

6.3.1 Baseline Survey to Establish Benchmarks

Livingstonia Synod HIV/AIDS Programme

Funded By:
The National AIDS Commission

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Report Information

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1 Executive Summary

The Livingstonia Synod AIDS Programme (LISAP) conducted a census from mid-November to mid-December 2006 of community groups affiliated with the Programme. LISAP trains community members in HIV/AIDS topics such as home based care, orphan care, and others (see list below of project types). The people trained form or go back to existing community-based groups. Incomplete record keeping created information gaps about these affiliated groups. Our main objective was to better understand the scope of LISAP's community groups to create a baseline on which to plan and measure future work. We collected data on the following topics to accomplish this objective*¹:

1. Quantity of community groups by project type
2. Location of the community groups by district, area, presbytery and traditional authority
3. Quantity of beneficiaries
4. Quantity of members
5. Quantity of groups submitting reports in a given month and to which organizations/individuals
6. Quantity of groups being supervised in a given month and by which organizations/individuals
7. *Quantity of trained and untrained members and who trained them
8. *Support being given to the group from the community and types of support being given from the group to its beneficiaries.
9. *Income Generating Activities (IGAs) of the groups
10. *Population size of the villages in which LISAP had affiliated beneficiaries/groups
11. *Flow of information from the community group to LISAP

In addition to determining the above characteristics about the groups, LISAP wanted to produce a map showing the areas in which it had affiliated groups.

LISAP has trained community groups in the following 11 project types to combat HIV and AIDS at the community level:

1. Children's Corner
2. Community Based Child Care
3. Funeral Education
4. Home Based Care
5. Marriage Counseling
6. Orphan Care
7. People Living with HIV/AIDS
8. Post-Test Club
9. VCT Motivators
10. Women's Groups
11. Youth Clubs

¹ * Indicates objectives which were only partially accomplished or not accomplished. See Limitations under the Discussion section for an explanation.

Around ten staff members assisted in the design of questions for 11 project-tailored questionnaires as well as one additional questionnaire for community supervisors. Time-sensitive questions were focused for the most part on information for October 2006. Each of the zone coordinators were responsible to provide a list of known community groups per area, plan a timetable for groups to be visited, and sensitize the communities. Pre-testing occurred in 5 areas over 3 days. Enumerators received one and a half days of training and additionally participated in one day of pre-testing.

The census required 12 enumerators, 3 drivers, and 1 team leader to visit around a hundred major areas to interview the groups. Community groups had been informed ahead of time through a letter about the date and time of LISAP's census and had been asked to supply one group representative to a specified general location. Data collection took around 20 days. Drivers used GPS devices to collect location data where the surveys were given as well as any other schools or various locations where we had affiliated groups when feasible.

A database in Microsoft Access 2003 was set up in which to enter the bulk of the data. Spreadsheets in Microsoft Excel 2003 also were set up to enter data which was not conducive to enter in Access. Analysis was done in SPSS 9.0 for Windows.

Results

In total, responses from 661 groups believed to be affiliated with LISAP were analyzed. These groups had a total of 4522 (43.2%) male and 5954 (56.8%) female members/caregivers as of October 2006 and 13,988 (46.5) male and 16,119 (53.5%) female beneficiaries.² 295 (45.3%) groups had been supervised by some organization in October 2006 and LISAP had supervised 60 (9.2%) of the 651 groups³. 438 (67.3%) groups had submitted an October 2006 report and 160 (24.6%) of the 651 groups⁴ had submitted a report to LISAP staff members. Of the total number of 31,258 beneficiaries, 66% belong to the Impact Mitigation Pillar, 27% to the Prevention and Behavior Change Pillar, and 7% to Treatment, Care, and Support Pillar.

Conclusions

1. LISAP's affiliated community HIV/AIDS groups reached 31,258 people in October 2006.
2. LISAP-affiliated community groups have been documented in a list format by Presbytery and main area.
3. Females outnumber males as members of community-based HIV/AIDS groups.
4. Females outnumber males as beneficiaries of community-based HIV/AIDS groups.
5. Many of the LISAP-affiliated groups had links to other organizations through trainings, supervision, and/or report submission.

² The genders of 1,151 beneficiaries were not known by the group representatives.

³ Not all of the 661 community groups were analyzed. See the caption under the Supervision Figure for an explanation.

⁴ Not all of the 661 community groups were analyzed. See the caption under the Reporting Figure for an explanation.

6. Most beneficiaries of LISAP-affiliated groups fall under the "Impact Mitigation" pillar. The next most popular pillar is "Prevention and Behavior Change" followed by "Treatment, Care and Support."
7. A map has been produced showing the quantity of beneficiaries of the 661 groups in 89 main areas.
8. LISAP staff supervised 9.2% of groups and received reports from 24.6% of groups for October 2006.

Recommendations

1. Find ways to increase male involvement in HIV/AIDS activities. Possible suggestions include: training more village headmen, encouraging males to join PLWA groups, and targeting Livingstonia Theological College students for HIV/AIDS messages.
2. Strategize how LISAP will supervise and receive reports from its affiliated groups. Will the programme attempt to supervise and receive reports from all of its affiliated groups? Once the programme decides which community groups it will receive reports from, the programme needs to decide how frequently it will receive the reports.
3. Decide the extent to which LISAP will use volunteer supervisors (HSAs, Church Volunteers, and other Community Volunteers) to provide information about the groups as opposed to collecting data firsthand from the groups themselves. In October 2006, LISAP staff supervised and collected reports from less than a quarter of its total groups. As LISAP develops its M&E system and decides the extent of supervision it would like to give, careful attention should be paid to division of supervision and reporting duties between the main office, zones, M&E Officer, and volunteer supervisors. A systematic schedule of supervision and reporting would enable greater efficiency and completeness of these tasks.
4. Make a checklist of the goals LISAP wants to accomplish in supervision.
5. Ensure that all of LISAP's affiliated groups know the reporting format.
6. Compile problems of the groups in a central database to better identify priority issues and propose solutions in technical staff meetings.
7. Decide whether LISAP wants to keep its main focus on the Impact Mitigation Pillar or put more emphasis on Treatment, Care and Support and Prevention/Behavior Change Pillars.

2 Introduction

2.1 Brief History of LISAP Growth

LISAP originated in 1994 with a small catchment area within Mzimba district. In 2005, LISAP massively increased its geographical coverage with the creation of the 3 zone offices in Karonga (Northern Zone), Mzuzu (Central Zone), and Mzimba (Southern Zone). In 2005, LISAP also

hired its first M&E officer. During the Programme's existence, it has trained or in other ways affiliated with a large number of groups. LISAP's increased complexity and scale in recent years has necessitated a new emphasis on its M&E system. Groups had not been documented in a central location and no uniform data collecting system for group characteristics had been created.

2.2 Mapping

In addition to lacking complete data on LISAP's community group members and beneficiaries, LISAP lacked a sense of geographic distribution of community groups. The Programme used the census to collect geographical information concurrently with other data about the groups. Drivers carried GPS units and recorded coordinates in latitude and longitude, datum WGS84. Drivers recorded coordinates for 217 sites. Most of these sites were where the census occurred. When circumstances permitted, drivers would go to other locations such as Community Based Child Care (CBCC) centers and schools where there were groups linked to LISAP. Because many community groups were in areas located closely together, only main areas are represented on the map. The 661 groups have been divided into 89 main areas. ArcView software was used to put these 89 points on a map of Livingstonia Synod.

2.3 GPS Coordinate Conversion

Coordinates were collected in the longitude and latitude coordinate system and WGS84 datum. To produce the map, the coordinates had to be converted into UTM coordinate system and ARC60 datum. This conversion happened in two steps. In the first step, the latitude/longitude coordinate system and WGS84 datum was converted into UTM and NAD83, respectively, using the following website: <http://www.gps2cad.com/coordtrans/coordconvert.aspx>. In the second step, these UTM coordinates obtained from the website were translated from datum NAD83 into datum ARC60 by adding 30 meters to the Northing Coordinate and subtracting 80 meters from the Easting Coordinate. Any future survey should use the UTM coordinate system and ARC60 datum.

2.4 History of M&E System at LISAP

In 2004, LISAP developed a Strategic Framework that would be implemented for four years, starting from that same year to 2008. In view of this, the Organization saw the need of designing an M&E Framework that would guide the implementation of the Strategic Framework. It was for this reason that in the late 2005, the process of developing an M&E system begun. However, many constraints were encountered within the development process. Firstly, LISAP had not then recruited an M&E Officer, who would coordinate the whole process. Secondly, LISAP had just started scaling-up through decentralizing into Zones, which needed time in order to have a clear information flow identified.

Although the process started in the late 2005, as has already been stated above, it was again blocked on the way by the resignation of the M&E Officer early 2006, who was coordinating the whole process. Furthermore, despite urgent recruitment of his replacement in the middle of that same year, a draft document of the Framework has not yet been finalized due to revision of the National M&E System, which is still in progress. Revision of the National M&E System has also

contributed to the delay in finalizing LISAP's M&E System, because much of LISAP's Operation Framework relies on the National Framework.

Finally, this means that finalizing National Framework will initiate completion of LISAP's M&E System.

2.5 Objectives

Our main objective was to better understand the scope of LISAP's community groups to create a baseline on which to plan and measure future work. We collected data on the following topics to accomplish this objective*⁵:

1. Quantity of community groups by project type
2. Location of the community groups by district, area, presbytery and traditional authority
3. Quantity of beneficiaries
4. Quantity of members
5. Quantity of groups submitting reports in a given month and to which organizations/individuals
6. Quantity of groups being supervised in a given month and by which organizations/individuals
7. *Quantity of trained and untrained members and who trained them
8. *Support being given to the group from the community and types of support being given from the group to its beneficiaries.
9. *Income Generating Activities (IGAs) of the groups
10. *Population size of the villages in which LISAP had affiliated beneficiaries/groups
11. *Flow of information from the community group to LISAP

In addition to determining the above characteristics about the groups, LISAP wanted to produce a map to show the areas in which it had affiliated groups.

2.6 Acknowledgements

LISAP thanks the National AIDS Commission (NAC) for providing financial support for this census and director, Dr. Andy Gaston, for technical support. LISAP would like to thank the enumerators: Alice Ngosi (supervisor), Victoria Nkhata, Laston Nyirenda, Glyn Gondwe (supervisor), Wezi Gondwe, Gray Sidira (supervisor), Jeffrey Nyondo, McNills Jere, Fishane Gondwe, Christopher Mtambalika, and Regent Gondwe. LISAP thanks Lazarus Harawa for supervising the logistics of the survey as well as driving and recording GPS coordinates. LISAP thanks the other drivers Henry Bandawe and Mark Gama who helped record GPS coordinates also. LISAP thanks Joyce Nyirenda for the data entry. Special thanks also to Annabel and Kirsty Douglas for their assistance in converting the coordinates. Thanks to the staff of the LaGrange College Library in LaGrange, GA, USA for permitting access to the SPSS software programme.

⁵ * Indicates objectives which were partially accomplished or not accomplished. See Limitations under the Discussion section for an explanation.

2.7 Authors

Kristen DeCelle received a Bachelor of Science degree from Davidson College in 2006. She volunteered with LISAP from August 2006-August 2007.

Grey Sidira received a Bachelor of Education in Social Sciences degree from the University of Malawi. He has worked as LISAP's Monitoring and Evaluation Officer since 2006.

3 Methodology

3.1 Data Entry

A database was designed in Microsoft Office Access 2003 (11.5614.5606) and Microsoft Office Excel 2003 (11.5612.5606). Data was entered using both Microsoft Access and Microsoft Excel. Excel was useful for entering data requiring multiple rows per group such as IGA lists. Questions whose answers could be recorded in one row per group were entered in Microsoft Access.

After most questionnaires were administered, participants had the opportunity to give comments. All of the comments made at the end of the surveys were typed into Microsoft Office Excel (11.5612.5606).

3.2 Data Cleaning

Data typed into Microsoft Office Access was checked for accuracy by sampling ten percent of the groups from all project types. Answers on the questionnaires were compared to data entered into the computer program. All errors found were corrected right then.

Many of the locations collected on the GPS units were close together and would have appeared on top of one another on a map. Therefore, an attempt was made to show only the main areas on the map.

Groups being trained at the time of interview were omitted from analysis.

A preliminary list of community HIV/AIDS groups which had been interviewed was submitted to 3 zone coordinators and 2 program coordinators for these staff members to look at and decide whether there was an affiliation between LISAP and the group. For roughly 10 groups which were interviewed there was no indication from either LISAP staff or the group's responses on the survey that any affiliation to LISAP existed. These groups were therefore omitted from analysis. If either the groups' responses indicated an affiliation to LISAP or a LISAP staff member did not eliminate the group, the group was analyzed. In less than 10 cases, there were discrepancies between what the group said and what staff members indicated as far as affiliation to LISAP.

3.3 Data Analysis

Data was analyzed with SPSS Version 9.0. Frequencies were calculated for answers to all questions. Sum, mean, median, mode, standard deviation etc. were obtained for numerical responses.

4 Results

4.1 Numbers of LISAP-Affiliated Community Groups

Table 4.1-1 Number of LISAP-Affiliated Community Groups

Project Type	Number of Groups
Community Home Based Care	226
People Living with HIV and AIDS	29
Post-Test Club	5
Children's Corner	7
Community Based Child Care Centre	82
Orphan Care	140
Funeral Education	7
Marriage Counseling	21
Voluntary Counseling and Testing Motivators	12
Women's Group	31
Youth Club	101
<i>Total</i>	661

Figure 4.1-1 Number of LISAP-Affiliated Community Home Based Care (CHBC), People Living with HIV and AIDS (PLWA), and Post-Test Groups by Presbytery as of the End of October 2006

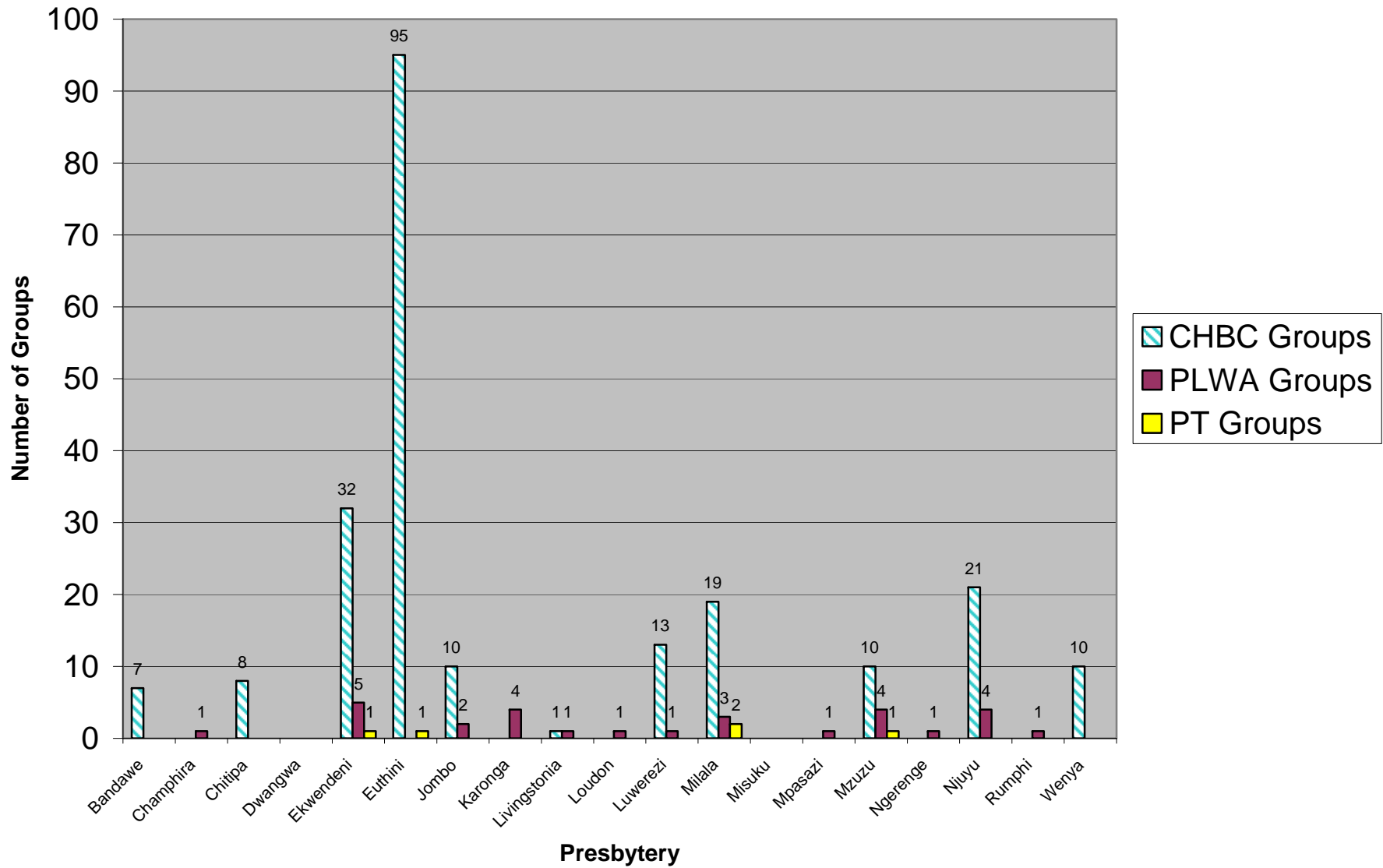


Figure 4.1-2 Number of LISAP-Affiliated Children’s Corner (CC), Community Based Child Care (CBCC), and Orphan Care (OC) groups as of the End of October 2006

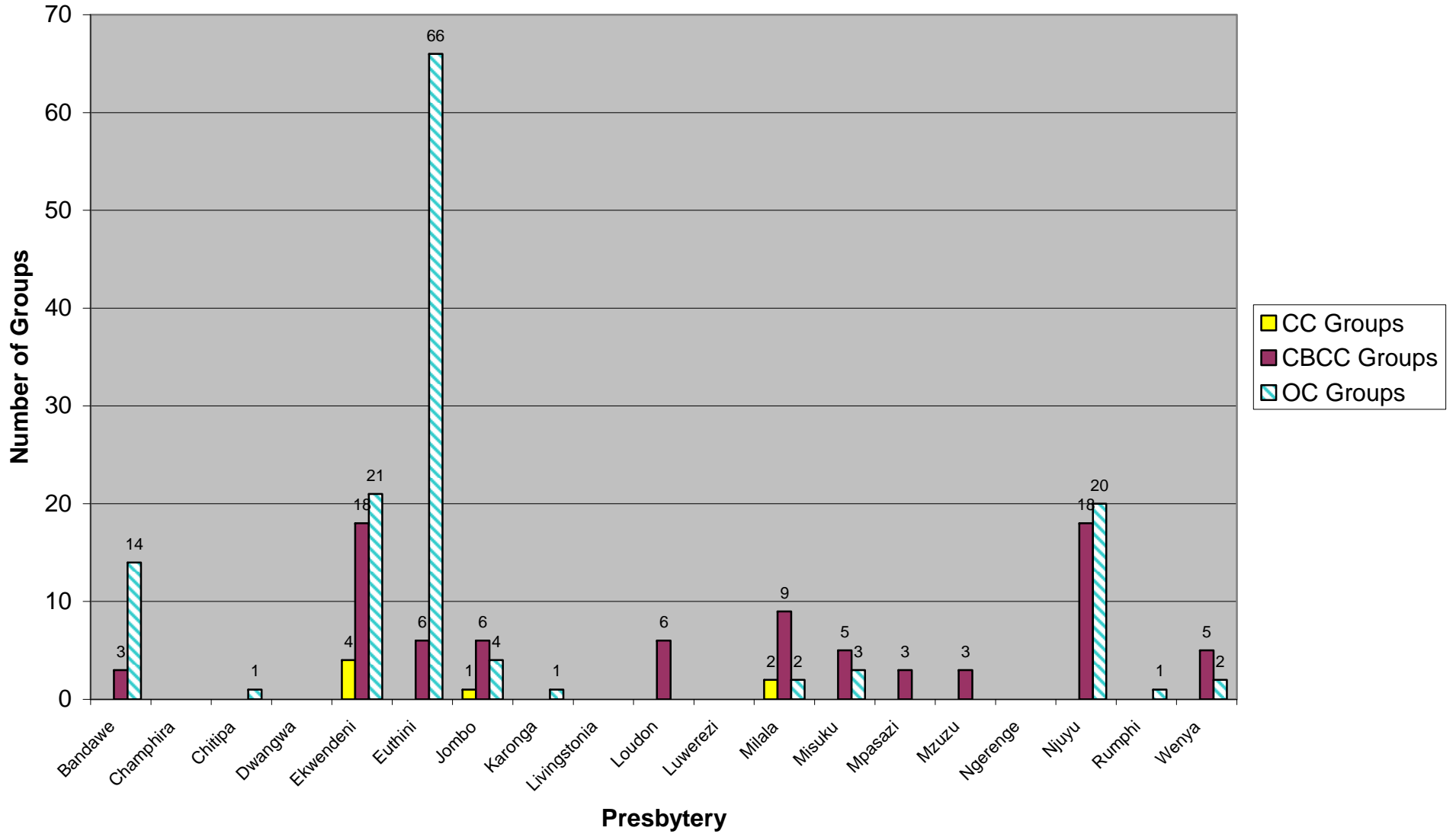
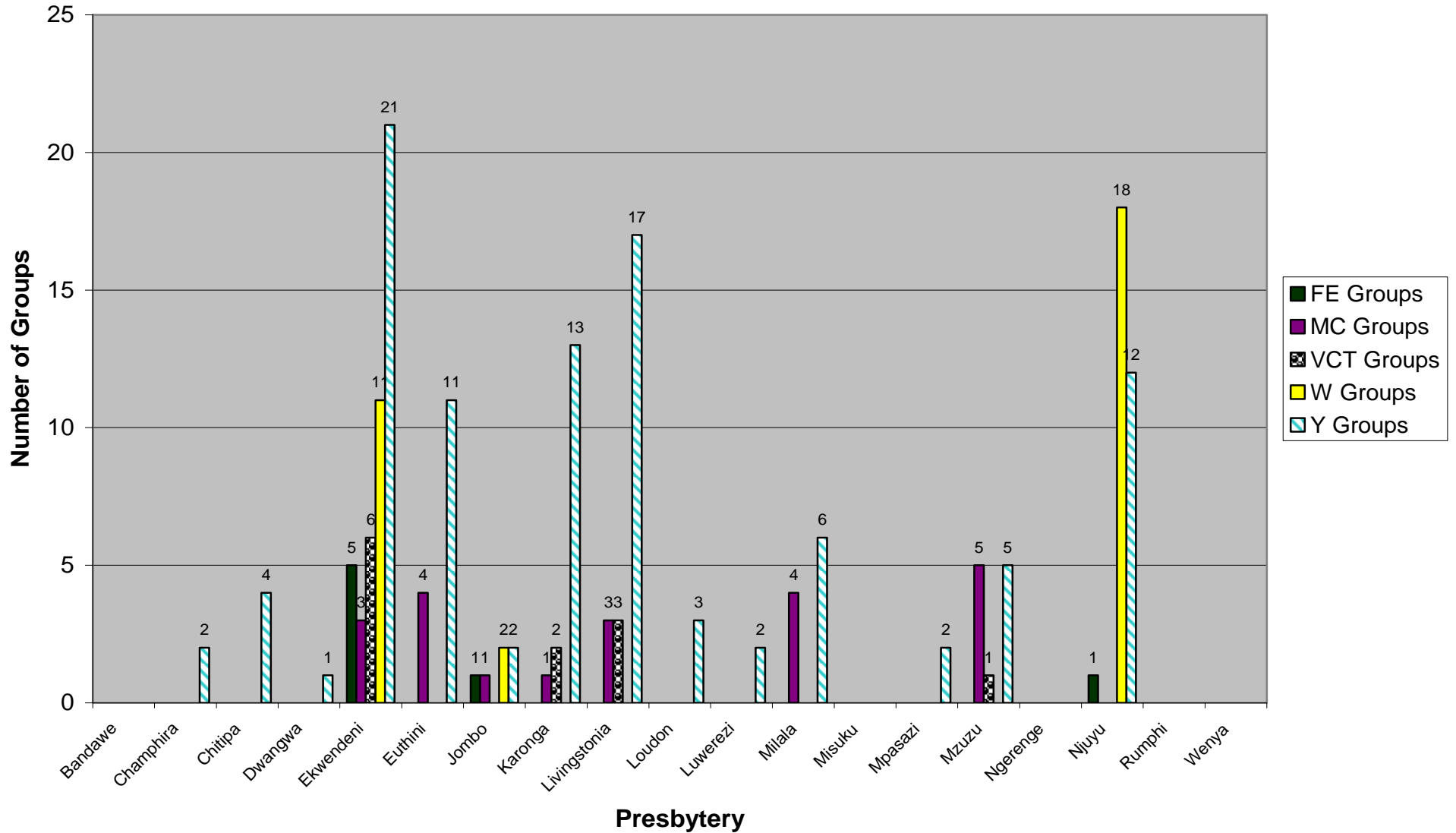


Figure 4.1-3 Number of LISAP-Affiliated Funeral Education (FE), Marriage Counseling (MC), VCT Motivators (VCT), Women’s (W), and Youth (Y) Groups as of the End of October 2006.



4.2 Numbers of Members and Caregivers in LISAP-Affiliated Community Groups

Figure 4.2-1 Number of Members and Caregivers in LISAP-Affiliated Community Groups by Project Type and Gender

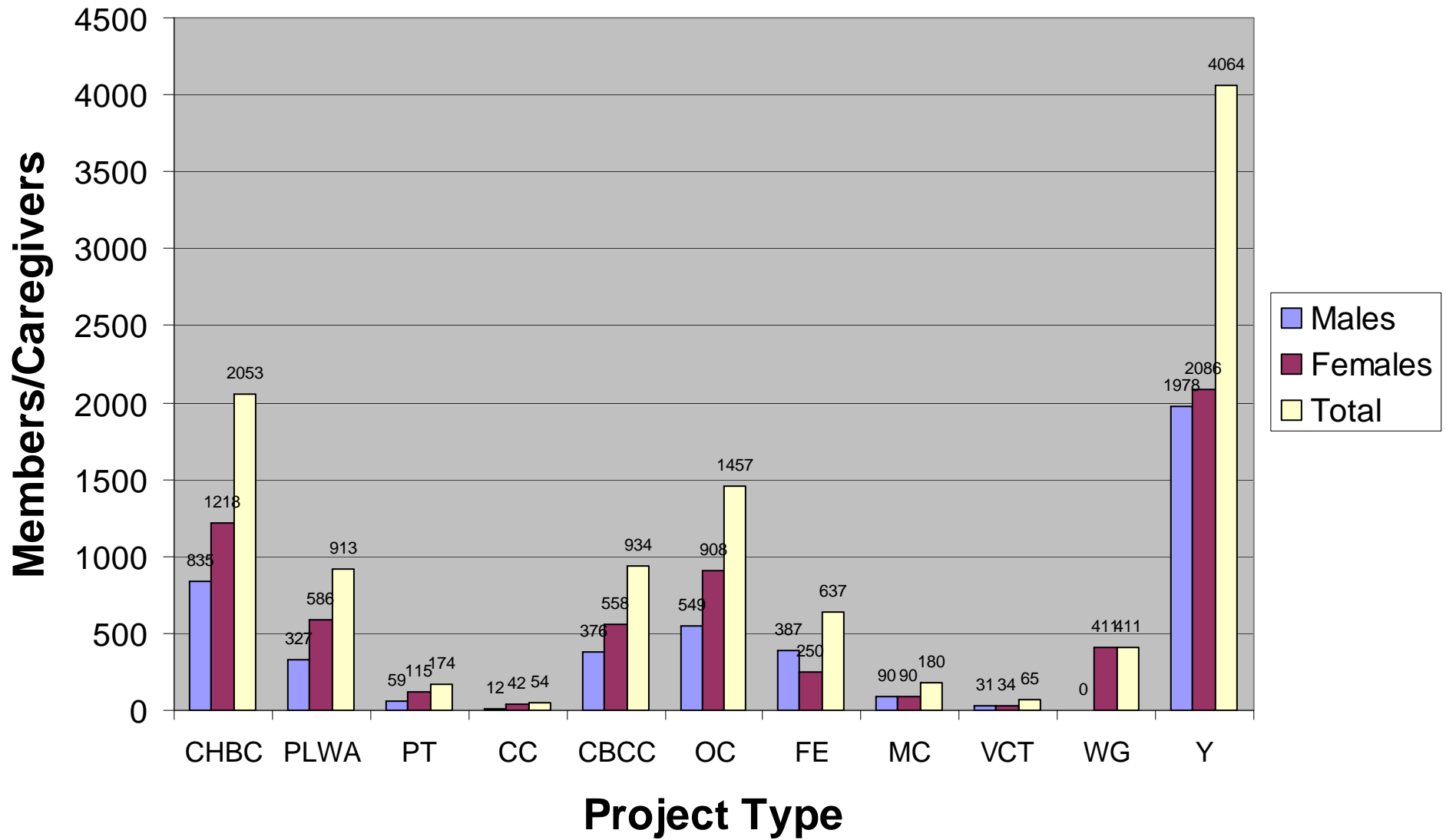
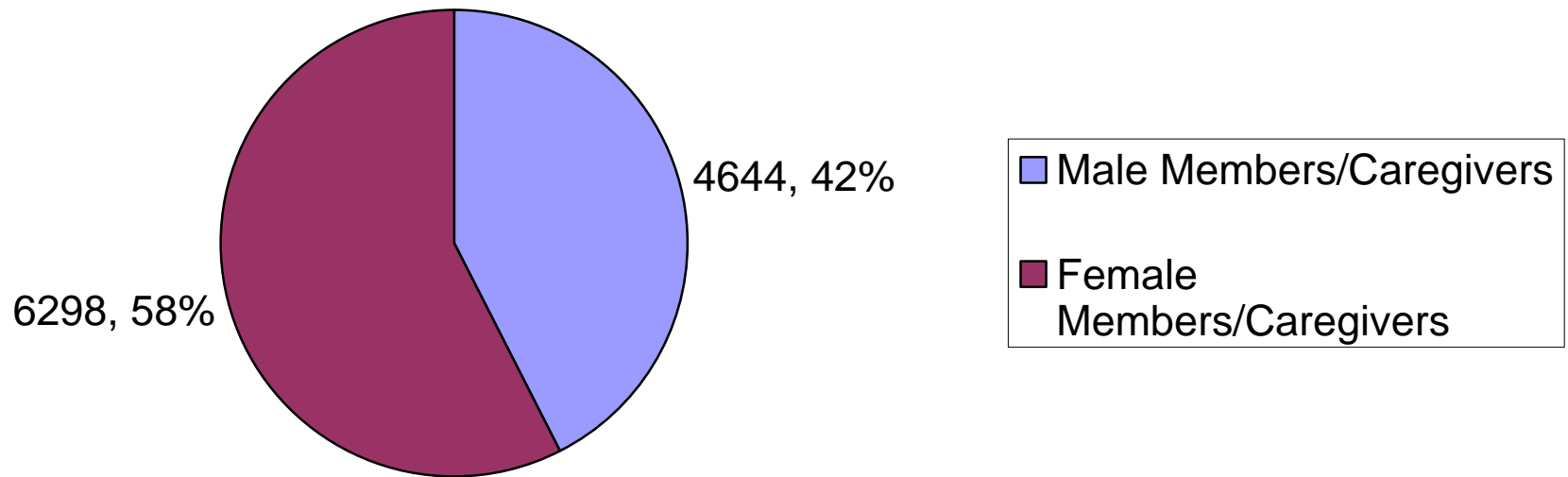


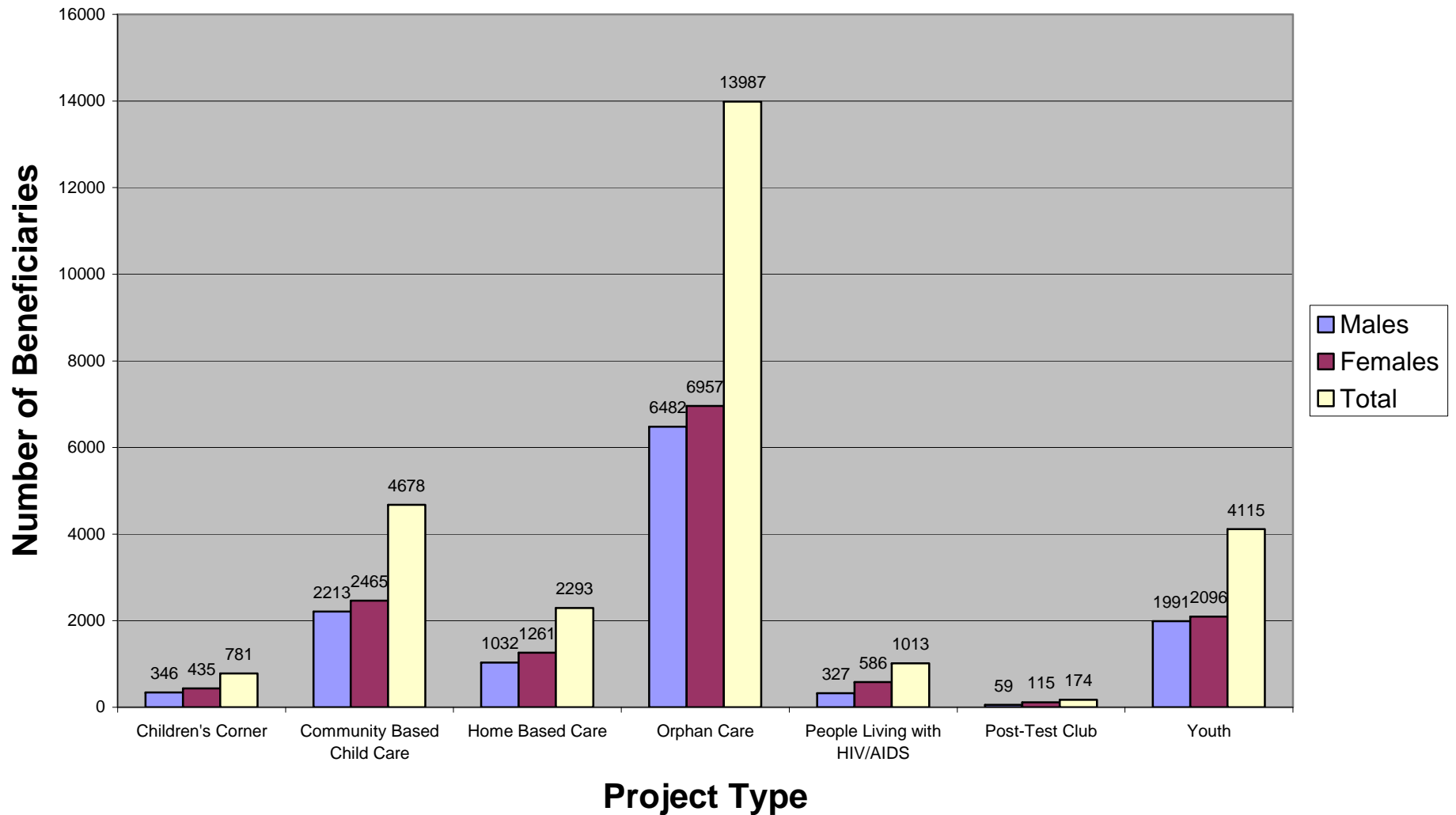
Figure 4.2-2 Number of Members and Caregivers by Gender



LISAP-affiliated groups have a total of 10,942 members/caregivers. Youth Clubs have the most members of any project type. The census showed that members/caregivers are 42% male and 58% female. Marriage Counseling has an equal number of male and female members. Funeral Education is the only project type where there are more male members than female members.

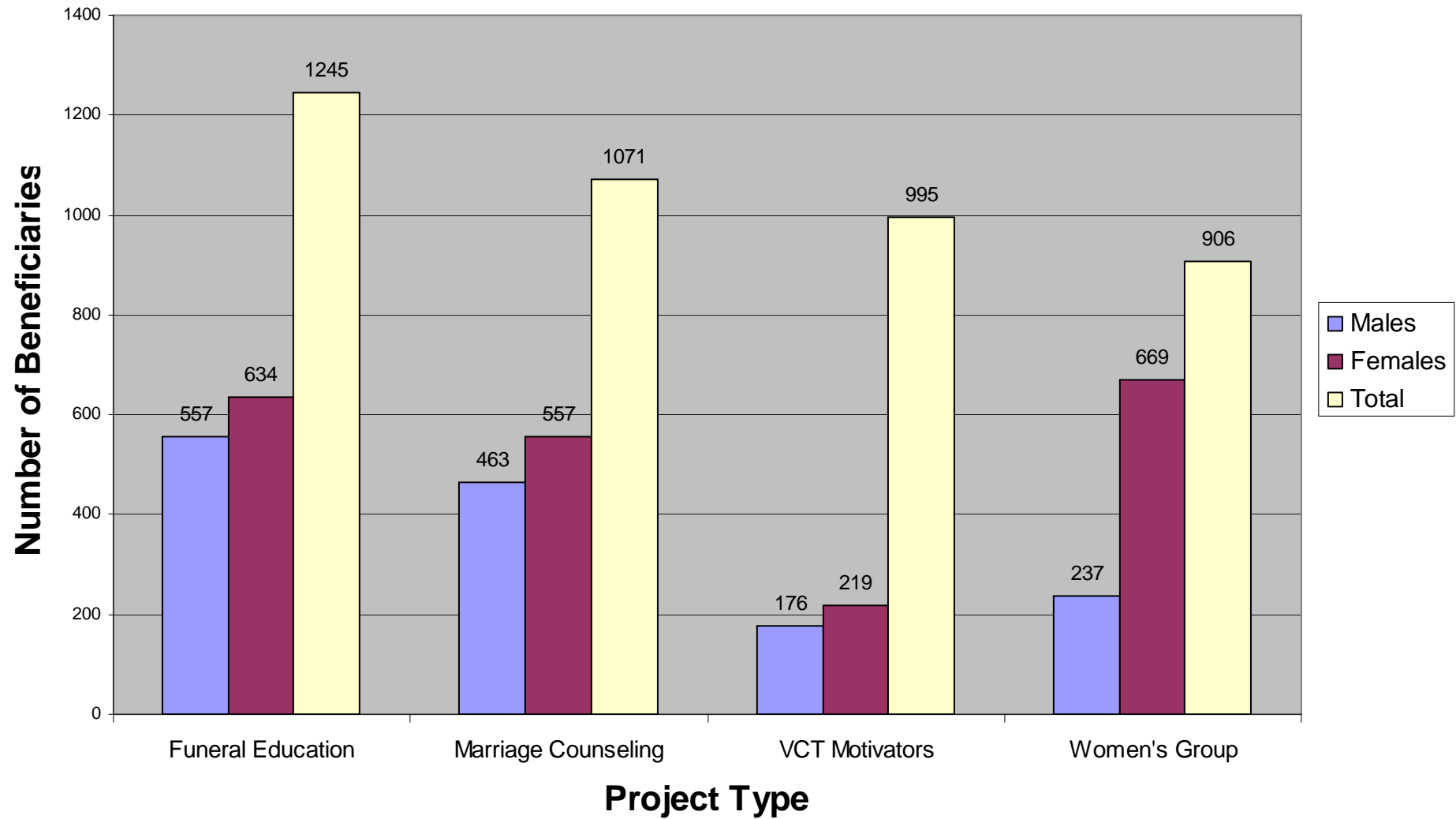
4.3 Beneficiaries

Figure 4.3-1 Number of Beneficiaries registered as of the End of October 2006



In Orphan Care, PLWA, and Youth there was at least one group which did not record total number of beneficiaries by gender and hence adding the male and female columns does not equal the total.

Figure 4.3-2 Number of Beneficiaries Reached in October 2006



In Funeral Education, Marriage Counseling, and VCT Motivators there was at least one group which did not record total number of beneficiaries by gender and hence adding the male and female columns does not equal the total. For VCT Motivators, the questionnaire never specifies that the people were reached in October 2006.

Figure 4.3-3 Number of Beneficiaries of LISAP-Affiliated Community Groups by Gender

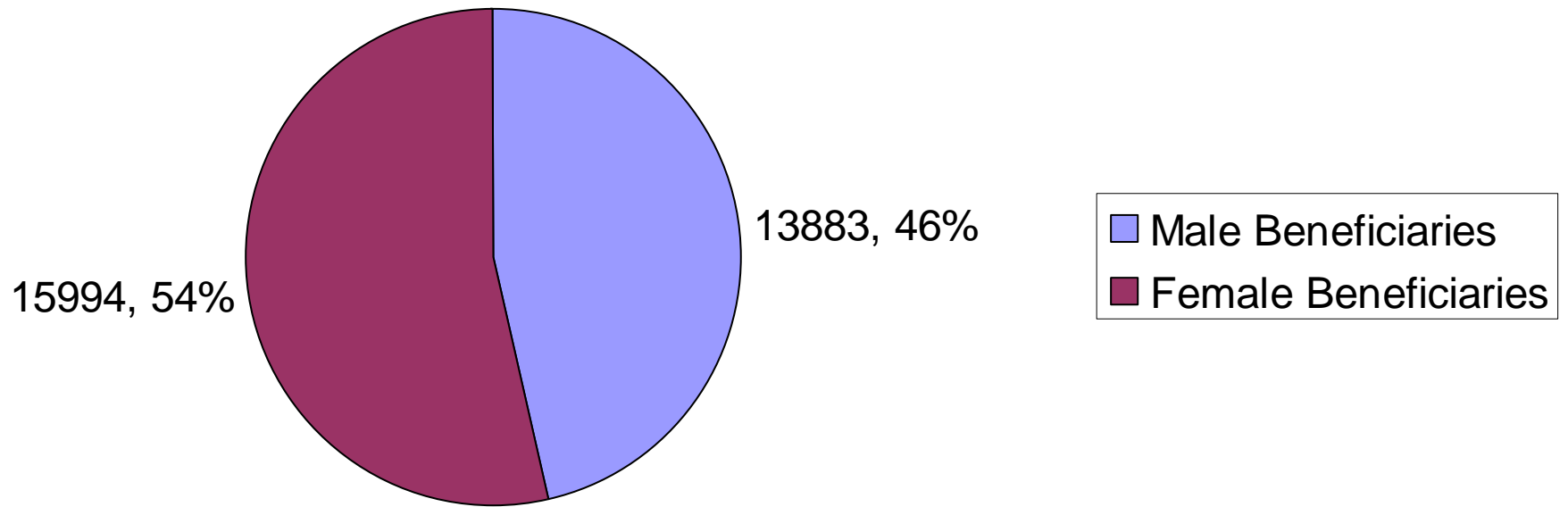


Figure 4.3-4 Number of Beneficiaries of LISAP-Affiliated Community Groups for Community Home Based Care (CHBC), People Living with HIV/AIDS (PLWA) and Post-Test Club Members

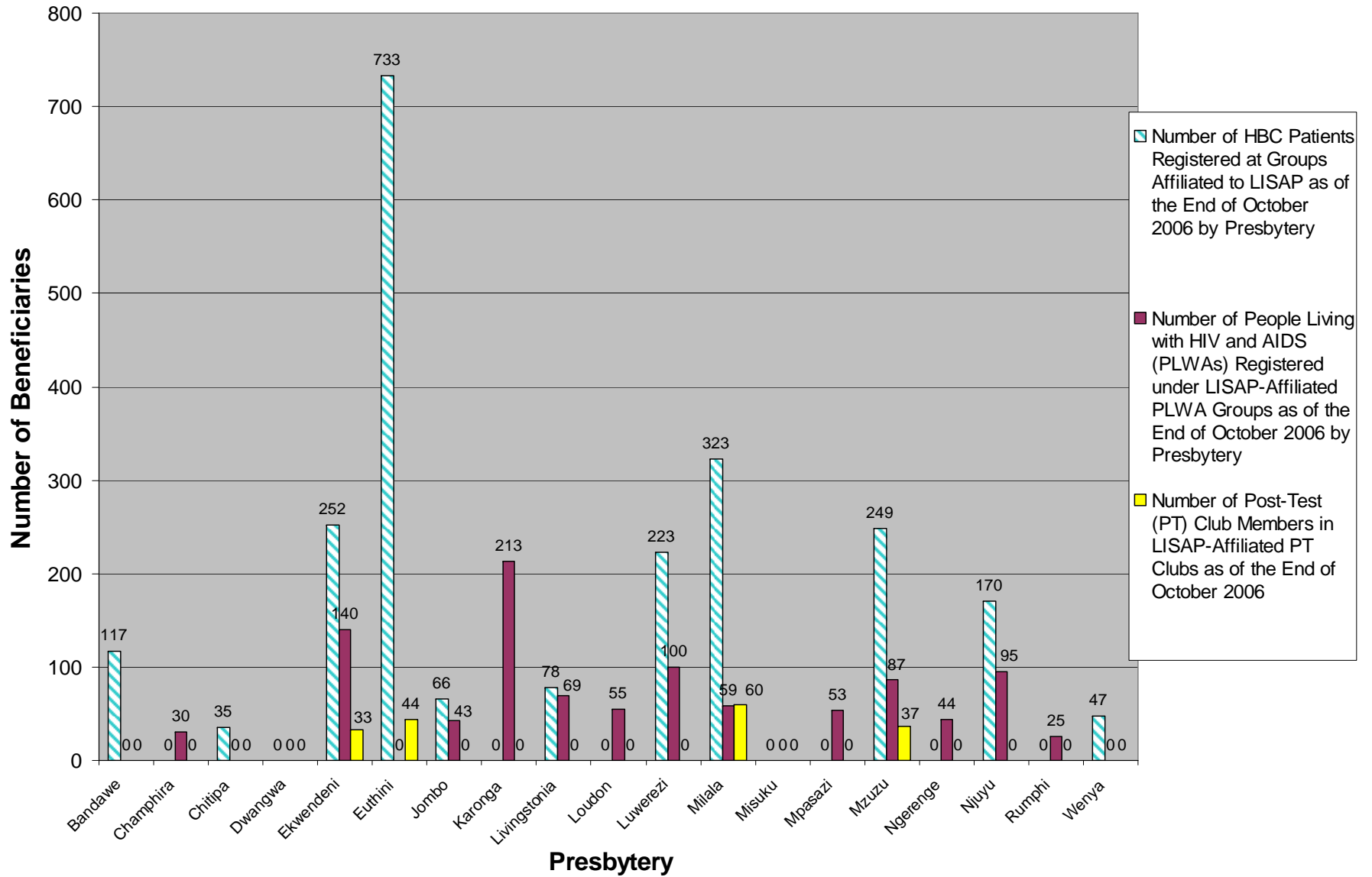


Figure 4.3-5 Beneficiaries of LISAP-Affiliated Community Groups for Children’s Corner (CC), Community Based Child Care (CBCC), and Orphan Care (OC) as of the End of October 2006

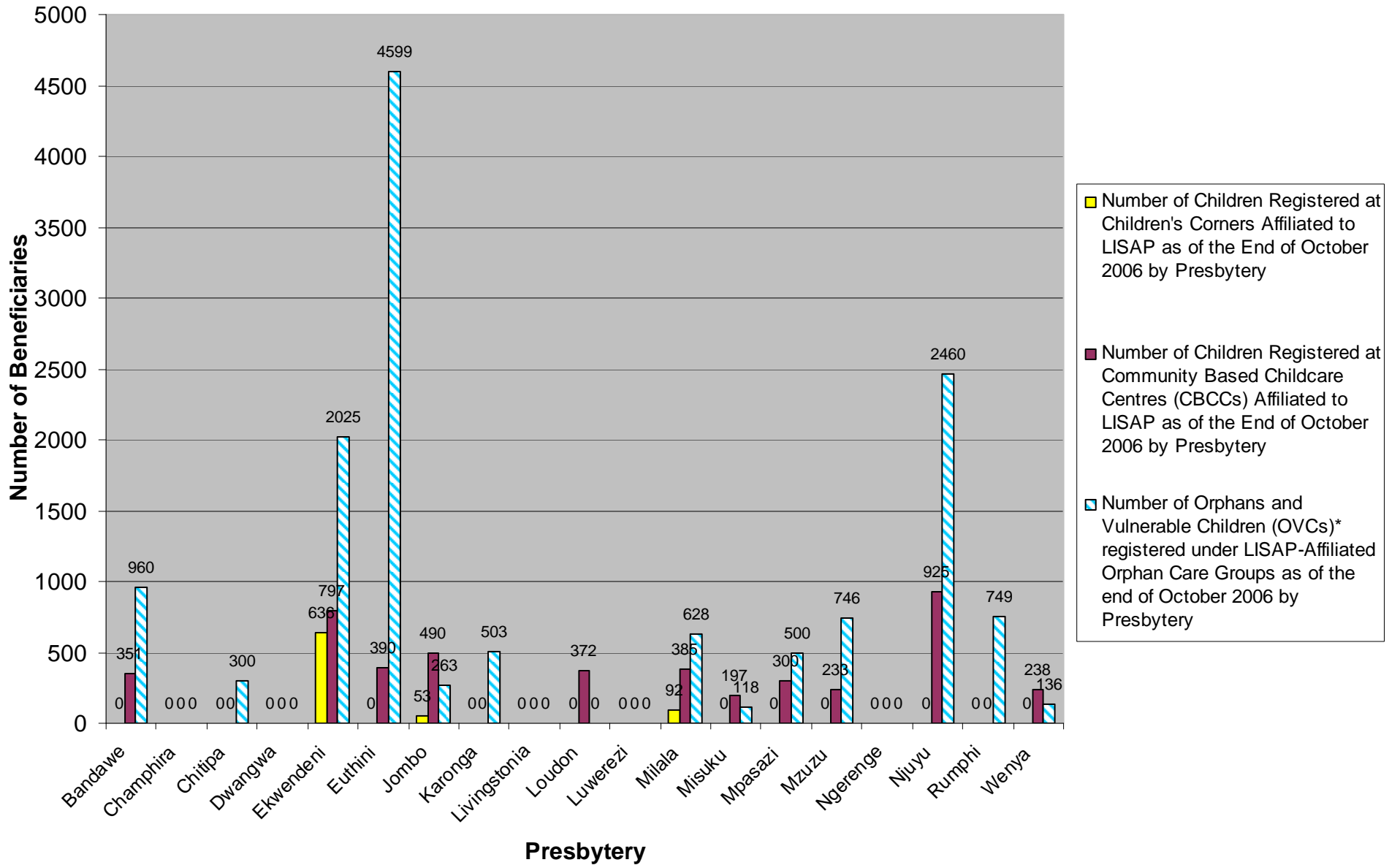
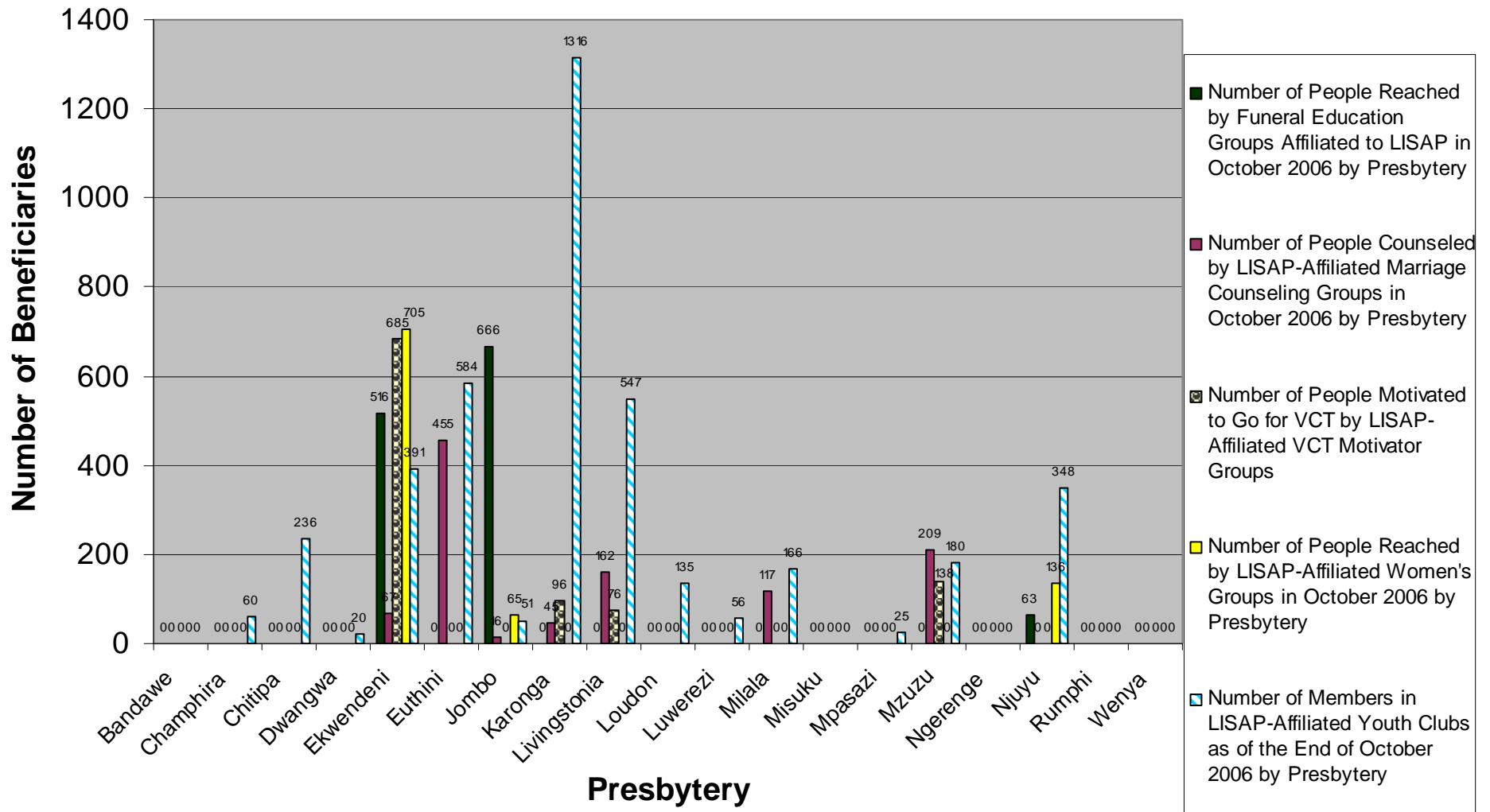


Figure 4.3-6 Beneficiaries of LISAP-Affiliated Community Groups for Funeral Education, Marriage Counseling, VCT Motivators, Women’s Groups, and Youth Groups



For VCT Motivation, the questionnaire never specified that the people were motivated in October 2006.

Figure 4.3-6 Number of Beneficiaries of LISAP-Affiliated Community Groups by Project Type

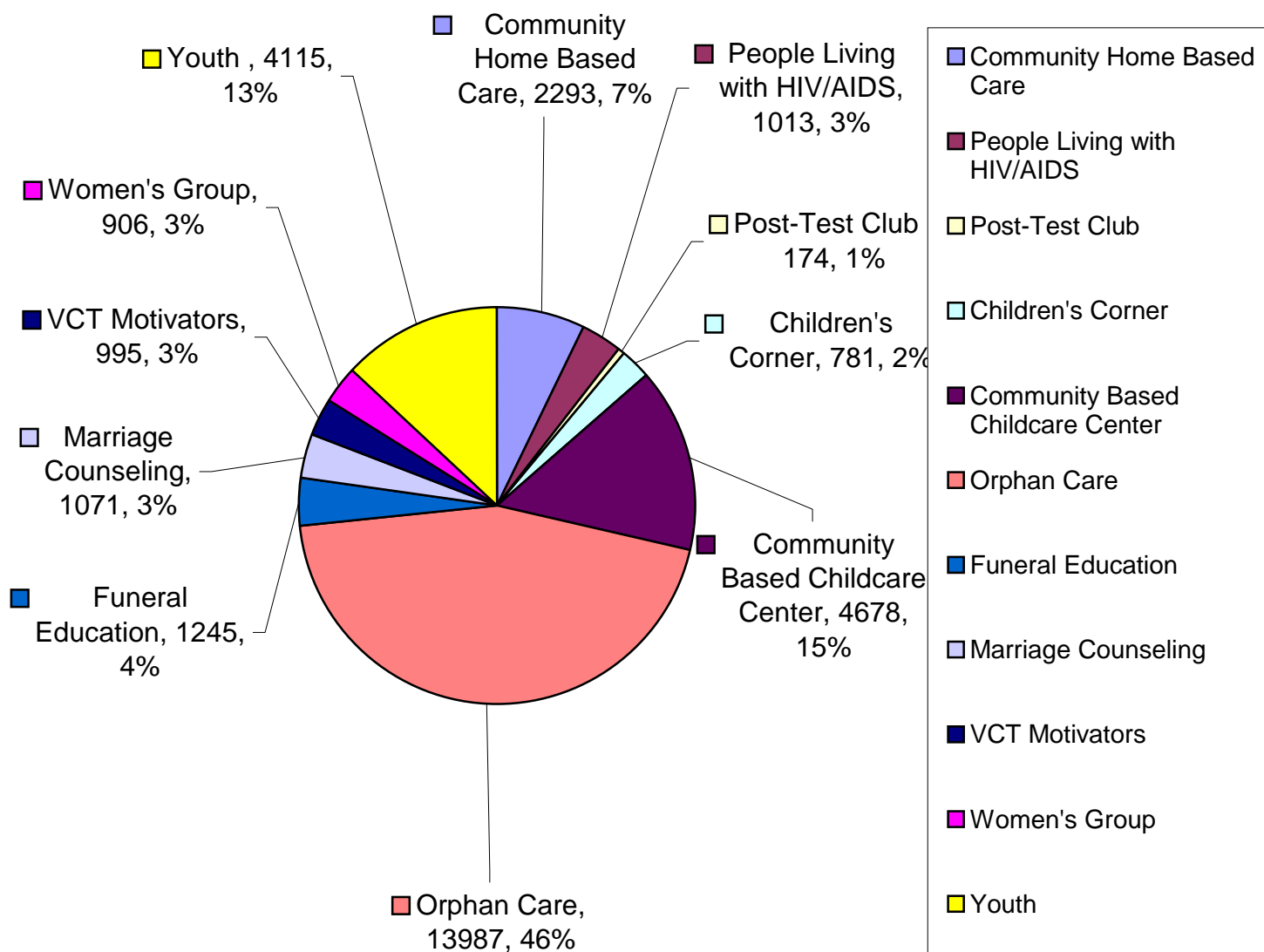
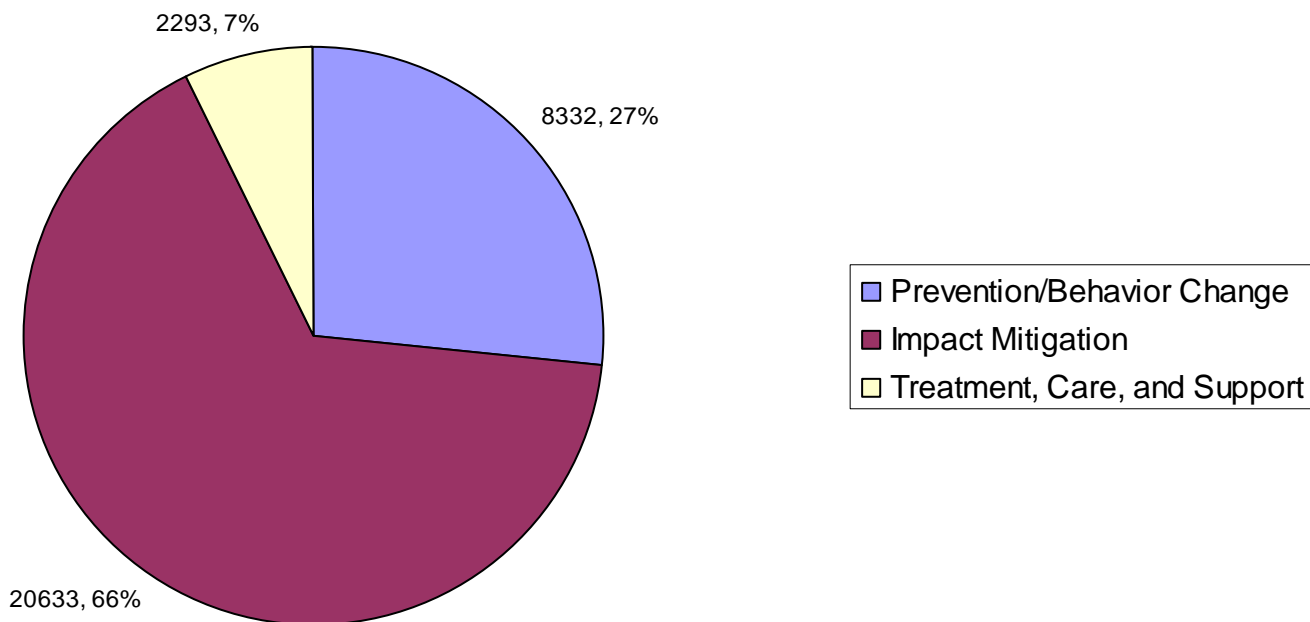
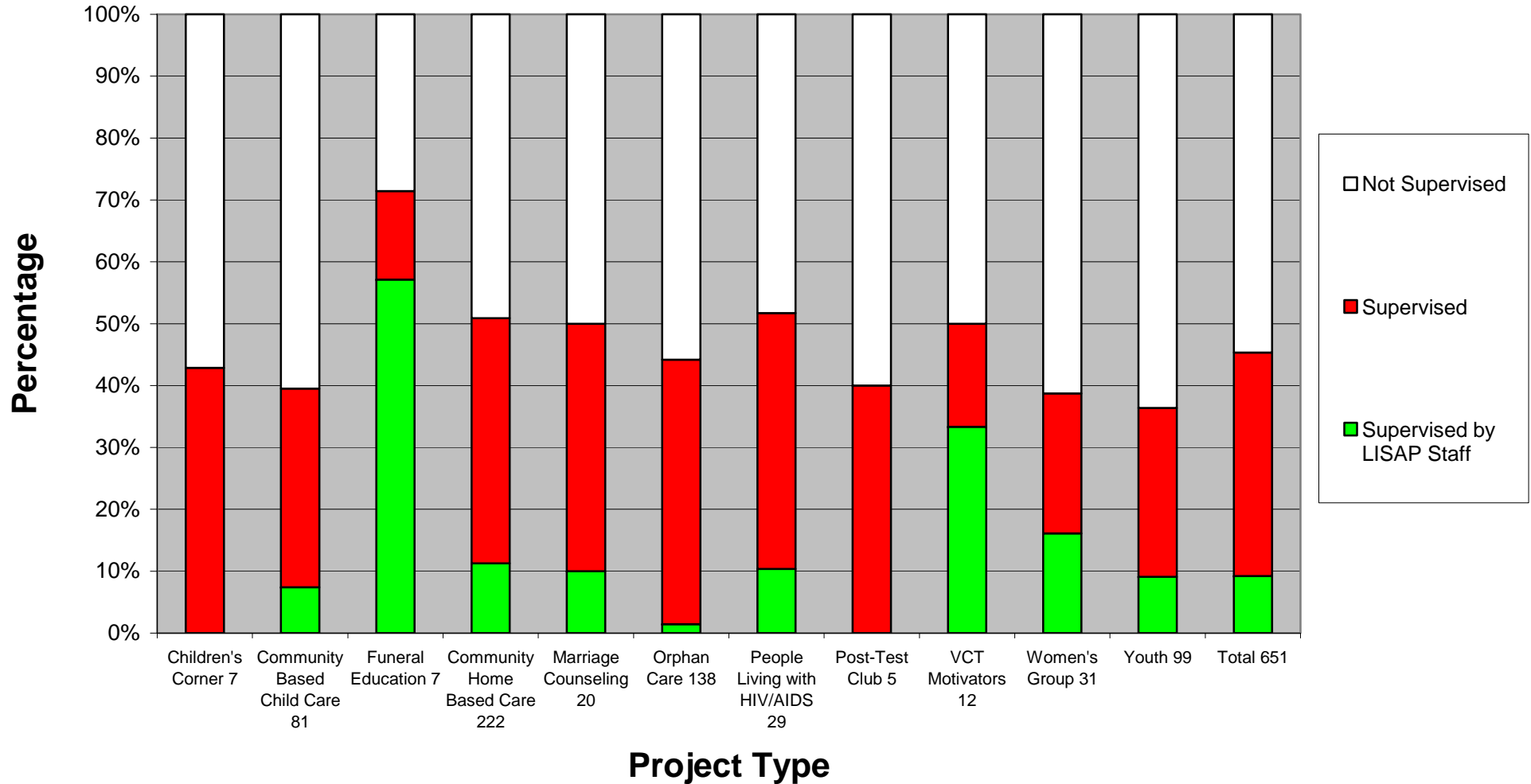


Figure 4.3-7 Number of Beneficiaries by Pillars



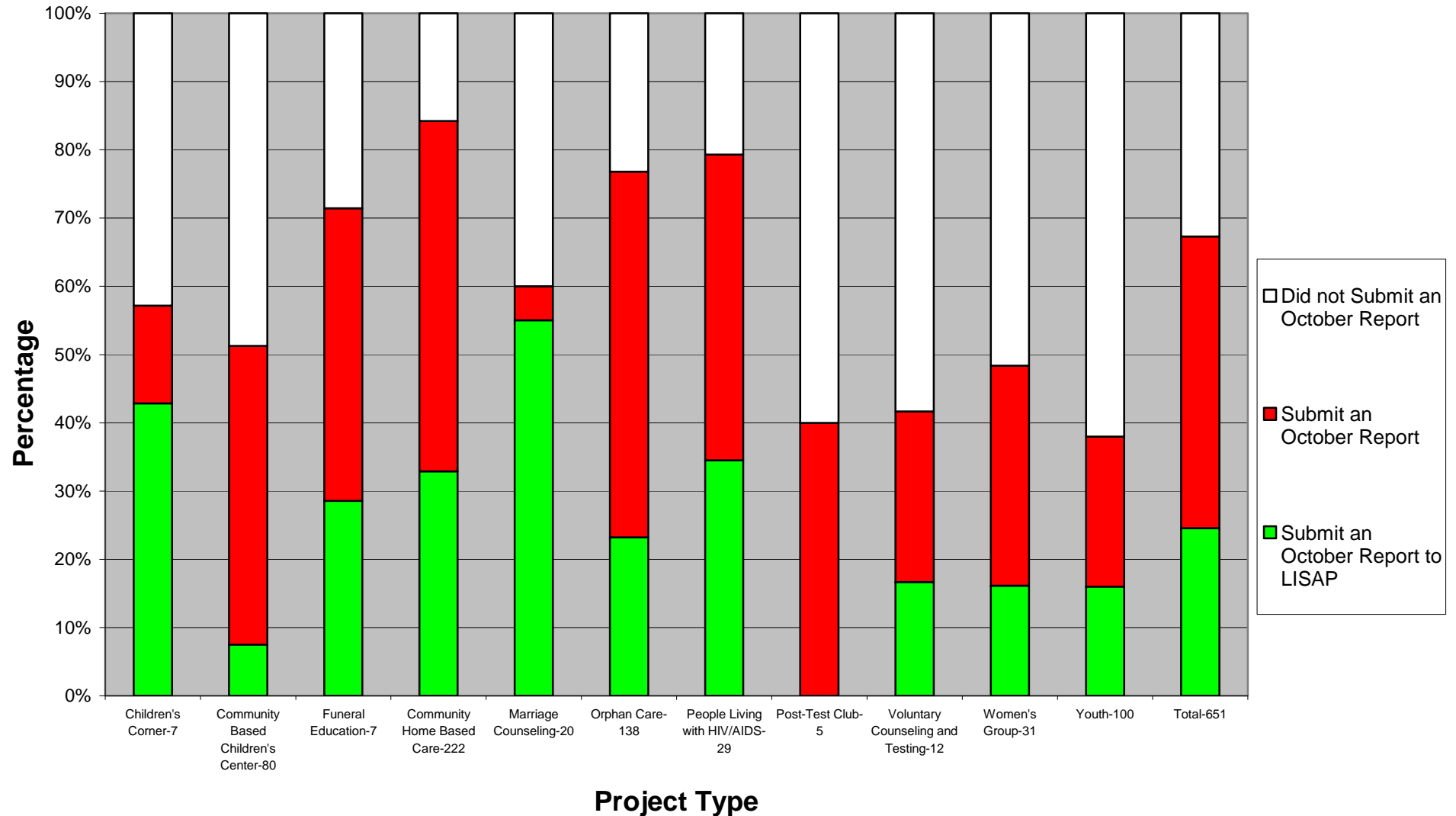
4.4 Supervision and Reports

Figure 4.4-1 Supervision of LISAP-Affiliated Groups in October 2006



Many LISAP-affiliated groups are supervised by individuals/organizations who are not LISAP staff members. Most groups are not supervised on a monthly basis. There are 10 groups out of the total of 661 for which data is not represented in this table either because the person interviewed was not sure whether the groups were supervised or there was no response to the question and significant other areas of the survey were omitted as well preventing data from this question from being ascertained.

Figure 4.4-2 Submission of the October 2006 Report*

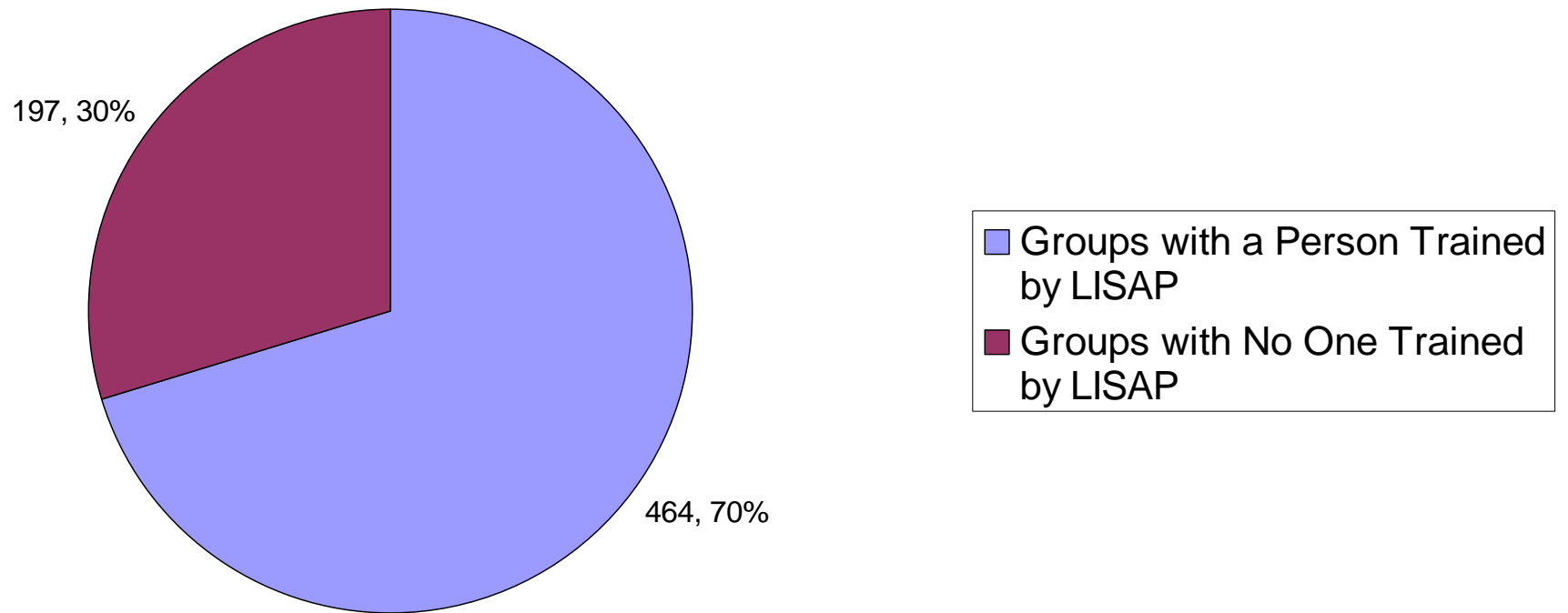


Most LISAP-affiliated groups submitted an October report although many submit the report to non-LISAP staff members. Ten of the LISAP-affiliated groups are not included in this analysis because the representatives interviewed either indicated they were not sure whether the group submitted an October report or in one case the representative did not answer the question and the group had no children registered.

*See the discussion on "Reporting" for a description of the confusion on the questionnaire wording.

4.5 *Trainings by LISAP*

Figure 4.5-1 Proportion of Community Groups Trained by LISAP



5 Discussion

5.1 Distribution of Groups between Project Types

Out of the 11 project types, LISAP has more affiliated groups in Community Home Based Care (CHBC) than in any other project type. This distribution most likely results from LISAP's frequent trainings in CHBC which has resulted in a lot of groups being affiliated with LISAP. Orphan Care has the second most number of groups, which is not surprising because Orphan Care is oftentimes done by the Community Home Based Care group.

5.2 Geographic Distribution of Groups

Funeral Education and Women's Group project types are only located in Central Zone, unlike the rest of the project types. The most geographically diverse project types are Youth Groups and PLWA groups which are in 14 and 13 presbyteries respectively. This distribution most likely can be attributed to when these groups were formed and whether there was funding available for trainings in the particular project type. If the groups were formed before the expansion in 2005 into the zones, then the groups were most likely closer to the main office of LISAP in Ekwendeni. LISAP's new vehicles as well as recent funding for trainings further away has also allowed for this dispersion of groups from the main office.

5.3 Members/Caregivers

The majority of members and caregivers of groups are women with the exception of Funeral Education. With funeral education, LISAP staff targeted village headmen. This target group helps to explain the male bias.

The fact that more females than males are members and caregivers suggests that females are more proactive in dealing with the HIV/AIDS problem. More women than men are members of PLWA groups as well as Post Test Clubs.

Since HIV/AIDS affects both men and women it is important that both genders learn ways to prevent the spread as well as care for those who are affected. Perhaps LISAP could target men with HIV/AIDS messages and/or try to encourage dialogue between the genders. At an HIV/AIDS Presentation and Discussion to Livingstonia Theological College in 2007, when the men were asked who had heard that a medicine was available to help prevent the spread of HIV from mother to child, no one raised his hand. If more ministers knew about this intervention, it may be able to be promoted in the church or in private counseling sessions.

5.4 Beneficiaries

LISAP-affiliated groups, according to the census, have 31,258 beneficiaries. Most of these beneficiaries fall under the impact mitigation pillar. Perhaps, mere quantity of beneficiaries is

not the best indicator of the work being done by LISAP's affiliated groups. For example, is counseling a person in marriage an equal intervention to providing a child with a bar of soap?

Taking these inherent discrepancies between the project types into account, LISAP needs to consider whether our current balance between project types is both meeting the needs in the community and fitting the current capacity that LISAP has. More research is needed to show whether impact mitigation is the most appropriate pillar that LISAP should be focusing on at this time. LISAP leaders should discuss whether they are focusing their energies appropriately given their capacity and the needs of the community.

The Orphan Care project type contained more beneficiaries than any other project. The beneficiaries for Orphan Care represent the number of orphans registered by a given group and not necessarily the number of orphans that the group visited in the month of October. More research would have to be done to clarify how many orphans a group was visiting in a given month. Similar clarification would also have to be done with home based care and the other project types in Figure 4.3-1 which show the beneficiaries registered as of October and not necessarily the number visited in October.

There was confusion regarding whether enumerators should include vulnerable children along with orphans in the counts of beneficiaries the community groups were reaching. If anything, our estimates of beneficiaries of children's projects may under represent the number of children being reached by the groups.

5.5 Reporting

Community Home Based Care and PLWA groups had a higher proportion of report submission than any other project type. Perhaps this high rate of submission could be attributed to strong governmental leadership regulating CHBC groups and PLWA groups. CHBC curriculum is regulated by the government and PLWA groups have supervision by the NAPHAM program. Perhaps this active involvement at a national level keeps the groups more active.

Marriage Counseling, Children's Corner and then Home Based Care had the highest percentage of groups submitting reports to LISAP. Because few organizations have marriage counseling programs, it makes sense that most of the groups who submitted reports, submit them to LISAP.

Most of the groups submitted an October Report, but less than half of those groups who submitted a report, submit a report to LISAP staff members. Future surveys should try to determine whether the people who are being given reports are volunteer supervisors for LISAP or another organization. It is possible that a greater percentage of the reports than are indicated in the charts were eventually given to LISAP, but because of the way the question was designed, it is impossible to know this. It would be helpful for future surveys to ask the organization for which an individual is receiving reports because just having an individual's name made these data difficult to analyze.

Furthermore, there was confusion on the survey regarding the wording of the question. The wording originally read, "Have you submitted a report in Oct?" It was discovered during an evening meeting that enumerators were asking this question two different ways. Some enumerators were asking whether the group had submitted a report in October while others were asking whether the group had submitted an "October report." The first version would allow for reports from any month before or including October. The second version would be more likely to elicit fewer people saying yes. Future surveys were printed with the latter version's wording.

Regardless of the confusion about which month's report was submitted, the data gathered still gives a good indicator of the relative frequency with which these groups are submitting reports. These data also indicate that LISAP-affiliated groups are most likely doing much more work than LISAP indicates to NAC in monthly reports.

5.6 Supervision

The least supervised projects by LISAP were Children's Corner, Post-Test Club, and Orphan Care. The low rates of Orphan Care supervision are particularly surprising given that many of the members of Home Based Care Groups work on Orphan Care also. Perhaps when LISAP was supervising Home Based Care, they did not ask about the Orphan Care activities of the group.

Surprisingly, Children's Corner had one of the highest report submission rates and one would also expect to have a high proportion of supervision if the report collection was done at the same time as supervision. Because, however, it was unclear which month the report was submitted in, it is impossible to say whether supervision coincided with report collection.

Fewer groups had been supervised than had submitted a report. Perhaps, the group may have submitted their report, but LISAP had not supervised the group. LISAP may have been picking up reports quickly and not had time to supervise.

While on the survey, it was discovered that many of the groups understand supervision as a time when an organization goes to the group individually in their own village to supervise them instead of meeting representatives from several groups in a central location. LISAP may be supervising more groups than are indicated in the survey but because we did not do so individually, the groups did not consider the visit supervision.

5.7 Trainings

Seventy percent (70%) of groups had someone who had been trained by LISAP in them. This proportion does not mean that only seventy percent of the groups had someone who had been trained. Other organizations had offered trainings to members of these groups.

One complicating factor of trying to understand what proportion of people had been trained comes from difficulty in identifying which trainings LISAP has offered. The types of trainings are inconsistent from project type to project type. For example, for Post-Test Club, the only type of training which was asked about was Positing Living. In contrast, PLWA groups had a list of 5 different possible trainings. In Community Based Child Care (CBCC), for example, there was

no specific type of training listed. Participants were just asked whether members or caregivers were trained.

5.8 *Limitations*

Several challenges were experienced during this census.

- **Inconsistent identification of groups as being “LISAP Affiliated”.** LISAP staff, intermediate supervisors such as HSAs and Volunteer Supervisors, and the community groups did not all agree which groups were affiliated to LISAP. For example, when given a list of community groups which were interviewed, LISAP staff members selected around a dozen groups which they said had no affiliation with LISAP. Looking at the data from those groups, however, revealed that many of these community groups had said that they had been trained by LISAP. The supervisor’s questionnaire attempted to collect data from the supervisors of LISAP groups, but the groups identified by the supervisors as being LISAP-affiliated differed so much from the groups which were interviewed as being LISAP-affiliated that the supervisor’s questionnaire was abandoned.
- **Cumbersome quantity of information.** The large quantity of information which was desired to be collected by the questionnaire designers proved to be cumbersome to collect, enter and analyze.
- **Clarifications to questions while in the field.** A few questions were discovered to not be specific enough to gather desired information and wording was clarified during data collection. Please see 8.2 in the Appendix for more information. One example of wording that was changed comes from the Home Based Care questionnaire. Enumerators originally had asked for the number of patients cared for in October, but groups did not keep such records. Instead, groups had recorded the number of patients registered as of October and so the wording of the question was changed to better correspond with the information which was available in the community.
- **Limitations of Definitions.** Not all community groups fit the definition of the eleven project types. For example, there was a widow’s care group, which did not fit the definition of a women’s group. There were adult peer education groups for which there were no questionnaires. There were some Orphan Care Centres, but they were doing activities that Community Based Child Care (CBCC) centres were doing. Some groups could have been grouped in multiple project types. For example, some groups incorporate HBC visits into their group’s activities. It would have strengthened the census to have asked the groups about their activities and for the enumerators to be more conversant with the definition sheet.
- **Some objectives were difficult to meet**
Quantity of trained and untrained members and who trained them - Some illogical data were collected in response to these questions. For example, in some cases, the total number of people trained was recorded as being fewer than the number trained by LISAP. Furthermore, different questionnaires asked the training questions in different ways which made comparisons difficult and may have contributed to the collection of illogical data.

Income Generating Activities (IGAs) of the groups - Many of the IGAs listed by the groups were not specific enough to be analyzed. For example, if the IGA listed was

"carrots" it was unclear whether the group was selling carrots they had grown, feeding the carrots to their clients, or buying carrots and selling them at a higher price. Furthermore, the questionnaire asked for income instead of profit which was not as meaningful.

Population size of the villages in which LISAP had affiliated beneficiaries/groups - In order to accomplish this objective we would have had to have matched village names from the questionnaires with the hundreds of villages listed from the HSA's, which would have been tedious. Furthermore, not all of the questionnaires asked for the villages in which the community group was working, and we were unable to get all of the necessary villages from the HSAs. Even if we had attempted this task, our result would have been incomplete.

Flow of information from the community group to LISAP - The supervisor's questionnaire was abandoned because of the discordance between the groups the supervisors said were LISAP-affiliated and the ones we interviewed. Therefore, the flow of information was not used from the supervisor's questionnaire.

It was hoped that all of the Presbytery HIV/AIDS Coordinators could be interviewed, but we did not succeed. Furthermore, the questionnaire which was designed for Supervisors was used for the Presbytery HIV/AIDS Coordinators and many of the questions about report collection did not make sense because these coordinators typically did not receive reports. The quantity of other information and the inconsistent questions with which the Presbytery HIV/AIDS Coordinators were asked resulted in the information from the Presbytery HIV/AIDS Coordinators to not be analyzed. Finally, information which asked about IEC materials was not analyzed.

- **Comments never analyzed.** Unfortunately, due to time constraints and complexity, the comments given to us by the representatives of the groups were never formally analyzed. Because of the format of the survey, it was difficult to discern which comment pertained to which group.

6 Conclusions

1. LISAP's affiliated community HIV/AIDS groups reached 31,258 people in October 2006.
2. LISAP-affiliated community groups have been documented in a list format by Presbytery and main area.
3. Females outnumber males as members of community-based HIV/AIDS groups.
4. Females outnumber males as beneficiaries of community-based HIV/AIDS groups.
5. Many of the LISAP-affiliated groups had links to other organizations through trainings, supervision, and/or report submission.
6. Most beneficiaries of LISAP-affiliated groups fall under the "Impact Mitigation" pillar. The next most popular pillar is "Prevention and Behavior Change" followed by "Treatment, Care and Support."
7. A map has been produced showing the quantity of beneficiaries of the 661 groups in 89 main areas.

8. LISAP staff supervised 9.2% of groups and received reports from 24.6% of groups for October 2006.

7 Recommendations

1. Find ways to increase male involvement in HIV/AIDS activities. Possible suggestions include: training more village headmen, encouraging males to join PLWA groups, and targeting Livingstonia Theological College students for HIV/AIDS messages.
2. Strategize how LISAP will supervise and receive reports from its affiliated groups. Will the programme attempt to supervise and receive reports from all of its affiliated groups? Once the programme decides which community groups it will receive reports from, the programme needs to decide how frequently it will receive the reports.
3. Decide the extent to which LISAP will use volunteer supervisors (HSAs, Church Volunteers, and other Community Volunteers) to provide information about the groups as opposed to collecting data firsthand from the groups themselves. In October 2006, LISAP staff supervised and collected reports from less than a quarter of its total groups. As LISAP develops its M&E system and decides the extent of supervision it would like to give, careful attention should be paid to division of supervision and reporting duties between the main office, zones, M&E Officer, and volunteer supervisors. A systematic schedule of supervision and reporting would enable greater efficiency and completeness of these tasks.
4. Make a checklist of the goals LISAP wants to accomplish in supervision.
5. Ensure that all of LISAP's affiliated groups know the reporting format.
6. Compile problems of the groups in a central database to better identify priority issues and propose solutions in technical staff meetings.
7. Decide whether LISAP wants to keep its main focus on the Impact Mitigation Pillar or increase its beneficiaries in the Treatment, Care and Support and Prevention/Behavior Change Pillars.

8 Appendices

8.1 Definitions

These definitions were created and/or checked before the survey by programme officers, HBC and BCI and assistant program officer for HBC and others. Copies were brought into the field on the survey.

1. **Home Based Care:** Holistic support (physical and spiritual) given to chronically ill patients right in their homes using local available resources. This assistance may include:
 - Medicine
 - Bathing patients
 - Washing clothes/ linen
 - Domestic work.
 - Psychosocial support
 - Food Support
 - Soap
2. **Children's corner:** A center where children aged 5-18 years, orphans and non orphans meet to learn artisan work, word of God, and information about HIV and AIDS. At the center, the children are grouped according to their age group. The Children's Corner is open only on Saturdays. The center typically opens around 8:00 am. Lunch is provided by the children's corner. At some centers lessons continue until 4:00 pm and at others only half day.
3. **CBCC:** A centre like a kindergarten where children 0-5 years are cared for whether orphan or non-orphan and learn simple maths, religious education songs, etc. every day. These centers typically serve tea and porridge when available. Children are screened or supported on health problems where possible.
4. **PLWAs :** People living with HIV who form a group to share experiences amongst themselves with the aim of promoting their life and encourage others to go for HIV test so as to know their sero status.
5. **Marriage Counseling:** Psychological support given by trained individuals to couples having troubles in their marriages. Through this support, counselors attempt to reunite the broken marriages.
6. **Funeral Education:** Teachings from traditional and religious leaders and local men and women in the community to break the silence on HIV and AIDS by counseling bereaved families to accept that their loved one died of HIV/AIDS.
7. **Post Test Club:** Group of people those who have under gone an HIV test whether positive or negative who try to encourage more people to undergo an HIV test in their respective communities.
8. **Women group:** Group of women trained in modifying some of the harmful cultural practices in different communities. These women often assist in supporting HBC patients and orphans in the community.
9. **Psychosocial support:** Assistance given to people which attempts to meet their spiritual and emotional needs. Any visit by a person which does not involve bringing medicine, food,
10. **Orphan care:** Support given to children ages 0-18 whose parent or parents have died. This service is sometimes a branch of HBC Committee that offers assistance to orphans. This service is not done through a center unlike CBCCs and Children's Corner. Orphan Care committee assists guardians of orphans under 2 in providing milk, medical care, and other necessities. In some places orphan care is completely separated from HBC

11. **Supervise:** To assist a group in solving their problems. To collect information about what the groups are doing.⁶

8.2 Links to Questionnaire Information

To view the 12 questionnaires please go to:

<<http://www.kristendecelle.com/resources/NAC+Questionnaire+26.11.06.pdf>>

To view the question clarifications made during the survey please go to:

<<http://www.kristendecelle.com/resources/Question+Clarifications+Made+During+the+NAC+6.3.1+Survey.doc>>

⁶ During a few discussions about the survey, it was revealed that the objectives of supervision were not clear and therefore a recommendation has been made for LISAP staff to clarify the goals of supervision.