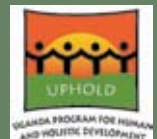


COMMUNITY HIV COUNSELLING AND TESTING

A Handbook on Participatory
Needs Assessment



USAID
FROM THE AMERICAN PEOPLE



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COMMUNITY HIV COUNSELLING AND TESTING

A HANDBOOK ON PARTICIPATORY NEEDS ASSESSMENT

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List of Acronyms

ARVs	Antiretrovirals
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
COVCT	Community-Owned Voluntary Counselling and Testing
DHAC	District HIV/AIDS Committees
FGDs	Focus Group Discussions
GIPA	Greater Involvement of People with AIDS
HCT	HIV Counselling and Testing
IGA	Income Generating Activities
IEC	Information Education and Communication
KI	Key Informant Interview
PLA	Participatory Learning and Action
PLWAs	People Living with AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PRA	Participatory Rural Appraisal
RRA	Rapid Rural Appraisal
TBAs	Traditional Birth Attendants
TASO	The AIDS Support Organisation
UPHOLD	Uganda Programme for Human and Holistic Development
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing

Acknowledgements

This field handbook on participatory learning and action is a product of inputs from various individuals and institutions.

Through UPHOLD, USAID provided support to AIC to conduct the first pilot on participatory learning and action for community-HIV counselling and testing needs assessment in Kayunga District. Our special thanks and appreciation go to AIC for the initial ideas on the need to develop a community-HIV counselling and testing approach. We would also like to recognize Dr Nosa Orobato (former Chief of Party-UPHOLD) whose ideas were very useful in the conceptualization and formulation of this Community-Owned HIV counselling and Testing (COVCT) approach to address HIV/AIDS and its challenges.

The UPHOLD HIV/AIDS technical team reviewed and provided inputs for improving this Handbook.

Our sincere appreciation goes to District Officials and the residents of Nyondo and Kakoola villages in Kayunga District for their participation in the pilot work that generated the various illustrations used in this manual.

J. Kasaija
X. Nsabagasani
May 2007

Foreword

In Uganda HIV Counselling and Testing (HCT) has traditionally been offered at static sites and mobile clinics, although of recent, new approaches such as home-to-home have been introduced. To a large extent these approaches have increased HCT coverage. However, there are still challenges of access, follow up and support to people living with HIV/AIDS. It is worthwhile to note that although communities and family members are the main providers of socioeconomic support to people living with HIV/AIDS, the traditional HCT approaches have not empowered communities to learn, plan and deal with the problem of HIV/AIDS. The approaches have not adequately equipped communities with information and strategies to cope with this kind of responsibility.

This handbook is therefore meant to provide guidance for conducting community needs assessment for HIV/AIDS initiatives and HIV counselling and testing in particular. It provides a menu of tools from which development agencies/service providers can choose to facilitate planning for access, utilisation of HCT services; and care and support initiatives at community level. The strength of this handbook is that it blends participatory learning and action approaches to enable the user put HIV/AIDS programming on the community agenda. It contextualises HIV/AIDS beyond the (traditional) health facility level, hence enabling consideration of the social economic factors in HIV/AIDS interventions.

The Uganda Programme and Holistic Development (UPHOLD) is happy to recommend to partners in the struggle against HIV/AIDS this handbook that provides guidance on how to engage communities to assess, analyse and take responsibility for collective mobilisation and mitigation of the effects on HIV/AIDS through a community approach. The handbook projects an appreciation of community competencies in mobilising for HCT and shows the numerous benefits that individuals and communities would get from HIV/AIDS community based interventions.

This handbook is a testimony to UPHOLD's continued commitment to enhance the capacity of partners to widen their out reach and make a difference in the lives of people living with HIV/AIDS, their families and communities at large. We would like in a special way to appreciate the contribution of AIDS Information Centre (AIC) to this handbook. UPHOLD encourages all partners engaged in the struggle against HIV/AIDS to utilise the information contained in this handbook as we all work towards preventing and mitigating the impact of HIV/AIDS.

Samson Kironde
CHIEF OF PARTY, UPHOLD

Introduction

Community HIV Counselling and Testing (COHCT) is an approach that utilises existing community competencies in dealing with HIV/AIDS in general, and HIV counselling and testing in particular. The COHCT concept is premised on the knowledge that HIV counselling and testing is an entry point into HIV prevention, care and support and that communities have a primary role to play in the HIV/AIDS intervention. The approach utilises participatory methodologies to engage community members in analysing their HIV/AIDS situation, and, from the existing social mechanisms and structures, identify the options that would enable them mobilise for HCT and thereafter deal with the usual outcomes of HIV test: These including enabling those who are positive to negotiate their new status, and disclose to significant others, supporting prevention of infection for those who test negative, and protecting the positive from reinfection, stigma and providing for their necessary care and support. Below is how COHCT would work.

- a) A development agency mobilizes the community through their local leaders (e.g. LCs) to engage in HCT needs assessment (using participatory learning and action—PLA—techniques; they are discussed in this handbook).
- b) Through a participatory process the community identifies their HCT needs to address the problems at hand.
- c) The development agency links the community with a health facility that will offer facility-based, home-to-home or outreach-based HCT to community members.
- d) The development agency plays a facilitatory and coordinating role in enabling the community to identify and utilize their own competencies in the implementation of the COHCT programme.
- e) The development agency agrees with the community on areas for capacity building and strengthens them in this aspect. Capacity building may include mobilization skills, training in peer counselling, rapid HIV testing, orientation in home based care among others.

COHCT Needs Assessment

COHCT needs assessment refers to the process through which community members are supported to assess their HIV counselling and testing needs in order to identify the key problems, and develop an action plan to address those needs. This handbook is meant for those planning to implement the community HCT program. It provides basic conceptual explanations and guidelines on how to conduct a COHCT needs assessment as an entry process for community planning for HIV counselling, testing, care and support.

Objectives of the Handbook

This handbook has two major objectives which are to demonstrate:

- How selected participatory learning and action tools can be used in conducting a needs assessment for COHCT; and
- How information generated out of the application of different PLA tools can be synthesized to come up with community action plans

This handbook is organised into five modules. It starts with an introductory module that deals with COHCT concept and its role in putting HIV counselling, testing, care and support on the community agenda. It specifically explains how the community interacts with a development agency to mobilize, analyze and plan for HIV needs/problems. It further explains why the participatory learning and action methodology is the best to use for COHCT needs assessment.

The other modules take the user through a step-by-step approach to understanding COHCT needs assessment. **Module II** is an expository presentation that focuses on the participatory learning and action (PLA) methodology, in the context of HIV/AIDS. It takes the user into the key planning issues to be considered before embarking on a COHCT needs assessment.

Module III provides a menu of PLA tools that the user can use to engage the community in analyzing its own HIV situation. This module discusses different tools that can be utilized to enable community members to identify problems around them, analyze them in relation to HIV and identify possible solutions. It also provides illustrations on experiences from a similar exercise that was conducted in Kayunga District.

Module IV focuses on data analysis and reporting. It explains how PLA data is analysed and also gives tips on what to consider when writing a field report.

Module V gives a step-by-step guide on how to facilitate community planning while using data generated from the COHCT needs assessment.

How to use this handbook

This handbook should be used like a menu or source for information on various participatory learning and action (PLA) themes and techniques that can be used in the preparation of COHCT needs assessment. The handbook does not provide fixed or rigid approaches to needs assessment; rather, the user is encouraged to selectively look for relevant tools as the situation may warrant as long as one adheres to participatory learning and action (PLA) principles.

MODULE I

THE IMPORTANCE OF COHCT AND PARTICIPATORY LEARNING AND ACTION

Rationale for COHCT

In Uganda, HIV Counselling and Testing (HCT) has been delivered at static sites and by mobile clinics. This approach—in spite of its many pay offs in terms of the number of people counselled and tested—has had limitations. The outstanding limitation is that facility-based HCT providers cannot cater for the emerging social and economic challenges that make it difficult for people to cope with the HIV test results.

On the other hand, communities and family members have always provided support to those who test for HIV and find themselves in need of different forms of support. Typically, however, these communities are not properly or adequately equipped with information to deal with this kind of responsibility. It is in this context that the COHCT approach becomes relevant in addressing social economic needs of HIV clients beyond the health facility. It is envisaged that when COHCT is well implemented, it will result in:

- Increased awareness on HIV and AIDS;
- More people supported to maintain their HIV-negative status;
- More people with positive behaviours directed towards HIV prevention.
- A sufficiently mobilized community utilizing HCT services;
- Increased understanding and support for people living with HIV by family and community members;
- Willingness by community members to mobilize resources (human, financial and time) towards supporting one another and hence reduce the impact of HIV and AIDS.
- An empowered team of people living with AIDS (PLWAs), able to stand out and disclose.

The need to complement social systems

In Uganda, it is a tradition for family and community members to look after the sick, the orphans and the elderly. With the advent of HIV/AIDS, this

traditional role has turned into a burden which has increased tremendously. Nevertheless, family and community members continue to be the main reliable and sustainable structures that voluntarily look after these vulnerable categories of people. Since people living with HIV spend most of their time with family and in the community, it has increasingly become important to explore ways of providing support to these institutions so that they are able to cope with the responsibility of looking after the sick. Social self-help initiatives like Muno Mukabi (friend in need) burial groups, and revolving funds for income generating activities (IGAs) are examples of structures that can be utilized to enhance the community's ability to cope with the AIDS scourge, and provide both financial and psychological support to members. These opportunities can be amplified with institutionalization of COHCT.

Increasing need for community dialogue

Counselling and testing is not an end in itself. It provides information, options and choices that if adopted can lead to positive behaviour and consequently a reduction in the transmission of HIV. Community dialogue is a communication approach that allows open discussion (specifically on HIV/AIDS) by men, women, girls and boys in a manner that promotes cohesion and mutual appreciation of issues concerning them. There are a number of sensitive issues and challenges that have emerged in the context of HIV/AIDS, which traditional communication approaches cannot adequately and effectively deal with. The sensitive issues include disclosure of HIV results between couples/spouses on the one hand, and parents and their children on the other. Others include the sexual practices that are expected as a result of learning one's own HIV status.

COHCT provides an opportunity to engage in community dialogue. The high-level involvement of community members in planning and managing HCT is a great opportunity for community dialogue on a range of HIV-related issues that would otherwise be ignored. It is therefore hoped that through community dialogue around the prevention of HIV will be increased through the COHCT approach. At the same time, more avenues for care and support—as well as treatment for those who are sick—will be enabled.

Putting HIV/AIDS on the community agenda

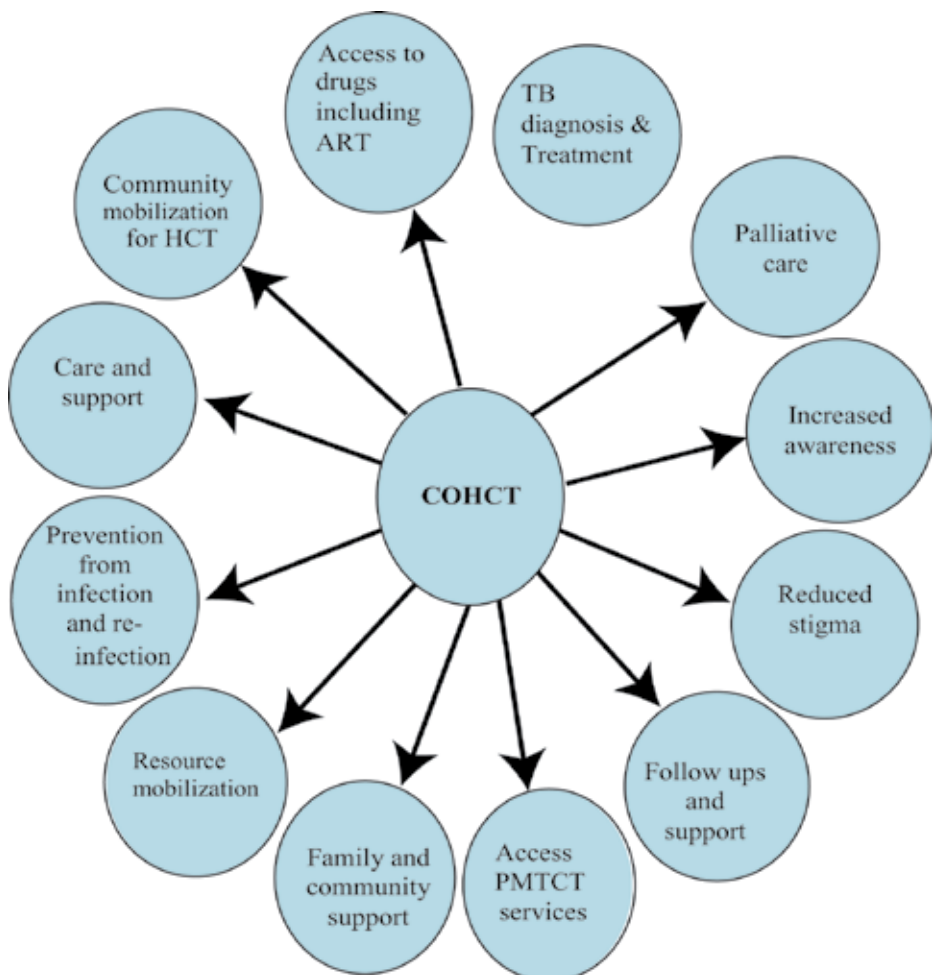
Research and experience have shown that HIV/AIDS is not only a medical but also a social problem. It is through social relations that transmission mostly takes place. At the same time, medical care, if not accompanied by peer and family support, remains wanting. The need to enhance nutrition for HIV/AIDS clients and the need to fight stigma are challenges whose

solutions are rooted in family relations and community beliefs, attitudes and practices. In this context, COHCT is a vital approach in enabling effective delivery of preventive messages as well as care and support for infected and affected persons and their families. COHCT enables communities to better understand HIV/AIDS-related problems around them and to identify strategies to address them. Through participation in the COHCT approach, members are able to develop their own management plans and ways of coping that address their unique needs.

Benefits of COHCT

As discussed above, COHCT is complimentary to facility-based HCT that if well organized and implemented will result in socioeconomic benefits to infected and affected HIV/AIDS persons. Some of these benefits are illustrated in figure 1 below.

Figure 1: Benefits from a successful COHCT



Community Mobilization/awareness for HCT: Traditional HCT approaches have successfully utilized existing local structures such as the local councils to mobilise people for facility-based and outreach HCT services. COHCT adds value to the existing good will of the leaders by enhancing their knowledge and appreciation of HCT. Since COHCT is community based, community mobilization becomes part and parcel of local leaders' daily work, thus enhancing the scope and number of people willing to undertake an HIV test.

While many health providers have invested heavily in information and education on HIV and AIDS, experience has shown that Ugandans have got so used to these messages to the extent that HIV-prevalence rate has stagnated in the recent past years at 6.4 per cent (Uganda Sero-behavioural Survey: 2005). Although many people know more about HIV/AIDS, behavioural changes still lag behind. COHCT enables community peers—who understand the social dynamics and vulnerabilities and can break through social networks—to offer on going counselling and sustain the awareness campaigns.

Access to drugs through increased access to HCT: More people through their social networks are informed of their status and are advised on appropriate treatment. Today about 70 per cent of Ugandans do not know their sero status due to limited access to HCT services and yet some of these Ugandans are in dire need of drugs such as septrin and ARVs. By building a close link between HCT providers (at facilities) and the community, those who are HIV positive find it easier to access drugs.

Reduced stigma: Although significant reduction of stigma for people with HIV and AIDS has been realized in Uganda, some myths, perceptions and beliefs that stigmatize people with HIV still prevail. The COHCT approach is designed to enable people in the community know all facts about HIV/AIDS, and appreciate positive living amidst the HIV scourge. The manual for COHCT includes facts about HIV/AIDS, ongoing counselling, referral for medical and palliative services within and outside the community, and use of people living with HIV/AIDS (PLWAs) in mobilizing for HCT, care and support services, among others. These services once rooted in the community, reduce stigma significantly by strengthening empathy towards PLWAs.

Care and support: One of the outstanding limitations for traditional HCT services is that these services are restricted to static facilities with occasional outreach services. Most people after testing for HIV/AIDS find themselves alone, with nobody to turn to for advice, say on how to disclose their status to others or even how to maintain a HIV-negative status if their test result

was negative. Those who are HIV positive, such as the mothers, find it very challenging to follow advice on not breastfeeding, for example. They cannot take such a decision without consulting their partners or relatives. COHCT compliments facility-based services by offering the natural support the community has always offered through counselling, family/peer support to those who are in need of advice and support. The COHCT approach equips community members with more knowledge and skill in offering care and support to those who need it.

While it is true that hospitals and other formal health facilities are known to provide palliative care for the very sick; these facilities are limited and constrained. Most of the HIV-positive clients in Uganda (especially those bedridden) are known to be cared for by relatives and friends. It is important to note, however, that most of these home-based care givers experience all sorts of stigma while caring for their sick. The palliative care givers (at family/community level) lack adequate knowledge of how HIV is spread, they also suffer negative comments from a less appreciative and stigmatized community around them. In addition, the home based care givers lack adequate resources (money, food, helping hands, etc.) to care for the sick in addition to their families. The benefit of having COHCT is that the community has not only extra pairs of supporting hands for a family tending to the sick, but also offer psychosocial, spiritual and sometimes economic support for the caregiver, hence boosting palliative care for the sick at community level.

Resource mobilisation: Accessing HIV counselling and testing, and other subsequent services, require one to have enough resources in terms of money for transport to health providers as well as people to support those who test to cope with the results. COHCT ensures that the necessary human and financial resources are mobilized to support HIV prevention, as well as provide care and support initiatives.

Participatory Learning and Action (PLA)

Participatory learning and action (PLA) embraces several methodologies, including Participatory Rural Appraisal (PRA), Rapid Rural Appraisal (RRA), and Participatory Action Research (PAR), among others. All of these approaches engage people in learning about their needs, available opportunities and working out actions required to address their needs. Participatory learning and action challenges the conventional biases that underrate local knowledge, values and solutions.

In PLA, therefore, much emphasis is put on interactive learning, shared knowledge and values. It is a multi-disciplinary approach to enable practitioners to envision a holistic view of livelihoods and well-being. PLA

is vital in the development of effective health communication strategies. PLA is usually a tool used to negotiate for a mutual agenda between communities and researchers (Mosavel, Simon *et al* 2005). PLA is meant to generate a dialogue that would function for both research and action. It has been argued that health promotion and education programs should be participatory in nature in order to help communities take ownership of health problems and the resources involved (Mosavel, Simon *et al* 2005). What distinguishes PLA from other methodologies is that through PLA, communities play a substantial role in the research process.

The researchers provide guidance instead of dominating data collection. PLA is a process through which researchers empower the communities to review their situation, identify problems and then suggest solutions, most of which should be within their means. The process transforms the researchers into learners and listeners and empowers community members since they begin to see themselves as part of the solution.

Why PLA is the Preferred Method

Some of the major reasons PLA is preferred include:

- **Use and respect for knowledge of the local people.** PLA acknowledges the fact that people know their area more than outsiders and hence are better equipped to identify and discuss the problems in their community. On the other hand, researchers and facilitators do the work of listening, and when prompted asking probing questions.
- **Multi-disciplinary outlook to solving problems.** PLA has to be implemented by a multi-disciplinary team since it involves understanding diverse aspects of the problems affecting the community. The PLA team should therefore have professionals qualified in different fields if they are to be effective in the area of investigation. To be a specific, the PLA team for community HCT would require health workers with experience in HIV prevention, social workers with experience in counselling and community approaches.
- They should be flexible to accommodate a diversity of issues although the approaches have a structured format emerging from the discussions.
- Iterative learning. The more researchers interact with the community the more new questions emerge and are discussed. The more the participation the more fulfilling the findings will become.



Participatory learning and action acknowledges that people know the problems that affect them better and should therefore be involved in identifying relevant solutions.

The Importance of PLA in COHCT

A systematic participatory learning and action process is crucial for the establishment of a meaningful community engagement in HCT. The following elements are very important for the development of an effective process:

- Raising the consciousness of members of the community regarding the reality of HIV/AIDS and what they can do about it to avoid or minimise the problem.
- Identifying key problems/barriers undermining utilization of the HIV/AIDS services in their area.
- Helping community members define their roles and responsibilities in identifying and solving problems associated with low utilization

of HCT services and those associated with the effect of HIV/AIDS on individuals and families.

- Guiding community members to identify key resources (both human and physical) that can be utilized in dealing with the problems under discussion.
- Discussing how the identified problems can be solved. In this case communities can indicate what they can do on their own, given the resources at their disposal, and also indicate areas where they need help.
- Training community members in methods that will enable them to understand, comment on and modify information collected through the use of visual materials such as maps and diagrams.
- Conducting joint planning sessions between development agents and the community.
- Learning and understanding the local context. In planning, due consideration is given to the local context, especially in terms of scheduling of activities according to the community's calendar. This is important because community priorities take precedence. Understanding the local context is important since it ensures that all interventions will not contradict community expectations.
- Providing opportunities for participation of diverse groups, including women, children, persons living with HIV, the elderly and persons with disability.

Limitations of PLA

- If not well handled and explained, PLA can raise expectations, especially financial ones, that may be difficult to meet. Communities may also think that "after PLA, comes money." Instead of thinking about what they can contribute, they think about what they will earn.
- Group discussions sometimes limit opportunities for learning important individual interpretations or sharing experiences. Hence, individuals with unique problems or specialized knowledge, and experience are often not provided with enough opportunity to share their knowledge and may at times be entirely left out.
- Limited experience and commitment in participatory work by some development workers can have a negative impact on the quality of the exercise.
- When plans are not implemented as expected people lose confidence in the program.

MODULE II

GETTING STARTED: PLANNING

Initiating PLA is a process that requires one to be conscious of all the preliminary issues and questions that enable effective planning for this activity. Below are some of the questions that need to be taken care of during the planning stage.

What is the purpose of a PLA exercise?

There are a number of reasons why a PLA exercise is important while planning for COHCT. These may include the need to establish:

- the nature of problems affecting the utilization of HCT services within the target community;
- the level and quality of knowledge the community has about HCT; and
- community values, views and conceptions about HIV/AIDS in general, and HCT in particular.

Whose needs are to be addressed?

It is always necessary to examine the needs for the entire community before embarking on any given programme. Although specific needs of people are studied, aggregating all the community's needs helps in understanding and informing key interventions for the implementation of COHCT. The following areas are important for the assessment of HCT needs assessment:

- perceptions regarding HIV and AIDS;
- knowledge about HCT;
- whether people living with HIV are stigmatized;
- basic infrastructure for HCT services delivery at community level;
- resource mobilization for HCT services; and
- care and support for PLWAs.

Community Empowerment and Mobilisation

It is good to explore possible options for working with the community to improve care and support for people living with HIV.

- a) Empowering the community even before the actual community HIV counselling and testing activities commence. The following are anticipated as possible areas for intervention to ensure community empowerment.

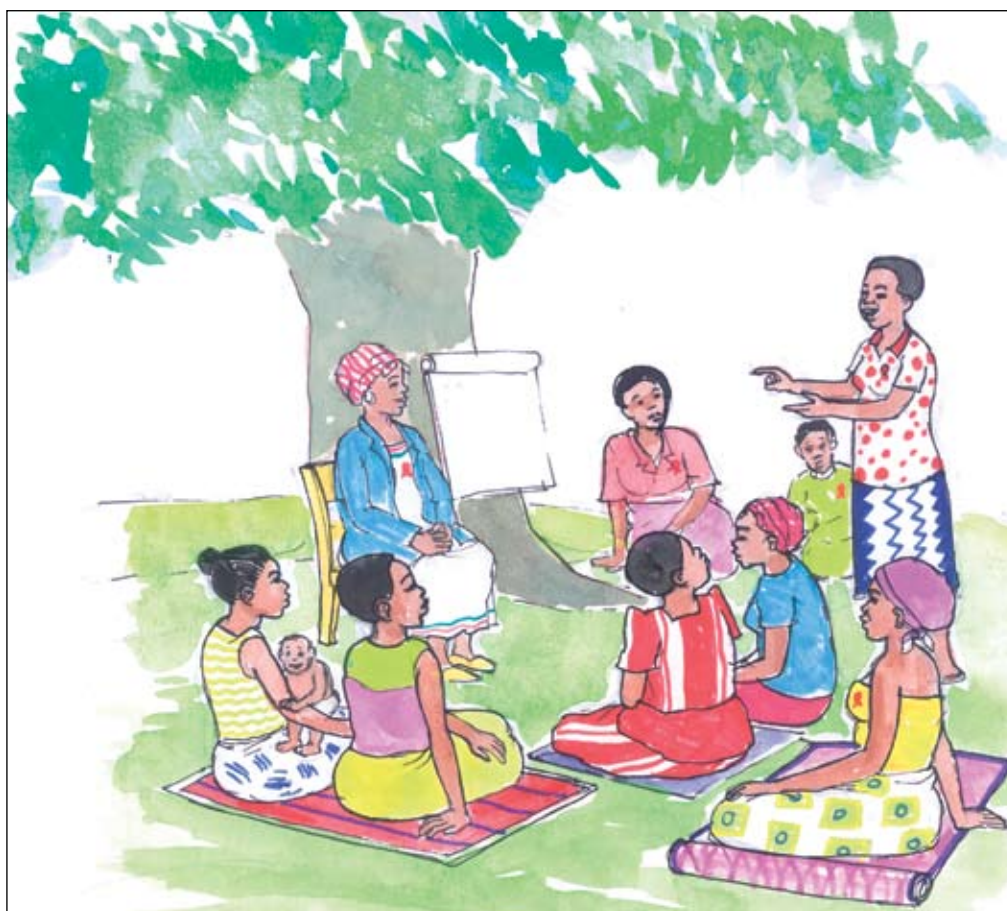
- o Creating awareness on HIV/AIDS.
- o Exploring what the community knows about HCT and using this knowledge to explore and find solutions that are within the community's means.

There is always a tendency to generalize that there is a lack of knowledge, and that the community does not correctly understand HIV/AIDS and that community perceptions are some of the problems affecting VCT utilization. Therefore it is important to establish the kind of knowledge and perceptions that people have and how these are likely to affect HCT.

- o Enable community members to engage in collective self-help activities that can enable them earn money to meet the needs that arise due to HIV/AIDS. It is necessary to support the community to start income generating activities that would enable them deal with their health conditions in times of scarcity and assist the community to assess and utilise possible economic opportunities available in the community to address their health, socioeconomic needs fuelled by the HIV/AIDS scourge.
- b) Identifying different stakeholders who will provide information for the preparation of the PLA exercise. These may be drawn from the District HIV/AIDS Committee, the District Directorate of Health Services and community leaders. Note: These categories of people will play different roles as pointed out under "Key Principles of PLA".
 - c) Organizing a multi-disciplinary team according to the likely problem areas.
 - d) Developing a detailed work plan and budget with the community.
 - e) Establishing contacts which will enable early networking and consultation with local leaders, including district officials, and sub-county and village leaders. A thorough explanation of the project could help harmonize expectations of the community. Right from the start, define the target group, i.e., people you think would help to move the discussion forward. It is important to do some contact-building beforehand to verify whether the people you are targeting will be around during the assessment. The local leaders will, for instance, advise on the groups to target and in proposing appropriate venues and the best time for the meeting. At the village level you will need to agree with the leader on the time and venue for meetings.
 - f) Providing clear instructions to local leaders. These may include:
 - o Who to invite. It may be necessary to organize separate meetings for

women and men. This must be put clearly.

- o Clarifying what the meetings are about and the expected outcomes. Mobilizers should be cautioned not to excite the community with promises in order to entice them to come for the meetings. Otherwise, the purpose of the meeting will not be achieved if their expectations are not met.
- g) Agreeing on dates and schedules of implementation with key stakeholders. You may want to pay visits to some sites or make phone calls to concretize the planning and ensure that all the people expected to participate are ready.
- h) Depending on the kind of data needed, consider assigning roles to the team members beforehand. Some of the basic roles include: the facilitating, note taking and translating (where necessary).



It may be necessary to organise separate group discussions for women and men while discussing sensitive gender-related issues.

Caution: You will, however, need to bring the two groups together and review each other's findings/recommendations

Organising logistics/materials

PLA requires a lot of materials which in turn need a lot of advance preparation. It is necessary to develop a checklist of all the materials needed for the whole exercise. You need to decide from the beginning which materials can be mobilised from the community, e.g. stones, beans, maize etc. Materials required from outside include manila paper, flipcharts, VIPP cards, masking tape, markers, chalk and board. List all the requirements including services, items and allowances. Below is an example of budget estimates.

Figure 2: Budget Estimates

	Item	Number	Unit cost/ Rate (per day)	Duration (Days)	Total
1	Personnel Requirements				
	Resource Persons	3	50,000	2	300,000
	Field Assistant	4	25,000	2	200,000
	Local Guide	1	25,000	2	50,000
2	Materials/Equipment				
	Camera (hire)	1	30,000	2	60,000
	Flip Chart	3	10,000	-	30,000
	Tape Recorders (hire)	2	30,000	2	120,000
3	Transport				
	Car Hire	1	70,000	2	140,000
	Fuel		45,000	2	90,000
	Driver	1	25,000	2	50,000
	Transport Refund	40	6,000	2	240,000
4	Refreshments				
	Water	40	500	2	40,000
	Soda	40	500	2	40,000
	Total				1,360,000

Decide whether you will provide refreshments and the type the participants will need and appreciate. Consultations with local leaders would enable you to get realistic estimates.

Orientation

After the multi-disciplinary team has been identified, arrange for its orientation on the principles of PLA, HIV counselling and testing, and provide them with more information on HIV/AIDS. More importantly, get the team to understand and appreciate the concept of community-owned HCT and go over the expected outcomes from a PLA training exercise. Emphasis should be put on the importance of local knowledge and respect for people's views on the one hand and using socially acceptable language on the other. Since

HIV/AIDS is a sensitive topic and people suffering from AIDS are in most cases highly stigmatized, there is need to get the team to appreciate this sensitivity. It is necessary to rehearse the principles in a mock PLA exercise before embarking on the actual PLA activity in the community.

Specific areas that the PLA team need to be introduced to include community entry approaches, questioning techniques, recording information, ending the discussion and pilot testing of research instruments.

Community entry and related introductions

It is important to have a dialogue with community leaders right from the start in order to give a detailed explanation of the exercise and the expected outcomes.

Knowledge and respect for community values are very critical; when members feel respected, it builds trust and confidence in the entire exercise. You need to emphasize the value attached to people's participation and how useful their contributions will be. Inform them that participation is voluntary and everyone's views would be highly valued.

Questioning techniques

The way questions are formulated will determine the kind of answers you will get. Ensure that questions are clear. It is important to remember that not all questions will lead you to the answers you expect. Different questions and the way they are asked will determine whether or not the PLA exercise will achieve its purpose. The following are some issues to consider when asking questions:

- Respect people's views, do not dismiss their answers;
- Stay neutral, do not take sides or become too emotional;
- Avoid criticizing the respondent for not being clear or not understanding your questions. Participants withdraw when criticized.
- Avoid asking culturally sensitive questions. After studying the context and cultural values of the area, you will know which questions to avoid. For example, in some communities, people prefer to use certain terms to describe sex and so you need to design your questions using those terms rather than the exact words, which would otherwise be considered obscene and can therefore easily put off people.
- Avoid questions that 'pin' down people. For example: 'You have just told me such and such..., how come you are now telling me something different?' etc. Such an approach embarrasses people and once asked, the person in question will get offended and might withdraw from the discussion.

- Pay attention—listen—to what people are telling you. If people think that you are not attentive they will be discouraged.
- Probe more on issues where you feel there is need for more information. Probing is also vital, especially when you feel that the response is not clear.



It is important to take notes during the meeting. It may also be necessary, with consent from the group, to tape record proceedings of interviews or discussions. Photographs can also be taken to supplement the documentation process.

Recording information

It is important to take notes during the meeting. For each meeting there should be a note-taker who will ensure that the proceedings of the meeting are properly recorded. The kind of notes to be taken will depend on the type of exercise. For instance during a mapping exercise, the note-taker may concentrate on the observations on how the mapping is being done in terms

of distances and landmarks. This information will be used to create a map of the territory in question. A note-taker can also take photographs to support the documentation process—but always ask participants' permission.

It may also be necessary to tape-record proceedings of interviews or discussions during focus group discussions (FGDs) and key informant interviews (KIs). In such cases it is important to seek permission from the participants to be tape-recorded. If they are not comfortable with the request and refuse, do not tape the session. Instead the note-taker should be aware of this limitation and thus take detailed notes. Even when the session is recorded, the note-taker should not relax in case the recording fails. In addition, the note-taker should record the general impressions, including people's expressions, body language, the interview environment, and how the respondents behave during the discussions.

Ending a discussion

After all the issues have been exhausted, encourage participants to ask questions. It is common for participants to ask questions that are beyond the team's capacity to answer or address. Answer only those questions that you are knowledgeable about and for questions that prove difficult explain that you will find out more on the topic and address it later if possible. The team members should respond to questions with caution. In case they are sensitive questions, especially where the community asks for things beyond what the project can afford. Only promise what is in the mandate of the project that you are representing. Simply say you understand how important their request is but it is beyond the scope of the project. However, you can tell them that you will propose that the government give it consideration.

To conclude the discussion, thank people for their participation and request they come for the data analysis and planning sessions that will follow later.

Pre-testing research instruments/tools

After going through all the above, it is important to engage the PLA team in a pre-test exercise to establish their readiness, and also improve the tools. The pre-testing should be done in a community with characteristics similar to the ones in which the actual PLA is to be done. Different professional team members should be allocated responsibility in line with their experience and professional background. A decision on which tools to be used during the fieldwork is important for planning and budgeting, as well as mobilisation of participants.

MODULE III

COHCT NEEDS ASSESSMENT USING PLA TOOLS

When all preparations have been made and the team is ready to start on data collection, it is important to identify and select the tools that will enable the team to collect relevant data for COHCT programming. In this section, eight tools which ideally should be used in data collection for COHCT are examined. These tools include maps, wealth ranking, gender analysis, preference ranking, direct-matrix ranking, pair-wise ranking, historical profiles, and seasonal calendars. There are three other very important additional participatory techniques. They are focus group discussions, observations and review of secondary data.

This section focuses on the steps to follow while conducting a community needs assessment for the COHCT. The tools can be used at any stage of the implementation of the COHCT project. The order in which the tools are invoked varies and depends on the purpose of the exercise. However, while in the community, it is important to first apply those tools that will obtain some general information about the community, such as social and resource mapping. These tools also help the PLA team to start a dialogue with the community, in addition to serving as an entry point.

Note: Please always ensure that the discussion groups are organized according to gender, with men separated from women. Do not interrupt the discussion. Let members say what they want to say, only guide the discussion. After the members have made their profiles, engage them in a discussion focusing on the implications of each profile.

Tool 1: Maps

Maps are the core of PLA as they generate a lot of basic information about the community profile. In most cases there is a tendency to think that a map is difficult to draw and community members are always reluctant to start on it. The facilitator should assure the participants that drawing a map is easy; explain thoroughly what a map is about, how it is drawn, and what should be included on it. The facilitator should first demonstrate the procedure to follow in drawing a map.

- Ask the participants to select from among themselves two people who would take the lead in drawing the map. In most cases it will be those

people with a certain level of education in the community that will take the lead.

- Begin by drawing the village boundaries. You do not need to be accurate; in some areas village borders follow some natural features such as rivers and ridges. Others follow the man-made boundaries such as roads. Ensure that participants understand these physical landmarks.
- Decide what to put on the map; this varies according to study needs. There are usually three types of maps used: the social map, the mobility map and the resource map. The contents of these three maps overlap and sometimes may be more convenient to present them on one map. On the other hand, separate maps may be better to avoid congestion. Groups in this exercise can be mixed, men and women together since the maps present general issues.



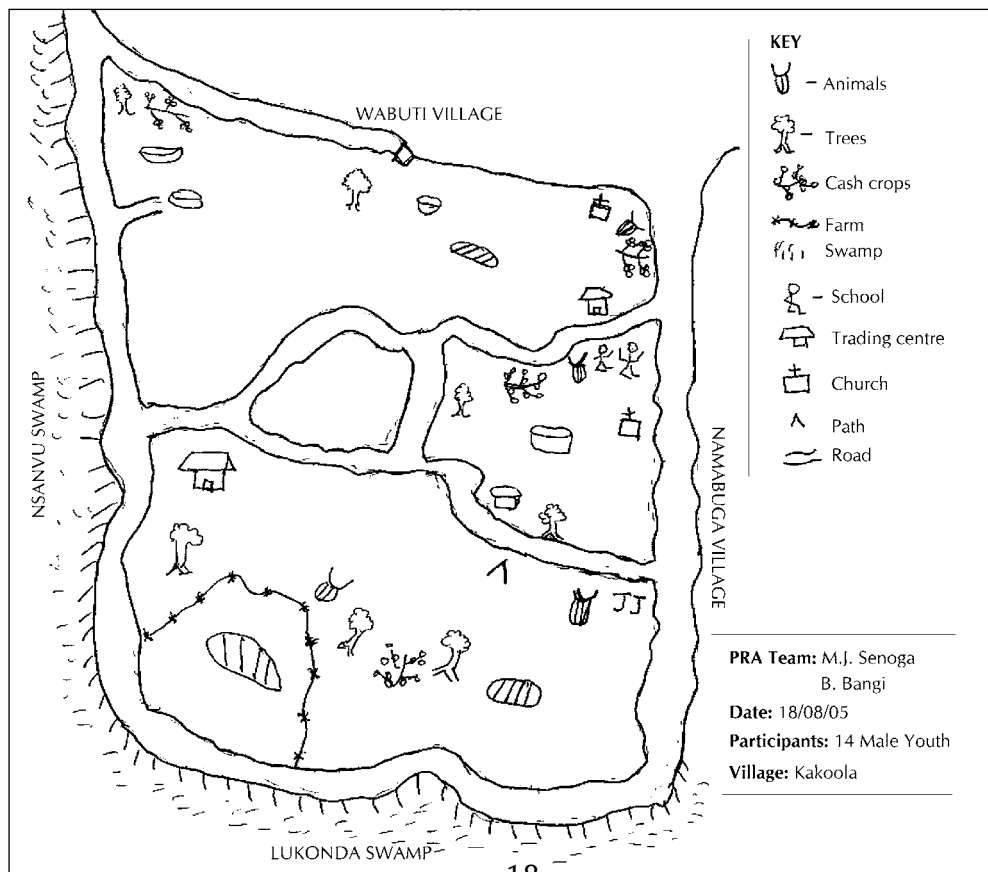
Using locally available materials, the facilitator should demonstrate the procedure to follow in drawing a map.

Maps can help community members to decide on how to think through their problems and plan accordingly. Using a map, the participants can discuss how they can use the available resources to solve some of the problems. For instance, if lack of a bridge across the river is a key hindrance in accessing a health facility offering HCT services, the community members can use available forests to get poles to make a bridge to enable them cross the river to access the health facility. Through the use of a social resource map, communities can identify resource persons who can help in providing community-based services like counselling services and home-care support for people living with HIV/AIDS. Using the same map, communities can also identify key venues for meetings and where to obtain services. For example, in water and sanitation projects, communities can use the map to locate places where to put up a borehole.

a) Resource mapping

A resource map is used to show where the different resources are located in a given community. The participants should brainstorm, agree and locate resources in their village on the map. In the context of COHCT, the relevant

Figure 3: A Resource Map of Kakoola Village



resources may include infrastructure (access roads, hospitals, health centres and drug shops), cash crops, key industries/factories, estates, and other kinds of economic resources that generate income for the community to address their problems.

During the resource-mapping exercise participants decide on the material to use to draw the map. It is usually good to let participants use locally available material resources such as stones, leaves and seeds. However, if these resources are not readily available or are not easy to use they can be given manila paper and markers so that they can put the map on paper. Below is a sample of a resource map drawn by Kakoola community members in Kayunga District.

Discussion guide

- What important resources exist in Kakoola village?
- Name possible sources of water, firewood, and herbs in this village.
- What are those resources that women, men, girls and boys use?
- What resources are abundant; what are scarce?
- What other resources could be available in this community?
- What are the implications of abundance or scarcity of resources in relation to HIV/AIDS?

b) Social map

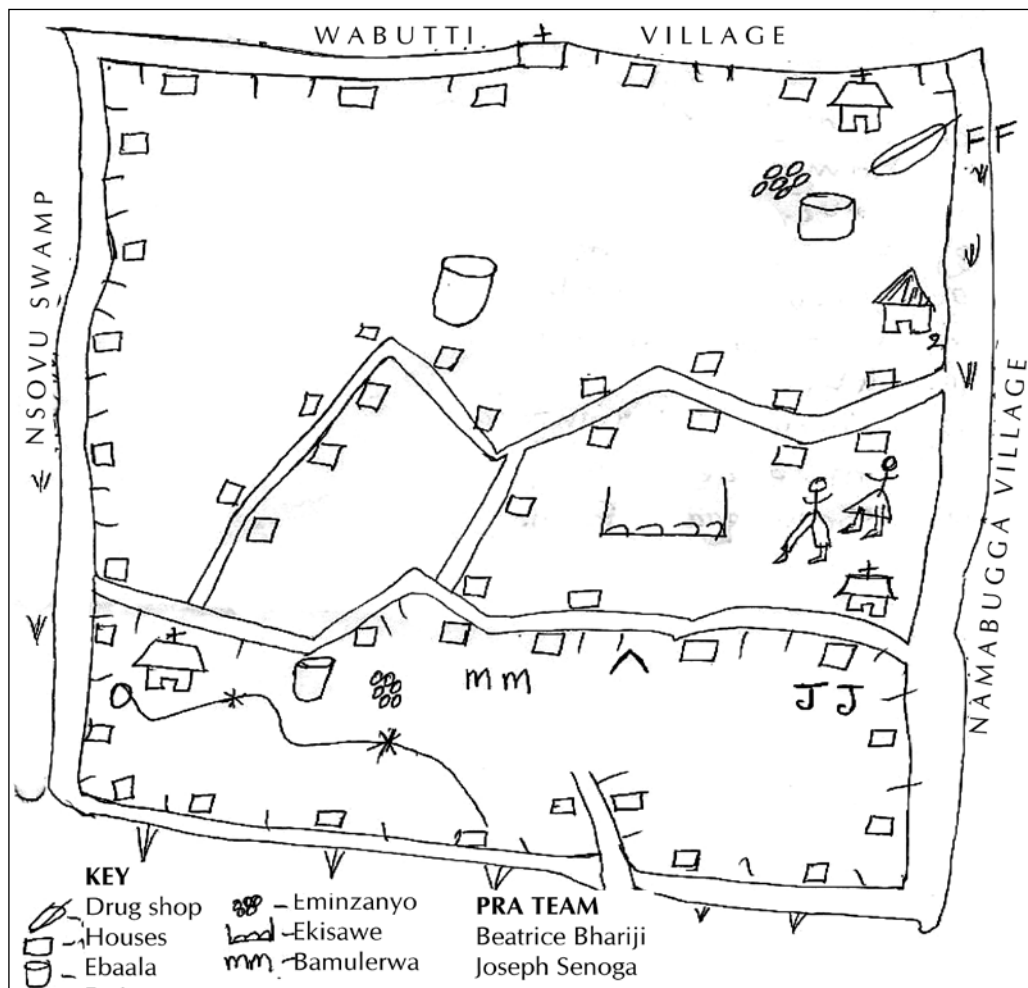
A social map is used to describe a social settlement, social services and facilities. The tool can also be used in locating the members' own households as well as identifying resource people (graduates, extension workers, community resource persons, trained counsellors, etc.) and institutions (churches, schools, and health facilities including HCT services, TBAs, traditional healers) that relate with them and are also relevant to HCT.

This is a map drawn by the community to show the settlement patterns as a significant community characteristic, the location of institutions and their relationship with the community. Below is a sample of a social map drawn by the Kakoola community members in Kayunga District.

Discussion guide

- What are the main features that the village borders?
- Where are the majority of households located in the village?
- Are there specific categories of households which are vulnerable?

Figure 4: Social Map of Kakoola Village



Discussion guide

- Has the number of households increased or reduced during recent years? If there have been any changes ask why and whether this has caused any problem for certain families or for the community.
- Show institutions (formal and informal) and individuals who offer some kind of social service or which are popular spots where people can meet and discuss. Examples: schools, churches, health centres, traditional healers, NGOs/CBOs, community groups, community centres, community leaders, local shops and drinking places, or other places where people frequently meet.

- Probe for type of health services and coverage that are provided in the community, especially HIV/AIDS-related services that benefit different social groups (women, men, youth and children). Who benefits from such services? Who provides the services? Are there needed services that are not provided?
- Probe for care and support services (package, target, and challenges).
- Which are the groups most vulnerable to HIV and why?
- What factors hinder utilization of health services including HCT? What factors promote the utilization of health services including HCT services?
- What are the health needs of the community and the different groups within the community that are currently met and those which remain unmet especially those impacting on HCT uptake?
- Get suggestions on which health services they would want to be improved and suggestions on how the improvements should be done.
- What constraints are likely to be encountered while implementing a development project in the community?

Tool 2: Wealth Ranking

This tool is used to help the community assess its well-being and classify households in relation to different levels of poverty. It is used to assess local perceptions of wealth differences in the community and how these affect the use of health facilities and other services. It also helps to understand how these differences influence or determine people's behaviour and coping strategies. In addition, it enables the team to identify and understand local indicators and criteria for wealth and well-being.

Steps to follow

Record the name of the village, the group and date on the map.

- (i) Estimate the number of families in the community.
- (ii) Prepare a number of cards equivalent to the estimated number of families in the community (but make a random sample if the families are more than 100).
- (iii) Write on each card the name of a family (one family per card).

- (iv) Write down on a separate piece of paper wealth categories (e.g. rich, moderately rich, poor and very poor). Determine what each category means in practical terms.
- (v) Ask participants to distribute the cards according to the wealth levels (e.g., create piles of cards for the rich, moderately rich, poor and very poor depending on their definition of the different categories of wealth).



A



C



B



D

Wealth levels can be defined according to the different types of houses that people live in.

- (vi) Ask the participants to discuss and decide amongst themselves where to locate each of the households.
- vii) Try to find out the criteria they used to decide on the household classification.
- (viii) Alternatively, if you realize that the participants are very sensitive, avoid mentioning any household names, but rather ask for the wealth categories and what criteria would be used to decide that a certain household belongs to a given category.
- (ix) Find out from the participants the factors which could have led to different wealth levels.

- (x) Ask them for factors that can lead anyone of them to 'move' from one category to another (become better or worse off).
- (xi) Participants can then summarize the characteristics that identify each category and estimate what proportion of the population falls into each one of them.
- (xii) Participants can summarize the kind of problems faced by households in the poorest and lowest ranks.
- (xiii) Where appropriate, action points on what can be done for those households can be suggested.
- (xiv) Record the information and leave a copy with the community.

Discussion guide

- Determine criteria to use to determine how to categorize households as either rich or poor.
- Why are some people rich while others are poor?
- How do people manage when they are poor?
- Which among the groups mentioned has more/least access to services (i.e., information, care and treatment, etc.)?

Tool 3: Gender Analysis

Gender analysis is a tool that analyzes the roles and responsibilities that men, women, girls and boys play in homes and communities and how these roles affect their lives. In the context of PLA for COVCT, it is necessary to use the gender analysis tool in order to understand gender-based needs that may affect access and utilization of VCT services.

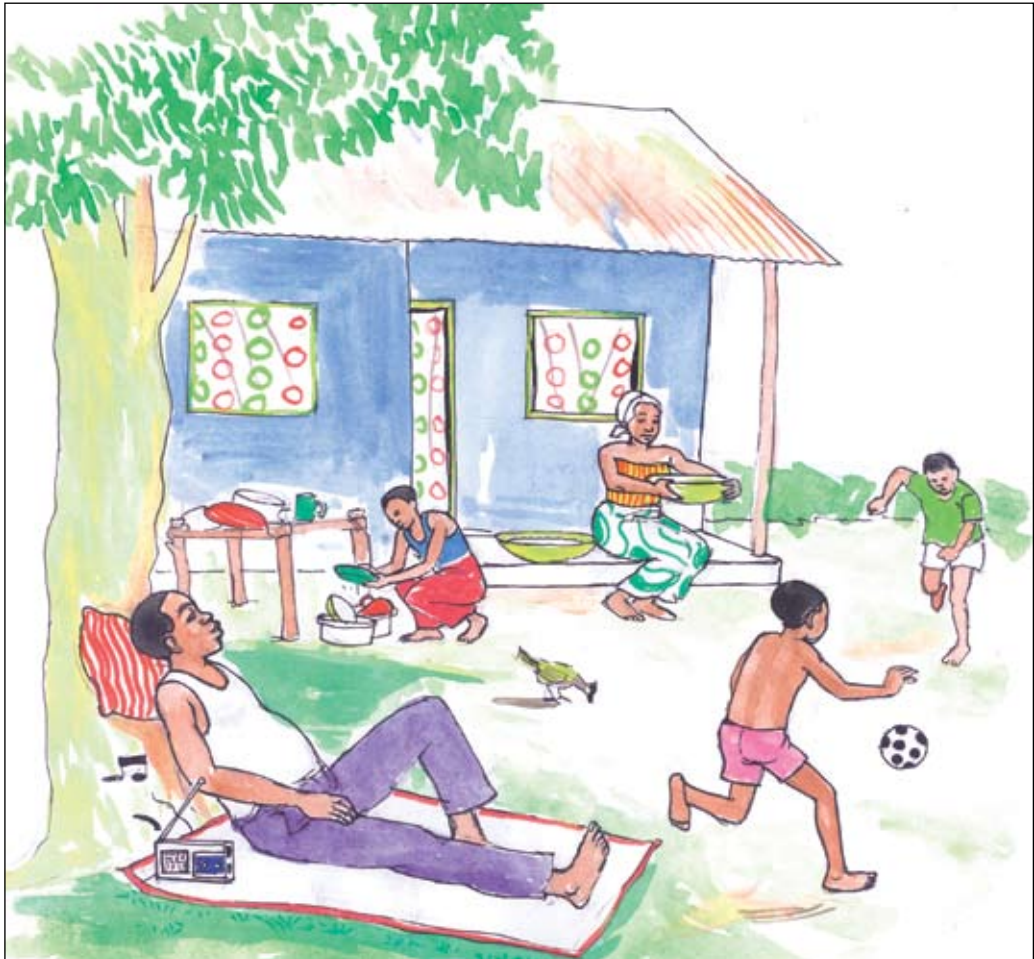
This tool helps in the analysis of the different roles and responsibilities in terms of activities, access, control, and ownership of resources and the implications for development work. This analysis also brings out implications of the inequalities on health care such as expenditure patterns, decisions on utilisation of health care services, and choice of treatment including VCT services, among others. This handbook utilizes the following profiles to analyze gender issues:

- Daily activity profiles.
- Access, ownership and control profiles.

a) Daily Activity Profile

This tool provides a detailed analysis of roles performed by women, men, girls and boys in the home and the community and how these affect access to and utilization of services. It is used to illustrate the activities carried out in a day. It is particularly useful in the analysis of relative workloads in terms of gender. Comparisons between profiles of men and women will show who works the longest hours, who concentrates on a few activities such as income-generating activities and social obligations like looking after the sick, and who has the most leisure time and sleep.

Note: It is important to understand the Daily Activity Profile for any given community before any HCT intervention is engaged. For example, the illustration below shows a situation where men and boys have more leisure time and women less. In this case, one might have to plan a home-to-home HCT in order to reach women.



What do you do after lunch?

Steps to follow

- (i) Divide participants into groups of male, female, boys and girls. Make sure that each group includes people from different socioeconomic groups.
- (ii) Ask them to collect local materials that will represent the different roles men and women perform.
- (iii) Ask them to list all the activities they do at home, activities from which they earn money and community activities. You can start by asking them about what they did the previous day or how they generally pass their day. If time allows, help them to understand this issue better by asking one of them to explain what they did the previous day or what they do each day from the morning to bedtime.
- (iv) Plot each activity in the matrix. Activities that are carried out at the same time (such as child care and cooking) can be noted in the same spaces.

Example of a Daily Activity Profile

Activity	Men	Women	Boys	Girls
Sweeping				
Looking after the sick				
Bathing children				
Taking child to clinic				
Working on community road				
Planting coffee				
Selling coffee				

- (v) Use local materials such as stones and seeds as scores to indicate the level of involvement of women, men, girls and boys in health related activities.
- (vi) When the matrix is completed, ask questions about the activities shown.
- (vii) Note the present season (for example rainy or dry season) and the activities undertaken.
- (viii) If there is time, ask the participants to produce a new matrix to represent a typical day in the other season.
- (ix) Discuss the implications of the information in the two seasonal matrices in relation to accessibility and utilization of health services, especially VCT services.

Figure 5: Nyondo Village Activity Profile Analysis

Activity	Men	Women	Boys	Girls
Animal rearing	ooo	o	oooo	oo
Cooking	—	oooooooo	—	oooo
Fetching water	—	oooo	o	ooooo
Land clearing	ooooooooo	—	oo	—
Ploughing	o	ooooo	oo	oo
Weeding	o	oooooooo	o	oo
Buying/selling produce	oooooo	ooo	o	—
Washing clothes	—	ooooo	oo	ooo
Washing utensils	—	oooooooo	—	oooo
Sweeping compound	—	oooo	—	oooooo
Ironing clothes	—	ooooo	o	oooo
Bathing children	—	oooooooo	—	oooo
Cleanining the house	—	oooo	—	oooooo
Slashing compound	oooo	o	ooooo	—
Attending to the sick	—	ooooooooo	—	oo
Repairing clothes	—	oooooooo	—	oooo
Building a house	oooooo	o	ooo	—
Collecting firewood	—	oooo	—	oooooo
Peeling food	—	oooooooo	—	oooo
Total score	29	83	22	60
PRA Team				
Florence Mahoro		Date: 3/8/2005		
Senoga Mubanda		Participants: 10 female youth		

Key: 1 circle = 1 response

Note. The analysis in the Nyondo profile shows that:

- Women and girls do more activities and hence will have less time to participate in workshops, and may not even have time to access health services at health centres.
- Most of the activities done by women and girls are mainly home-based and this limits their opportunities to access information on health.
- Men and boys do less work.
- The work done by men and boys takes place both at home and outside. Activities performed outside the home allows them time to participate in extra-domestic activities.
- Men and boys have more free time than their female counterparts.

If one was to use this information to programme a COHCT project, one would need to design a flexible schedule that allows women to come for the services.

Alternatively, a COHCT project could be designed on a home-to-home basis so that women do not have to abandon their work to access services. At the same time gender-sensitive COHCT could also target men and boys to do community mobilization since they have more time.

Discussion guide

- For each group, ask how is their time divided?
- What is the difference between women and men's workload?
- Who has the heaviest workload?
- Who has time for rest and leisure?
- How much time do women or men, girls or boys spend on looking after the sick?

b) Gender Resource Analysis: Access, Ownership and Control

This tool is used to analyze how women, men, girls, and boys access and control the resources they use in the pursuit of individual and family needs and obligations. This tool is intended to enable the PLA team and the community to get a clear understanding of the resources required to undertake the activities listed on the activity profile and their gender implications. At the end this will enable the team to clearly assess how the resources are controlled, managed and utilized. Gender Resource Analysis also helps the communities to focus on who controls resources and how men, women, boys, and girls access such resources for various activities and how that control is likely to affect access and utilization of COHCT and other services. This tool, in addition focuses on resource allocation and the implications this has for planning for their utilization at the community level. It helps define who is likely to have power and authority to decide on the use of resources in order to utilize HCT services.

This tool further helps the community to understand the inequality in power relations between men and women. It helps them identify the constraints faced by men, women, boys and girls in order to plan interventions accordingly.

Figure 5 is an example of a gender resources analysis of Nyondo village in Kayunga District.

Figure 6: Access and Resource Control Analysis of Nyondo Village

Resources	Access				Control				Ownership			
	M	W	B	G	M	W	B	G	M	W	B	G
Cow	♣♣♣♣ ♣♣	♣♣♣	♣	♣	♣♣♣♣ ♣♣♣♣	♣♣♣			♣♣♣♣♣ ♣♣♣♣♣	♣♣		
Land	♣♣♣♣ ♣♣	♣♣♣♣ ♣	♣		♣♣♣♣♣ ♣♣♣♣♣ ♣♣				♣♣♣♣♣ ♣♣♣♣♣ ♣♣			
Food crops	♣♣♣♣ ♣♣♣♣	♣♣♣♣♣			♣♣♣♣ ♣♣♣♣	♣♣♣♣ ♣			♣♣♣♣♣ ♣♣	♣♣♣♣ ♣		
Radio	♣♣♣♣ ♣♣♣♣	♣	♣♣	♣	♣♣♣♣♣ ♣♣♣♣♣	♣♣			♣♣♣♣♣ ♣♣♣♣♣ ♣	♣		
Farm implements	♣♣♣♣♣	♣♣♣♣	♣♣	♣	♣♣♣♣ ♣♣♣♣	♣♣♣♣ ♣			♣♣♣♣♣ ♣♣♣♣♣	♣♣♣♣		
Bicycle	♣♣♣♣ ♣♣	♣	♣♣♣♣	♣	♣♣♣♣♣ ♣♣♣♣♣ ♣♣				♣♣♣♣♣ ♣♣♣♣♣ ♣♣			
Household utensils	♣	♣♣♣♣ ♣♣	♣	♣♣♣♣	♣♣♣♣♣	♣♣♣♣ ♣♣♣♣			♣♣♣♣♣ ♣♣♣♣♣	♣♣♣♣		

Key

♣ Represents one vote M – Men W – Women B – Boys G – Girls

Note: The access and resource control analysis of Nyondo village above shows that:

- Men have greater access to, control and ownership over most of the resources. Women have some access to some of the resources but virtually lack control and ownership over most of those resources.
- Boys and girls have very limited access to resources and absolutely no control and ownership.

Implications of Gender Resource Analysis

If COHCT was to be implemented in Nyondo village one would need to:

- Target men so that they can allow women to share the resources to enable women to access HCT services.
- Support women through their social and economic structures to enhance their incomes so that they can control some resources which they can use to access HCT services.
- Work with the community to establish subsidized youth-friendly services to enable girls and boys (who have no resources) to be able to access and utilize HCT services.

Steps to follow

- (i) Identify and discuss local terminologies for access, ownership and control – examples are very useful.
- (ii) Divide the participants into smaller groups of men, women, boys and girls, as was the case during the preparation of the activity profile.
- (iii) Ask the participants to list the services, resources, assets, etc., needed to undertake the activities listed in the activity profile. After that ask the group to list all the resources that men, women, boys and girls need in order for them to carry out their different activities. Then ask: “Who controls the resources that are needed?” Ask for details of specific resources using the list the group created earlier on.
- (iv) Stand back and let the people complete their own access and control profile. Use the questions you prepared in advance to encourage and keep them focused on the subject.
- (v) After making the access ownership and control profile, discuss the results with the participants.

Discussion guide

- What resources (money, time, tools, credit, transport, labour, decisions, machinery or equipment, food, etc.) are needed to carry out the activities that women and girls do?
- What resources are needed to do the activities that men and boys do?
- For each activity, who has control over the required resources?
- How does lack of access to resources by the people who need such resources affect their performance in the fight against HIV and AIDS?
- Why are some resources not under the control of the people who actually need them most?
- What have been the changes in ownership, access, and control over the last 10-15 years?

Decision-Making Matrix

Figure 7 illustrates a gender decision-making matrix for management and prevention of HIV/AIDS. This tool helps men and women to analyze their decision-making abilities in areas that affect their lives. In this context, the matrix focuses on resource utilization decision-making powers in relation to access and utilization for health services and more specifically to HIV/AIDS-related services.

Figure 7: Gender Decision-Making Matrix for Kakoola Village

Decisions	Men	Women
Purchase and use of ARVs	♣♣♣♣♣♣♣♣	♣♣
Condom use	♣♣♣♣♣♣♣♣	♣♣♣
HIV testing & counselling	♣♣	♣♣♣♣♣♣♣♣♣ ^a
Family planning	♣♣♣♣♣♣	♣♣♣♣
Payment for health services	♣♣♣♣♣♣	♣♣♣♣
Antenatal care (ANC)	♣♣♣♣♣♣	♣♣♣♣
PMTCT	♣♣	♣♣♣♣♣♣♣♣♣
Breastfeeding (post natal)	♣♣♣	♣♣♣♣♣♣♣♣

Key: ♣ Represents one vote

Note: From the figure, it is visible that in Kakoola:

- Men take most decisions on ARVs, condom use, family planning, ANC, and payment for health services. This means that when programming for such an area one needs to target the men, and sensitise them, hoping that they will understand the value of the different services to be able to allow and support the women to access them.
- Women take most decisions on HCT. This means that a special mobilization effort has to be made for men if they are to benefit from HCT services and also support the subsequent services such as disclosure, care and support. It is important to note that women have no easy control over use of condoms and ARVs.

Steps to follow

- Community members need to be assisted to draw a matrix, preferably on the ground. This will consist of three columns as shown in Figure 7 above.
- Each row represents a decision: this is where the community can be asked to list about five important decisions that have to be taken at individual level, five at household level and five at community level. Use symbols such as stones or seeds to represent decision-making powers. One stone or seed will represent a decision.
- Ask community members to score whether women or men normally take a given decision by counting the number of stones or seeds put together.

- (iv) A final summary row can be added and scores used as above. The last row could be in answer to questions:
- o So who has the power to make such and such a decision?
 - o What kind of problems does this create?
 - o How does household decision-making affect VCT utilization, support and care for people with HIV/AIDS?
- (v) Help community members to develop action points on desirable changes in view of various scores.
- (vi) Ask participants to decide on what could be done to improve on their situation.

Discussion guide

- Who determines what to do in case of a health problem in a household?
- What problems are likely to result from decisions made by men only? What about problems that result from decisions made by women only? How can these problems be addressed?
- In case of disagreements, what do you do as men or women?
- How are household resources allocated in case of ill health and who does the allocation?

Tool 4: Preference Ranking

This tool is used in the prioritization of problems, options or preference by the community or a particular group within the community. Community members can use it to prioritize a wide range of options, opportunities or problems. This tool can also help to highlight differences in opinion between different groups within a community. For example, when discussing a water problem, women are likely to focus on it in terms of domestic needs and health of the family; whereas men might discuss it in relation to Constitution; while children are most likely going to mention it as a big problem at school where they spend most of their time. On the other hand, the tool helps the PLA team to better understand community priorities or how a particular situation is perceived (such as HCT services).

Steps to follow

- (i) Facilitate the community to list sites providing HCT services.
- (ii) Represent sites on the ground with a symbol as they are listed. Arrange them in a line.
- (iii) Ask all members to collect the same number of stones or seeds. Guide them to place them against each of the symbols, distributing them in a line according to their preference.
- (iv) Once everyone has voted, the total number of votes for each option can be counted and the preference of the group established. Make a matrix showing the votes, with the highest ranking taking the first position.
- (v) Guide the discussion, probing for reasons on preference, and the implications for the community. Make detailed notes about reasons for the preference given.
- (vi) Where different groups have worked separately, compare the results.
- (vii) On completion, ask community members to capture the results on a piece of paper for their record and for future reference.



Resources are perceived and ranked in different ways by different people

Figure 8: Preferential Ranking of Selected HCT Service Provider Institutions

VCT providers	Married women	Single women	Married men	Single men	Boys	Girls	Score	Rank
Government health units	5	8	4	7	5	5	34	2
NGO/Religious health units	6	0	8	10	5	5	34	2
Clinics	7	0	8	6	8	8	37	1
Referral hospitals	8	7	1	6	2	3	27	4
Traditional health practitioners	7	8	5	4	5	4	33	3

Interpretation of the table

- a) From the above table it is clear that community members ranked clinics as the most important site for HCT, followed by government and NGO health units. Hence the importance of clinics in this locality in providing effective HCT service delivery.
- b) If one is to utilise the above information, one would link up with clinics in the locality and develop some kind of partnership for providing HCT services to community members.
- c) Traditional health practitioners are very much valued and can be useful in mobilizing and sensitizing the community on the importance of HCT service.
- d) There is no big difference in preference by gender and age in this locality. The final score can be applied to all when planning.

Tool 5: Direct Matrix Ranking

This is a ranked list of the most important problems identified by the community. This will enable the PLA team to rank community problems for action. It also enables the team to understand the preferences of groups in the community. The criteria may change from group to group and by gender. Figure 9 is an example of a matrix that demonstrates direct ranking of health problems.

Discussion guide

- What are the major health problems that members of the community have faced during the past year?
- Rank these problems in order of importance by giving 10 or 5 marks to the biggest problem depending on what one selects.
- Find out who is affected most, by what illness, why and how they cope.
- What are the causes for these problems?
- What are the possible resources needed by the community, households and individuals to prevent the mentioned problems from recurring?

Figure 9: Direct Ranking of Health Problems in a Community

Problem	Group I	Group II	Group III	Group IV	Total score	Rank
Malaria	5	5	5	5	20	1
Measles	2	1	4	1	8	4
Diarrhoea	3	3	2	3	11	3
Cough	4	4	3	4	16	2
Pneumonia	1	2	1	2	6	5

Note: The higher the figure of the score, the greater the problem. In this example, malaria and cough were ranked high and so when one is planning HCT, one needs to address malaria and cough as well, either by directly providing the treatment or referring clients to appropriate providers.

Tool 6: Pair-wise Ranking

This is a tool for analyzing community needs and their relative importance. The tool helps to determine the main needs of preferences of individual community members and compares the different needs in pairs.

Steps to follow

- (i) Explain the purpose of the exercise.
- (ii) Let participants list a set of problems to be prioritized (there is need to reach consensus on the priority questions).
- (iii) Select the first 5-7 highly ranked problems/preferences.
- (iv) Request members to draw a matrix on the ground with 5 or 7 rows and columns.

Using local materials, help them to plot the selected needs in a pair, i.e. list the same problem down in the first column and access in the first row. Go on until you have filled the seven rows and columns. Then rank the needs according to the order of importance as reflected in their frequency. The elements to be compared are placed on the vertical and horizontal axes of a simple table. In each square indicate the decision as made between the two elements represented by that square. The elements that appear most often are most popular.

- Compare the first problem in the first column with each need in the first row in order to weigh the relative importance of one need against the others. Continue comparing one need against all the other needs listed in the row, then move to the second column and do the same till all the columns are covered.
- Add the number of times a particular problem appears and put the number in the score column and do the ranking in the last column.
- After scoring and ranking, ask reasons for and against each alternative, one by one, and carefully record the results for each.
- Finally transfer the matrix onto a sheet of paper for conclusions.

Figure 10: Pair-wise Ranking of Community Problems in Kakoola Village, Kayunga District

Need	Food scarcity	Lack of Secondary school	Lack of Vocational school	Water	Lack of HIV/AIDS treatment	Bad roads	Health unit	Score	Rank
Health unit	Health unit	Health unit	Health unit	Health unit	Health unit	Health unit		6	1
Bad roads	Bad roads	Bad roads	Bad roads	Water	HIV/AIDS treatment	HIV/AIDS treatment		3	3
Lack of HIV/AIDS treatment	Lack of HIV/AIDS treatment	Lack of HIV/AIDS treatment	Lack of HIV/AIDS treatment	Water				5	2
Lack of Water	Water	Water	Water					5	2
Lack of Vocational school	Vocational school	Vocational school						2	4
Lack of Secondary school	Secondary school							1	5
Food scarcity								0	6

Implications/interpretation

The emerging picture from Kakoola's pair-wise ranking is that lack of health units is the most pressing problem that the community wanted to be addressed, followed by water and lack of HIV/AIDS treatment. This gives an indication of where community members feel there is the greatest need.

Conclusions

- a) It also means that the intervening development agency should support the construction of a health centre through which COHCT will be implemented.
- b) In case the agency cannot construct or even provide water, it should link up with potential partners who are able to help meet the required need.

Tool 7: Time Line/Historical Profile

The time line is presented in the form of flow charts about key events that happened in the past. This is important especially in gauging whether the situation is improving or worsening as time goes on. This tool will help the community to understand the past better in order to analyze the present conditions. It will also help people understand how the bad and good times have influenced their lives, how they have coped with problems and can predict future trends on the basis of this information. Historical profiles help the community to predict the likely way forward.

Steps to follow

- (i) Ask participants to form a circle in a place where they can easily draw on the ground or floor.
- (ii) Get one member to find a stick, chalk or piece of charcoal and draw a long line on the ground or floor on which the events will be plotted.
- (iii) Ask the participants to help in identifying major events that occurred in the community with a major impact on their lives (even as long ago as 20 years). It can be war, an epidemic, famine, a locust invasion, drought or a devastating flood. The time line can show how persistent the problem was and how that problem was dealt with. Discussion of a time line would include development of basic infrastructure such as construction of health facilities, schools and roads. These developments may have affected the community in different ways. The historical profile will enable the participants to reflect on how

they dealt with the problems. People, for instance, could discuss the first time people started dying of AIDS: How people initially interpreted those deaths and how this interpretation has changed over time. Having these discussions helps the team to start visualising how the HCT can be planned building on the community expenses.

- (iv) Make sure that the stick, charcoal or chalk is passed on from one member to the next. Listen carefully to ensure that all major events that affected the community over the period under examination are captured. Plot events on the line, with the oldest events first and the most recent events last.
- (v) Probe for events that are of interest to you and get to understand how they affected the community. How would the community react if a disaster happened again. Would the community react differently than before?
- (vi) At the end of the exercise ask if anyone has anything else to add to the information already generated.
- (vii) Ask one of the participants to transfer the time line to a sheet of paper for the record and further discussion.

Discussion guide

- When did the event take place (year or period)?
- What actually happened?
- How did the event or the occurrence impact on the community?
How did the different social groups (women, men, girls, boys, the elderly, people living with HIV, and persons with disability) cope?
- What was the community response?
- Could the community have responded differently?

The discussion on the timeline will assist in identifying community coping mechanisms with various challenging events. These mechanisms should be noted and can be re-introduced again at the time when the community is developing their action plan. Their specific role/contribution in COHCT, can be borrowed from their previous experiences.

Figure 11: Time line for Kakoola Village, Kayunga District

Year	Event	Comment
1980	Famine-locally known as “ <i>ani amuwadde akatebe?</i> ”	People ate ‘ <i>kayinja</i> ’ and forest food called ‘ <i>kama</i> ’ and there were increased thefts.
1994	Cassava mosaic	There was a famine which affected men most because they had to look for food to feed the family.
1995	Coffee boom	People gained more income (one kilogram of coffee was sold at Ug. shs 1,000/=). People constructed permanent houses, and stocked shops. Others bought assets such as motorcycles (10), land, car (1), bicycles. People could also afford basic necessities: education, clothing and food. More market places emerged. There were increased coffee thefts and fights.
2000	Coffee wilt disease	Low incomes and thus poverty reduced agricultural production owing to inability to hire labour which they depended on most. There was a high dropout rate of children from school.
2004	Vanilla production	Increased income – a kg of vanilla was at Ug shs 100,000/= . People bought assets – cattle, mobile phones, plots (2) and constructed permanent houses.

Tool 8: Seasonal Calendar

This is a tool that looks at seasonal variations that influence the livelihood of the community members in different ways. Harvest seasons are good because people do not only have enough to eat but also extra food to sell and earn some income. With this income they can afford to pay for services. On the other hand, some seasons are hard, and are marked by food shortages or epidemics that impact negatively on the people.

When planning for COHCT, it is important to know the seasonal variations and how they are compatible or incompatible with communal programs. The seasonal calendar is used to show periods when communities are very busy or not during the year and how these are likely to influence their participation in development activities. During busy periods, such as the planting seasons, people may not find time to engage in community projects such as attending seminars.

The seasonal calendar identifies the months of greatest difficulty and vulnerability, or other significant variances with the greatest impact on people’s lives. For example, it will show variations in climate, rainfall

patterns, crop sequences, income and expenditure, nutrition, health and disease patterns, periods of scarcity and periods of abundance.

Steps to follow

- (i) Introduce the topic for discussion and explain the purpose of the exercise clearly.
- (ii) Divide the participants into smaller groups on the basis of age and sex.
- (iii) Guide the PLA team to prepare locally available materials to use during the exercise. These materials could include stones, seeds and flowers. The months are arranged in one row at the top of the matrix and the topics on a vertical column.
- (iv) Proceed by asking the participants to fill the calendar using the selected materials.
- (v) Find out the characteristics of the different months/seasons, for example by asking when is the harvest season? When are the children in school? When is there is “more” or “less” disease prevalence¹, rainfall, fever, etc.? Discuss the score given in the matrix (high or low). Move on to the next month and discuss whether the elements under analysis are more, equal or less than the previous month. Do the same for the remaining months. When the first topic is covered, then move to the next until all of them are covered. On top of that ask the participants about the worst and best months and why they think so.
- (vi) After the calendar is filled in ask the group about the possible linkages that could be connecting different topics of the calendar. Encourage the group to discuss on the basis of what they can see on the calendar. What does the calendar tell us in terms of problems and how it can help the community plan to tackle?
- (vii) Transfer the data on to a sheet of paper and leave a copy with the community. Make sure that the calendar has a key explaining the different items and symbols used.

¹ You may want the participants to be more specific regarding which diseases are prevalent in a given season.



Time of harvest is a time of plenty

Discussion guide

- What activities do people perform in the year?
- What are the busiest months of the year?
- What do you do during those months?
- When are you least busy during the year?
- What do you do when you are least busy?
- When is food scarce or in plenty? What happens?
- What diseases are common? When and how do they impact on the productivity of the community?
- What is the most problematic season of the year?
- What could be the most appropriate season for additional activities for men and women? What time constraints do exist and for what reason?

Figure 12: Seasonal Calendar for Kakoola and Nyondo Villages

Event	J	F	M	A	M	J	J	A	S	O	N	D
Drought	**	*** **	*** **			**			**			*
Rainfall				***	*** **	**				**	*** **	*
Malaria						*** **					*	*
Diarrhoea				*** **	*** **	*** **					*	*
Cough & flu	*** **	*** **				***						
Famine				*** **	*** **							
Harvesting	****					*** **	**					
Income						*** **	***					***
Expenditure		*** **										***
Poverty				*** **	*** **				**			
Participation	***	**	*				*** **					

Using the calendar for planning

If HCT was to be undertaken in Nyondo village, the following would be considered:

- i) Engaging the community members during the months of July, August, September, and most of October, since these are less busy months. Community meetings, for instance, can be convened during these months.
- ii) It is also necessary to note the months when the disease burden is high, so that you do not demand time/engage women in community activities since they are likely to be over stretched. During Action Planning, these issues should be considered.
- iii) One should avoid planning mobilization activities in April, May, and June, since these are likely to be planting season, etc.
- iv) If one wants to mobilise funds from the community then one should avoid April when poverty is outstanding but should target January and July.

Other participatory techniques for data collection

a) Focus Group Discussions (FGDs)

This method aims at obtaining opinions and perceptions from a specific group. Focus group discussions are participatory in nature. They can be used to voice the opinions of marginalized groups such as the poor, people affected by HIV and AIDS, women, disabled persons, children, and minority ethnic groups.

When mobilizing participants for an FGD it is advisable to do purposeful sampling and select people with similar characteristics. Draw participants from the same social setting, age group, or gender. In this case they will feel more comfortable talking to one another and are more likely to talk openly. The recommended number for a focus group is between 6 and 12 participants. FGDs are moderated using a discussion guide with a list of themes or topics.

How to conduct an FGD

Focus group discussions are managed using an instrument called an FGD guide, which comprises of a list of questions and themes on the subject under discussion. The moderator is in charge of asking these questions. It should be noted that moderators have leeway to add extra questions in the probing process. Moderators can rephrase the questions depending on how the participants understand and respond. The FGD guide is usually a summary instrument which the moderator operationalizes by breaking it down into sub-questions.

Focus groups serve to initiate a discussion that focuses on people's opinions about a certain phenomenon. FGDs generate information that helps in the understanding of attitudes, values and perceptions. FGDs usually take up to one hour of discussion time. However, FGDs may go beyond one hour when participants are particularly interested in the discussion and decide to expound more.



Groups should be made up of participants from the same social setting, age group, or gender.

Steps to follow

- (i) The topic for discussion should be well-defined and a few guide questions should be prepared. Decide on the target group and invite them for a discussion. The group should be about 6 to 10 people. Groups should be made up of members with fairly homogeneous characteristics. These characteristics would include sex, age, ethnicity, education level and social-economic status.



Groups should be made up of members with fairly homogeneous characteristics

- (ii) Select a convenient venue. A quiet, fairly private and neutral venue is preferred since it enables people to feel free to talk to one another.
- (iii) Reach the venue early before the scheduled time of the meeting. This will enable you to get acquainted with the setting such that you can easily decide on how the people are going to sit. Places where there is shade are preferred; if there is too much sunshine some shelter may be needed.
- (iv) Once the people are gathered, begin with introductions; self-introduction is preferred. Introduce yourself to the participants. Ask the participants to also introduce themselves and record all their names down. Explain why the meeting has been convened, and emphasize what the information collected will be used for. This is important for creating an atmosphere of openness and confidence and also for demonstrating the importance of the discussion.
- (v) Introduce the subject for discussion. The moderator should ask the participants to respect one another's views and confidentiality.
- (vi) Agree with the participants on the method of recording information such as flip charts, use of a voice recorder or another method you want to use. In case you are going to use a tape recorder, explain the purpose of using it and ask for permission to tape record the discussion. Explain that it is intended for accuracy in capturing their views rather than for other purposes such as broadcasting. If they refuse, do not use the recorder.
- (vii) Start with general questions to set the mood for the discussion. Try to be as clear as possible when asking questions.
- (viii) Observe whether everybody is following and participating. Encourage those who are less confident to talk by asking them to contribute views on general issues. Give opportunity to each participant to comment on what is being discussed. Some people have the tendency to speak more frequently than others. The moderator should be cautious and ensure that the dominant characters are controlled as the reserved ones are encouraged to speak. The moderator should be able to judge that sufficient information has been collected on a certain question before moving on to the next. The time should be well managed to ensure that all the questions are addressed without taking too long, which would tire the participants, leading to impatience when it gets late.
- (ix) Towards the end, summarise the main points and crosscheck with the group to confirm that they agree.
- (x) In conclusion, thank everyone for their participation.

Note:

- Sometimes participants may not agree on some of the issues being discussed. This is normal. Avoid forcing conclusions on participants. In an FGD, it is the disagreements and the moods in which they are expressed that matter more than consensus.
- The moderator should try to probe on issues that are not clear or where there is insufficient information and yet the moderator feels it is important to get more details.
- The moderator should remain objective and avoid taking sides with some participants or expressing shock or disappointment regarding some of the responses. The moderator must remain neutral to all the responses and should not reject any answers or declare them irrelevant.

b) Observation

This is a technique that involves watching and recording behaviour and the characteristics of living things under study. In the case of needs assessment where there is no time for systematic observations, it is better to integrate the observation component into other methodologies.

Observations are useful in cross-checking information collected on sensitive topics such as AIDS, alcohol, drug use and abuse. Observation can also be a primary source of information, e.g., observing children as they play, or the status of physical infrastructure such as availability of a latrine, etc. Through observation, you can arrive at an understanding of the local context. Photographs can supplement recorded data.

c) Review of secondary data

There is often a large body of data already collected by others on the subject you may be interested in. Locating existing sources and retrieving the information is a good starting point in any research effort.

Analysis of secondary data is important in enabling the researcher to identify gaps in the subject to be studied or problems in the implementation of a particular activity. Data sources include published books and monographs or unpublished reports. They are obtained from archives, libraries, websites, or in offices at various levels of service delivery. Data may be collected using a compilation form or a checklist.

MODULE IV

DATA ANALYSIS AND REPORTING

Data analysis is a process through which the collected data is combined to make meaning in relation to the study objectives. For example, if one of the objectives for a needs assessment was to establish the extent to which a given community can provide psychosocial support services, the following questions would be examined using data that has been collected:

- a) What counselling opportunities exist in the community, e.g., are there community counselling aides or their equivalent;
- b) What are the community perceptions and expectations regarding voluntary work? Does the data show a presence of volunteers in other development activities? And if yes, how are volunteers managed and motivated? etc.

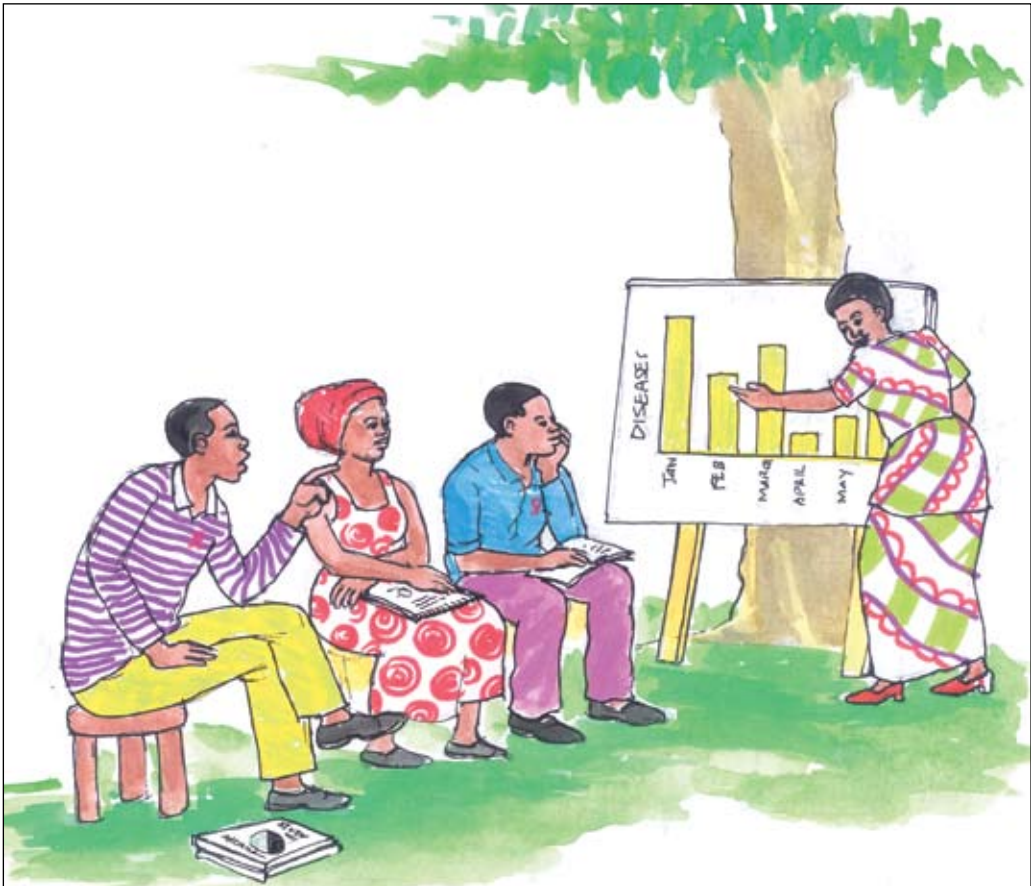
Data analysis is an ongoing activity that the PLA team does at the end of every field day to make sure that the data they are collecting is relevant to the objectives of the PLA exercise. The advantage of raising analysis questions daily is that one is able to identify information gaps in a timely manner and notice and seek clarification on issues that may not be clear so as to get clarification before leaving the community. It also enables the team to triangulate information and ensure that it is accurately recorded from the field. Once everything has been clarified, one can then proceed to turn the raw data into well-developed arguments/discussion. The translation of raw data into text enables one to make sense of collected data. The following are key features in this process:

- classifying, categorising, coding or collating data (Coffey and Atkinson 1996);
- analysis, depending on which approach one decides to use;
- analysis of data according to the objectives of the study.
- organising data into thematic areas, this can help in the development of a qualitative argument.

Key points to note on analysis of PLA findings

- Analysis in the context of PLA is done on a daily basis to ensure that responses are captured and classified. It involves its classification, formulation of additional questions that enable verification, and arriving at conclusions. Analysis is the process by which we make sense of the collected information.
- Prepare a list of key issues and arrange your findings according to that list. Re-arrange, break up, and re-assemble pieces of data. Sort and sift through information and look for patterns, differences, variations, and contradictions. Weigh the relative importance of the information.
- Formulate a series of questions based on the research topic (including new questions which may have come up during fieldwork) and try to answer them with the help of the collected information.
- Discuss each sub-topic in turn, summarize the results, and draw conclusions based on the information gathered from the field.
- Use diagrams, matrices, ranking methods, and other analytical tools.
- For further clarification tabulate the information. Tabulating pulls out key information from interviews and observations, and allows comparison of differences between individuals. Tabulating also helps the team to avoid relying on general impressions rather than facts.
- Check your findings and conclusions by presenting them to key informants or to a group of community members.
- Findings have to be consistent without contradictions. If the findings contradict secondary or any other sources you must be able to explain and account for those discrepancies.

- Once the team has collected data from the field, they should set time aside (on a daily basis) to share and analyze the information. Discussion of the information helps to clarify areas that may not have been captured well but also helps in enabling the team to reach a common understanding of the data being collected.
- The analysis meeting also helps the team to review their experiences in the field and to make adjustments on tools/approaches where this is found to be necessary.



The team should, on a daily basis, set time aside to share and analyze the data collected from the field.

Discussion guide

Possible key questions to ask when synthesising and analysing the data are:

- What does the response provided mean?
- Why is the respondent saying that?
- What are the consequences/implications of the response?
- What are the contradictions between what is expected and the reality?
- Who is responsible (cause and possible solutions)?

Tips on data collection, analysis and reporting

Duration of Participatory Rural Analysis (PRA) processes

A typical PRA exercise lasts about seven days or more depending on the circumstances such as the:

- time available to both community members and the PRA team;
- number of the moderators to facilitate the process; including HCT specialists.
- number of community members able and willing to participate; and
- number of tools that are going to be applied.

Time needed for each tool/exercise

Each tool usually takes between two and four hours, although some tools may take less than two or more than four hours, depending on:

- the level of detail of the information required; it should be able to bring out all issues related to HCT;
- whether the facilitator has previous experience in the application of the PRA tools;
- the time that community members require to understand and actively participate in the exercise; and
- the time needed to discuss a particular topic or theme.

Issues to consider when writing a field/PLA report

- a) Always write daily exercise reports. Each team should summarize key findings under the following headings:
 - (i) topic of discussion e.g. access to HIV/AIDS services
 - (ii) methodology/tool used
 - (iii) target respondents e.g. LC leaders, health officers, community members, etc
 - (iv) key findings and key group conclusions
- b) Merge the daily exercise reports into a main report.
- c) While compiling the report, reflect on the following questions:
 - (i) Audience: Who will read the report (the community, government, District health office, NGOs, donors)?
 - (ii) What will the report be used for? In this case the report will be used for planning COHCT.
 - (iii) What should the report contain?
 - (iv) How should the information be presented?

Report outlines

- (i) Keep it short and clear.
- (ii) Use short sentences.
- (iii) Prepare it as soon as possible, as the findings are time-bound.
- (iv) Organize the report in a logical, easy-to-follow outline and make it as easy to understand as possible. Use sub-headings.
- (v) Concentrate on what the community will use.
- (vi) Make full use of charts, tables, diagrams and illustrations prepared/ collected during the PRA.

General Report outline

1. Title/Topic–This should state the title of the subject being reported on.
2. Executive summary–The executive summary highlights all key issues in the report. The executive summary should not exceed two pages, and it should be able to put across the main findings in brief concise statements.
3. Introduction/background information–The background highlights all contextual information on what is being reported on. This includes the reasons behind the exercise, when it was conducted, how and by whom, etc.
4. Objectives–This states the reasons why the exercise was conducted.
5. Methodology–This section explains the methods utilised, approach used to collect and analyse data, the sampling of respondents, etc.
6. Main findings–These should be tailored to the set objectives or agreed upon themes.
7. Recommendations–Show practical suggestions of what needs to be done.
8. Action steps–This is a list of actions that will be undertaken thereafter.
9. Appendices–Can include references, acronyms used, selected diagrams, maps, statistics, secondary sources used, among others, and can also include question/interview guides.

Once the report has been completed:

- Make sure it reaches the right audience so that the results can get factored into decisions.
- Distribute and provide a brief of the report to stakeholders, individuals and institutions.

MODULE V

UTILIZING NEEDS ASSESSMENT FINDINGS FOR PROGRAMMING

Community Vision and Action Planning

During the initial stages of project design, it is important to have an idea about what needs the community has that would most likely be addressed by the planned project. The vision—the clear picture of what the community members want to realise—should reflect their development aspirations. It transcends community capacity or what the members of the community possess, it is a true picture of what they want to be. As a final step in the PRA exercise, it is important to discuss what the community would like to see happening in relation to their key priorities and arrive at an action plan on the basis of this vision.

The process should enable participants to reflect on their current reality, then the future they have envisioned. It involves them thinking about the gap between the current situation and the desired future and what it would take to enable them to realize their vision. After this reflection, community members should then list the action steps that they need to take in order to arrive where they want to be. It is at this stage that participants will go into the community action planning exercise.

Action planning involves community members in drawing up a plan that can be used to address their problem(s), showing what will be done, how, when, and by whom. It also shows the required resources and the possible sources. The exercise should enable community members to take on the responsibility to undertake certain tasks in order to realize their common vision.

Purpose: This exercise helps the participants to develop a common long-term goal for their community and decide on how to achieve that goal. This would be through directing their energies towards a desired future, and through action planning of how the goal will be reached, rather than through focusing on current problems.

Duration: 2 hours.

Materials: Cards, flip charts, and markers.

Steps to follow

- (i) Introduce yourself and the rest of the team and explain the purpose of the exercise.
- (ii) Introduce the visioning exercise by explaining what a vision is (a clear mental picture of what one truly wants to realize in the long term).
- (iii) Divide the participants into two groups, ensuring that each has a mix of women and men, in order to get a true perspective of the community.
- (iv) Let the groups each discuss and draw the picture depicting the present situation in their homes and the community. The picture should relate to what has emerged out of the PLA for the COHCT exercise.
- (v) Let one group discuss what they want to see at household level and the other at community level after a specific period of, say, five years.
- (vi) Ask the group to draw a picture of the vision as discussed. This could be on the ground, floor or on a piece of paper. Ask them to compare their current picture with their desired future and take note of the gap.
- (vii) When this is done, call back the two groups and facilitate them to discuss both drawings, allowing for changes if required.
- (viii) Guide them to discuss and come up with all the activities that have to be undertaken to move from the present picture to that of their expressed vision.
- (ix) Discuss the next steps (action plan). The action plan should also specify sources of resources (human and financial), and should clearly spell out the contribution the community will make and the contribution by the project being run by non-community members.
- (x) Handing over to the community: Once the plan has been drafted, the facilitating team should complete it, make copies and share it with the community leaders and other significant partners, making it ready for implementation.

Discussion guide

- What is your current reality (relate it to the project)? What problems are we trying to deal with?
- How different would you like your future to be (vision) ?
- How will the vision contribute to the well-being of the community, households and individual?
- What has the community got to do to make the vision real?
- Who should we involve, and how will the community be involved?
- What actions will be taken and by whom?

Planning for Monitoring Community HIV Counselling and Testing

It is important to note that community planning cannot be complete unless it addresses issues of COHCT monitoring. COHCT monitoring is a way of going back and checking whether the plans are being realised as earlier intended. In addition, the PLA facilitator needs to anticipate the key questions that the community members need to discuss and agree on. These include: what needs to be monitored, and when and how often we need to engage in COHCT monitoring. The principles of community monitoring are the same as those of community needs assessment and planning, that is, one has to use participatory approaches to engage the community in assessing the changes that have taken place over a period of time. The PLA facilitator has to guide the team to brainstorm and agree on how often community members would like to meet and discuss the changes, successes and challenges they are experiencing. Planning for community monitoring requires one to go through the following steps.

- (i) Introduce the concept of community monitoring for COHCT, that is, it is a process that involves community members discussing and taking note of the changes (positive and negative) in HIV/AIDS that are happening in their community. Let them know that this process is important because it enables them to identify challenges and devise collective strategies to overcome them.
- (ii) Let the members ask any questions they might have regarding COHCT monitoring; and once these are clarified ask them to discuss and agree on how often they would like to have meetings for monitoring their COHCT activities in general for example, after 6 months, 1 year or two years?
- (iii) Once the frequency for monitoring COHCT activities has been agreed on, explain to the team that the same tools they used for COHCT needs assessment can be used to conduct COHCT monitoring.
- (iv) Take the team through the example of using a community map; use similar steps to draw a map as earlier described in this handbook. The main concern is to visualise the changes and barriers in relation to access and use of HIV/AIDS services within their community. Once the map is drawn, the team should be able to discuss it and compare it with the map they had at the time of COHCT needs assessment (this should be in the custody of a community leader). They should discuss the changes that have come up in their community and the likely reasons for these changes. Where they identify gaps/challenges, they should be able to plan for ways of addressing those gaps. They

should also agree on the people to be responsible for leading the implementation of their new plan.

Discussion Guide

- What is your current reality in relation to HIV/AIDS?
- Which people/institutions provide HIV/AIDS services in your community (probe more on this to ensure that they do not forget the community resource persons).
- What changes have taken place since you started implementing COHCT in terms of access and utilisation of services, reduction of stigma etc? (They should plot these changes on their new map, for example new facilities, new resources etc?)
- What are the causes for these changes?
- How shall we maintain the good changes in the community HIV counselling and testing?
- How shall we remove the current challenges that are preventing us from realising our community vision?
- Whether the community is aware of the changes in the HIV interventions, for example new medicines, new approaches.

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COMMUNITY HIV COUNSELLING AND TESTING

Community HIV Counselling and Testing (COHCT) is an approach that focuses on utilizing existing community competencies in dealing with HIV/AIDS in general, and HIV counselling and testing in particular. The COHCT concept is premised on the knowledge that HIV counselling and testing is an entry point into HIV prevention, care and support and that communities have a primary role to play in the HIV/AIDS intervention.

The approach utilises participatory methodologies to engage community members in analysing their HIV/AIDS situation, and, from the existing social mechanisms and structures. It enables members to identify the options that would enable them mobilise for HCT and thereafter deal with the usual outcomes of HIV test: These include enabling those who are positive to negotiate their new status, and disclose to significant others, supporting prevention of infection for those who test negative, and protecting the positive from reinfection, stigma and providing for their necessary care and support. Below is how COHCT would work.

COHCT needs assessment refers to the process through which community members are supported to assess their HIV counselling and testing needs in order to identify the key problems and needs, and develop an action plan to address those needs. This handbook is meant for those planning to implement the community HCT program. It provides basic conceptual explanations and guidelines on how to conduct a COHCT needs assessment as an entry process for community planning for HIV counselling, testing, care and support.

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