International HIV/AIDS Alliance

Supporting community action on AIDS in developing countries

EVALUATION OF THE ALLIANCE'S AFRICA REGIONAL PROGRAMME PHASE 2

March 2011

Acknowledgements

The evaluation was conducted by consultants Robin Brady and Mimi Khan, in liaison with Alliance Secretariat Staff.

Many thanks to all those who took part in this evaluation and made such a valuable contribution including: ARP members (staff of Alliance Country Offices and Linking Organisations and ARP advisory group members), the regional stigma training team, stigma trainers, social return on investment focus group participants, Alliance secretariat staff, and donors.

This publication was made possible by the support of the Swedish International Development Cooperation Agency (Sida) and the Norwegian Agency for Development Cooperation (Norad). The contents are the responsibility of the International HIV/AIDS Alliance and do not necessarily reflect the views of Sida or Norad.

Information contained in this publication may be freely reproduced, published or otherwise used for non-profit purposes without permission from the International HIV/AIDS Alliance. However, the International HIV/AIDS Alliance requests that it be cited as the source of the information.

Cover image © Gideon Mendel for the International HIV/AIDS Alliance
© International HIV/AIDS Alliance, 2011

ISBN No: 978-1-905055-85-2

Table of Contents

Glossary 2
Executive summary 3

1. Introduction 5
Background 5
History of the ARP 5
Evaluation methodology 6
Limitations 6

2. Findings 7
Reducing stigma & discrimination faced by people with HIV & vulnerable groups 7
Increasing the access of vulnerable and stigmatised populations to effective prevention interventions 12
Strengthening meaningful involvement of national & regional networks of people living with HIV in HIV policy development & implementation 16
Programme management and structure 19
Added value 20

3. Recommendations 22

Appendices 25

Glossary

AFRICASO	African Council for AIDS Service Organisations
AIDS	Acquired Immunodeficiency Syndrome
ARP 1	Africa Regional Programme (Phase 1)
ARP 2	Africa Regional Programme (Phase 2)
ARP 3	Africa Regional Programme (Phase 3)
CO	Country Office
DANIDA	Danish International Development Agency
EANASO	East African Network of AIDS Service Organisations
GIPA	Greater involvement of people living with HIV
HIV	Human Immunodeficiency Virus
KANCO	Kenya AIDS NGOs Consortium
LO	Linking Organisations
MRS	Alliance Monitoring and Reporting System
NAP+	Network of African People Living with HIV
NEPHAK	National Empowerment Network of People Living with HIV/AIDS in Kenya
RAANGO	Regional African Network of AIDS Service Organisations
RATN	Regional AIDS Training Network
RENSIDA	Rede Nacional de Associacoes de Pessoas Vivendo com HIV/SIDA
SADC	Southern African Development Community
SAfAIDS	Southern Africa HIV and AIDS Information and Dissemination Service
SAT	Southern African AIDS Trust
Sida	Swedish International Development Agency
SROI	Social Return on Investment
SWAA	Society for Women against AIDS in Africa
The Alliance	International HIV/AIDS Alliance
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS

Executive summary

Background

This report is an evaluation of the Africa Regional Programme Phase 2 (ARP 2), which ran from April 2008 to March 2011 and was funded by the Swedish International Development Agency for an initial budget of US $5 million.

The ARP 2 had three main objectives:

- To reduce stigma and discrimination faced by people living with HIV and vulnerable groups
- To increase the access of vulnerable and stigmatised populations to effective prevention interventions
- To strengthen meaningful involvement of national and regional networks of people living with HIV in HIV policy development and implementation.

A total of 20 countries have participated in ARP 2 carrying out a range of activities according to their own capacity and local HIV context.

Evaluation findings

Overall, the programme has been successful, although there have been significant challenges and we have identified recommendations not only for programme design, but also programme management and monitoring that should be considered during the design of ARP3. The regional nature of the programme has allowed knowledge sharing and activities to take place across the ARP countries that would not have otherwise happened.

Objective 1: Stigma and discrimination

Broadly there have been positive changes in the attitudes of service providers and communities in countries where stigma sensitisation activities took place. Significant changes – some unexpected – have also occurred in the lives of people living with HIV and their families as a result of the stigma work. While the stigma training of trainers model remains reliant on external funding, encouraging entrepreneurial approaches can increase its sustainability.

Objective 2: Access to HIV prevention

There is some limited evidence that ARP prevention grants have succeeded in overcoming barriers to effective prevention for key populations. However, capacity building of ARP partners and national and regional networks to deliver effective HIV prevention interventions has been slow and patchy. ARP workshops and other prevention training have had some limited impact building the capacity of LOs to engage with the national response and influence evidence-informed responses. Good links have also been established between the ARP 2 and the Global Prevention Campaign, but there is no evidence yet that learning from national studies funded by ARP 2 prevention grants has contributed to the campaign.

Objective 3: Strengthening networks

The ARP is strongly engaged at the regional level and has had some success empowering national networks of people living with HIV to have a greater voice in decision-making, but it is too early to measure specific impact and policy change from its networks component.

Programme management, structure and added value

Programme planning in the ARP 2 has been strong, but the programme's management structure has not functioned as effectively as it could. Overall monitoring and evaluation across the ARP 2 is inadequate and inconsistent, and there is a lack of systems knowledge and compatibility outside the secretariat. While the ARP 2 has enhanced the regional profile of the Alliance, further work is needed to ensure that learning is shared and implemented on a regional basis.

Key recommendations:

- Review the structure and business case for a stigma training consultancy.
- Develop a better understanding of how stigma activities can impact end beneficiaries and plan for the consequences.
- Strengthen the on-going ties with the National Partnership Platforms in ARP 3 as these present a unique approach that could support national campaigns through learning and best practice sharing.
- Better follow up of ARP prevention outcomes and impacts is needed, and more consistent monitoring.
- Rethink the strategy for engaging with networks to ensure it complements future ARP work.
- Carry out a general review of the functioning of the ARP management structure before ARP 3 is implemented.
- Plan the implementation of objectives in a more strategic way in ARP 3 for greater joined up programming across the region.
- Find an effective way of incorporating better ARP monitoring within the monitoring currently undertaken by the Alliance secretariat.
- Ensure that the monitoring framework includes identified indicators and assumptions about the planned consequences of interventions.
- Find a focal point for advocacy in each CO/LO. COs/LOs should also be encouraged to include aspects of advocacy/policy in their existing staff job descriptions, as should the secretariat.
- Put in place more formal and relevant knowledge sharing systems, and ensure they become culturally embedded.
- Ensure that a full evaluation of 2010/11 ARP 2 activities takes place so that the lessons and learning from these activities are not lost.

1. Introduction

Background

The Africa Regional Programme Phase 2 (ARP 2) was implemented by the International HIV/AIDS Alliance (the Alliance) from 2008 to 2011. It aimed to support Alliance Country Offices (COs), Linking Organisations (LOs) and regional partners to increase the quality of HIV programmes and ultimately contribute to universal access to prevention, treatment, care and support. ARP 2 was a continuation of an earlier Africa Regional Programme (known in this report as ARP 1).

The ARP 2 has three main objectives:

1. To reduce the stigma and discrimination faced by people living with HIV and vulnerable groups
2. To increase the access of vulnerable and stigmatised populations to effective HIV prevention programmes
3. To strengthen meaningful involvement of national and regional networks of people living with HIV in HIV policy development and implementation.

A total of 20 countries have participated in ARP 2 at national and regional level. COs and LOs have implemented activities in one or more of these three objectives, at different times and to different degrees. Programme activities have included training and follow up for HIV-related stigma and discrimination, producing stigma and discrimination training materials, organising regional workshops for knowledge sharing on HIV prevention, some national network capacity building in countries across the region and the Indian Ocean Islands, and a range of other activities funded by ARP 2 prevention grants.

Programme activities during ARP 2 have been undertaken in 16 countries in sub-Saharan Africa: Burkina Faso, Burundi, Cote d'Ivoire, Ghana, Kenya, Lesotho, Madagascar, Mozambique, Namibia, Nigeria, Senegal, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe. Countries from the Alliance's North African Regional Programme have also taken part in ARP 2 regional meetings to increase knowledge sharing.

History of the ARP

The Alliance implemented its original Africa Regional Strategy from 2002-2004. The Africa Regional Programme Phase 1 (ARP 1) followed from 2005-2007, with the ARP 2 following from 2008 to 2011.

The Swedish and Danish International Development Agencies (Sida and DANIDA) and the Dutch Ministry of Foreign Affairs funded ARP 1 with a budget of US $5 million. While the ARP 1 implemented a wide range of activities, a mid-term review suggested that the programme was filling gaps in funding and activities in national Alliance country programme work, rather than serving as a truly regional programme[1].

In response, the new ARP 2 focused on just three objectives around stigma and discrimination, access to HIV prevention, and strengthening regional networks – aiming for a more coherent regional programme supported by a new management structure. ARP 2 members (countries with Alliance COs or LOs) and partners selected activities according to their specific needs.

The ARP 2 has been characterised by overarching regional activities distinct from the on-going in-country programme activities of ARP members. ARP 2 received 75% of its funding from Sida ($5 million). Activities at the start of ARP 2 were delayed, so the programming years were changed and divided into four periods: April–December 2008 (Year 1); January–December 2009 (Year 2); January–December 2010 (Year 3); and January–March 2011 (Year 4).

[1]Mid-Term Review of ARP. 2005-2007.

Methodology

This evaluation was undertaken jointly by Mimi Khan and Robin Brady, and supported by Alliance secretariat staff. The evaluation uses a number of different methodologies including desk review of documents, interviews with key participants (by telephone and in person), and the collection of quantitative and qualitative data from beneficiaries and those who participated in stigma training.

- A list of the reports, documents, meeting reports, presentations and other materials reviewed by the evaluators are recorded in Appendix B.

- A total of 45 interviews were carried out. Interviewees included members of the ARP Advisory Group, staff of ARP members (Alliance COs, LOs and other partners), Alliance secretariat staff, and donors. (See Appendix A for a list of respondents.)

- At the beginning of 2009 baseline data was collected on stigma and discrimination in a sample of three ARP 2 countries – Kenya, Mozambique and Senegal. These countries represented East, Southern and West Africa, and were chosen as they had planned to implement activities in all three ARP 2 objectives. This evaluation followed up the baseline data, collecting endline data at the same sites, in the same countries. Where possible the same research teams were used; where not, new research teams were identified and trained. During the collection of this endline data three different methodologies were used:

  – a quantitative community survey. This used a questionnaire with a sample size of 1,368 (460 in urban Nairobi, Kenya; 501 in Mozambique; and 407 in Senegal). In addition, qualitative data was collected using focus group discussions with a range of people including sex workers, men who have sex with men, people living with HIV and health workers (see Appendix D for the focus group discussion format). Local consultants were commissioned to undertake this endline data collection in Mozambique and Senegal; in Kenya the Alliance LO (the Kenya AIDS NGOs Consortium or KANCO) participated.
  – case studies were researched and written up on the impact of ARP 2 activities using interviews and focus group discussions in Kenya, Senegal, Uganda and Zambia.
  – articles and stories on the impact of ARP activities in Uganda and Zambia were also commissioned and written by local Key Correspondents (citizen journalists) who formed part of a network of people in the region with whom the Alliance had established relationships.

- A separate study on the social return on investment (SROI) of the stigma and discrimination component of ARP 2 was undertaken in Zambia by Robin Brady (see Appendix G).

- A stigma trainers survey was carried out to follow up a global stigma survey undertaken at the beginning of ARP 2, but with four questions added to reflect the SROI methodology. Questions looked into stigma trainers' activities, attitudes and perceived impact. (This survey was conducted using Survey Monkey, with stigma trainers offered a prize incentive to complete and return the questionnaire online.)

Limitations

This evaluation was carried out between August and December 2010, while ARP 2 activity was still ongoing (the ARP 2 is expected to close in March 2011). As a result some activities could not be evaluated, either because they were still ongoing or because it was too soon to verify their outcomes and impacts. The 2010 work plan for ARP 2 has been appended to this report, including an update for each activity as at December 2010.

The results from both the baseline and the endline versions of the stigma trainers survey are illustrative only as there were not enough respondents (20 in the endline and 49 in the baseline). The proportions of Francophone to Anglophone respondents had also changed markedly, with stark differences in responses between the two.

2. Findings

Overall, the move from the ARP 1 to ARP 2, and its focus on just three objectives, has been successful and has led to activities of a more regional nature, although there have been significant challenges.

Objective 1: Reduce the stigma and discrimination faced by people wih HIV and vulnerable groups

Overview of key ARP stigma and discrimination activities

The stigma programme aimed to reduce stigma and discrimination in order to increase access to HIV prevention, treatment, care, and impact mitigation interventions. The programme used a national 'training of trainers' model, training members of networks of people living with HIV, government and policy workers, nurses, clinical officers, and members of the community. These trainers then integrated the training and approaches within their own work (using an action plan to track progress of their activities), and took responsibility for rolling out the training nationally. Follow up meetings were held to support the national training teams and to provide an opportunity for knowledge-sharing, monitoring and further training if required.

The participative training was based on the Alliance's anti-stigma toolkit, which was developed with communities in Africa and has been revised with input from regional trainers, taking into account the changing face of stigma. New modules have been added including tools to explore stigma faced by children, young people, and men who have sex with men, as well as looking at stigma linked to home-base care and to antiretroviral treatment.

TABLE 1: Indicators for Objective 1

Intervention logic	Objectively verifiable indicators	Targets	Actual	Source
To contribute to the increased quality of HIV programmes, enabling communities to be actively involved in achieving universal access to prevention, treatment, care and support	Increase in the number of vulnerable and stigmatised populations reached with HIV prevention programmes in the targeted countries	None supplied	650% increase reported by Anglophone trainers	Endline global stigma survey
	% of people with accepting attitudes towards people living with HIV in the targeted countries	None supplied	- Mozambique: 89%* - Kenya: 89%* - Senegal: 72%*	Endline global stigma survey
To reduce stigma and discrimination faced by people living with HIV and vulnerable groups	Number of programmes, organisations, and institutions that have integrated anti-stigma activities in their strategies/plans/ activities	None supplied	9 reported countries	Document review and key interviews

Intervention logic	Objectively verifiable indicators	Targets	Actual	Source
	% of trainers still carrying out stigma and discrimination reduction activities in their community/ organisation/ institution one year after training	None supplied	100%	Endline global stigma survey
1.1 Sustain and scale-up stigma training model in 11 countries in sub-Saharan Africa	Number of stigma trainers followed up after their initial training	75%	90%	Document review and key informant interviews
	Number of 'district' or community workshops undertaken	50	16	Document review and key informant interviews
	Number of individuals reached through stigma and discrimination reduction initiatives	None supplied	142 participated in these activities**	Document review and key informant interviews
1.2 Initiate and support stigma training programmes in five countries in sub-Saharan Africa	Number of service providers trained in HIV-related stigma and discrimination reduction	100	None supplied	
	Number of individuals reached through stigma and discrimination reduction initiatives	None supplied	119 participated in these activities**	Document review and key informant interviews
	Number of tools developed and disseminated	3	3	Document review and key informant interviews

1.3 Advocate for changes in policies or laws to address stigma and discrimination faced by people living with HIV and vulnerable populations	Number of policymakers and opinion-formers reached about the impact that stigma has as a barrier to universal access	25	90	Document review
	Number of people attending regional lesson-sharing workshops for stigma	50	121	Document review and key informant interviews
	Number of change stories and lessons learnt captured	40	None supplied	

*This question was not actually asked in the community survey. Instead we have reported the positive responses for the statement: 'People living with HIV should be allowed to fully participate in social events' as an indicator for the degree of accepting attitudes likely to be in a community.
** This is not the same as numbers reached.
*** The majority of these indicators measure outputs only (numbers of activity), which means that the organisation has not necessarily collected data that can verify the outcomes from the activities and the impact that has been achieved. We have seen evidence of significant impact, but this has not been recorded in a systematic manner.

Finding 1: Broadly there have been positive changes in the attitudes of service providers and communities in countries where stigma sensitisation activities took place

The results of the community survey, global stigma trainers survey, and focus group discussions paint a picture of gradual improvements in attitudes to people living with HIV, although the evidence is not all positive. Table 2 shows the results of the community survey carried out in Kenya, Mozambique and Senegal.

In Kenya the results show overall improvements in knowledge of HIV, reductions in the shame and blame attached to HIV, less unfounded fears of contracting HIV, and a reduction in the levels of stigma and discrimination witnessed against people living with HIV. Focus group discussions with female sex workers and people living with HIV also provided evidence of more supportive attitudes among health workers, teachers and chiefs, although not among churches.

In Senegal, the results paint a similar picture, although knowledge of HIV appears to have gone down slightly. Focus group discussions here supported the positive impact of ARP activities, with people living with HIV seen as more accepted users of health services. People living with HIV and men who have sex with men have also become more accepted by their communities.

Mozambique shows the most mixed results, with a significant increase in the proportion of people seeing HIV as a punishment from God and significantly more people saying they would be afraid of telling anyone if they had HIV. The findings of focus group discussions were more positive with stigma and discrimination reported to have declined considerably as a result of ARP activities. However, the respondents in this group were engaged stakeholders such as people living with HIV and health workers, which may account for the difference in views.

The global stigma trainers survey provides more mixed evidence. Individuals who participated in the workshops, and trainers trained by the stigma team, have provided anecdotal reports of the

positive impact that the training and the toolkit have had. However, the proportion of trainers reporting that more people are being open about their HIV status as a result of stigma activities fell in the endline compared to the baseline study – from 89% to 50% among English-speaking respondents, and from 70% to 62% among French-speaking respondents. Also, fewer respondents in the endline survey felt attitudes within families had improved compared to the baseline – down from 73% to 66% among Anglophones and 90% to 27% among Francophones.

Evidence from service providers points towards both the stigma training and treatment support workers being crucial to improving both access to voluntary HIV counselling and testing and antiretroviral treatment services, and for improving the general knowledge of their patients, thereby improving the quality of the consultations that they have with them.

Overall the evidence from Mozambique, Senegal and Kenya highlights just how varied the impact in different countries can be. Both the community and stigma trainers survey indicate that stigma within families is still present. And in the focus groups discussing social return on investment, health workers, teachers and other important community roles were still highlighted as contributing to stigma through their own behaviour, if not through overtly stigmatising others. Health care workers are seen as such a significant group that a new module of the Alliance stigma toolkit has been developed and will be rolled out in 2011. Clinical officers have reported that new health care worker-specific stigma and support activities will be warmly welcomed.

TABLE 2: Results of community survey

	Response (%)								
Indicator	**Kenya**			**Mozambique**			**Senegal**		
	B	**E**	**☺/☹**	**B**	**E**	**☺/☹**	**B**	**E**	**☺/☹**
Knowledge of HIV									
1) % reporting a healthy looking person can have HIV	94	88	☹	96	78	☹	63	74	☺
2) % reporting you can get HIV by sleeping in the same room as an infected person	89	88	☺	75	64	☺	14	19	☹
3) % reporting you can get HIV by sharing a meal with an infected person	90	89	☺	71	62	☺	90	89	☺
Shame and blame									
4) % agreeing with the statement "HIV is a punishment from God for bad behaviour"	31	16	☺	14	29	☹	54	50	☺
5) % agreeing with the statement "I would feel ashamed to be seen in public with anyone who is known to have HIV"	26	19	☺	13	17	☹	27	22	☺
6) % agreeing with the statement "Spiritual leaders do more stigmatising of people living with HIV than supporting them"	26	26	-	30	27	☺	45	27	☺
7) % agreeing with the statement "Community leaders do more stigmatising of people living with HIV than supporting them"	35	20	☺				35	10	☺
Fear of contracting HIV									
8) % agreeing with the statement "I would be afraid of telling anyone if I had HIV"	56	53	☺	17	32	☹	40	39	☺
9) % agreeing with the statement "If my relative became sick with HIV virus I would be willing to let him/her stay in my household"	74	83	☺	85	80	☹	76	80	☺
10) % agreeing with the statement "HIV-positive children should not be allowed to study with other children"	20	28	☹	35	32	☺	39	41	☹
11) % agreeing with the statement " I would buy vegetables from a vendor if I knew this person had HIV".	75	80	☺	78	82	☺	61	-	

	Response (%)					
Indicator	**Kenya**			**Mozambique**		
	B	**E**	**☺/☹**	**B**	**E**	**☺/☹**
Stigma and discrimination witnessed 12) % of people that had witnessed an act of discrimination against a person living with HIV.	64	52	☺	50	51	☹

	Response (%)					
Indicator	**Senegal**					
	B	**E**	**☺/☹**			
Stigma and discrimination witnessed 12) % of people that had witnessed an act of discrimination against a person living with HIV.	11	10	☺			

Notes: B=Baseline findings, E=Endline findings, ☺=positive change, ☹=negative change.

Groundbreaking work

In 2009 a new programme with the Kenyan department of defence piloted the suitability of the stigma training model for tackling institutionalised stigma. Twenty-two high ranking personnel were trained as trainers and a follow up meeting in early 2010 highlighted that this training and the resulting action plan had had an impact on policy discussions about the department of defence's policy on HIV-positive people serving in the armed forces.[2]

A personal transformation

"On a personal level I must admit that I have gone through some sort of transformation during the workshop when we tackled the issue of men who have sex with men… Since a long time ago I had been looking at these men as people who were sick and needed help to be cured of their 'abnormality'. However, during the workshop I was challenged when one of the participants said 'what if the man being persecuted was your son, how would you feel?'… Upon returning to the ministry I introduced the issue of men who have sex with men and at first it was a very sensitive issue… I need some space to push the agenda, through the influence that I have at the Ministry – it could take a while but I am most confident we will do a lot of work."

Stigma trainer from the Ministry of Social Action, Burkina Faso

Finding 2: Significant changes – some unexpected – have occurred in the lives of people living with HIV and their families as a result of the stigma work

The community endline survey (being a repeat of the baseline survey) was not structured to address this point. However, we know from key informant interviews that there have been significant impacts for children living with HIV. Mostly interviewees reported that children could once again attend school and that there was a greater awareness of their needs, although less awareness of how HIV can be transmitted.

The global stigma trainers survey also highlighted that people living with HIV are finding more work. This is supported by the findings of the community endline survey, which highlighted less stigma towards HIV-positive stallholders and teachers for example (see Table 2). The focus group discussing social return on investment (SROI) in Mazabuka, Zambia, alsomentioned that it was now easier to get a stall in the market, and that this was a direct result of the stigma activities of ARP 2.

[2]Regional Stigma Training Programme Annual Report 2009, Alliance Zambia; Interview with Stigma Training Team, 5 November 2010, Robin Brady

As part of the SROI evaluation, Zambian focus group participants also reported that they had improved self-confidence, improved likelihood to find work, improved health, and that children with HIV and orphans could once again attend school without fear of reprisal. In Burkina Faso, major policy changes for men who have sex with men are being considered, which may significantly improve their access to services. This came about as a result of the attitude change of a civil servant who had attended an ARP trainers' workshop (see 'A personal transformation' on previous page).

However, decreased stigma and greater acceptance of people living with HIV have also had impacts that the programme had not anticipated. Waiting times for antiretroviral treatment services at clinics have increased significantly, which has a detrimental impact on an individual's ability to work or look after dependants. Equally there are increased costs associated with the burden of care within the home, for example, higher monthly food bills for the improved nutrition that antiretroviral treatment adherence needs. Additional costs associated with children going back to school also have an impact on the family unit. It must be stressed that although these are extra challenges for individuals, we are not suggesting that the stigma and discrimination work should not have taken place, rather that the impacts of the activity appear not to be well understood or well thought through.

Finding 3: The stigma training of trainers model remains reliant on external funding, but encouraging entrepreneurial approaches can increase its sustainability

Evidence from the stigma survey shows the training model has been highly successful, with activities across 20 countries reporting an impact and some examples of high profile policy influence. Like most NGO activity the training of trainers model is reliant on external funding, which is by its nature uncertain. However, there is an opportunity to generate income from this model by creating a consultancy out of the stigma team that can be contracted into other organisations and countries to undertake stigma training. In this way the model can generate income as well as attract investment, which would increase its sustainability significantly.

Trainers can also be categorised into three groups: those who are already employed by an agency to do similar work and who have integrated the stigma training toolkit into their activities; those who have obtained work with other agencies as a result of doing the stigma training; and those who can only work as trainers when external funding is found. There is a core group of trainers who have never stopped working and about 20% of trainers find other employment as a result. However the third group of trainers represent a lost opportunity. These individuals have been given valuable skills without the resources to follow them up. By encouraging an entrepreneurial approach as part of the initial training, some trainers could generate their own activity, reducing the wastage and increasing the penetration of the stigma activities.

Objective 2: Increase the access of vulnerable and stigmatised populations to effective prevention interventions

Overview of key prevention activities

The aim of the ARP objective for prevention was to facilitate effective evidence-based prevention interventions at the national and regional level, especially those that may not otherwise be supported by donors. It was anticipated that ARP regional meetings would act as a forum to cascade learning on prevention.income as well as attract investment, which would increase its sustainability significantly.

There have been three successful regional prevention workshops held during ARP 2 on a range of key prevention issues. They were held in Nairobi, Johannesburg and Pretoria and were attended by 80 participants from 17 different countries. Participants included members of the ARP Advisory Group and partner organisations including the Southern African AIDS Trust (SAT), Society for Women against AIDS in Africa (SWAA), Regional AIDS Training Network (RATN), Southern Africa HIV and AIDS Information and Dissemination Service (SAfAIDS), and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Following the workshops, members were able to apply for prevention grants of up to $65,000 (in Year 1 grants were found to be too small to be effective and the size of grants was increased). The criteria of the grants gave participants the flexibility to address specific needs in their own countries. A total of 20 prevention grants were awarded to 11 countries over the life of ARP 2 totalling $700,000. These funded prevention activities including research, documentation, workshops (for national policy, advocacy and prevention dissemination) and technical support to manage other donor funds.

Specific examples include adapting a Senegalese toolkit on working with men who have sex with men and drug users for use in Burkina Faso; research on truck drivers and sex workers in Cote d'Ivoire; a prevention capacity building workshop for ten civil society organisations in Nigeria; and advocacy training for regional leaders in Kenya. It was anticipated that participants' activities could influence their own organisations as well as the national response.

TABLE 3: Indicators for Objective 2

Intervention logic	Objectively verifiable indicators	Targets	Actual	Source
2.1 Influence national prevention programmes to improve effectiveness and coverage of vulnerable groups	Evidence of effective prevention strategies (from ARP and other partners) documented and/or disseminated	6 effective HIV prevention strategies documented	3	ARP Annual Report 2009
2.2 Support national prevention programmes to improve the quality of prevention interventions used by vulnerable groups	Number of technical exchange and mentoring visits to national partners in order to develop prevention responses with vulnerable populations	3 technical exchange visits and 3 mentoring visits	3 technical exchange trips, no mentoring visits that we are aware of	
2.3. Share effective interventions with key populations at regional meetings and use these to develop strategies for national ownership, policy influence and programme implementation	Number of regional best practice meetings Number of people attending regional best practice meetings	4 100 (4x25)	3 2008:16 2009: 34 + 30 Total: 80 from 17 countries	ARP regional meeting reports

Intervention logic	Objectively verifiable indicators	Targets	Actual	Source
2.4 Integrate issues of vulnerable and stigmatised populations in national prevention programmes	Number of LOs/COs who have documented needs of vulnerable groups and effectiveness of community responses for national meetings	68		
	Production of at least policy briefs to highlight how the needs/issues affecting vulnerable and stigmatised populations can be integrated into national prevention programmes	8		
	Number of national workshops and number of people attending based on regional best practice meetings	12, 20 per meeting	80 people from 17 countries	ARP regional meeting reports

Finding 4: There is some limited evidence that ARP prevention grants have succeeded in overcoming barriers to effective prevention for key populations

Implementation of prevention grants was shown to be most successful in Senegal, Burkina Faso and Zambia. In Senegal the results of a study on men who have sex with men acted as a catalyst for meetings with policymakers and for a wider-ranging national study. In Burkina Faso the ARP programme was instrumental in effecting a policy change for men who have sex with men in conjunction with the stigma activities. In Zambia a national prevention convention for HIV was held to affect policy changes and the initial relatively small prevention grant was used to leverage a large amount of funding in country. Attitudes within Alliance Zambia also changed during ARP 2 as a result of the regional prevention workshop. They now support the local lesbian and gay association, helping it to overcome barriers for effective prevention for gay men and women.

Important prevention research and documentation has been undertaken through ARP 2, which would not otherwise have been funded by donors. This includes the documentation of three effective HIV prevention strategies in Senegal and Nigeria, and the production of a facilitator's guide for working with men who have sex with men. The cost of the prevention grants is small compared with the huge impact they can potentially have. However, very little outcome and impact measurement and reporting exists to determine the lasting impact of the grants

Finding 5: Capacity building of ARP partners and national and regional networks to deliver effective HIV prevention interventions has been slow and patchy

We believe that this is partly the result of delays in rolling out prevention grants and the relatively small-scale of the funding available, which has not encouraged LOs or COs who are recipients of large funds from other donors to participate. Tighter requirements for participation in ARP 2 might have helped to ensure activities were carried out in a timely fashion and that changes in capacity could be appropriately measured. Measurement appears to be predominantly quantitative, with only short qualitative narratives contributed to the annual reports. As a result, changes in capacity are not possible to evaluate from the data being collected.

However, regional workshops have provided ARP members with a good background to help them understand the nature of the HIV epidemic in the region, as well as the particular needs of key populations including sex workers, men who have sex with men and injecting drug users. During these workshops the skills and knowledge of participants were built up, enabling and supporting them to plan for appropriate HIV prevention interventions relevant to their own national contexts and based on best practice.

Finding 6: ARP workshops and other prevention training have had some limited impact building the capacity of LOs to engage with the national response and influence evidence-informed responses

Activities under the prevention objective such as the regional technical prevention workshops have given ARP members the skills and confidence to undertake prevention planning for their own needs, as well as to influence the prevention agenda in their own countries. In some cases government representatives have attended workshops providing direct engagement with national policymakers. Technical staff exchanges between ARP members have also taken place, and there are some instances where the ARP 2 has successfully influenced national prevention platforms and promoted buy in at the highest level.

For example, In Burkina Faso the ARP 2 has been instrumental in effecting a policy change for men who have sex with men. In Zambia the LO organised a national prevention convention following on from a regional prevention workshop. This convention appears to have developed a momentum in country to affect policy changes, which then need to be tested and reviewed.

The ARP 2 has also been successful in supporting post-conflict countries. In South Sudan prevention activities have helped to influence the new national HIV prevention strategy; studies in Burundi have been planned by a committee including the National AIDS Committee, key national actors and international donors. Prevention activities have helped ARP members to improve their relationships with their governments and a number are now included in national prevention task forces.

Finding 7: Good links have been established between the ARP 2 and the Global Prevention Campaign, but there is no evidence yet that learning from national studies funded by ARP 2 prevention grants has contributed to the campaign

The Alliance Global Prevention Campaign was established in mid-2010. At the time of writing this report the campaign was only six months old, but good initial efforts appear to have been made to engage with the ARP 2. In Senegal the campaign has supported the strategic development of advocacy on prevention for men who have sex with men, and in Uganda the focus has been on commissioning a baseline study to map out the main barriers to prevention activities.

The campaign and the ARP have influenced each other, and there has been strategic thinking as to how the campaign can provide an overall framework and better links to ARP members in the future – in particular strengthening the exchange of ARP prevention policy work and that of the Alliance as a whole. There is also evidence of linking the prevention component with National Partnership Platforms and the Department for International Development's Maternal Health Programme.

Objective 3: Strengthen the meaningful involvment of national and regional networks of people living with HIV in HIV policy development and implimentation

Overview of key network activities

The intention of ARP 2 was to strengthen the Network of African People Living with AIDS (NAP+), develop the capacity of two sub-regional networks within NAP+, and to develop the capacity of three national-level networks in Burkina Faso, Mozambique and Uganda. Capacity building was to focus on developing strong leadership skills and skills to allow leaders to mentor others. By strengthening and supporting NAP+, it was expected that there would be increased and informed participation of people living with HIV in national and regional policymaking.

Due to internal changes in NAP+, the original strategy of the networks component could not be followed. The Alliance agreed with Sida and the NAP+ Board to vary the approach and work directly with sub-regional and national networks to build their capacity.

TABLE 4: Indicators for Objective 3

Intervention logic	Objectively verifiable indicators	Targets	Actual	Source
3. To strengthen the meaningful involvement of national and regional networks of people living with HIV in HIV policy development and implementation	Number of supported regional and national networks of people living with HIV with increased capacity in organizational and policy interpretation and analysis that results in improved engagement with policymakers on reducing stigma and discrimination and increasing access to HIV prevention	10 continental, regional and national	4 national; 2 regional	Document reviews and key informant interviews
	Evidence of meaningful participation of people living with HIV in the development, implementation and monitoring of national and regional policy on HIV prevention and reduction of stigma and discrimination	None given	Potentially 2: Zambia (prevention); Burkina Faso (stigma)	Document reviews and key informant interviews
	Number of policymakers and opinion-formers demonstrating an in-depth understanding of the impact stigma has as a barrier to universal access	None given	1 reported and recorded	Document reviews and key informant interviews

Intervention logic	Objectively verifiable indicators	Targets	Actual	Source
3.1 Enhance the capacity of one regional network and two sub-regional networks	Capacity analysis and capacity building plan developed for one continental and four regional networks	5	7 (5 national and 2 regional)	Document reviews and key informant interviews
3.2 Enhance the capacity of three national level networks of people living with HIV	Capacity analysis and capacity building plan developed for five national level networks of people living with HIV	5	4 (RNP+, RENSIDA, NEPHAK, REGIPIV)	Document reviews and key informant interviews
	Number of technical support to 5 networks of people living with HIV provided by Alliance LOs/COs	15		
	Number of people living with HIV involved and participating in Country Coordination Mechanisms	(3 CCMs)	0	Not reported or verified
3.3 Support the increased and informed participation of people living with HIV in national and regional policy as a result of strengthening and supporting NAP+ and ICW at the regional level	Policy dialogues planned, linked thematically and hosted on the continental, regional and national level (1 continental, 4 sub-regional and 3 national policy level)	8	2 at a national level (Zambia and Mozambique)	Document reviews and key informant interviews
	Research conducted and disseminated to impact on programming into an identified need of people living with HIV	1	Not completed – ongoing	Document review
	Number of people living with HIV actively engaging in national and regional policy dialogues	None given	Not recorded	Document review

Finding 8: The programme has had limited success empowering national networks of people living with HIV to have a greater voice in decision-making, but it is too early to measure specific policy change

There have been significant challenges with the networks component of the ARP 2, partly due to external factors in NAP+. However, the ability to reach agreement with the donor to reorient the programme shows strong leadership and maturity. Although work on the new strategy only began in 2009, some success at this level has already been achieved.

An example of this is organisational development at the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK). This has been supported by KANCO and has strengthened governance and leadership through a new constitution, a new board, and more democratic representation at the national delegates conference; produced a new strategic plan, and built capacity (by establishing standards and developing finance and HR manuals). NEPHAK

is currently holding regional meetings and functioning with key staff in place. The Alliance has also worked with and supported national networks of people living with HIV to improve governance and leadership in Burkina Faso, Cote d'Ivoire, Mozambique, Senegal and Uganda, as well as the Indian Ocean Islands network of people living with HIV.

Because of the delay in starting sub-regional and national network capacity building programmes, it is difficult to adequately measure the impact that Objective 3 has had on empowering people living with HIV to have a greater voice in policy decision-making. It should be noted, however, that we have seen significant similar achievements under Objectives 1 and 2, influencing policy on men who have sex with men in Burkina Faso and influencing the national HIV plan in Zambia. We also know that a report funded by a prevention grant on the impact of truck drivers and sex workers on the epidemic in Cote d'Ivoire has been used to advocate for change.

One final issue of note is that there still remains a vacuum at continental level for representation of people living with HIV that can adequately respond to, and interact with other continental and regional bodies such as the African Union, UN and the regional economic co-operation areas.

Finding 9: The ARP is strongly engaged at the regional level, however it is too early to identify successful policy influence from its networks component

The ARP 2 has forged new and strong links with regional partners both in Southern, West and North Africa including SAT, SAfAIDS, the East African Network of AIDS Service Organisations (EANNASO), RATN and the Regional African Network of AIDS Service Organisations (RAANGO). It has shown excellent regional engagement throughout its life, particularly with the Southern African Development Community (SADC), regional donors, and the African Council for AIDS Service Organisations (AFRICASO[3]). The ARP 2 was one of the few international programmes invited to attend the SADC Prevention Meeting in June 2009.

The Alliance regional representative in West Africa has represented ARP 2 in a number of regional fora, with ARP technical support sought by other key players as a result. The ARP 2 has also had good engagement with UNAIDS regional bodies covering Eastern and Southern Africa, and UNAIDS has requested Alliance technical expertise on building networks in Cameroon. ARP lessons have also been applied globally with the programme represented at the UNAIDS HIV consultation in Bangkok.

However, the delay in starting Objective 3 activities due to structural issues with NAP+, impacted heavily on the Alliance's planned capacity building outcomes for national and regional networks, and it is too early to evaluate networks' lasting policy influence across Africa.

From the interviews undertaken with Alliance secretariat and CO/LO staff there seem to be two different views of the value of networking activity. On the one hand the strategy to engage with networks to enable wider change appears sound. However, networks appear to have had significant funds invested in them over time, which has led some to question whether a different sort of engagement is required to best support them to effect change.

[3]Africa Regional Programme. Annual Reports 2008 and 2009.

Programme management and structure

Finding 10: Programme planning in ARP 2 has been strong, but the programme's management structure has not functioned as effectively as it could

The management structure of ARP 2 has included the secretariat, working groups for each objective, the Regional Advisory Group, and Alliance COs and LOs. Some of these levels are not functioning as effectively as they could in spite of concerted effort by the Programme Manager to inform everyone of their roles and responsibilities.

- The three *ARP working groups* set up for each objective have not been working effectively nor been very visible during ARP 2. Factors impeding the effective functioning of these working groups are that the allocated leaders don't have any formal ARP role in their job descriptions, and two of the technical leaders left their post during ARP 2.
- *The ARP Programme Manager's* time is overstretched and split between too many activities. We believe this is because the post is located in the secretariat rather than in the region. This also makes it difficult to represent the Alliance in high-level meetings in Africa as often as is desirable.
- The role of the *Regional Advisory Group* is to advise and support the development and implementation of the ARP. However, some members feel that engagement levels have slipped, with a declining sense of ownership, and that the role of the advisory group had diminished to that of providing information to the ARP management. The advisory group has not met as regularly as planned and although the group has broad terms of reference its roles and responsibilities need further clarification. It is very capable of giving support to ARP members on programming but it is not clear the extent to which it has done so.
- The ARP 2 model intends for ARP-funded activity to be integrated into other work within the *Alliance CO/LOs*. While integrated working is good, it does present significant monitoring and management issues and reduces the profile and visibility of ARP activities.

Programme planning:

- Identifying the need to adapt the programme at key stages showed strong programme management, as did the subsequent good negotiation and agreement with the donor. This is particularly obvious for the networking component.

- The three ARP 2 objectives have not been implemented in an integrated or equitable way across the region, and this is evident for advocacy and knowledge sharing (which have focused on stigma and discrimination) and the exchange of country staff for cross learning.

- There is evidence of good consultation and communication with ARP countries by the ARP Programme Manager throughout the programme life. This has led to good buy in for a number of important processes including the development of the prevention funding guidelines.

Policy and advocacy:

- Currently policymaking is not being integrated across all the ARP objectives, but rather arises around each individual objective. LOs also have difficulty undertaking follow up ARP advocacy work, because there are few LO staff posts dedicated to advocacy.

Budgeting for ARP 2:

- Good leadership enabled a problem solving approach to be taken to the budget shortfall of 25%, in particular liaising with the donor regarding the pruning of ARP activities, and through a cost-sharing initiative with the regional partner SAT for the costs of the regional best practice advocacy meeting.

Finding 11: Overall monitoring and evaluation across the ARP 2 is inadequate and inconsistent, and there is a lack of systems knowledge and compatibility outside the secretariat

Reporting against the monitoring plan has been challenging because of the lack of identifiable evidence, partly resulting from integrated working. While annual reviews have been produced that have provided a flavour of each year's activity, they have not related to the indicators that had been agreed with the donor as included in the ARP monitoring and evaluation plan. This has meant that the Alliance has not necessarily had all the information it could have had on an annual basis to manage the programme strategically.

The Alliance Monitoring and Reporting System (MRS), run by the secretariat, currently does not track activities supported by particular donors including ARP activities. Within LOs there is also a general lack of systems knowledge and in some cases incompatibility with the current version of MRS.

Monitoring for the stigma and discrimination component still needs to be improved. Although the Zambia stigma team have made their best effort to assess the impact of activities during workshops, monitoring has not been well integrated with that of on-going efforts by CO and LOs.

The evaluators feel that the ARP 2 programme has made many achievements, however the ARP 2 monitoring framework does not currently have the space to ask about and pick up intended and unintended consequences of ARP 2 activities. This has lead to the under reporting of the actual achievements of each of the objectives. Overall monitoring and evaluation across the ARP is inconsistent and relies on existing ability rather than training or capacity building.

Added Value

Finding 12: While the ARP 2 has enhanced the regional profile of the Alliance, further work is needed to ensure that learning is shared and implemented on a regional basis

The funding for the ARP 2 has provided an opportunity (at small capital cost) to focus on three key areas of HIV across Africa that other donors are unlikely to fund. In addition, a social return on investment pilot study undertaken at two sites in Zambia during 2010 as part of the ARP 2 has also shown that for every $1 invested in a programme, between $13.75 and $21.20 in social value is being generated (see appendix G).

Flexibility has enabled ARP members to take different approaches according to their different contexts and there have been clear efforts to engage and work with other regional players. The regional focus of the programme developed well during ARP 2, allowing countries with high HIV prevalence to work alongside low prevalence countries for mutual leaning.

This learning and knowledge sharing has taken place through the ARP annual reports (which have been translated), the regional best practice workshops, advisory group meetings, the annual ARP meetings, and technical exchange visits – as well as programme tools, best practice briefings, and policy and advocacy materials. In addition, information has been shared through a stigma e-forum, the Alliance website and regular e-newsletters. Knowledge has also been shared more widely with members of the North Africa Regional Programme some of whom attended the regional workshops.

However, knowledge sharing does not appear to have been equal for each of the three objectives with noticeably more focus on stigma and discrimination and less for prevention and networking. There is no knowledge sharing strategy or framework to systematically share important ARP 2 successes and problems across COs/LOs, and COs/LOs have not tended to take much initiative to actively share knowledge among themselves. Knowledge sharing from ARP 2 does not appear to have fed into Alliance learning across regions, and this is particularly obvious for stigma and discrimination activities.

Also, the secretariat's reliance on electronic communication (via email and the intranet) does not always match LOs infrastructure. Indeed in some cases LOs access to the intranet is theoretical only. Hence we believe that more needs to be done to ensure good dissemination of reports and best practice. The language barriers identified as a problem in ARP 1 appear to have abated during ARP 2 with concerted efforts to address this.

Overall, while the ARP 2 has enhanced the regional profile of the Alliance somewhat, more work is needed to ensure that learning from its activities is actually implemented regionally. This might require a firmer control of programming, timing of activities and participation by LOs and COs within the ARP, all of which may present significant relationship challenges.

3. Recommendations

We have identified here recommendations not only for programme design, but also programme management and monitoring that should be considered during the design of ARP Phase 3 (ARP 3).

Objective 1: Stigma and discrimination

1. Review the structure and business case for a stigma training consultancy.
2. Develop a better understanding of how stigma activities can impact end beneficiaries and plan for the consequences.
3. A longitudinal study of a few trainers over a longer period of time (more than five years) would enable better reporting and verifying of evidence to demonstrate substantial impact better.

Objective 2: Prevention

4. Strengthen the on-going ties with the National Partnership Platforms in ARP 3 as these present a unique approach that could support national campaigns through learning and best practice sharing.
5. Carry out a quick analysis of the capacity of ARP members to identify whether they need additional support to undertake the prevention activities.
6. Ensure that the most appropriate staff attend regional workshops to maximise the workshops' potential to catalyse change.
7. Better follow up of ARP prevention outcomes and impacts is needed, and more consistent monitoring.

Objective 3: Networks

8. Focus on institutional capacity before awarding funding. Leadership is particularly key.
9. Develop better coordination with donors at country level who are also funding networks and advocacy.
10. Rethink the strategy for engaging with networks to ensure it complements future ARP work.
11. Clarify the role of networks in delivering and supporting activities.
12. Ensure strong and equitable regional engagement continues.
13. Review the organisational assessment tool used to evaluate NAP+ to build in additional checks to prevent future problems arising.

Programme management structure

14. Carry out a general review of the functioning of the ARP management structure before ARP 3 is implemented.
15. Embed ARP better in the secretariat structure, including though job descriptions.
16. Investigate whether the new Alliance secretariat structure will be able to service ARP 3 effectively.

17. Relocate the ARP Programme Manager to the region to ensure that the Alliance can be fully represented at high level meetings in the region.
18. Create a new post of ARP Programme Officer to be based at the secretariat, to support the Programme Manager in the region.
19. The ARP working groups should be adapted, revitalised and re-launched to suit the final design of ARP 3.
20. Review the role of the Regional Advisory Group taking into account its role in supporting ARP 3. If the Regional Advisory Group is kept in ARP 3 it should be re-launched at the beginning of the programme to help it realise its full potential. Link the Global Prevention Campaign more closely to the Regional Advisory Group. During ARP 3 the advisory group has the potential to evolve into a forum for disseminating policy.
21. Clarify who is supervising the technical work of the regional stigma team.

Programme planning

22. Plan the implementation of objectives in a more strategic way in ARP 3 for greater joined up programming across the region.
23. Consider the profile of ARP 3 at both secretariat and CO/LO level, and whether it should be a stand-alone or complementary programme.
24. Ensure that ARP activities link with CO/LO strategies.

Programme monitoring

25. Improve stigma and discrimination monitoring activities in country.
26. Find an effective way of incorporating better ARP monitoring within the monitoring currently undertaken by the Alliance secretariat.
27. Ensure that the monitoring framework includes identified indicators and assumptions about the planned consequences of interventions. Ensure it is set up to monitor all potential impacts.

Policy and advocacy

28. Consider developing a framework for measuring policy activities over a longer time frame.
29. Find a focal point for advocacy in each CO/LO. COs/LOs should also be encouraged to include aspects of advocacy/policy in their existing staff job descriptions, as should the secretariat.
30. Clarify to external donors and stakeholders the value the Alliance can bring to working with both key populations and in generalised epidemics in Africa where relevant.

Knowledge sharing

31. Put in place more formal and relevant knowledge sharing systems, and ensure they become culturally embedded.
32. The secretariat should be responsible for managing models of good practice and disseminating this information through a two-tier system of information sharing (annual summaries and detailed project evaluations).
33. Country programme officers need to push forward ARP activities and general programme communication must be embedded across the Alliance.
34. Undertake further follow-up of how prevention guides are used, as part of good practice management in the future.
35. Ensure that a full evaluation of 2010/11 ARP 2 activities takes place so that the lessons and learning from these activities are not lost.

APPENDICES: available upon request

A. List of respondents interviewed

B. Publications reviewed

C. Questionnaire

Used to interview ARP 2 Advisory Group Members and member of Alliance COs and LOs.

D. Endline data collection

Survey formats used to collect data in Kenya, Mozambique, and Senegal

- Focus group discussion format
- Baseline data community survey format
- Case study format (Uganda, Kenya, Senegal, and Zambia)

  Global stigma trainers survey format

E. Endline data findings

- Kenya
- Senegal
- Mozambique
- Global stigma trainers survey (English and French)

F. 2010 ARP 2 work plan with December 2010 update

G. Social Return on Investment (SROI) case study

H. Evaluation terms of reference

I. ARP prevention outputs and programme monitoring reports

A global partnership:
International HIV/AIDS Alliance
Supporting community action on AIDS in developing countries

Established in 1993, the International HIV/AIDS Alliance (The Alliance) is a global alliance of nationally-based organisations working to support community action on AIDS in developing countries. To date we have provided support to organisations from more than 40 developing countries for over 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to HIV treatment.

The Alliance's national members help local community groups and other NGOs to take action on HIV, and are supported by technical expertise, policy work, knowledge sharing and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice programme development, as well as policy analysis and advocacy.

www.aidsalliance.org

International HIV/AIDS Alliance
(International secretariat)
Preece House
91-101 Davigdor Road
Hove, BN3 1RE
UK

Telephone: +44(0)1273 718900
Fax: +44(0)1273 718901
mail@aidsalliance.org
Registered charity number: 1038860