IYOLWA: Project and Evaluation

Edited from project evaluation reports by the Iyolwa community and Tim O'Shaughnessy

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Précis

The Iyolwa Project is special in several ways. The first is due to the comprehensive fashion in which the project addressed HIV/AIDS prevention and care. Second is the innovative manner in which the project used credit as an HIV/AIDS prevention measure. Third, because the Iyolwa HIV project paved the way for the subsequent Area Development Programme (ADP).[1]

Prevention usually involves behavioural change. Adult and youth education programmes informed people about how HIV is contracted, and how it is not. Prevention measures to avoid the disease focused on faithfulness in sexual relationships, abstinence, and the use of condoms. The preventative measures were widely accepted, and some risky behaviours were changed.

Not changed was the popular desire to attend discos and other events where alcohol freely flows and casual sex is encouraged. Even so, the HIV prevention programme has made people more cautious, possibly less promiscuous, and certainly more conscious in protecting themselves.

Care and education changed community attitudes towards people living with AIDS (PLWA). Through education and the work of village health volunteers, most people know that PLWA are not beasts to be shunned. It's probably fair to say that PLWA are generally accepted if not mainstreamed in the Iyolwa communities.

The credit and loan component was designed as an HIV prevention measure. The assumption was that the poorer young people are, the greater the pull of nefarious "sugar daddies and mummies" who are likely to have HIV/AIDS. A partial answer was to create more wealth through enterprise development.

The concept was laudable, but the overall results were not. Some business were started or expanded employing poor people. Yet with a 70% payback rate, the credit system shows grave weaknesses and is unsustainable. Some problems may occur in the future when the credit programme is brought under professional management. Many clients have a slack attitude about repayment. To insist on timely interest and principal instalments may create resentment in the Iyolwa communities during the ADP phase.

While the legacy of the credit programme was mixed, the groundwork for the transformation from a HIV/AIDS project to an ADP was well laid. Community participation and involvement in the Iyolwa Project is seen in behavioural changes, a generally favourable view of the credit programme (perhaps not knowing that it is unsustainable), and ready participation in the evaluation of the Iyolwa Project itself.

Foreword

The Iyolwa Project evaluation is the culmination of a stimulating and rewarding participatory process unique in the experience of all participants. One of the most exciting and unusual features of this project evaluation is that community members were involved in all its phases: planning, data gathering, data analysis, feedback to key stakeholders, and report writing - and hopefully, implementation of the key recommendations.

The main evaluation report was written by a team composed entirely of community members, assisted by the project manager. Many, perhaps most, evaluations of overseas aid projects are done or dominated by people external to the project. Some evaluations involve project staff in the planning as well as the implementation of the evaluation. Other overseas-aid evaluations may include project staff in brief data analysis. Few evaluations include project staff in detailed data analysis or in writing the report. Even fewer overseas-aid evaluations include community members in the evaluation team. Very rare it is for project staff, let alone community members, to be involved in all phases of an evaluation. It is extraordinary for community members to remain as key players in the writing of the final report.

Summary

The principal goal of the Iyolwa HIV/AIDS Prevention and Control Project (Iyolwa Project) was to reduce HIV/AIDS infection rates and mitigate the effects of the epidemic in Iyolwa sub-county by equipping the population with knowledge, skills and resources needed for HIV/AIDS behaviour change and control. A second goal was to increase household income. The working assumption was that the incidence of HIV/AIDS would be reduced among women and children, who are the most vulnerable, if more economic opportunities became available.

Overall, the most outstanding achievement of the Iyolwa Project was empowerment of the community with skills, knowledge and resources for effective HIV/AIDS prevention and control. This was made possible through activities as community AIDS education campaigns, training of counsellors, school outreach program, the establishment of a revolving loan to raise house hold incomes, especially among women, and the establishment of cost effective management system. Sub-parish based Associations of People Living with AIDS (PLWA) were formed with psychological, moral and material support provided to PLWA.

At the output level, the Iyolwa Project had most success in the formation of Vision Clubs and PLWA Associations, mobilisation workshops for community leaders, awareness workshops for the community and project management. Despite being burdened by administrative difficulties, the credit program approached its goal of people contracted for loans. On the other hand, the goal of 100 counsellors trained and operating in the field was only partly met. Only 58 counsellors were in the field at the time of the evaluation.

The Iyolwa Project has been more successful in facilitating increased knowledge among adult community members than in facilitating behaviour-change. The project appears to have facilitated increased knowledge and increased condom use among high school children and among the community counsellors trained by the project.

The creation of local organisations supporting behaviour change, such as Vision Clubs, Counsellors Association, and four PLWA Associations, was a key achievement of the Iyolwa Project. The high level of community involvement in operating the project was also an achievement for both project staff and community members themselves who gave generously of their time and skill. In fact, during the course of the evaluation, these initiatives emerged as aspects of the project that could be shared with UNAIDS Best-Practice Series. It appears likely that the Iyolwa Project's community-based structures have influenced the behaviour of children more than of adults.

Recommendations

- Focus more on the promotion of condom use/safer sex through opening of distribution points in the sub-county. Subordinate goals are to discourage discos, burials, funeral rites and widow inheritance and to encourage increased abstinence and fidelity.
- Continued attention to create local HIV/STD (sexually transmitted disease) prevention and care strategies, using messages and resources with particular focus on participatory identification and use of what works best in Iyolwa sub-county. These could be supported by developing methods of negotiating safe sex, abstinence and fidelity that may be included in a training manual for use in the project and beyond.
- Increased focus on education, especially the construction of more schools.
- Greater focus on youth and children (in and out of school) concerning HIV/STD prevention and care, including:
  - Creation of Vision Clubs in every school in Iyolwa by the time World Vision's work ends. No limits should be placed on the size of the group; and
  - Special attention placed on assisting young boys and girls to identify and address their psychological, social, cultural and economic needs.
- Recruitment of a staff member at the parish level to increase the link with project personnel and the community in the implementation of project activities, particularly the credit program.
- Targeting viable, "bankable" clients with business experience, in order to establish a sustainable revolving loan scheme.
- Offer training to people currently unable to secure loans due to lack of business experience and very low income. Provide income-generating activities to assist these clients acquire and service loans.

Evaluation Methods and Tools

A number of methods were used in evaluating the project. These included:

- Problem trees
- Focus group interviews
- Key informant interviews
- Observation
- Stories
- Sampling and surveys
- Data analysis

Problem trees

The evaluation team discussed the objectives and activities of the Iyolwa Project and drew up problem trees to stimulate discussion on the project's definition of the "problems" and how definitions of problems matched proposed responses.

The evaluation team divided into four groups. Each group developed a problem tree for one Iyolwa Project component. The "trunk" and "branches" of the tree represented the project's response while the tree's "roots" represented the prior situation or problems that the project was trying to resolve.

The groups presented their work at the plenary session. Overall the groups did well in identifying their assumptions about the needs to which the project responded, although some groups had trouble in representing the direction of causation in their problem trees.

Focus group interviews

The team decided to use focus group interviews (FGIs), key-informant interviews and a survey, as well as less formal observation and story telling. These discussion guides were expanded as team members practised using them in-groups and in plenary sessions. The initial focus was on developing question guides for school children in order to complete data gathering before the school term ended. Once the children's questionnaire and focus-group-interviewer guide were ready and a sample of research sites was selected, the surveys and FGI with children went ahead.

Some 36 FGIs were organised with various stake-holders in the project area. Participants included:

- 6 FGI with Iyolwa Project committees.
- 4 FGI with PLWA.
- 4 FGI with community-based AIDS counsellors.
- 6 FGI with children.
- 12 FGI with committee members.
- 4 FGI with borrowers.

Key informant interviews

Multiple semi-structured interviews were held face to face with opinion leaders, local council chairpersons, project staff and government officials. This method provided opportunities for discussion on specific questions and to follow up on issues raised in the FGI and survey.

Observation

The evaluation team visited some Iyolwa Project beneficiaries in order to make first-hand observations of the impact of the project. During the exercise the team observed a client who acquired an ox-plough from the profits realised through the loan programme. The team was also shown a jacket and dry food ration given to a member of a PLWA Association.

Stories

All members of the evaluation team were encouraged to prepare stories about the Iyolwa Project and their experiences. Community researchers were provided with a pencil and notebook to capture stories that emerged during the interviews. While few written stories were collected, team members grasped the idea, livening up the trips between survey points.

Sampling and surveys

In consideration of the time available to collect information, the team agreed to select eight villages from the Iyolwa sub-county and four similar villages from an adjoining sub-county (Nabiyoga) for comparison.

After a debate on the merits of "purposive" and "random" sampling, the team agreed that the villages would be randomly sampled with at least one village chosen from each sub-parish. Four locations were chosen from outside the project area. The sampling exercise began with the entire evaluation team, and later continued with smaller groups where this was appropriate.

The primary criterion for selection of non-project-area locations was that the socio-economic and geographic profile of the sampled project and non-project sites should be similar. Further, the non-project areas should be places where little HIV education had occurred. This stipulation generally meant villages with no local or international non-governmental (NGO) facilitating HIV/AIDS prevention and care. It became apparent after the fieldwork while discussing the data on condom

use, that The AIDS Support Organisation (TASO) had been involved in two of the four non-project-area villages (Pombelo and Matchko). Nevertheless, as the two remaining non-project sites were areas with little organised HIV prevention and care, the non-project sites remained useful for comparison. The expectation was that the project-area respondents would rate more highly than the non-project-area in terms of HIV-related knowledge, attitudes and practices.

The children's and counsellors' questionnaires were designed to be filled-in by the respondents themselves. The community questionnaire was administered as a face-to-face interview. (The interviewer asked the questions and recorded the interviewee's verbal responses.) The surveys were all written in English as the local language lacks an agreed written form.

The original evaluation team was expanded to include a group of female counsellors and teachers. This action addressed the relatively low numbers of women in the team. The evaluation team found it preferable to employ women to administer the survey as both male and female respondents were likely to feel more comfortable speaking with a woman. In consideration of the tight timelines in which to achieve the number of surveys needed, the team was again expanded to include more men, though the principle of women interviewing women and women and men interviewing men was upheld.

Training was held continuously over a four-day period as new researchers joined the team. Before they began interviewing, the team had opportunities to provide feedback to the writers of the survey on words or concepts that might not be understood by the community, usually followed by heated debate on appropriate local equivalents. Once the survey was ready and sufficient copies had been printed, interviewers formed groups of three and were dropped in a central location of each sampled village. Proceeding in directions chosen randomly by the spin of a pen (the direction in which the lid of the pen pointed), the researchers interviewed the first willing people they came across.

Data analysis

Once much of the fieldwork had been completed, 22 members of the evaluation team, including three school children, were invited to form a smaller analysis group. Using a range of tools, this group analysed data from FGI, surveys and key informant interviews. The composition of this team was maintained during the third and fourth weeks, carrying out extensive qualitative and quantitative analysis of data gathered.

The analysis group was trained to undertake a quality-assurance check of each questionnaire prior to the data being entered into a Filemaker Pro.[2] The group checked each questionnaire for sense, consistency and errors. A sample of questionnaires was checked twice.

Analysis was undertaken in a convivial team environment with all analysis team members sitting around a large table outside the project office. Some of the most vigorous, illuminating and educational discussions of the evaluation took place during the analysis process, concerning condom use and the role of various "cultural factors" such as discos, funerals, polygamy, early marriage, and widow inheritance in "causing" HIV infection compared to unsafe sex in any situation.

The 22-member analysis team divided into seven groups and analysed the typed-up notes of focus group and key-informant interviews. Each group was asked to focus on one of the following themes:

- Stakeholders' knowledge of Iyolwa Project activities,
- Iyolwa Project strengths,
- Weaknesses,
- Constraints,
- Suggestions for improvement,
- Future needs (local needs that could possibly be addressed in the future),
- Evaluation team comments on data.

Representatives of the community (young woman, young boy, project chairperson, chairperson of the community counsellor association, person-living-with-AIDS) were elected to present the findings to senior management of World Vision Uganda and to write up an evaluation report with project staff. World Vision staff prepared a technical advisor' report and edited the 'community report' to send to the donor. This was one of the few evaluations where community members went the whole journey from planning to reporting an evaluation. Since the evaluation also involved planning for a new ADP that would take-over from the former HIV project, it was also a best-practice example of community participation in planning.

Main Findings

1. The Iyolwa Project fully achieved or exceeded four of its eight stated output targets. These were the goals that appeared to be the most important to the project participants and included:

- Four AIDS education clubs formed, one each in four schools (100% achieved).
- 12 community leaders mobilisation workshops (100% achieved).
- Six community HIV/STD/AIDS awareness meetings (600% achieved).
- Three parish-based associations for PLWA (133% achieved).

2. The project mostly achieved its target of 28 groups receiving loans (82% target achievement or 23 groups received loans). The project achieved its target of giving 60% of loans to women.
3. The project partly achieved its target of training 100 local volunteers in counselling and patient care (62% achieved or 80 volunteers attended training of whom 62 graduated; 58 were active at the time of the evaluation).
4. A functional cost-effective project management system was established.[3]
5. The Iyolwa Project is on the way to achieving its purpose, 'To have equipped up to 17,000 people with knowledge skills and resources effective for HIV/AIDS behaviour change and control'.
6. The Iyolwa Project has probably helped to develop the knowledge of children and community members about HIV transmission, prevention and PLWA acceptance and care. Behaviour change is a more challenging and difficult objective. There are signs that the project may have helped to bring about behaviour change in the project area, including the following:
   - School children sampled in the Iyolwa Project area demonstrated higher levels of HIV-related know-ledge. They reported higher levels of condom use than school children sampled outside the project area;
   - Higher proportion of "never married" adults sampled in the project area reported that they had never had sex than unmarried adults outside the project area;
   - Large sample of project-trained community counsellors surveyed and interviewed by the evaluation team showed higher levels of HIV-related knowledge and reported more widespread condom use than community counterparts inside and outside the Iyolwa Project area. A higher proportion of sampled counsellors reported fidelity as one of the ways that they had changed their behaviour compared to other community respondents inside and outside the project area.

Project Strengths

- Iyolwa Project facilitated identification, selection, and training of counsellors;
- Community participation in identification of counsellors: village communities selected people to undertake counsellor training;
- Iyolwa Project facilitated the creation of counsellors' association;
- Counsellors' association wrote a constitution and taking steps towards being registered as NGO;
- Good level of activity, knowledge, skills and motivation among counsellors given that the counsellors are volunteers;
- Iyolwa Project facilitated creation of PLWA associations;
- Counsellors played a valuable role in the support and care of PLWA and their families;
- Good level of community involvement in project implementation including participation of community members as counsellors, credit committee members, project committee members generally; participation of community in identification of counsellors;
- Involvement of school children and other community members in production and presentation of behaviour-change materials (such as drama written and presented by Magola Primary School Vision Club and drama/songs produced by women's clubs). Arguably, localised and participatory behaviour-change strategies are likely to be more effective;
- Counsellors were moving toward a primary health care role (illustrated by their local informal title "doctor" and their involvement in giving first aid);
- Idea of involving school-children in project through Vision Clubs was excellent;
- Idea of empowering women was excellent: empowering women and girls is an important part of any best-practice HIV prevention strategy;
- Iyolwa Project has produced its own HIV prevention video and developed its own HIV-related materials;
- Likelihood of sustainability of project's HIV-related activities and structures looks good;
- Iyolwa Project strengths identified by local stakeholders include:
  - Provision of drugs and food,

- Use of condoms
- Provision of T-shirts and jackets
- Counselling units established
- Drama shows
- Training of Vision Clubs
- Giving pigs
- Provision of bicycles
- Training counsellors and equipping them
- Sensitisation on HIV/AIDS
- Mobilisation and training of the community
- PLWA associations
- Provision of loans
- Films shows
- Capacity building in the community
- Facilitation of Elisa test
- Awareness creation and behaviour change on HIV/AIDS
- Giving certificate
- Opening bank accounts
- Focus on project goals
- Relationship built between families, community, non-governmental organisations (NGOs) and government leaders
- Training of trainers
- Renovation of community centre and staff office
- Deployment of Technical Associates
- Installation of solar system

Project Weaknesses

- Some Iyolwa Project staff and volunteers appeared to be negative towards condom use and condom promotion.
- Questionable connection between the credit and HIV components of the program. The credit component was not understood by project participants as *primarily* HIV-related. Some association between HIV and credit program were suggested including:
    - Credit directly helped poor clients avoid the attractions of "sugar daddies" and "sugar mummies" who may be infected with HIV/AIDS.
    - Credit helped indirectly by creating employment for poor people, making them less susceptible to sugar daddies and sugar mummies.
    - The Iyolwa Project proposal noted that "women will be provided with leadership and credit training to enable them to participate freely in decision-making and hence effectively contribute to family needs and reduce risk of AIDS in women." It is not clear that women had "leadership training";
    - Local people were involved in administering the loan program. They probably were too lenient towards their fellow community members when it came to recovery of arrears;
    - Loan recovery rates were very low (around 70%), and credit records not well kept.
- The Iyolwa Project's reliance on education in its HIV-specific components is unlikely to result in widespread behavioural change without being complemented by actions to change power relations between males and females and between economically better off and worse-off people.
- A number of other weaknesses identified by community and government informants during the evaluation included:
    - Insufficient sites for voluntary counselling and testing
    - Insufficient attention given to orphans
    - Lack of funds prevented counsellors from sufficiently visiting clients
    - Iyolwa Project doesn't help people with funeral expenses
    - Lack of transport for competitive events
    - Iyolwa Project failed to provide condoms
    - Some committee members missed the film shows

Constraints

- "Limited budget" and "inadequate budget" mentioned by project manager and book-keeper, respectively;
- Limitations of voluntarism (volunteers don't have infinite time, patience, skills, and altruism that is sometimes wished for by donors and intermediary agencies);
- Parts of Iyolwa were inaccessible during rainy seasons;
- Behaviour change in the community is slow;
- Transport limitations for most counsellors (credit

committee members were given bicycles, but counsellors were not);

- Transport and distance constraints for PLWA in accessing treatment;
- Poverty;
- Poor education, health and transport infrastructure.

What difference has the project made?

HIV/AIDS awareness?

In general, many focus groups and key informants felt that the project had helped to increase the general awareness about the spread of HIV/AIDS. The three main areas of increased awareness about the transmission of HIV/AIDS were unprotected sex, sharing sharp objects, and blood transfusion.

Table 1 indicates that a higher percentage of the children in schools with Vision Clubs gave the “correct” answer to the questions testing their knowledge. The general trend is for children in Vision Club schools to rate the highest in knowledge, followed by children in the project-area schools without Vision Clubs, followed by children going to schools outside the project area.

While it is difficult to pinpoint the causal factors behind the different levels of knowledge in Vision Club schools, project area schools and non-project area schools, it is fair to suggest that the Iyolwa HIV project has probably had a key role in helping to increase the knowledge of school children about HIV/AIDS transmission and how to protect themselves from infection.

To oversimplify, the Iyolwa Project has put:

- Most effort and resources into Vision Club schools, especially the 40 children in the Vision Clubs from each school. These youth, however, are likely to have a ripple effect through speaking to other children as well as their parents);
- Less effort and resources into other schools in the project area, and
- No effort and resources into the non-project area schools.

The level of knowledge of the different groups of children appears to be associated with the level of effort/ resources of the project (high effort = high knowledge; lower effort = lower knowledge; no effort = lowest knowledge).

It is worth noting that TASO has been involved in promoting HIV awareness (including condom use) and care in some areas of the non-project area. In other non-project areas, there is little government HIV activity and no non-government organisations in operation.

It should be noted that there are three answers that may not have clear true and false responses. A good diet and healthy lifestyle does help the immune system to fight of infections of various sorts, yet one would not want to recommend that people rely solely on a good diet and lifestyle for their own and others’ protection. On balance, the statement *good diet does not protect people from infection* is more true than false.

Many women who have stayed faithful to their partner have become HIV positive. They have had unsafe sex with their partners who have become infected through unsafe sex with other partner(s). A person cannot be sure that he or she is safe from infection by staying faithful to one partner. Mutual fidelity between two uninfected partners gives 100% protection from infection through sexual intercourse. One the other hand, it could be said that, a faithful partner reduces her or his risk of infection from other partners (especially where unsafe sex is involved) and therefore offers a degree of protection.

Added to the standard WHO/UNAIDS list of questions is “not going to discos or funeral rites,” because community people promoted this idea for people’s protection. Certainly discos and funerals are associated with drinking alcohol that could lead to unsafe sex, especially given the reported low level of condom usage in the project area. Those youth who felt that avoiding discos and funeral rites would not protect them from HIV infection also had a point, given that HIV is spread through unsafe safe and other risky behaviours in many settings apart from discos. Using condoms in the context of discos and funerals rites does not guarantee 100% protection. Nevertheless, it is likely to provide a high likelihood of protection if used correctly.

Project staff and volunteers should look closely at Table 2 and work to increase school children’s knowledge of how HIV is transmitted and how it is not transmitted and similarly, how school children can protect themselves. Note for example, the low percentage of “correct” answers given to “avoid mosquitoes” (only 37% of children with a Vision Club in their school answered correctly and only 31% of children in the project area but without a Vision Club in their school answered correctly).

It is gratifying that more youth in schools knew that

Table 1: School children's knowledge of ways of protecting themselves					
People can protect themselves by ……	(1) 2 sampled Vision Club schools (2) 2 sampled schools in project Area without Vision Clubs (3) 2 purposely sampled schools in Non-project Area	True No. of children answering 'True' (% only shown where 'true' is correct answer)	False No. of children answering 'False' (% only shown where 'false' is correct answer)	No. of children answering 'Don't Know'	Total
Having a good diet	 3	22 28 33	33 (50%) 29 (45%) 30 (38%)	11 8 16	66 65 79
Staying faithful with one partner	1 3	45 (71%) 41 (63%) 51 (62%)	10 14 19	8 10 11	63 65 81
Avoiding public toilets	 2 3	18 10 18	36 (57%) 44 (69%) 40 (51%)	9 10 21	63 64 79
Using condoms during sexual intercourse	1 2 3	54 (86%) 51 (78%) 50 (62%)	7 11 16	2 3 15	63 65 81
Avoiding touching a person with AIDS	 3	16 8 12	44 (70%) 44 (66%) 49 (61%)	3 15 19	63 67 80
Avoid wearing clothes of a person who has AIDS	1 2 3	10 17 18	46 (75%) 40 (62%) 51 (54%)	5 8 25	61 65 94
Avoid sharing of food with a person who has AIDS	 3	10 18 23	51 (81%) 28 (51%) 41 (51%)	2 9 16	63 55 80
Avoid being bitten by mosquitoes or similar insects	1 2 3	31 25 31	23 (37%) 20 (31%) 29 (36%)	9 19 21	63 64 81
Making sure that any injection they have is done with a clean needle	 3	44 (70%) 40 (65%) 33 (47%)	18 11 16	1 11 21	63 62 70
Not going to discos or funeral rites	1 3	40 (71%) 42 (81%) 35 (43%)	8 (14%) 5 (9%) 31 (39%)	8 5 14	56 52 80

“using condoms during sexual intercourse” was a way of protecting themselves. Unfortunately, abstinence was not listed, and fidelity depends on two uninfected partners being faithful to each other in order to achieve effective protection. While 86% and 78% of school children in the Iyolwa Project area, in Vision Club schools and non-Vision Club schools, respectively, knew that using condoms was one way of protecting themselves, 14% and 22% of children did not know this. An even lower percentage of adults in the project area (73%) identified condom use as a way of protecting themselves.

Table 2 suggests that community members in the Iyolwa Project area are better informed on the basic facts of HIV transmission and protection than are community members in non-project areas. In all questions, higher proportions of project area respondents cite the “correct” answer about how to protect themselves from HIV infection. The one possible exception is that a higher proportion of project area respondents answered that “not going to discos” was a “true” means of HIV protection. However, this response was in line with project messages, the low level of condom use in the project area, the relationship between alcohol consumption and increased likelihood of unsafe sex.

Behaviour change?

HIV prevention. In response to the question, “Have you made any changes to protect yourself from HIV infection?”, 30 counsellors (91%) said “yes,” compared to 80 Iyolwa community respondents (80 %) and 74 Nabiyoga respondents (74 %). Some 15 respondents from Iyolwa and Nabiyoga (15 %) said “no,” they had not changed their behaviour. No answer is recorded for three respondents from Iyolwa and 11 respondents from Nabiyoga. Multiple responses to the follow-up question of, “How have you changed your behaviour?” were possible in the community and counsellor surveys.

Numbers and percentages of community survey respondents are generally the same (sample sizes of 100 in Iyolwa and 98/99 in Nabiyoga, depending on the question). To facilitate the analysis, percentages were used. Unfortunately, HIV/AIDS prevalence and incidence rates for the project area were not available. It would be good for project area figures and trends to be regularly monitored by the project in co-operation with the Government.

Condom use. In response to a survey question, “How have you changed your behaviour?” (asked only of those who said that they had changed their behaviour), 15 % of Iyolwa community respondents, 12 % of Nabiyoga community respondents, and 52 % of Iyolwa counsellors (17 of 33 respondents) said condom use.

In response to specific questions in the community survey concerning condom use, a smaller proportion of the sampled adult community members in the project area said that they had ever used a condom (24% compared to 42% of the sampled adults outside the project area). A smaller proportion of sampled adults in the project area also said that they had used a condom the last time they had sex (41% compared to 54%). Reported condom usage is higher among sampled youth and adult community members in non-project areas, while the trend is reversed among school children.

Few respondents answered questions on their own sexual behaviour. The sample size for sensitive questions like these was very small and the trends cannot be generalised to the general population with any level of confidence. About 35% of the 26 counsellors who answered the question said that they had used a condom the last time they had sex.

The exposure of volunteers to the clear condom-promotion messages of TASO may have influenced the behaviour of the project’s community counsellors: 71% of the project’s volunteer counsellors said that they had ever used a condom and, as noted earlier, 52 % gave condom use as an instance of change behaviour.

A higher proportion of youth in schools in the Iyolwa Project area compared to non-project area reported that:

- They had ever used a condom (37% of the 65 school children in the project area who answered question compared to 14% of school children outside the project area);
- They used a condom always or mostly (28% compared to 1%);
- They used a condom on the last occasion they had sex (37% compared to 14%).

An even higher proportion of Vision Club members reported that they had used a condom the last time they had had sex (44% of the 18 Vision Club members who answered the question compared to 22% of the 87 non-Vision-Club members inside and outside the project area who answered the question).

This suggests that the Iyolwa Project may have been more successful in influencing the behaviour of school children and volunteer counsellors towards safer sex than efforts designed to change the behaviour of adults.

Table 2: Community members' knowledge of ways of protecting themselves					
People can protect themselves by ……	(1)Community members within project area (Iyolwa) (2)Community members outside project area (Nabiyoga)	True	False	Don't Know	Total
Having a good diet	1	9	86 (88%)	3	98
	2	16	71 (76%)	7	94
Staying faithful with one partner 2 Outside project area	1	86 (88%)	10	2	98
	2	80 (84%)	12	3	95
Avoiding public toilets	1	11	(81%)	8	98
	2	11	61 (66%)	21	93
Using condom during sexual intercouse	1	73 (74%)	10	15	98
	2	50 (53%)	17	27	94
Avoiding touching a person with AIDS	1	10	86 (88%)	2	98
	2	8	73 (78%)	12	93
Avoid wearing clothes of a person who has AIDS	1	7	81 (83%)	10	98
	2	8	74 (79%)	12	94
Avoid sharing of food with a person who has AIDS	1	6	87 (89%)	5	98
	2	14	69 (73%)	11	94
Avoid being bitten by mosquitoes or similar Insects	1	24	65 (67%)	8	97
	2	25	50 (53%)	19	94
Making sure that all injections they have are done with a clean needle	1	91 (94%)	4	2	97
	2	80 (85%)	9	5	94
Not going to disco's or funeral rites	1	59 (61%)	36 (37%)	2	97
	2	45 (48%)	40 (43%)	8	93

It is noteworthy that "increased use of condoms" in the project area was noted as one area of project impact in focus group and key informant.

Abstinence. In the area of abstinence, a similar proportion of school children inside and outside the project reported that they have ever had sex (59% and 58% respectively). Some 59% of the sample of unmarried people in the project area said that they had ever had sex (10 out of 17 who answered question) compared to 94% of the sample of unmarried people outside the project area (15 of the 16 who answered the question). Only 33 of the sample of 198 adults identified themselves as "never married".

As in the case of other questions with a small number of respondents, one can not confidently generalise the results to the community as a whole. Nevertheless, data suggest that abstinence *may* be practised more among people who have never married in the Iyolwa Project area compared to the non-project area. If this is the case, it is consistent with the project's emphasis on promoting abstinence, fidelity and the avoidance of "culturally risky practices," such as discos, funeral rites, widow inheritance, and polygamy more than condom promotion.

About 36% of counsellors (12 respondents) reported abstinence as one of the ways that they had changed their behaviour compared to 21% of Iyolwa community respondents and 19% of Nabiyoga respondents. Once again, reported change is more widespread among counsellors than among community members. Reported change is slightly higher among Iyolwa residents than Nabiyoga residents.

Fidelity. There is no strong evidence from group comparisons that the Iyolwa Project may have helped to facilitate fidelity among married people residing in the project area. Some 22% of the married respondents in the project area (20 out of 80) compared to 18% of married respondents outside the project area (12 out of 66) reported having extramarital sex in the past 12 months. Interestingly, equal numbers of men and women inside the project area reported having extramarital sex (10 and 10) and not having extramarital sex (30 and 30).

While questions on extramarital sex were not asked of counsellors, given the small sample and sensitive nature of the information, some comparable information on fidelity from counsellor and community respondents was obtained. About 85% of counsellor respondents compared to 53% of Iyolwa respondents and 50% of Nabiyoga respondents gave fidelity as one of the ways that they had changed their behaviour to protect themselves against HIV infection.

Other ways of self-protection. In the Iyolwa community, 9% of respondents mentioned that they no longer shared needles or other sharp objects compared to 6% of Nabiyoga respondents. Only 1% of Iyolwa community respondents and no Nabiyoga respondents mentioned that they no longer attended discos and burial/funeral rites. Unfortunately, some of the data within the counsellor computer files has become corrupted, making it difficult to gauge other ways that people have protected themselves against HIV infection. Other examples of project impact mentioned in focus groups and key informant interviews included "reduced going to discos," "reduced over drinking", "reduced outdoor stay late at night," and "widow and widower inheritance reduced."

Community members active in HIV prevention and/or care. The project facilitated another area of behaviour change in the community through building the capacity of community members to take action on HIV/AIDS. The project co-ordinated the creation of a cadre of community volunteer counsellors. The summary table on project impact prepared by community members from group and key informant interview noted 'counselling skills available in community' as an area of project impact. Three specifics were noted: trained counsellors available, empowerment in public speech and leadership skills.

In response to a question in the counsellors' survey, "What do you do?", the following activities were mentioned by the sample of 33 counsellors who filled out the survey:

- Creating awareness among community;
- Sensitisation of community;
- Visiting clients or PLWA;
- Registering clients (so that they are eligible for a local tax exemption);
- Counselling;
- Collecting drugs and giving them to clients.

Nineteen (58%) of the sampled counsellors said that they took part in education[4] and care[5] activities; 13 or 39% named only education activities; one counsellor (3%) did not record an answer to this question. Having nearly six out of 10 counsellors report that they have been involved in caring for people living with AIDS (PLWA) is a relatively high percentage compared to the

other World Vision HIV/AIDS projects.

This relatively high percentage of counsellors involved in caring is possibly indicative of counsellors' acceptance of PLWA as continuing community members. Project staff and counsellors usually call PLWA "clients" rather than "patients" or "AIDS victims."

It is also possibly an indicator of the willingness of PLWA in Iyolwa to acknowledge their status to themselves and to others in the community. The project's role in facilitating this relative openness is difficult to discern with precision in the time and resources available.

The role of the project in facilitating greater acceptance of PLWA among themselves and the broader community was often mentioned. Arguably, project staff and volunteers—and PLWA themselves—facilitated by project staff and volunteers, played a significant role in promoting a more positive social climate for PLWA to "come out" and to live with dignity.

The Ugandan government and communities, too, deserve recognition for their historical willingness to be more open to acknowledging HIV/AIDS and its effects than counterparts in many other areas of the world. This greater openness is often said to be part of the reason for Uganda's relative success in fighting HIV/AIDS.

The project also facilitated the creation of women's clubs that promoted HIV/AIDS prevention messages through drama and song. These helped develop the capacity of club members to help develop community awareness about HIV/AIDS.

In response to the question "Who conducts HIV/AIDS activities in this area?", the sample of counsellors mentioned women's groups more frequently than any other category of agents apart from themselves. Specifically:

- Women's groups were mentioned as active by 12 counsellors;
- School children were mentioned as active by eight counsellors. Counsellors giving the general answer of "school children" were probably thinking of Vision Club children or schools where there are Vision Clubs;
- Community were mentioned as active by seven counsellors;
- Community leaders were mentioned as active by five counsellors;
- Religious leaders were mentioned as active by three counsellors;
- Iyolwa Project staff/manager were mentioned as active by 12 counsellors;
- AIDS trainers, such as TASO, were mentioned as active by 8 counsellors.

Changes in lives of PLWA. From various interviews with PLWA, six areas of change in the lives of PLWA were highlighted:

- Having hope of living positively for more years;
- Coming out openly;
- Developed friendship with fellow clients;
- Mobilising other clients.
- "Free association with PLWA" as a project effect, in particular, specifying PLWA "staying together" and "drinking together." It also refers to formation of association group of PLWA;
- "Behavioural change in PLWA," specifying fidelity to one sexual partner, abstinence, and frequent use of condoms as instances of behavioural change.

A key area of project impact mentioned in group and key informant interviews was the "Changed attitudes towards PLWA (positive change)." Included are four examples: washing clothes, eating together, buying their goods, and reduced fear of PLWA. Of these four "changed attitude" examples, three are examples of changed behaviour. Now non-infected people are not afraid to wash clothes of PLWA, eat together with PLWA, and buy their goods.

Other Benefits. "Building spiritual strength"' and "attending church" are suggestive of the project's emphasis on moral/spiritual reform and renewal as an end in itself as well as a means to prevent HIV/AIDS:

- "Behavioural change towards community hygiene", specifically, cleaning of water sources and good family sanitation;
- "Benefits of loans to the community," including "increased family income," "facilitated business skills," "acquisition of assets" and "recording skills."

Suggestions for the Area (Community) Development Programme

- Creating Vision Clubs in every school in Iyolwa by the end of the ADP;
- No limit on membership of Vision Clubs. The current limit is 40 members for each Vision club.
- Give special attention to assisting young boys and

girls to identify and address their own psychological, social, cultural, and economic needs;

- ADP should develop an integrated plan to empower women and girls as far as possible with the support and assistance of men and boys;
- ADP should avoid giving handouts and doing things for the community. It should be a social catalyst rather than a provider of funds or other material resources. In other words, the ADP should help the community to help itself even though that means:
  - Moving slowly, with the community in the driver's seat,
  - Changing the expectations of those community members who want the ADP to be like the government and do things *for* the community, such as building schools, roads and hospitals.
- ADP should include a strong focus on the poor and marginalised groups in the community. These include casual labourers, widows, orphans, disabled, and resource-poor generally, with special focus on women;
- ADP should undertake further participatory identification of needs and possible responses concerning marginalised groups. The ADP should involve some members of the project's research team and include some members of the marginalised groups;
- ADP could explore whether and how to support and promote barter as a form of community self-help. Note: poor labourers in the project area, especially females, often prefer being paid in-kind for their work. In contrast, credit programs generally target and benefit the near poor. The challenge for the ADP is to find ways of supporting the community and government to directly assist the very poor;
- In line with the project manager's existing idea, the ADP should consider helping to further develop counsellor's capacity to perform primary health care (PHC) roles, such as first aid, hygiene and sanitation;
- Counsellors' Association could consider:
  - Recruiting and training additional number of counsellors/primary health care workers to cope with possible increased workload flowing from a strengthened PHC role;
  - Renaming themselves as village health volunteers or some such broader term to acknowledge the expanded PHC role;
  - Increasing variety of volunteers in terms of religion, age, and HIV positive status. Specific examples include more children, youth, people from non-Christian religions, and PLWA. It is very important to include PLWA in HIV prevention and care as much as possible;
  - Distinguishing between *peer trainers* regarding HIV/AIDS/STDs (mainly educational role) and *PHC volunteers* whose role includes basic medical and PLWA-care components;
  - In consultation with Counsellors' Association, PLWA Associations could consider nominating PLWA members to be counsellors.
- ADP could consider recruiting a health/HIV/STD specialist. One responsibility of this position could be to help community counsellors to further develop their primary health care role and expertise, including HIV/STD prevention and care. The level of HIV/STD-related knowledge of adults, children and even counsellors in the project area could be improved and the health/HIV/STD specialist could play an important train-the-trainer role. This does not mean that the role of TASO in training should stop. The project's relationship with TASO is good. It should continue and be developed;
- ADP should continue to support the counsellor's organisation, albeit in a way that respects and helps the organisation to further develop as an independent organisation and consistent with the wishes of the members of the association;
- ADP should focus more on helping to reduce risky behaviours, including and especially unprotected sex, and increasing availability and accessibility of condoms in project area. Those counsellors who are comfortable with condom promotion and sale could be condom vendors selling at the same price as market outlets and retaining commissions.
- ADP should consider supporting the development of a revolving drug fund and revolving saving-and-loan scheme, especially for families caring for PLWA. The scheme could take the form of a revolving pig or other animal bank along the lines already used by the project with women's HIV drama groups. The project should continue the women's group scheme and consider extending it to PLWA. This may also provide an incentive for more PLWA to "come out" and acknowledge their health status.
- More emphasis should be put on improving girls and women's skills in raising issue of HIV prevention in conversation and negotiating issue of safe sex and

other prevention methods with partners. One idea is for counsellors to identify:

- Girls and boys, women and men who support and advocate safe sex, abstinence, or fidelity may be trained as community role-models, peer trainers to raise topic in informal conversation with friends, work colleagues and the like;
- Girls and women, boys and men who have been able to negotiate safe sex, abstinence, or fidelity with their partner to train and empower their peers;
- Methods of negotiating safe sex, abstinence, or fidelity that can be included in a training manual for use in project and beyond, developed by local people with assistance of ADP.

- Participatory planning and evaluation should be mainstreamed into the normal operations of the ADP.

Consideration should be given to including team members of this evaluation in the project's ongoing evaluation team. However, it would be wise to ask community members to nominate some team members to enhance the idea that it is their team, as it is their ADP.

Notes

[1] "ADP" is the term World Vision uses for the organisation's community development work. Generally, ADPs extends over many communities, permitting economies of scale.

[2] Filemaker Pro is a relational-database computer program.

[3] The term 'cost-effective' is probably out of place as an output given that cost-effective refers to the unit cost of producing outcomes or purpose-level effects. It makes more sense to assess cost-effectiveness of a project rather than of project management on its own.

[4] Classing all mentions of sensitisation, education, mobilising for education, arranging women's groups for education purposes, encouraging use of condoms, telling people to go for blood test, training counsellors, counselling on its own or counselling community as "education".

[5] Classifying all the activities relating to clients (including counselling) as "care".

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