Project participants emphasised reform of underlying moral-social causes of HIV/AIDS.

The evaluation team's impression and hypothesis was that the Arumeru Project accepted and worked within the dominant local "moral universe," most elements of which are shared by most religious leaders, secular leaders and community members in most parts of the world, including:

- Valuing marriage
- Valuing fidelity in marriage
- Valuing the channelling of individual/social energies towards productive positive ends.

In this interpretation, the Arumeru Project linked an HIV prevention message to existing community and government attitudes and values. An example of the project working in with existing government policies was the project's efforts to encourage the enforcement of existing government regulations concerning the opening hours of bars in rural areas and the reduction or discouragement of "loitering."

These government policies were not created to prevent HIV. Among other things, they could be seen as an attempt to discourage the dissipation and diversion of energies away from "useful" economic and social activities that benefited households and community. The project tried to encourage the enforcement of existing by-laws.

So, it is possible that the Arumeru Project did not bring in an alien message that "taught" people about the underlying "immoral causes" of HIV transmission, such as adultery, prostitution, alcoholism and drug abuse. Arguably, many religious and community leaders, government officials and the community in general held these views independently of the Arumeru Project. The prominence and pervasiveness of "moral causes/reform" themes in-group interviews suggested both high emphases on these items among project staff and local leaders.

Some of the more technical or surface reasons contributing to the spread of HIV were mentioned in the group interviews. For example, traditional birth attendants (TBAs) indicated that they learned about infection control from the project.

The fact that few focus group discussions (FGDs) mentioned that they learned about HIV transmission from the Arumeru Project does not mean that FGD participants did not learn about technical or biological issues. Key informant interviews and Community Counsellor FGDs suggested that the Community Counsellors did include technical information about transmission and prevention in their training (although the community survey found that there were many misconceptions about HIV transmission). It was possible that people mentioned what they valued and what fitted into their "moral-value universe." They mentioned the "angle" that they valued and incorporated into their own meaning systems. It also appeared likely that the Community Counsellors emphasised the "moral" side of HIV causation and prevention in their training.

*Summary of project impact on HIV/AIDS knowledge and beliefs.* The quantitative and qualitative data on knowledge, attitudes, beliefs regarding HIV suggested that:

- In Poli Division, although the level of awareness about HIV was already high before the current project began, the depth of understanding about HIV transmission and risk of infection increased significantly during the period of the project implementation.
- The length of time that the Arumeru Project was in place appears to affect HIV related knowledge. Comparing data from Poli Division with other project areas revealed higher levels of HIV/AIDS knowledge in Poli than King'ori. The major difference between the two divisions was that the Arumeru Project was implemented for longer time in Poli than King'ori.
- It was not possible to say how much of the higher levels of knowledge about HIV/AIDS in the Arumeru Project areas compared to Mukulat could be attributed to the project. *However, it was clear that the project was making a difference to HIV/AIDS knowledge where it was operating.* An interview with the District AIDS Control Co-ordinator (DACC)

revealed that about 65% of funding for HIV/AIDS prevention and care activities in Arumeru district were from the Arumeru Project.

- Women had a higher perception of personal risk to HIV infection than had men. Yet a large proportion of women indicated that they could not change their risk to infection because they had no power over their partners' behaviour outside the home.

## Behavioural changes

### *Changes in traditional practices and health services*

- Decrease in traditional harmful practices, such as female circumcision and widow inheritance.
- Traditional circumcision practitioners used a new blade for each person they circumcised. They also wore gloves.
- Everyone used his/her own syringe in the hospital.
- There was an increase in voluntary testing and counselling, including pre-marital testing.

### *Changes in family relationships*

- Changed attitudes, norms and behaviours. For example, there is less adultery.
- Many men and women go home early to be involved in family productive activities. For example, men who used to go to Mirerani town now return home early - in time to eat with their families.
- Marriage was strengthened.

### *Changes in condom use*

- The majority used condoms.
- Women asked for condoms.

### *Other*

- The habit of girls going to mining town/area for prostitution has stopped.
- People talked openly about HIV/AIDS, including in schools.

Many of the behaviour change indicators identified by the community related to the social reform interest that appears to underlie the approach of the project. For example, decreased "loitering," less alcohol consumption, strengthened marriage relationships and reduction in adultery. In particular, there was strong emphasis on changing alcohol consumption behaviours. Selecting alcohol consumption, especially in bars and nightclubs, as an indicator of behaviour change that could reduce risk of HIV infection was supported by experience from other programs. Numerous studies identified alcohol and drug intoxication as influencing sexual behaviour, highlighting the importance of understanding (and influencing) the social context around sexual behaviour.

Some of the indicators were very specific to the local context. For example, "loitering" in the Arumeru context mostly referred to young people who were not in school and who seemingly walked around without any purpose. The validity of using reduction in loitering as an indicator of reduced vulnerability to HIV was questionable. The assumption was that people who were not busy with "productive work" were more likely to engage in sexual activities. There was no evidence that those who work do not engage in risky sexual behaviour.

The indicator of reduction in adultery could be linked to the internationally accepted behaviour change indicator, "reducing the number of sexual partners." However, expressing it as reducing adultery and strengthening marriage ties was more meaningful for the community. The indicator of increased condom use was not supported by other evidence.

In summary, the evaluation team supports the selection of indicators of change by the community. However, if the Arumeru Project is going to use these community-identified indicators, it will be important to undertake research to determine whether the social revolution required will have an impact on HIV transmission.

### *Condom Use*

Focus group discussions (FGDs) and in-depth interviews revealed a deep ambivalence towards the promotion and use of condoms in the community.

*Women in the community.* Focus group discussions with women revealed that there is some support for the promotion and use of condoms. Yet this support was tempered by the realisation that women have little power to enforce condom use with their partners. The following notes from the FGD with women from Ngurodoto indicated the role of the Arumeru Project in condom promotion. (Questions asked by the facilitator are capitalised).

*HAS THE PROJECT TOLD YOU ABOUT CONDOMS?*

*Yes. Some get condoms that are distributed. Community Counsellors distribute condoms.*

*DO YOU KNOW ANYONE WHO CAN SAY TO HUSBAND OR BOYFRIEND, "USE A CONDOM?"*

*Those who are married can't ask their husbands to use condoms. There is no need for unmarried (couples) to talk.*

*DO YOU EVER TALK AMONG YOURSELVES ABOUT CONDOMS?*

*Yes, we talk,* said another. *There are some with condoms in their pockets. One woman said that most people say it is better not to have sex before marriage. That is better than using condoms. A few prostitutes use condoms.*

*WHAT DOES THE PROJECT SAY?*

*Project talks about using of condoms. For those who cannot avoid having sex it is better to use condom while deciding. Most people decided not to use condoms and have opted for fidelity in marriage.*

The constraints faced by women who wanted to protect themselves from infection by using condoms was highlighted during a FGD in King'ori:

*Women can't easily say to a man to use a condom. Few women can say to a man, "Use a condom." But many are waiting for a man to say, "Let's use a condom."*

*Religious Leaders.* Religious leader FGDs had strong, negative views on condom promotion and use. This kind of opposition to condom promotion from respected and authoritative religious leaders could make it difficult for any "harm-reduction" approach to be accepted among the church-going community.

A Ngurodoto women's FGD suggested that *religious leaders should have more HIV/AIDS education* in the light of their involvement and collaboration in AIDS education.

*Community counsellors/TOTs (trainer-of-trainers).* There was ambivalence on the part of the Community Counsellors/TOTs who were at the frontline in HIV/AIDS education and awareness raising. They were the primary contacts for the members of their community on all issues to do with HIV prevention and care. Therefore, Counsellors/TOTs views on condoms were very important in shaping attitudes in their communities.

The following excerpt from one of the Community Counsellor FGDs affirmed that the Arumeru Project included condom promotion to some degree. The FGD suggested that many Counsellors share some of the religious leaders' attitudes to condom promotion and use.

*Condom use is included in seminars. Few accept condoms. (Some say) if you ask us to use condoms, you are encouraging us to have sex. For religious leaders, those who use condoms break God's rule. Religious leaders are not free to talk about condoms. But Community Counsellors are allowed to talk about condoms to the congregation after church service.*

*We show how to use condoms during the seminars. Some people come privately and get condoms from us after the seminar. Some get them from shops. During the seminars, Counsellors don't say, "Come and get condoms from us."*

It was clear that Community Counsellors distributed very few condoms. They might have regarded being asked to do so with some hostility. When asked to specify how often members of their communities approached them for condoms, none of the 12 Community Counsellors in a focus group had been asked for condoms in the last month. More importantly, they expressed the view that they would regard being approached for condoms by community members as a sign of failure by the Arumeru Project. As one Community Counsellor explained:

*The main objective of the project is to reduce adultery. When we educate people, we educate to reduce adultery. If ten people come (to ask for condoms), my lesson is not heard; I should try to further educate.*

This quote threw some light on why condoms do not appear prominently in focus group discussions (FGDs) in response to questions on Arumeru Project benefits and impact.

A strong feeling that condoms promoted immorality and possibly even HIV was widespread among Christian community members, religious leaders and village elders. The prevalence of a similar view among Islamic community members and leaders was not systematically explored. However, a community counsellor FGD included one Moslem, and he appeared to share the dominant view.

The evaluation team noted that the Arumeru Project participants appeared to work mainly within a "moral" perspective on HIV causes and legitimate responses. Condom promotion as an HIV prevention tool was associated with a "harm-reduction" perspective. Essentially, the harm reduction approach places pragmatism over moral considerations. It takes a "let's use what works" to reduce harm in the short term.

The Arumeru Project included a harm-reduction element insofar as it incorporated an element of

condom promotion. However, condom promotion and distribution by the project appeared to be half-hearted at best. Increasing community acceptance and use of condoms remains a significant challenge for the project. This is an issue that needs to be addressed with urgency.

## Support and care for people living with HIV/AIDS

By conservative estimates, there were an estimated 26,000 people living with HIV/AIDS in the Arumeru District. Yet only two people were open about their HIV+ status. The silence and secrecy that surrounds HIV/AIDS, even in countries with high prevalence, is one of the most baffling aspects of this epidemic. This phenomenon is not specific to the project, or to the Arumeru District. It is common the world over.

The evaluation team intended to talk with PLWHA during visits to the villages. This did not happen because few PLWHA acknowledged their HIV+ status to anyone outside their immediate families and sometimes the Community Counsellors. The stigma surrounding HIV/AIDS discouraged most HIV positive people from publicly "coming out."

Some focus group discussions mentioned that the people dying or have died of HIV were shrouded in secrecy. The King'ori religious-leader FGD included the comment:

> *People dying of AIDS are not publicly announced to the community so people do not exactly know the extent of people dying of AIDS.*

The notes of the Ambureni/Moivaro religious-leader FGD recorded the remark:

> *Those already with HIV/AIDS should declare it openly.*

The idea of introducing a new by-law to mandate the public announcement of people living with or having died of HIV/AIDS is a possible route, suggested in some FGDs and household interviews. The community needs to show its acceptance of HIV and HIV positive people before any but the most courageous individuals will publicly declare themselves as HIV positive.

In many ways, the Arumeru Project worked hard to reduce the stigma surrounding HIV/AIDS. It was not a coincidence that the only two people who live openly with HIV work as volunteer Community Educators/Counsellors for the project. Nevertheless, much more could be done to improve the situation for PLWHA.

Many of the songs, drama and poetry used to educate people about HIV/AIDS used messages of fear and death. These images became transferred from the disease to the people with the disease, making it very difficult for the community to live with them without fear. To begin to change community attitudes, the Arumeru Project will need to develop new HIV/AIDS education messages that do not harp on fear.

Interestingly, despite the stigma attached to AIDS, families and communities accepted the responsibility to care for people infected and affected by the virus. The community survey found that in the Arumeru Project areas, more than 40% of respondents knew a relative, friend or neighbour with AIDS. All respondents in Poli and 85% in King'ori indicated that they were willing to care for a family member with AIDS.

The Arumeru Project involved two HIV-positive people as volunteers, one as a Community Counsellor and the other as a trainer. The evaluation team recommended that the project should employ these people as full-time staff and include one of them as a member of the Arumeru Project Committee. The project could take a leadership role in showing that PLWHA are employable, even when their HIV status is known to the employer. This will be a big step in promoting positive living for PLWHA and their families.

## Participation of community members in the Arumeru Project

One of the most striking aspects of the Arumeru Project was the very strong sense of ownership expressed by various members of the community. The evaluation team felt that the widely expressed sense of community ownership of the Arumeru Project was suggestive of broad community participation. Almost every community member interviewed during the evaluation participated in the project via one or more of five participatory roles.

- All members of the Arumeru Project management committee belonged to the community and live in the project area.
- Community representatives made up the village, ward and district committees that helped steer and facilitate the project activities at all levels under general oversight and direction of the Arumeru Project Management Committee. For example, TOTs and Community Counsellors were chosen by village committees).
- The Arumeru Project's prevention and care work with communities was primarily done by community members, the TOTs/Community Counsellors. With

the emphasis on HIV/AIDS prevention activities and the formation of community groups, the project enhanced communities' participation in all activities. The extent of community involvement was such that apart from the two hospital-based counsellors (HBCs), all the Community Counsellors (two per village) and trainers were drawn from the community.

- Community members were involved in the Arumeru Project as participants in, and "beneficiaries" of, the various Project activities. While the target group of the Arumeru Project was the whole community, the project gave special emphasis to assist people and families living with HIV/AIDS, including the orphans and widows or widowers.
- TOTs/Community Counsellors who were teachers involved school children through school-based education on HIV prevention and care. Special efforts were made to involve youth in income generation and recreation activities. For example, in Poli Division, the project pilot area, 17 groups were formed and provided with loans to run their own income generating activities.
- Community members along with government and NGO colleagues participated in planning and conducting the evaluation.

The term "participation" had diverse meanings for different people. Definitions ranged from passive participation, where people were involved by being told what was to happen, to self-mobilisation, where people took initiatives independently of external institutions. The participation of community members in village, ward, district and project management committees suggested movement towards the high ends of the participation ladder.

Group discussions generated information suggesting a high level of local ownership of the Arumeru Project, exemplified by the following quotes:

*The project belongs to the village.* "This is our project; the project has great benefits to this community."

Indeed, the steps taken by the communities to raise funding from their own resources to support the Arumeru Project activities was strongly indicative of a community mobilised to respond to HIV/AIDS.

The evaluation team encouraged the project to take the participation of community members up the ladder of participation. More people could be routinely asked for their feedback about the Arumeru Project during annual planning and reviews. More people could also move from being seminar-attendees to being peer educators.

## Strengths and Challenges of the Project

### *Strengths of the Project: Community participation*

- Community leaders—government, clan and religious—made excellent contributions to the success of the Arumeru Project. There was excellent networking between the project and government.
- There was a true sense of community ownership with strong community and government support for the Arumeru Project. Division lines between community, government and the Arumeru Project were blurred because of the extent of mutual ownership.
- The presence of Community Counsellors in the villages provided an excellent opportunity for ongoing provision of information, counselling and support.

*The project strategy.* An important strength of the project was that it adopts a holistic approach - tackling deeper underlying causes of HIV/AIDS and working towards social and spiritual transformation.

*Focus on youth.* The incorporation of schoolteachers into the ranks of Community Counsellors was a strength of the project. Reaching school-age children (both in- and out-of- school) was regarded as a key element and high priority of UNAIDS' global HIV/AIDS strategy. While HIV/AIDS education was formally included in the Tanzanian school curriculum, in practice it did not always receive its allocated time or attention. The Community Counsellors who were teachers appeared to take their school-based HIV-education responsibilities more seriously than did many government teachers. As the Project Manager put it:

> Although HIV was in the school curriculum, many teachers did not take it seriously. Project tried to encourage teachers to take it seriously for example by going to the head teacher and asking for time to come and teach.

### *Challenges and suggestions for improvement*

In response to the questions, "What are the weaknesses of the Arumeru Project?" and "What can the Arumeru Project do to improve?", most FGDs focussed on the role and tools of Community Counsellors. This was not surprising given that the Arumeru Project mainly relied on its network of Community Counsellors to achieve its objectives. Apart from the Project Manager and two hospital-based salaried counsellors, the volunteer Community Counsellors *were* the project.

*Increasing coverage of HIV education.* Most community members explicitly or implicitly pointed to the existence of unmet educational needs among Arumeru Project communities. For example, religious leaders from Ngurodoto stated that *we don't have enough education.* Usa-River community members lamented that *there are other community members who are our neighbours who have not yet got the education on HIV/AIDS.* Since the Arumeru Project relied on Community Counsellors/TOTs to undertake education activities, this suggested a need to increase the number of Counsellors as well as finding ways to motivate them to expand their education activities.

The evaluation team determined that although the Arumeru Project did very well in increasing awareness about HIV in the community, there was now an urgent need to enhance the depth of understanding about risk and vulnerability to the virus. There was also a need to assist different members of the community to develop skills required to prevent infection. The HIV education seminars were not the appropriate forum for enhancing understanding or learning skills. The Arumeru Project will need to learn about and introduce strategies such as peer education that allow different members of the community to explore their risk and vulnerability to infection while learning skills needed to prevention infection.

### *Community Counsellors*

- References to the need to increase the number of Community Counsellors were common. Some Arumeru Project participants suggested that the number be increased to having Community Counsellors in every sub-village.
- A recurring theme in FGDs was the need to improve the Community Counsellors' tools. Improved transportation was the most commonly mentioned item. Bicycle was the most frequently suggested form of transport.
- Three of the four items that Community Counsellors reported liking least about being a Community Counsellor related to transport. There was also mention of improving the range of training materials available to Community Counsellors. For example, several Arumeru Project participants stated a need for new HIV/AIDS information videos, posters and magazines.
- The idea of introducing allowances for Community Counsellors was raised in some of the FGDs and individual interviews.
- In response to the question, "What more can the project do to help you to do your job?", a focus group of Community Counsellors raised the following points:
  - Transport, more bikes,
  - Uniforms,
  - Opportunities to visit and learn from communities with high HIV prevalence rates,
  - Training on treating minor ailments related to AIDS. This will reduce the need to take PLWHA clients to the doctor for minor illnesses,
  - Training on how to train adults for all Community Counsellors,
  - Increased knowledge in health education including primary health care and identifying and preventing other sexually transmitted infections.

*Youth Challenge.* A concern that emerged from group discussions was that young people do not take the threat of HIV seriously, as illustrated by the following comment from the FGD with Ngudoroto village leaders:

> *...youth take the disease [AIDS] as a joke.*

Several comments noted during the Ngurodoto women's FGD concerned the need to reach children with HIV education.

*School pupils need more information.* Reaching young people with information about HIV and equipping them with the skills to protect themselves needs to be addressed with some urgency by the Arumeru Project. It appears that the current Community Counsellors, who were mostly aged over 30 and none under twenty, were chosen by village leaders for their leadership qualities, among other things. Experience from other countries suggests that young people are more effective at educating each other about preventing HIV infection than being taught by older people. This will require the recruitment and training of young people as peer educators.

The concept of peer education could apply more widely within the community. The evaluation team recommends that the Arumeru Project complement its current leadership educators with peer educators. Peer educators should be as diverse as the community in

**Table 1:** Assessment of Project Sustainability

| Sustainability Indicator | Assessment of Project performance | Comments |
|---|---|---|
| Many community members in the area knew about the Arumeru Project | YYY | See the section on the "Arumeru Project Activities and Coverage." |
| Many community members in the area saw benefits flowing from the project | YYY | The community identified benefits and indicators resulting from the Arumeru Project. |
| Many government/NGO staff in the area knew about the Arumeru Project | YYY | The project worked hand-in-glove with the government and churches. Collaboration with other NGOs could be better. |
| Many government/NGO staff in the area saw benefits flowing from the Arumeru Project | YYY | The District Commissioner, District Medical Officer, District and Regional AIDS Co-ordinators all identified benefits of the project. |
| Many community members were involved in the planning of the project | Y | There was little evidence of community members' participation in initial planning of the project or on-going planning processes. |
| Many community members were involved in the implementation of the Arumeru Project | YYY | The project had only 3 paid staff members. Much of the community education and mobilisation was done by the army of Community Counsellor volunteers, 2 per village. |
| Many community members were involved in monitoring and evaluating the Arumeru Project | Y | There was little evidence of the involvement of the community in monitoring and evaluation. This was the first participatory evaluation event by the Arumeru Project. |
| Many community members saw themselves as owners of the project | YYY | Many community members interviewed by the Evaluation Team stated that, The project belongs to us. |
| Many community members supported continuation of Arumeru Project | YYY | The efforts made by the community to continue the Project are described in this report. |
| Many community members said that they were prepared to contribute to the continuation of the Arumeru Project | YYY | |
| The project used a community-based train-the-trainer approach (mainly worked with and through "support groups," "middle" community people or institutions that did most or all the direct project work with other community members). | YYY | |
| The community-based train-the-trainers were active | YYY | Volunteer Community Counsellors/TOTs contributed between one and two days per week to the Arumeru Project. |
| Local stakeholders accepted the Arumeru Project's technology | Y | There was hostility to the promotion and use of condoms among opinion leaders in the community. |
| The Arumeru Project worked with and through existing structures | YYY | Works hand-in-glove with the government structures from village to district level. |
| The Arumeru Project addressed key felt needs of communities | YYY | The project emphasised an approach built on a felt community moral reform agenda of reducing alcoholism, adultery and loitering. |
| The project was gender-sensitive | Y | The strategies promoted for preventing transmission of HIV do not sufficiently acknowledge the power imbalance between men and women. |
| The Arumeru Project had a sound sustainability strategy | YY | The sustainability strategy had mobilised members of the community to support the project with funds, time and other resources. Yet it was important for the project to mobilise more resources from the government for the HIV response. |

terms of age, gender, ethnicity, occupation, class, residence, sexual-preference and other characteristics/ activities. Peer educators should be trained to work through informal conversations with individuals and small groups integrated into routine, everyday-life activities.

## Sustainability Issues

Sustainability emerged as an important priority for community members interviewed during the evaluation including the Community Counsellors/TOTs and Arumeru Project Committee members. Yet people understood the word "sustainability" differently. For many members of the community who participated in the evaluation, sustainability simply meant finding ways to continue with the HIV prevention and care activities that the Arumeru Project did for the past four years. The Australia AID (AusAid) NGO Package of Information defined sustainability as "the ability of a development activity to deliver substantial benefits for an extended period of time after financial, managerial and technical assistance from a donor diminishes."

The evaluation team combined both understandings of sustainability and assessed the likelihood that project activities and benefits will continue after the current funding stops. The evaluation team used a framework developed by Dr. Tim O'Shaughnessy, WV Australia Evaluation Co-ordinator and a member of the evaluation team. In Table 1the Arumeru Project was assessed according to the sustainability indicators using a scale of one to three ticks, representing low (Y), medium (YY) or high (YYY) ratings. The indicators were derived by the experience of the evaluation team and literature on sustainability.

## Assessment of project sustainability

*Planning for sustainability.* The community was acutely aware that funding for the Arumeru Project from external sources would cease at some stage. People also knew that the response to the epidemic needs would not only continue but would intensify significantly in order to cope with the increasing numbers of PLWHA and orphans.

Continuing the Arumeru Project's activities was of great concern to the community. Various strategies were developed to address sustainability. Of primary importance was the willingness of the community members to contribute time, money, food and other resources to support the continuation of the project.

For example, members of a focus group discussion conducted in Ngurodoto stated that:

- *Yes, I am ready to contribute towards the existence of the project.*
- *I can contribute my time on voluntary basis.*
- *I will participate in different meetings.*
- *I will contribute cash, foodstuffs, as can be agreed upon with the village government.*

In the same FGD, one or more members suggested a mix of local and external funding towards continuing the Arumeru Project after the present donor left.

> *We have to understand that this is our project so we have a task to contribute both in cash and kind so that the project can proceed even after the withdrawal of sponsor.*
>
> *We request WV Tanzania to find us another sponsor or to request for the existing sponsor to proceed with child sponsorship.*
>
> *...We are ready to contribute ourselves. But (We) need the support of donors.*

The willingness of the community to contribute to the continuation of the Arumeru Project was translated into a local government law to mobilise funding for the project. A proportion (7 to 10%, depending on the Division) of the Development Levy paid by all taxpayers was allocated to the HIV activities implemented by the project. For example, the Development Levy in Moshono Division is Tsh200 per year for each taxpayer. There are approximately 1,000 taxpayers in the Division, so the total amount of the Development Levy per year is Tsh2,000,000. Of this, 10% (Tsh 200,000) per year will be contributed by the community to support the HIV response in Moshono Division.

***Support of the local government.*** Support of the government is an important ingredient for the continuation/sustainability of many projects. The passing of legislation that allocates a portion of the Development Levy to the Arumeru Project's activities was unusual and suggested a high level of support, not only for the project itself, but more specifically for continuing the response to HIV in the District. In addition, the District Commissioner (the head of the local government) asked that:

- All public meetings conducted by Divisional Secretaries should include discussion about HIV/AIDS.
- All District Council meetings should have HIV/AIDS on the agenda.

*Summary on sustainability of the project.* Overall, the evaluation team rated the Arumeru Project highly in terms of sustainability for reasons that had emerged from the description of focus group information. In brief, the Arumeru Project was:

- Socially viable as its theory, content, such as HIV education curriculum and method were congruent with local mainstream understanding and culture.
- In line with government strategies and policies, such as those that encouraged industrious attitudes and practices.
- Worked through government structures. As a result, it was more difficult than with conventional projects to tell where the Arumeru Project began and ended as it formed an integrated, seamless web of HIV prevention and care with its partners, governments, village leaders, religious leaders and the general community.

## Recommendations and Planning Issues

### *Project continuation and coverage*

1.1 Project partners did an excellent job in raising awareness about HIV in Arumeru District. HIV is firmly on the agenda in the community. Nevertheless, the epidemic remains and continues to expand. Given that the Arumeru Project was the major response to HIV/AIDS in Arumeru District, it is imperative that the project continues.

1.2 The Arumeru Project area should be expanded to include Mukulat and Enaboishu divisions and Mirerani mining village.

### *Project approach*

2.1 The Arumeru Project supported an approach that targeted some of the contributing causes of HIV. It is important that this approach continue and expand to include issues not currently addressed such as the marginalised position women in negotiating safe sex or abstinence and the socio-economic causes of "loitering" and of alcoholism. This might be best done through community development programmes that address wider contextual issues.

2.2 There is a need for constant dialogue between religious leaders and other Arumeru project partners to derive a common stand on the use of condoms as one of the main measures in the prevention and control of HIV/AIDS in the area. The Arumeru Project approach to HIV prevention should include vigorous promotion of condom use as one of the methods for preventing infection.

2.3 The Arumeru Project should work to address the relative lack of gender-sensitivity in the HIV prevention, care and support. Embedding HIV prevention and care activities in broader community development programmes operating within a *gender-sensitive empowerment* approach (also referred to as Gender and Development) is one way to address gender-sensitivity. Additionally, the evaluation team recommends that the Arumeru Project use a checklist for assessing gender sensitivity of HIV/AIDS & STD policies and programs.

2.4 There was little attention paid to diagnosing and treating other sexually transmitted infections by the Arumeru Project. The evaluation team recommended that the project develop strategies to increase awareness about sexually transmitted diseases (STIs) in the Arumeru project area and collaborate with the District Medical Service to improve access to treatment by community members in the project area.[1]

### *HIV/AIDS education*

3.1 The Arumeru Project should work to increase awareness about mother-to-child transmission of HIV through community education programs. At the same time, community-counselling processes should include assistance to couples to understand ways of reducing the chances of mother-to-child transmission

3.2 Assess the quality of seminars, other HIV/AIDS education activities, and the effectiveness of Community Counsellors and TOTs across the four divisions and ensure a consistent high quality.

3.3 Adopt a peer education approach to educating various community members about HIV. This allows for better opportunities to teach skills for behaviour change and will require the identification and training of a range of educators such as young men and women.

3.4 Ensure that peer and community educators provide training in skills needed by different community members to prevention HIV infection. For example, teaching men to use condoms; confidence building for young people to overcome peer pressure for early initiation into sexual activity; and assertiveness training for women to negotiate condom use with their partners.

*Condoms promotion and use*

4.1 The Arumeru Project should make a concerted effort to increase community acceptance of condom use by facilitating dialogue among various members of the community, particularly religious leaders.

4.2 The Arumeru Project should promote the use of condoms as an important means of preventing transmission of HIV. The Project should also increase the distribution of condoms through community counsellors and TOTs

*Community Counsellors and TOTs*

5.1 The evaluation team recommends that the Project expand the role of Community Counsellor from HIV educators to Primary Health Care Volunteers. This will require additional training for counsellors, but it will address an area of expanding need — providing home-based care close to where people live.

5.2 The workload of Community Counsellors if very high. The evaluation team recommends that the Arumeru Project increase the number of Community Counsellors/TOTs to spread the workload and increase the project's reach into every household of the community through counsellors and peer educators.

5.3 The evaluation team recommends that the Arumeru Project enhance the adult education skills of current Community Counsellors and provide them with better transportation and training materials, including videos and pamphlets.

*Care and support for PLWHA*

6.1 To reduce the fear and stigma associated with HIV/AIDS and to change community attitudes toward PLWHA, the Arumeru Project should develop new HIV/AIDS education messages that do not promote fear of people infected with the virus.

6.2 The Arumeru Project should take a leadership role in showing that PLWHA are employable, even when their HIV status is known to the employer, by employing the PLWHA community educators who have been volunteers for a number of years.

6.3 The Arumeru Project should include a PLWHA of them as a member of the Project Committee.

6.4 The Arumeru Project should promote the development and maintenance of a PLWHA support group and advocacy group if there is interest and support for this idea among PLWHA.

*Income generation strategies (IGAs)*

7.1 The Arumeru Project should address the sense of helplessness of women about protecting themselves from infection with practical measures such as increasing women's access to micro-enterprise opportunities.

7.2 The evaluation team recommended that the Arumeru Project expand and improve the support for IGAs, including training in business management and marketing.

## Note

1. Facing the challenges of HIV/AIDS/STDs: A gender-based response. Royal Tropical Institute & Safaids, 1998