2

Stakeholder participation

Introduction

World Vision International has recognised the value of a participatory approach to development. It has put the principle at the heart of its transformational development policy which calls on World Vision staff and projects to 'engage communities and families as agents, planners, implementers and evaluators of transformational development, where the vision comes from these people and the ownership is theirs'.[1]

Participation is widely accepted as a best-practice principle in overseas aid and development. As the ELDIS website of the British Institute of Development Studies puts it: 'The past two decades have seen an increased recognition of the importance of participation by beneficiaries (and a wide range of other stakeholders) in decision-making'.[2]

In this chapter, the discussion of participation in WV's HIV/AIDS interventions is divided into four parts:

- participation in initial planning;
- participation in planning during implementation;
- participation in implementing the project;
- participation in monitoring and evaluation.

Best-practice principle

Include local stakeholders (especially people living with AIDS and other community members) as far as possible in planning, implementing, monitoring, evaluating and managing interventions.

Let's now turn to discuss WV performance in facilitating stakeholder participation within projects. Issues relating to gender and people living with AIDS (PLWAs) will be deferred to later chapters.

Participation in initial planning

Fifteen of the 19 projects reviewed appeared to have a low level of local-stakeholder participation in the initial planning of the HIV/AIDS intervention. In these projects, most of the key local stakeholders in the project area were not intensively involved in developing the initial HIV plan or project proposal. Most HIV project proposals arose mainly in national or district capitals through discussions with national or district stakeholders, rather than through discussions with community members and other local stakeholders in rural villages or urban neighbourhoods.

Participatory HIV/AIDS responses

Achievement of the overarching aim of the global response requires leadership commitments…

- to expand efforts to support community-focused action on the epidemic by affirming and strengthening the capacity of local communities to be assertively involved in all aspects of the response…
- to seek out actively and support the development of partnerships required to address the epidemic among the public sector and civil society, including the private sector.

Textbox 2.1
Source: *The Global Strategy Framework on HIV/AIDS* (2001), UNAIDS, Geneva, pp. 14-15.

This appears to be a common trend in overseas aid and development projects[3] despite widespread enthusiasm for the principle or rhetoric of participation expressed by most players in the aid and development sector.[4] There is often a low level of participation of local stakeholders (especially community) in planning, management, monitoring and evaluation in many or even most projects, HIV and

Low level of stakeholder participation in planning overseas-aid projects

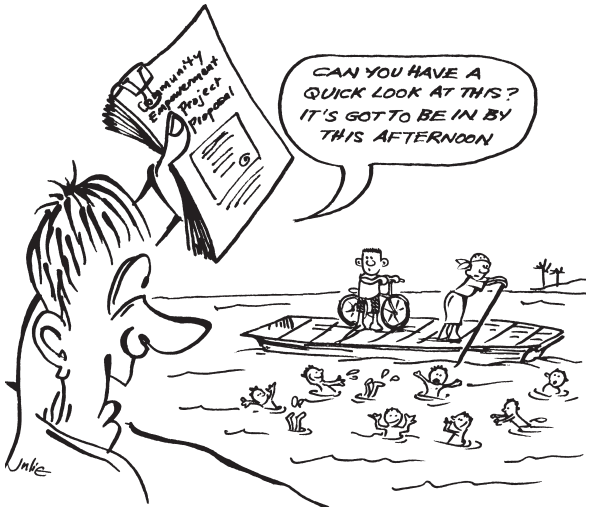
The Simons Committee (so called after its chair, H. Paul Simons), reviewed the Australian overseas aid program in 1996-1997. Its report stated:

> The Committee is also concerned that attention to issues of local participation … has been patchy in AusAID's project preparation processes. One of the strongest lessons emerging from the international literature has been the importance of local participation and local ownership to the success and sustainability of development projects. One of the weaknesses of the current AusAID approach to project development is the short period allowed for project design in the country concerned. One of the difficulties this causes is that it does not allow sufficient time for investigating local perceptions of development constraints and building projects in ways which incorporate local community initiatives. The risk is that this can result in imposed solutions with little or no local commitment or ownership.[5]

Edwards and Hulme, for example, note that: 'there is increasing evidence that NGOs and grassroots organisations do not perform as effectively as had been assumed in terms of … popular participation (including gender)'.[6]

Fowler and Biekart note that: 'overall, despite the misleading, but politically correct use of the term empowerment, the bulk of the [NGO] agency community is developmentally conservative and unempowering, happily fulfilling traditional roles of social support and welfare provision.'[7]

Textbox 2.2
Sources cited in notes at end of chapter



otherwise. Local participation is more common in the implementing of projects than in steering and supervising projects.

Exceptions to the general finding of a low level stakeholder participation in initial planning are found in the Nankumba, Iyolwa, Nkoaranga and Arumeru projects. Community-participatory planning was also part of the end-of-project evaluations in Iyolwa, Kawthaung,[8] Kariobangi and Arumeru.

Nankumba

The Malawian Nankumba project extended its area of operation in consultation with community members, local non-government health organisations and the government health ministry officials.

Iyolwa

In 1996, the project site in Iyolwa, Uganda was chosen by WV Uganda and Ugandan government district health staff following rapid participatory learning and action (PLA) activities in several sub-counties. WV Uganda was looking for a suitable site for HIV intervention near a main road running through several counties and Iyolwa was near this major HIV-transmission route. WV Uganda and Ugandan government health staff undertook further PLA activities in Iyolwa.[10]

As the HIV project began to transform into an area development program (ADP),[11] a community-based research team evaluated the HIV project and facilitated a consultation on community needs. The team included children, young people, PLWA, volunteer AIDS counsellors, project committee members and loan recipients—all community members. Other members included one non-government representative and one government health worker. The research team had 33 community members.

With the assistance of project staff, WV Uganda and WV Australia staff, the research team designed, facilitated and took notes during:

Local stakeholders participating in planning

Nankumba HIV/AIDS project started in July 1997… The aim of this project was to reduce HIV prevalence in the Nankumba area by raising HIV/AIDS/STD awareness among community members.

Nankumba HIV/AIDS project is located in the Southern region of Malawi and faces the challenge of being among areas of high HIV prevalence according to regional distribution cases. There is no HIV testing centre within the project area. There are three testing centres in the Mangochi district.

The project also faces the challenge of mixed cultures and high risk sexual behaviours due to the combination of being located along the lake shore where the fishing industry, holiday resorts and tourism attracts a transient/mobile population that mixes briefly with the local indigenous population.[9]

WV Malawi operated a seed project funded by WV Germany from 1994 to 1997. This project was situated in Monkey Bay within Nankumba community. The seed project endeavored to educate the community's populace on HIV/AIDS/STD transmission, prevention and dangers. Messages were passed mainly through local drama and band performances.

The Monkey Bay project operated in four villages with a population of 4500. As a result of the perceived success of this project several requests were received to conduct AIDS education sessions for the Malawi Army Navy Unit in the area, Ministry of Health's health centres of Nankumba and Monkey Bay, and the safe motherhood project for traditional birth attendants. Community members requested expansion of the project to cover the entire sub-district of Nankumba during community meetings. Their main argument was that their HIV awareness in Monkey Bay would not necessarily improve health if neighbouring areas continued to have little knowledge of HIV and continued to mix sexually with the locals. The majority of the community members get their health care services from traditional birth attendants and traditional healers who may not have been trained in HIV/AIDS.

In collaboration and consultation with ministry of health health centre staff, Mangochi District Hospital staff, Christian Health Association of Malawi health centre staff, safe motherhood staff and community members of Monkey Bay HIV/AIDS project, a Nankumba HIV/AIDS project proposal was compiled. The proposal was submitted for funding and it was funded. These same partners/stakeholders above and other related stakeholders within the district had a day-long planning meeting on September 20, 1997. This meeting was held after the community meetings in all the six commitment areas of the project. Community planning meetings were conducted in the first two weeks of September 1997. With this information, the first Nankumba HIV/AIDS annual implementation plan was compiled in September/October 1997. Consecutive annual plans followed similar pre-planning meetings with stakeholders, but this time through project coordinating committee meetings prior to the annual implementation plan compilation.

Monitoring of activities was done through project coordinating committee meetings. These meetings were organised for all stakeholders including the community to discuss the progress of the project activities to control activities and to bring about corrective measures where things were not on track. These meetings—usually attended by around 100 people—helped staff to focus even when they were conducting their follow-up and monitoring activities with community support groups.

Textbox 2.3
Source: Nankumba Evaluation Report (2000), p.13.

- 36 group interviews with members of the project's community-based committees, PLWA, community-based AIDS counsellors, children and project-loan recipients;
- individual interviews with 198 adults, 100 children, 33 of the 58 active community AIDS counsellors, one non-government agency stakeholder and seven government stakeholders (mix of officials from village through to district level).

Iyolwa community members went on to:

- analyse the information;
- feedback key findings to community members and senior management of WV Uganda;
- write the final report;
- oversee implementation of the findings through community representatives on project committee.

Nkoaranga and Arumeru

The third exception to the low-participation-in-planning finding occurred in Nkoaranga and Arumeru, Tanzania. In Nkoaranga, a group of hospital staff and church members invited WV to start an HIV/AIDS project in 1990. This became the Nkoaranga HIV/AIDS Prevention and Control Project (1990-1995). Government and non-government health staff and community members in neighbouring divisions in the Arumeru district invited the project management to expand its project area from the Poli division to the three adjoining divisions, King'ori, Mbuguni and Moshono.[12] The expanded project became the Arumeru HIV/AIDS Prevention and Care Project (1996-2000).

Community involvement with planning occurred at the end of the Arumeru project as the evaluation team used a participatory approach to evaluate the project and plan its future. The team included project staff, community members—project committee members, volunteer community counsellors, two PLWA who were active project volunteers—government and NGO staff living in the project area and the district AIDS coordinator.

The team recommended extending HIV prevention and care activities to a mining town (Mirerani) across the district border. Many men from the project area went to work in Mirerani and often stayed on after work to drink and have sex with commercial sex workers. The evaluation informed a new project proposal to initiate HIV prevention and care activities in Mirerani. Fortunately, Mirerani was part of an existing WV area development program (Moipo ADP) allowing the possibility of integrating HIV prevention and care into a broader development program. The proposal was successful and is now being implemented as the Moipo Division HIV project.

Government involvement in planning

Although the planning process was generally not described in detail in project documents, most project sites and designs appear to have evolved from discussions between government ministry staff at provincial or district levels and WV staff. In WV's HIV projects in Asia and Africa, the main planning partner was the government health ministry. The end-of-project evaluation of Chiangmai I, for example, notes that:

> The project has a close relationship with the Thailand ministry of public health (MOPH). It was designed in close collaboration with the MOPH and follows the recommendations set out in the recent WHO/MOPH review of Thailand's National AIDS Medium Term Plan…
>
> The project is located in five districts in rural areas of Chiangmai. The districts were chosen on the basis of MOPH district staff cooperation and the practical consideration of distance from project base. Each area also reported a high incidence of HIV infection.[13]

The HIV/AIDS projects in Africa were more likely to have community members playing a role in requesting WV to locate a project in their area (Nkoaranga, Arumeru, Nankumba). This difference between projects in Africa and Asia was not necessarily attributable to different WV practices across the continents. It may have also reflected greater community participation or influence in government and NGO activities. This hypothesis is tentative and deserves more research to substantiate or disprove it.

Participation in planning during implementation

The main way that HIV/AIDS projects involved local stakeholders in planning during the implementation phase was through project committees. Of the 19 evaluated projects, 12 had established project committees of various types: Arumeru, Iyolwa, Kahama I and II, Kariobangi, Nankumba, Chiangmai II, Highway One, Songkhla II, Danang 1 and II and the Thai-Burma/Myanmar[14] program (Ranong, Mae Sot and Mae Sai projects).

Of these 12, seven included community members: Arumeru, Iyolwa, Nankumba, Kariobangi, Kahama I and II, Thai-Burma/Myanmar (Ranong and Mae Sai).

While documentation of the composition and role of project committees was usually scanty, it was possible to distinguish eight types of committee (see Table 2.1).

Community participation in HIV/AIDS responses - CIDA's guideline

CIDA's programming in HIV/AIDS is guided by the following principles ….

> Supporting communities and vulnerable populations, including children, youth, women, as well as people affected and people living with HIV/AIDS and AIDS, and encouraging their involvement in program design, implementation and evaluation.

Textbox 2.4
Source: Canadian International Development Agency's HIV/AIDS Action Plan (2000), http://www.acdi-cida.gc.ca/cida_ind.nsf/0/1e4364421dcbfc685256918006292ea/$FILE/aidsactionplan2.pdf.

Type 1 was the most official, authoritative type of project committee having strategic planning and management functions. An example of the strategic planning role of the Kahama II project coordinating committee (PCC) is the decision to amend the recommendation of the mid-term evaluation concerning Kahama I, the first phase of the project. The Phase I mid-term evaluation was written in the context of an extension of the project being unlikely. As a result it recommended the gradual phasing out of the project activities as a test of sustainability in Masumbwe Division. Once the extension was approved, the PCC decided not to withdraw completely, but to conduct a sustainability test. The sustainability test was designed so that there was minimal involvement of WV Tanzania. However, project activities, such as presence of village health workers, village health committees and immunisations would remain *in situ* and the PCC was to monitor the results.[15] See Textbox 2.5 for further Kahama mid-term evaluation team's comments on the Kahama project coordinating committee.

Type 2 project committees were likely to have strategic planning and management functions. Such committees often consisted of government nominees, a WV National Office nominee and a project manager—often seconded or retired from the Ministry of Public Health (MOPH). For example:

- Chiangmai II's advisory committee consisted of five representatives from Chiangmai MOPH and two from the WV Foundation of Thailand;
- Songkhla II also appointed a project advisory committee consisting of MOPH officials (especially those involved in control of sexually transmitted infections) and the Assistant Director of the Provincial Fishery Office;
- the steering committee of the Danang I included:
  - key staff from the Vietnamese government's preventative medicine centre (part of the government's Ministry of Health);
  - selected members from the provincial AIDS committee;
  - A representative from WV Vietnam's Danang office;
- according to the 1995 end-of-project evaluation of Danang I, 'All plans of action are drawn up by this committee'.[16]

Type 3 project committees were decentralised community committees with planning and management authority over local activities. In the Thai-Burma/Myanmar program, there was no project committee for each project and no program committee for the program as a whole.

Type 3 committees provided a community management structure for different project communities (see Textboxes 2.6 and 2.7). Iyolwa established one committee in each of the four sub-parishes in which it was working. As one sub-parish committee member put it, the sub-parish committee activities were mainly to 'ensure that the project is doing its work, elect community counsellors and other sub-committees and vision club identification and making'.[17]

Delegated authority and functions of Type 3 Project Committees varied greatly. Some project committees in the Thai-Burma/Myanmar program appeared to sit further towards the high authority-autonomy and self-management end of the continuum while sub-parish committees in Iyolwa appeared to sit further towards the low-authority end of the continuum with a focus mainly on monitoring and implementation. The scope and authority of localised project

Table 2.1 Eight types of project committee

	Membership profile	Main roles	Project	Comments
1	Donor, host-government, community representatives and project manager	Strategic planning and management	Kahama I Kahama II	The most official and authoritative type of steering committee was the project coordinating committee. Met twice yearly. Kahama also had a multi-tiered credit committee structure (mixture of Type 5 and Type 7).
2	Host-government, implementing-agency nominee and project manager	Strategic planning and management	Chiangmai II Songkhla II Danang I	More common in projects in Asia. Usually met monthly. Projects with this type of committee usually did not have other types of project committee, although each of the eight types can be combined with other types.
3	Community members	Local planning and management of activities in different localities of project area.	Ranong, Mae Sai II, Mae Sot communities of the Thai-Burma/Myanmar program	Appropriate to encourage decentralised community management and ownership. Usually met monthly. Projects with this type of committee had only one type of project committee. There are advantages in combining Type 3 committees with other types, including some form of project-wide committee.
4	Community members and project manager	To keep community members informed and involved as implementers. Less focus on strategy and planning	Kariobangi 'project health committee'	Usually met monthly. Kariobangi had only one type of project committee.
5	Community members, host-government officers. Sometimes project staff member	Specialist function or sectoral focus, usually operational rather than policy making role	Iyolwa credit Committees Kahama II credit committees	Commonest examples were credit committees. Usually met monthly. Kahama's credit committee structure was three-tiered: project-wide, locality-specific and group-loan-beneficiary committees.
6	Wide range of local stakeholders represented, including community, government and NGO in the project area	Advisory role in planning; role in monitoring and review		Project 'council' with large number of members, met once or twice a year
7	Community and government representatives, with project manager a member of project-wide committee	Planning, monitoring, review (management in Arumeru)	Arumeru, Iyolwa	Projects with this type of project committee also operated with a two- or three-tiered project committee structure—that is, had a project-wide committee and ward/parish committees. Arumeru had a third tier, village-level committees. Non-staff-member participants in Arumeru's committees appeared to have more authority vis-à-vis project staff than in Iyolwa. Arumeru's project-wide committee met quarterly, the other levels met monthly.
8	Clients, service users, beneficiaries	Planning, managing, monitoring and evaluating specific project-related activities	Kahama, Kariobangi, Iyolwa, Kahama	User committees of this type were encouraged and facilitated in projects with group-loan components

committee decision-making reflects the degree of a particular project's centralisation–decentralisation.

Type 4 project committees usually comprised community members and the project manager. The function of such committees often appeared to be to keep community activists in the loop and involved as implementers rather than to play strategic management and planning roles. An example was the Kariobangi project health committee, composed entirely of community members and the project manager (see Table 5 for composition of committee).

Iyolwa had a project committee composed of the project manager and community members, including government nominees. Project staff, especially the project manager, appeared to be in the driver's seat vis-à-vis community members of the project committee(s), but the end-of-project evaluation with project manager's full support was designed to empower project committee members and other project volunteers.

Type 5 committees had a specialised function or sectoral focus. The degree and kind of delegated authority of these groups varied, but they were subordinate to mainstream project management and in the case of credit committees, subject to national credit policies of WV National offices designed to minimise 'creative' policymaking at local level.

In Iyolwa, community volunteers and local government personnel (who were also community members) sat on the project's four sub-parish credit committees that were overseen by the project's sub-parish committees. Among other functions, credit committees made decisions on loan applications and were active in monitoring and encouraging loan repayment.

Kahama II established a three-level committee structure to manage the credit component of the project. 'The committee structure was designed to assume more responsibility as the component continues and the structure will manage the scheme'.[18] The three levels were:

- Central Credit Committee (CCC):
  - two representatives (beneficiaries) from each area credit committee (ACC), District Government Community Development Officer (patron), project manager (WVT-Kahama), Monitoring and Evaluation Coordinator (WVT-Kahama), Project Accountant (WVT-Kahama), Credit Coordinator (WVT-Kahama);
- Area Credit Committee (ACC)
  - two representatives (beneficiaries) from each group credit committee (GCC), one Government Divisional Secretary (ex-officio), one Government Ward Executive Offier (ex-officio), Project Credit Coordinator (WVT-Kahama);
- Group Credit Committee (GCC):
  - All participants of the local income generating activity (IGA) were members.

Type 6 was a project council with a large membership meeting less often than most other types of project committees. Nankumba was the only project to use a Type 6 project committee. 'The project has had more than four council meetings since it started. Each meeting has attracted around 100 members representing their organisations as stakeholders. These meetings have facilitated planning, implementation and monitoring of project activities and some strong decisions have been made. Membership including community, all government and non-governmental organisations/institutions working in Nankumba project area, including some at district level.'[19]

Type 7 project committees had a mix of community and government representatives along with project staff. Arumeru's executive (district) committee had 21 members who included representatives from each project division, District Commissioner's office, District Directors' 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 met quarterly and its role was to review project progress and plan strategies for mobilisation and supporting the ward and village committees.

Type 8 project committees were committees of users and clients with a focus on planning, managing, monitoring and evaluating project-related activities. All Type 8 committees in our sample of HIV/AIDS projects were loan-group-beneficiary committees. The third tier of Kahama consisted of Type 8 committees. Kahama may have been exceptional in that the user communities were explicitly linked into a three tier structure with possibilities of, and formalised channels for, user-feedback into the credit component.

Eight HIV/AIDS interventions appeared to have project committees that played strategic or generalised project-planning roles. These were either advisory or authoritative: Kahama I and II, Danang I and II, Songkhla II, Chiangmai I and II, Highway One.[20] Kahama PCC appeared to play an authoritative role (that is, the project manager was required to follow its decisions). See Textbox 2.5 below. The steering committee of Danang I and II also appeared to have an authoritative role.

One HIV/AIDS intervention (Thai-Burma/Myanmar program) established a number of locality-based project committees (Type 3) that played localised planning roles.

Project committees most likely to have played a strategic planning role (Types 1 and 2) were composed exclusively or mainly of host-government staff.

Type 1 and 2 project committees appear to have participated in project strategic management (a key role of management or steering committees). Type 3 project committees were likely to have been involved in project administration and implementation and in the case of the Thai-Burma/Myanmar program, in managing their local program (given that much of it was on their own initiative and own resources). Although not well documented, it is likely that all project committees (Types 1 to 8) played monitoring and evaluating roles.

While most cases of stakeholder participation in management and planning through the

Kahama's project coordinating committee (PCC), Tanzania

The Kahama PCC meets regularly with representation from all stakeholders and provides a valuable forum for coordination, monitoring, information exchange, priority setting and management.

There are ten PCC meetings scheduled for the Kahama Child Survival for Development Project (KCSDP). To date, the PCC has met regularly and punctually… The membership of the PCC is described in the Memorandum of Understanding (MOU) and currently membership is as follows:

- Regional Administrative Secretary—Chairperson
- Australian High Commission representative
- WVA representative
- Ministry of Finance representative
- World Vision Tanzania (WVT)—National Director and Program Director
- KCSDP Project Manager and Secretary
- District Executive Director, Kahama
- District Executive, Bukombe
- District Medical Officer, Kahama
- District Medical Officer, Bukombe
- Community Representative, Kahama
- Community Representative, Bukombe

The community representatives are normally ward councillors. The KCSDP Phase II has a policy that there must be gender balance between the two community representatives…

The PCC meeting is a residential meeting conducted over a two day period with a visit to one of the project focus villages. On the first day, the PCC members meet with representatives from the various project core groups. This seems to be a very useful practice in terms of providing the PCC members with contact with the project beneficiaries …

Consideration should also be given to inviting a number of observers to the PCC meeting, especially the District Planning Officers, District Village Health Worker Coordinator, representatives from the Department of Agriculture and Livestock, Department of Water and the District Maternal and Child Health Coordinator. These district people work closely with both WVT and the project focus villages and would benefit from being present when the PCC meets.

Textbox 2.5
Source: Kahama Child Survival for Development Project Phase II (1998), Evaluation Report, pp. 53ff.

Type 3 decentralised project committees in Mae Sot, Thailand

Among the Asian HIV/AIDS projects, the Thai-Burma/Myanmar AIDS program appeared to be most committed to, and successful, in facilitating the development of decentralised community management structures. The projects that make up this program, Ranong, Mae Sot and Mae Sae, have been using participatory learning and action (PLA) methods to develop the planning and management capacities of communities and government in Thailand and Burma/Myanmar. The end-of-program evaluation report conveys the community diversity and project's decentralised, bottom-up response to the diversity:

> There are four communities targeted by the Mae Sot project. Three of them are Thai with small segregated communities of migrants. The total number of migrants is estimated at over 50,000, approximately 40 per cent are Mon and Karen, and the rest are Karenni, Burma/Myanmarn, and Arakanese. The fourth community is made up of migrants and is divided into four clusters. There are management committees for each cluster and each has its own community health volunteers who have now merged with the peer trainers (PTs) of the project. The establishment of these structures and positions is an initiative of the project, implemented in conjunction with community leaders, municipal officials, and the hospital. It is now recognised as an officially designated village with authorised health volunteers. There is great variation between, and often within the four clusters, with a rich-end-of-town where accumulated and inherited wealth comes from previous and current associations with war lords and political opposition groups in Burma/Myanmar, to a devout Muslim community in village houses, to overcrowded makeshift homes and small apartments.[21]

Textbox 2.6
Source cited in chapter notes.

implementation phase are limited to government staff, examples of an excellent multilayered management structure with a mix of government and community representatives are found in the Iyolwa and Arumeru projects.

Widespread community participation beyond the project staff and committees in strategic planning during implementation was rare. Extensive participatory planning during the implementation phase was not common in the sample of HIV/AIDS responses. In this context, extensive participatory planning refers to a wider group of local stakeholders being involved in planning beyond the project's normal management structure including project committees.

Several evaluation reports noted the low level of community participation in ongoing planning and recommended that communities be more intensively and extensively involved in planning subsequent phases of the project. For example, the Chiangmai II mid-term evaluation found that:

> Specific communities have little [planning] input into the project operation. They are the direct beneficiaries of the project as village members are trained as peer educators. It has been suggested that more community input into peer educator selection, project strategy and evaluation would greatly increase community ownership of the project objectives and responsiveness to education material. In turn, the project might develop new and more effective strategies as a result of community feedback. This has not so far been possible given the broad nature of the project and the limited resources available.[22]

Some examples of widespread participatory planning during the project's implementation follow:

- Songkhla II staff held monthly meetings to discuss problems with the peer trainers on how to continue the process of educating the fishermen. The meetings focused on numbers of crew members trained, problems and obstacles.
- Danang II evaluation commended the project for 'consulting widely in designing the curriculum'. The same report notes that 'parents and other community groups had little involvement' and that 'early attempts at including parents were not successful, perhaps because it is not customary in Vietnam for them to play this role'.[23]

The Kawthaung end-of-project evaluation team noted that the project's community development volunteers (CDVs):

Example of Type 3 project committees in Ranong, Thailand

To provide continuity and cohesion to many of these interventions, the project has facilitated the development of community committees. Previously, there had been little community organisation which is hardly surprising considering the difficult and often complex living environment. These committees are elected by the community members and are empowered to oversee initiatives designed by the community (and often supported by the project either through technical advice or, less frequently, provision of materials and financial support) to address their immediate as well as long term problems. Actions of the steering committees, among other things, have included:

- HIV/AIDS interventions particularly the promotion of condoms and information dissemination:
- comprehensive measures to create an enabling environment to support behaviour change including activities such as:
  - sporting festivals and cultural events;
  - regular recreational activities;
  - support groups for housewives;
  - development of alternative income opportunities for women to enable them to earn supplementary money to survive economic difficulties while their husbands are away at sea.
- coordination of sanitation programs;
- coordination of educational programs.

The above programs initiated through PLWA would not have been possible without a more formal representation in programming and planning. These and other inter-ventions have been largely successful through the dedica-tion of staff who have come from the communities themselves. There are a number of different levels of such staff and volunteers.

When the Ranong project first began, the only commu-nity representation was through peer trainers (PTs) who were selected from the various target groups and trained… To enable the consistent involvement of PTs [addressing the problem of high turnover of volunteers from highly mobile populations], the frontline social networker (FSN) concept was developed. This saw the employment of a number of the most competent PTs as paid volunteers. As full time members of the project team, they began to have a greater impact on the formulation and implementation of activities. The perspective of target communities themselves, therefore, became an integral part of project planning.

Textbox 2.7
Source: Naing, (1997), *Removing Borders: HIV/AIDS Program and the Ranong-Kawthaung Sea Border Crossing,* paper presented at the 4th International Congress on AIDS in Asia and the Pacific, Manila, October.

- had developed on their own initiative creative additions to the initial plan of the project, namely orphan care and helping the poor;
- were self-managing a community-development fund donated by the United States Embassy to support their efforts. The CDVs used this fund to help orphans and the poor. 'The donation is also a sign of confidence in the CDVs capacity' says the report.[24]

Thai-Burma/Myanmar end-of-project evaluation commented that, 'In Koh Charng, [PLWA] support groups seek to assist each other by meeting regularly and discussing problems. In addition they seek funds, have fund raising activities and manage a revolving fund. They also organise sporting activities, and study tours which the project has initiated.'[25]

Participation in developing educational materials

Perhaps the strongest area of community involvement during implementation was in contributing to the development of HIV/AIDS aware-raising materials. Community members contributed to the development of written and oral materials in the majority of projects. In all East African projects, community members created their own HIV/AIDS prevention songs and/or plays under general guidance of project staff.

In most Asian projects, too, community members had input into the development of materials. An opera promoting community care and acceptance of PLWA was written by a community volunteer,drawing on her own experience, and performed in Kawthaung. Peer trainers were involved in the selection of information, education and

communication (IEC) materials. Factory workers and government staff developed different educational modules in Songkhla II and the IEC materials were pre-tested with community members.[26] Community and government stakeholders were involved in producing and testing IEC materials in Highway One. The Mumbai evaluation report noted that:

> A number of IEC materials have been produced including posters, newsletter, two pamphlets in Hindi and Marathi, and education models. The display education models have been developed on the basis of qualitative studies in the community and have been modified as the result of experience. There is potential for further development of models, and for new ideas from materials produced elsewhere in India and in other countries. The project has also produced a number of street plays written and acted by the community. These have engaged the community in the work of the project.[27]

Evaluation teams remarked on community non-involvement in developing or testing HIV/AIDS messages in four projects: Songhkla I, Ranong, Senegal, Danang I (where government stakeholders were involved in developing school HIV/AIDS curriculum) and Mongla.[28]

In general, there was a low level of stakeholder participation (including community participation) in strategic project planning outside the structure of project committees. There was, and is, room for developing broader and deeper stakeholder participation, especially by communities (and PLWA) in the development of HIV/AIDS prevention and care messages and in project planning more generally.

Participation in implementation

Participation by local stakeholders attracted more people and involved them more actively in implementing the HIV plans normally designed by others.

Stronger community participation in implementation

Community volunteers were the backbone of most HIV-related projects evaluated. Their focus varied with the project's emphasis. In the 1990s, the most common community role in WV's HIV projects in Asia was peer education. The peer educators were often drawn from:

- high-risk groups (such as commercial sex workers, their clients, mobile or migrant populations like fisherman or truck-drivers); or
- people likely to interact with high-risk group members (such as hairdressers, beauty advisors, cosmetic agents, taxi drivers and wives of fishermen).

The Chiangmai I project was exceptional among Asian HIV projects in the early 1990s in taking a strong community-wide focus.[29] With the aim of establishing a broad-based HIV/AIDS education campaign in five rural districts in Chiangmai, project staff and Thai Ministry of Public Health (MOPH) staff trained a wide range of community volunteers to be peer educators. In the second half of the 1990s, several HIV/AIDS interventions in Asia adopted a community-wide approach in specific parts of the project area (Highway One, Songkhla II) or in the entire project area (Mumbai, Kawthaung, Thanh Hoa and Thai-Burma/Myanmar).

In African WV HIV projects, from the very first projects in the early 1990s, the focus of projects and of community volunteers was usually on raising community awareness. Volunteers in the project were often informal community leaders. As the 1990s progressed, projects and volunteers focused more on the counselling, treatment and care of PLWA and their families.

Community members have also participated in a variety of other ways. In the Mumbai AIDS project, community members provided resources towards training sessions, space for sewing classes etc. Some community leaders were willing to send their adolescent children to participate in HIV training.

Government participation in implementation

According to the evaluation reports, all WV's HIV projects were working closely and well with host governments. Governments participated in a variety of ways, including:

- providing office space and equipment such as vehicles (Songhkla I);

The important role of volunteers in the Mongla project, Bangladesh

Different local community groups are involved in the program implementation process. Basically the program is based on community ownership by involving different stakeholders through various workshops, seminars, training, meetings, gatherings and collaboration activities. There are different partners from the community groups who have been directly or indirectly working with the project to achieve its target. They are community volunteers (mainly college students), peer educators from different segments, counsellors (Government and NGO officials), school and college teachers, pharmacist groups, advisor groups from every target groups and local leaders and elites.

Of the project objectives, one was to enhance knowledge of target groups of HIV/AIDS, its transmission and prevention. The results indicate that the project has worked very successfully with the sex workers and housewives whose knowledge of transmission increased considerably. This was mainly achieved through the development of peer educator groups who worked closely with the women providing information and education in small groups and to individuals. The dockworkers' knowledge of transmission and prevention of STD/HIV/AIDS did not increase satisfactorily. Among youth, knowledge of transmission has not increased but knowledge of prevention has increased...

The percentage of CSWs able to name at least two specific ways that HIV/AIDS is transmitted increased from 22 per cent in the 1997 survey to 93 per cent in this 1999 survey. The percentage of CSWs able to name at least two specific ways to prevent HIV/AIDS increased from two per cent in the 1997 survey to 100 per cent in the 1999 survey! The percentage of housewives able to name at least two specific ways that HIV/AIDS is transmitted increased from 14 per cent in the 1997 survey to 97 per cent in this 1999 survey. The percentage of housewives able to name at least two specific ways to prevent HIV/AIDS increased from 5 per cent in the 1997 survey to 80 per cent in this 1999 survey. These increases in knowledge were facilitated through the development of peer educator groups who worked closely with the women providing information and education in small groups and to individuals. There were 13 peer educators trained to work with the sex workers and 18 to work with housewives. The data suggest that the project has worked very successfully with the sex workers and housewives to help them increase their knowledge of HIV/AIDS transmission and prevention…

From the results, it is noted that the sex workers and brothel clients have started using condoms increasingly. There is also a reported increase of use of condoms among dockworkers and youths. The main strategies to disseminate information among the target groups was through the formation of peer educator groups and volunteers who used a variety of strategies and IEC materials.

Textbox 2.8
Source: *Mongla HIV/AIDS Prevention Project Evaluation,* 1999, pp.16, 6.

- seconding government staff to project (Arumeru);
- providing government officials as members of project committees (Arumeru: see chapter 3).
- providing training to project volunteers assisting the project prior to commencement (Songkhla II: see Textbox 2.10).
- providing training to project volunteers (Provincial AIDS Committee in National Highway One).
- government and project staff collaborate to organise events, such as annual World AIDS Day activities (Kawthaung).

Some projects—mostly in Thailand and Vietnam—included a component focusing on helping to develop the capacity of Ministry of Public Health staff, especially in areas relevant to HIV/AIDS prevention. Projects supported government health services in a range of other ways including:

- funding the supply of drugs for sexually transmitted infections (STIs) to clinics in the project area (Nankumba).
- funding and supporting condom supply and distribution (Mongla, Danang)
- funding two government-counsellor positions based in hospital and HIV/AIDS test centre in Arumeru;
- providing equipment such as bicycles (Kahama I and II) to existing government community health volunteers or to newly-mobilised community volunteers (Iyolwa) to support their work and motivation;

- providing loans to existing government community health workers where governments have trouble maintaining promised payments (Thanh Hoa).

Stakeholder participation in monitoring and evaluation

Project committees

The most common way for government and community stakeholders to participate in project monitoring and evaluation is through their participation on project committees, for example project advisory committees or project steering committees.

It is likely that stakeholders in at least 12 of the sampled 19 HIV/AIDS interventions were involved in some kind of monitoring and evaluation role in project committees. Seven of the HIV projects enabled a community role in project monitoring and evaluation through inviting community participation in the project committees.

Participation in special evaluations

Special evaluations are evaluations that involve team leaders, technical advisers and/or team members external to the project. The evaluation reports that inform this publication are special evaluations in this sense. The few project completion reports cited are exceptions, usually compiled by project staff.

Of the 19 HIV-project evaluations or project completion reports in our sample, four included community members in the research teams (Iyolwa, Arumeru, Kariobangi and Kawthaung). The community members involved were mainly project volunteers who were active as:

- community counsellors or village health volunteers; and/or
- members of project committees.

Some of these evaluations were described earlier in the chapter in the context of participatory planning prior to the commencement of a new project or phase. The other 15 evaluations informing this chapter's discussion included project staff usually with WV Australia staff and an external consultant.

Varied roles of volunteers in Kawthaung, Burma/Myanmar

The Kawthaung evaluation commended the 'team of talented, enthusiastic and active community development volunteers (CDV) for their contribution to HIV prevention and care in the fishing town of Kawthaung, Mynamar. The report contained the following list of activities commonly done by the CDVs:

- helping orphans (HIV-related and others), taking care of them, help them to attend school;
- home and hospital care for PLWA, especially for PLWA with no relatives in Kawthaung;
- domestic chores for PLWA without family;
- counselling;
- health education;
- pamphlet distribution;
- condom distribution;
- helping PLWA visitors to Kawthaung to return to their homes elsewhere;
- data collection (including interviewing other community members for this evaluation);
- attending CDV monthly meeting;
- reporting;
- giving medicine;
- playing drama/music;
- helping the poor.

Textbox 2.9
Source: Kawthaung Evaluation Report (1999), p.5.

To anticipate the theme of promoting learning and interaction across projects:

- seven evaluations included other WV staff, mostly from other projects (Iyolwa, Arumeru, Nankumba, Kawthaung, Mongla, Mumbai, Highway One) and on one occasion from the WV Regional Office in Bangkok (Mumbai);
- five evaluations (Nankumba, Iyolwa, Arumeru, Danang II, Songkhla I) included government staff on the evaluation team—most others consulted with government staff at various stages of planning, implementing and sharing preliminary findings for comment;
- five evaluations included a staff member from another NGO operating in the project area (Songkhla I, Nankumba, Kawthaung, Arumeru, Danang II).

Most projects did not develop or implement feasible plans to monitor and evaluate the difference that the project was making in the project area. In other words, all local stakeholders, including project staff, were usually not involved in monitoring and evaluating project effects. This finding is consistent with common findings of international studies of overseas-aid evaluations (see Textbox 2.11 above).

Example of government-project collaboration, Songkhla II, Thailand

Each community has about 20 health volunteers which are trained by the MOPH and municipality. The project staff selected one health volunteer from each of the eleven communities to be the core health volunteer for the project. They received training in AIDS information, participatory rapid appraisal techniques and communication skills. They also continued with their other health volunteer work ...

The project coordinated with related organszations to conduct World AIDS Day activities including Songkhla Public Health Office, VD Centre (Region 12), Songkhla Municipality, Ratchapat Institute, Songkhla Navy, Pang La Public Health Sadao District, Songkhla Municipal School, Sri Nakarintaraviroj University Southern Region, and the border police ...

The project coordinated with related organisations to organise training for the motorcycle taxi drivers in Songkhla Municipality including Songkhla Public Health Office, Songkhla Hospital, Hat Yai Hospital, VD Centre (Region 12), the provincial constabulary, and Infectious Disease Prevention (Region 12) ...

The project drew on a wide selection of IEC materials for each target group. They sourced materials from the National AIDS Committee, the Songkhla MOPH and the VD Centre (Region 12). From these materials they selected pamphlets and booklets which were appropriate for this target group. Colourful posters focusing on sex with CSWs and intravenous drug use were selected as this reflected fishermen's lifestyles. Peer trainers were involved in the selection of these materials and they were all pre-tested before being widely distributed.

A priority for the project was the establishment of a counselling and recreation centre. This was implemented in coordination with a number of government and non-government bodies: The Provincial Fishery Office; The Labour and Social Welfare Office; the local Police; the Ban Sooksan Centre. It was located in the Lang Praram area near the harbour in part of the police box. The location was a function of the police attempting to improve their community image. The centre was informal and provided fishermen ostensibly with recreational facilities. Condoms and HIV information was also available and the centre was generally staffed by one or more peer trainers from the project.

'The project worked closely with the VD Centre (Region 12) which is responsible for providing health check ups and medical treatment forcommercial sex workers(CSWs) in Songkhla Province. Further networking between World Vision Foundation of Thailand (WVFT) and government organisations) revealed that the VD Centre (Region 12) was implementing almost identical activities as the project for CSWs. The VD Centre was receiving funds from Songkhla University to do this. In order not to replicate services, the project decided not to implement any of its planned activities for CSWs other than encouraging them to see doctors for regular check-ups and to undertake further vocational study to have alternative options in livelihood. Substantial budget savings were made because of the networking of WVFT and a local government organisation.

… The VD Centre (Region 12) is currently implementing all project activities for CSWs.

Textbox 2.10
Source: Project Completion Report, Songkhla II, 1996.

Demonstrating impact

The poor performance of Development NGOs (DNGOs) in demonstrating what difference they are making is often remarked on in literature on DNGOs and on overseas-aid evaluations. Many evaluations of overseas-aid projects— and synthesis evaluations summarising the findings of many project evaluations—have found that project monitoring and evaluation, especially concerning project influences and effects, could be improved.[30]

Textbox 2.11
Source cited in chapter notes.

The most common exceptions to the general neglect of monitoring the differences or effects facilitated by the project occurred when WV staff from outside the project facilitated a special mid-term or end-of-project evaluation with or without extensive government and community involvement.

Suggestions for the future

Organisations auspicing HIV/AIDS interventions should consider:

- mainstreaming and practising the principle of participatory planning, implementation, monitoring and evaluation, including:
  - disseminating guidelines for participatory planning, managing, implementing, monitoring and evaluating projects;
  - ensuring that each design team includes at least one team member with strong knowledge of, and skills in practising, participatory approaches;
  - strengthening appraisal structures, processes and capacity, ensuring that attention to the kind and degree of local-stakeholder participation is a key dimension of each appraisal;
  - ensuring that each staff member involved in project design, implementation, management and evaluation is familiar with participation guidelines and knows how to apply them in practice;
  - supporting participatory approaches with appropriate processes, structures, capacity-building components and budgets.

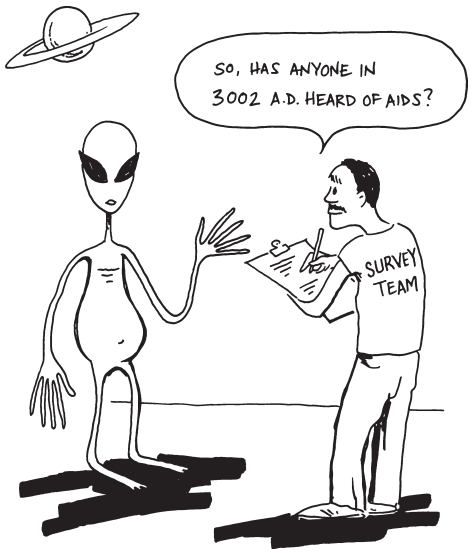
In particular the following guidelines are suggested at project level.

- Careful consideration with local stakeholders should be given to the type, membership and role of project committees. Each project should have one or more project committees with local stakeholders actively involved, increasingly in leadership roles over time. Local stakeholders include representatives of project volunteers, project-service-users, community leaders, PLWA, government and non-government staff, main religious denominations, private-sector employers and unions, youth and child representatives, mix of males and females, mix of ages, mix of ethnic groups.
- In most cases, include in the project design a plan to build the capacity of staff and local-stakeholder members to run the project committees (as recognised in Kahama II and recommended for the latest phase of Kariobangi HIV/AIDS project, now the Kariobangi Primary Health Care Project).
- Probably, guidance and training for both project managers and committee members is required to assist committee members to move more into leadership roles and to know what roles are expected of both themselves and the project manager. Ideally, the role of the project manager on project steering committees is to sit as an informant and advisor rather than as a full member of the committee.
- Project designers should consider including in HIV/AIDS/STI interventions a component focusing on capacity development of stake-holders in participatory management (including participatory planning, monitoring and evaluation).
- Where possible, local participatory monitoring of met and unmet needs should occur routinely in ongoing projects. Ideally, identification of unmet needs, planning and proposal-preparation should not be solely triggered by the opening of specific funding windows. Such processes should occur independently of specific funding opportunities. Proposals can be marketed to various donors and finetuned to suit particular donor guidelines. One option is to include capacity building in planning,

management, monitoring and evaluation in proposals.

Summary

The kind and degree of participation of local stakeholders in initial planning, implementation, management and monitoring/evaluation in a sample of 19 World Vision HIV/AIDS interventions was discussed.



The main findings concerning stakeholder participation in initial planning were:

- usually, provincial or district government officials, especially from health ministries, participated in initial planning;
- generally, there was a low level of local stakeholder participation in planning—local stakeholder meaning people or organisations from the project area;
- community members were not normally involved in initial plans, although there are encouraging signs in some recent instances of new-phase planning in established project areas (Kawthaung, Kariobangi, Arumeru/Moipo, Iyolwa).

The main findings on stakeholder participation in planning during project implementation were:

- it was more common for government staff rather than community members to be involved in general, strategic project planning during the implementation of a HIV/AIDS response;
- community and/or government stakeholders contributed to the development of IEC materials in most projects;
- there was a low level of stakeholder participation (including community participation) in strategic planning outside the structure of project committees;
- there was room for broader and deeper stakeholder participation, especially by communities (and PLWA) in the development of HIV/AIDS prevention and care messages and in project planning more generally;
- there were exciting examples of decentralised community-planning structures in Thai-Burma/Myanmar program.

The main findings on stakeholder participation in implementing the project were:

- participation by local stakeholders was widest and deepest in implementing the HIV plans normally designed by others;
- community members and government staff were involved in the implementation of all projects.

The main findings on stakeholder participation in managing the HIV/AIDS projects were:

- promoting stakeholder participation in management was not a central feature in most project designs;
- projects with Types 1, 2, 3 and 7 project committees tended to involve government and/or community stakeholders in aspects of management;
- by and large, project committees with government stakeholders were more likely to be involved in aspects of project-wide management than community committees.

The main findings on stakeholder participation in monitoring and evaluating projects were:

- government stakeholders were involved in some kind of monitoring and evaluation of project activities in at least at least 12 of the sampled 19

interventions;

- community members were involved in some kind of monitoring and evaluation of project activities in at least seven of 19 interventions;
- government and community stakeholders who are members of project committees participated in some kind of monitoring and evaluation of project activities more than project effects.

The discussion above suggests a medium rating for the WV's program performance in facilitating the participation of stakeholders in the light of the findings that there was:

- little community participation in initial planning, monitoring and evaluation;
- more participation in implementing project, and in planning specific components during implementation; and
- some involvement in monitoring, evaluating and managing some aspects of projects through project committees.

Notes and References

1 World Vision International (undated) *Transformational Development Policy,* p. 1.

[2] http://ids.ac.uk/eldis/hot/pm1.htm. For further references and discussion of participation, see Dorning, K. and O'Shaughnessy, T. (2001) *Opening Spaces for Children's Participation*, World Vision International, Geneva; Blackburn, J. with Holland, J (1998) *Who Changes? Institutionalizing participation in development*, Intermediate Technology Publications, London; Carmen, R. (1996) *Autonomous Development*, Zed Books, London; Marsden, D., Oakley, P. and Pratt, B. (1994) *Measuring the Process,* INTRAC, Oxford*;* Chambers, R. (1993) *Challenging the Professions*, Intermediate Technology Publications, London.

[3] See, for example, 'Eldis' development-information website (2001) www.ids.ac.uk/eldis/eldis.htm; O'Shaughnessy, T. (1999) *Capacity Building: A New Approach?* World Vision Australia, Melbourne; Carmen, R. (1996) *Autonomous Development*, Zed Books, London; Marsden, D., Oakley, P. and Pratt, B. (1994) *Measuring the Process*, INTAC, Oxford*;* Chambers, R. (1993) *Challenging the Professions*, Intermediate Technology Publications, London.

[4] See, for example, Blackburn, J. with Holland, J (1998) *Who Changes? Institutionalizing participation in development*, Intermediate Technology Publications, London.

[5] The Committee of Review ('Simons Committee') (1997) *One Clear Objective: Poverty Reduction Through Sustainable Development*, AusAID, Canberra, pp. 169-170.

[6] Edwards, M. and Hulme, D. (1996) *Beyond the Magic Bullet: NGO Performance and Accountability in the Post-Cold War World*, Kumarian Press, Connecticut, p.5.

[7] Fowler, A. and Biekart, K. (1996) 'Do Private Agencies Really Make A Difference?' in Sogge, D. with Biekart, K. and Saxby, J. (ed) *Compassion & Calculation: The Business of Private Foreign Aid*, Pluto Press with Transnational Institute, London.

[8] To my knowledge, World Vision has phased out its support role in Kawthaung.

[9] Notes from Nankumba HIV/AIDS Project – FY98 Quarter One Progress Report.

[10] Tim O'Shaughnessy, interview with Iyolwa project manager, September 2000.

[11] See glossary for brief description of Area Development Program approach.

[12] Arumeru Evaluation Report (1999); Tim O'Shaughnessy, interview with Dr Petronella Katyega, District Medical Officer, Arumeru Project Chairperson and community member.

[13] Chiangmai I Evaluation Report (1993), p. 52.

[14] No political implication is intended by the use of the two terms Burma and Myanmar. The rationale for the two terms was well put in a recent publication, International Crisis Group (2002) 'Myanmar: The AIDS Crisis' in *Myanmar Briefing*, 2 April, Bangkok, Brussels, p.1 (http://www.unaids.org/publications/documents/care/general/JC637-GlobalFramew-E.pdf):

A note on terminology. This report uses the official English names for the country, as applied by the UN, most countries outside the US and Europe and the national government – that is, 'Burma' for the period before 1989 and 'Myanmar' after 1989. The same criteria are used for other place names such as Rangoon (now Yangon). This should not be perceived as a political statement, or a judgement on the right of the military regime to change the names. In Burma/Myanmar, 'Bamah' and 'Myanma' have both been used for centuries, being respectively the colloquial and the more formal names for the country in the national language.

[15] Kahama II Evaluation Report (1998), p..50.

[16] Danang I Evaluation Report (1995), p.43.

[17] Focus group interview notes, Nyemera sub-parish project committee, August 2000, James Owino (community member), notetaker.

[18] Kahama II Evaluation Report (1998), p. 34.

[19] Nankumba Evaluation Report (1999), p. 18.

[20] Highway One Evaluation Report (1998) makes many

references to the Provincial AIDS Committee – with whom the project obviously worked closely and well - and one reference to a Project Management Committee. Membership of the latter is not described, but I would guess that it follows the Type 2 model.

[21] Thai-Burma/Myanmar (1998), p. 53.

[22] Chiangmai II Evaluation Report (1994), p. 52.

[23] Danang II Evaluation Report (1998), p. 19.

[24] Kawthaung Evaluation Report (1999), p. 6.

[25] Thai-Burma/Myanmar Evaluation Report (1998), p. 50.

[26] Songkhla II Project Completion Report (1996).

[27] Mumbai Evaluation Report (1998), p. 23.

[28] The Mongla Evaluation Report (1999) suggests that the IEC materials were procured or developed by the training and communications officer. It recommended that materials be prepared with the participation of the specific intended populations.

[29] Interventions normally emphasise locality or place, category of people and type of function to varying degrees. All World Vision-assisted African HIV/AIDS interventions focussed on the general community living in a particular locality. Some Asian HIV/AIDS interventions focused on particular sub-groups of people staying in a particular locality. A few Asian project did have a locality-wide focus as a central or component focus (eg Thai-Burma/Myanmar Program, Chiangmai I and II). Songkhla I and II, for example, mixed a categorical and locality focus (eg fishermen, factory workers and slum dwellers residing in a particular part of Ranong). One factor contributing to differences of focus was that most Asian HIV/AIDS projects were located in urban settings, most African were situated outside major cities and towns.

[30] For example, Kruse, S-E., Kyllonen, T., Ojanpera, S., Riddell, R., & Viewlajus, J-L. (1997) S*earching for impact and methods: NGO evaluation synthesis study* (Vols. 1 & 2). Helsinki, Finland: Ministry for Foreign Affairs, Department for International Development Cooperation. Sixty evaluation reports for 240 projects in 26 developing countries were reviewed, and then 13 country case studies were completed over a five-month period. See also Chambers, R. (1993) *Challenging the Professions*, Intermediate Technology Publications, London; Marsden, D., Oakley, P. and Pratt, B. (1994) *Measuring the Process;* Carmen, R. (1996) *Autonomous Development*, Zed Books, London; 'edlin' development-information website (2001); Simons Committee (1997), various authors in David Sogge (ed) 1996) *Compassion & Calculation*, various authors in Michael Edwards and David Hulme's (1996) *Beyond the Magic Bullet*. See Mande website for reference to overseas-aid evaluations.