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A Study of Three Program Types' Effectiveness in the Prevention and Awareness of HIV/AIDS in Sub-Saharan Africa

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A STUDY OF THREE PROGRAM TYPES' EFFECTIVENESS IN THE
PREVENTION AND AWARENESS OF HIV/AIDS IN SUB-SAHARAN AFRICA

A project based upon an independent investigation, submitted in partial fulfillment of the requirement for the degree of Bachelor of Arts in Social Work

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Abstract

Sub-Saharan Africa is home to over 60% of the world's AIDS cases; thus, HIV prevention and treatment is a pressing global issue that needs to be addressed with governmental assistance, medication, education, and overall community support. This research paper examines and compares the success of HIV/AIDS treatment, education, and prevention programs in sub-Saharan Africa in order to determine which type of program is the most effective. The three program types that are examined are large-scale governmental policies and organizations, local community run grassroots organizations, and programs that combine grassroots initiatives with umbrella organization assistance. The general consensus of the reviewed literature implies that combination programs will be most effective due to their relative financial stability (as opposed to grassroots programs) and consistent interaction and involvement with the community (unlike large-scale organizations). This study gathered data through a qualitative survey distributed to key stakeholders of organizations in sub-Saharan Africa that represent the three types listed above. Eight programs were contacted, but due to international communication barriers and limitations on releasing private program information, only one key stakeholder completed the survey, while an additional two followed up with other information. Still, through careful examination of these particular programs it was determined that, contrary to the literature, the grassroots program was most effective in terms of education, treatment, and prevention.

Preface

In this relational study, the HIV/AIDS epidemic in Africa will be addressed with respect to the success of education, treatment, and prevention programs. Three different types of programs will be examined: community-based grassroots programs that have a limited access to resources; large scale governmental and non-governmental organizations that do not have much personal involvement within their target communities; and programs that combine both grassroots and governmental efforts. Within this examination, overall limitations to program development will be studied.

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Introduction

The HIV/AIDS epidemic in Sub-Saharan Africa is a pressing world issue that needs to be addressed with governmental assistance, medication, education, and overall community support. While Sub-Saharan Africa is home to over 60% of the 33 million people infected with HIV/AIDS, this region only represents 10% of the world's population (Fredriksson-Bass, 2008). Even though these statistics are devastating, Africa still does not have nearly enough advantageous programs to fight against the HIV/AIDS pandemic. This research paper will examine the success and effectiveness of three different types of programs and their attempts to provide treatment, support, and education about HIV/AIDS for regions in Africa severely affected by the epidemic. Grassroots organizations that have scarce access to monetary and resource assistance, but a high level of personal involvement in the community will be explored initially. These small-scale programs will in turn be compared to large scale umbrella organizations, such as non-governmental organizations (NGOs), Inter-governmental organizations (IGOs), Government plans, and research organizations that have minimal personnel working within the community at a grassroots level, but greater access to funding and medication. Finally, programs that demonstrate a combination of both large-scale resources and grassroots efforts will be studied.

Numerous cultural, political, and economic barriers make it difficult for programs that promote condom use, structured treatment therapy, and education on sex and health to be both well received and successful in sub-Saharan Africa. From a cultural perspective in many parts of Africa, there is a stigma attached to HIV and AIDS. Several misconstrued beliefs exist regarding what AIDS is and how one becomes infected,

leading to the negative connotation associated with the syndrome. Furthermore, an overall fear is associated with the disease and the people who have it. As a result, these individuals are often shunned and rejected.

Certain practices (such as condom use or abstinence) have never been observed in many of these at-risk communities in the past, and it is extremely difficult to change tradition-based cultures. Strong political figures can have a large effect on individuals' acceptance and knowledge of HIV/AIDS. Former South African President Thabo Mbeki had a significant impact on his country's political refutation of HIV and AIDS by denying the existence of these illnesses himself (Stine, 2008). In order for an education and awareness program to succeed in such communities, the program must embrace and understand certain cultural beliefs and integrate these viewpoints into the education process (Cherian, 2005). In terms of economics, numerous communities simply do not have sufficient resources to provide education on HIV/AIDS, nor do they have enough funding to acquire treatment medication. Moreover, many countries have very little support from social welfare organizations that are present in other regions of Sub-Saharan Africa (Fredriksson-Bass, 2008). The above information was reviewed because in order to determine how both large-scale organizations and grassroots programs can be as effective as possible, it is tremendously important to first examine the barriers that they may face, whether cultural, political, or economical.

The involvement of the Social Work profession in global issues such as ensuring that there are successful and effective HIV/AIDS awareness, education, and treatment programs, is imperative. According to the National Association of Social Workers (NASW) Delegate Assembly and Code of Ethics, "Social workers should promote the

general welfare of society, from local to global levels, and the development of people, their communities, and their environments” (1999, p.1). International interventions related to human welfare have been successful when initiated from both macro and micro arenas. Fredriksson-Bass (2008) notes that organizations like the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund provide vital support not only to needy communities, but also to grassroots organization that are working in Africa to help provide direct relief. However, oppositional arguments to this viewpoint also exist and will be addressed. For instance, the Home-Based Care Alliance (2008) places emphasis on the importance of grassroots organizations with the claim that while there are billions of dollars being given to the fight against HIV and AIDS in Africa, grassroots programs are the ones doing the majority of the effective work. On the other hand, many agree with Fredriksson-Bass’ (2008) statement that “one of the most important ways in which the situation in Africa can be improved is through increased funding” (p.8). All viewpoints will be researched thoroughly due to their equal importance in the evaluation of HIV/AIDS prevention, education, and treatment grassroots programs, large scale organizations, and initiatives that combine the two.

As the preamble to the Social Work Code of Ethics states,

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (1999, p.1).

Ultimately, this research paper will demonstrate that hundreds of communities in Sub-Saharan Africa struggling with HIV/AIDS need more than monetary assistance to fight

the battle against the epidemic. These regions need assistance in advocating for their rights and needs as human beings, provision of resources that they cannot procure for themselves, and assistance in building their own network of educators and support systems. As previously stated, this study will examine three different program types – small scale grassroots organizations, large scale organizations, and organizations that combine large scale program assistance with grassroots efforts and communication – in order to determine which program type is most effective and successful in supporting destitute communities in need of assistance. The results of this study will demonstrate which aspects of certain programs are effective or ineffective, and in turn will help all program types working with HIV/AIDS reevaluate and improve their organizations' efforts.

Literature Review

This study will provide a collaboration of points in order to ultimately provide a general demonstration of both the effective and ineffective aspects of HIV/AIDS micro and macro level programs in sub-Saharan Africa. Macro-level programs such as, NGOs, IGOs, Government plans, and research organizations, are more likely to use monitoring and evaluating (M&E) tools due to the fact that these organizations want to ensure the money they are spending is put to good use. However, often times this information is not accessible as public information. Grassroots programs are less likely to evaluate themselves because they do not necessarily have the time or the means. Therefore, limitations exist in finding published information on the success and/or failure of both of these program types. Nonetheless, the research will examine a sufficient amount of evaluative information in order to develop a solid concluding argument.

Cultural limitations

While varying program types are likely to face different limitations to their effectiveness, certain barriers also exist that affect nearly all HIV/AIDS treatment initiatives in sub-Saharan Africa. A study was conducted among sixteen South African university students in the hopes of gaining a sense of why people may be ignoring the presence of HIV/AIDS in their communities (Cherian, 2005). The understanding gained by this review of individuals' reasons for either their lack of knowledge regarding HIV/AIDS or their unwillingness to accept the epidemic may be beneficial in building a foundation for a successful HIV/AIDS prevention, education, and treatment program in terms of the issues that will have to be addressed.

The students involved in the study were all asked the following question: "What ideas have you heard about HIV/AIDS which may encourage people to ignore health promotion efforts to prevent the spread of HIV/AIDS?" (Cherian, 2005, p.2). The most highly ranked responses were: traditional healers can cure AIDS, having sex with a virgin can cure AIDS, one can get HIV through witchcraft, old women can cure AIDS, have sex with a disabled person can cure AIDS, having sex with a baby can cure AIDS, using Vaseline or baby oil can lower the chance of getting HIV/AIDS, and AIDS is a Western idea to control the African population (Cherian, 2005). These are examples of cultural barriers to the provision of services. As stated by Cherian (2005), "if these beliefs are not taken into consideration when educating people, the efforts on AIDS education will be fruitless. The concept of science and community working together to create a unified program should form the pillar of intervention programmes" (p.3). Although some

western ideas, such as condom use, need to be taught in order to curb the HIV/AIDS epidemic in developing nations, respect for community rituals and behaviors is crucial.

Treatment limitations

A common limitation to effective HIV/AIDS treatment programs is the availability of Anti-Retroviral (ARV) Treatment. Anti-Retroviral Treatment is the medication regimen used to enhance an individual's immune system functioning and is currently the most effective form of HIV and AIDS treatment. Each person requires an individualized drug regimen, usually consisting of over five different types of medications. Not only are ARVs expensive, but they must be taken at very specific times on a regular basis. This is a discipline that requires a sufficient amount of education on each individual drug and poses a challenge in providing the millions of individuals in Africa infected with HIV or AIDS with adequate and regular treatment. Nonetheless, universal access to ARVs for all individuals who meet the medical criteria is the ultimate goal of the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS).

Monetary issues are not the only factors limiting certain individuals' access to ARV treatment. As stated by Jones (2005), "Scaling up ARVs takes place...against a more general backdrop of health interventions that seldom reach the poor and reflect a skewed distribution of basic health services within and between countries" (p.78). This issue of equity in access to treatment is rarely addressed, particularly in documentation of criteria for services, by the organizations that have the capability of providing such treatment (Jones, 2005). Ultimately, the problem proves to be that while the amount of ARVs that can be provided through UNAIDS, WHO, and other similar organizations is limited, there is still no written criteria on how to determine who should be first in line for

receiving this treatment. In the country of Zambia in 2004, Jones (2005) conducted a series of interviews with “key cross-sectoral actors” in the distribution of ARVs in Zambia with the intentions of establishing criteria for the ARV selection process. From these interviews, Jones (2005) found that

The financial contribution that people living with AIDS (PLWAs) were required to make toward their ARVs, as well as associated costs such as those for testing – was identified as the fundamental barrier to access and the greatest engine of inequity (p.88).

Jones’ (2005) examination of Anti-retroviral treatment availability and access demonstrates that while these medications are an extremely valuable addition to any HIV/AIDS treatment program, large scale organizations such as WHO and UNAIDS are still struggling to find the most effective and ethical provisions of these resources.

Grassroots programs

For the purpose of this study, Grassroots organizations will be defined as programs with scarce access to monetary and medical resources, but a high level of personal involvement in the community. A program in Maasai, Tanzania called “consciousness to all” is an excellent example of a program developed and run by members of the community; a true grassroots organization. Typically, Maasai gatherings are a time for celebration and festivities. However, in 2003 the leaders of “Consciousness to all,” an organization that is raising awareness about HIV/AIDS in the Maasai community, decided to meet to discuss how effective the program has been since its establishment in 2001. The main HIV/AIDS risk factor of the Maasai community is that the concepts of abstinence, faithfulness, and condom use are not accepted. Furthermore, Maasai labor

migrants are at a great risk of contracting HIV due to their common numerous unprotected sexual encounters with unfamiliar women outside their village. However, one of the elders claims that “despite their deep-rooted traditions, the Maasai have acknowledged the new challenge [that HIV/AIDS brings forth], and do seem prepared to adapt” (May & McCabe, 2004, p.2). This program has been positively received by community members, and in that sense, is successful.

However, it seems that cultural practices and HIV/AIDS misconceptions are playing a role in the message that Maasai elders are sending to their community. For instance, the Maasai men proudly proclaimed that “at our village, we know most in our age set are good and do not have sex with women outside the Maasai community. This protects us and our traditions” (May & McCabe, 2004, p.3). The majority of the men are no longer practicing polygamy in regions outside of their own, but they are making the potentially false assumption that all members of their community are not infected, and are therefore safe sexual partners. If this supposition is incorrect, the polygamy that is still practiced in Maasai could lead to a very rapid spread of HIV/AIDS.

The Kagera AIDS Research Project (KARP) was developed in 1986 to study HIV/AIDS risk factors, community response, and social impact of the epidemic in the Kagera region of Tanzania. Overall, it has been documented that there is a declining prevalence of HIV infection in this region (Emmelin & Lugalla, 2004). The study suggests that these changes are largely a result of micro-level interventions (such as health education, distribution of condoms, AIDS education in schools, and voluntary HIV counseling and testing) that have been a part of the region since 1987 (Emmelin & Lugalla, 2004). Although these interventions are not a part of a specific program, they are

still representative of grassroots initiatives aiming to curb the spread of HIV/AIDS in Tanzania. KARP “associated the use of condoms by the general population, but particularly among youths, with the increased knowledge, awareness, and understanding of HIV/AIDS and fear of death caused by AIDS” (Emmelin & Lugalla, 2004, p.3). However, there are still some societal and local governmental factors limiting individuals’ access to condoms and education about sexually transmitted diseases, many of which cannot be fixed by large scale organizations or grassroots programs; It will have to be a gradual developmental process of the country itself.

One of the most successful and innovative HIV prevention programs to date was initiated in Thailand in 1991. The spread of HIV and unwanted pregnancies was rampant in this area after the Vietnam War due to an extreme growth of the sex industry. A single man, Mechai Viravaidya, took note of this and decided to make changes by starting a nonprofit family planning program through which he distributed contraceptives and educational materials. From 1980-1990 Mechai faced great limitations in his attempts to start this program due to the country’s denial of their AIDS problem at that time. The prime minister that was elected in 1991 took a serious approach to the HIV/AIDS pandemic in Thailand and appointed Mechai Viravaidya as his AIDS Czar, with the blessing of the Buddhist Clergy. Mechai became known as the “condom king” and successfully demonstrated that taboo topics could be discussed more comfortably with the use of humor. Mechai consistently expanded the initiative, and in addition to passing out condoms to the sex trade, he also ordered routine testing of the sex workers. If a worker was diagnosed as HIV positive, a series of warning were delivered to the owner of that worker’s brothel. If the HIV positive sex worker was still employed by the brothel

after the third warning, the club would be shut down until the worker was fired (Hutton, 2005).

Mechai spread the word of his program through 400 radio stations and 6 television stations; every hour and a half one minute of educational information was played. In order to reach out to youth, Mechai went to local schools to educate students on HIV risk factors and modes of transmission. Overall, Mechai's work turned out to be enormously successful in the depletion of HIV infections and the increase of safer sexual behavior in Thailand. Everyone in the community was involved in giving out contraceptives and AIDS information – even police men. Within a decade, the birth rate dropped by more than half, the use of condoms in brothels rose from 10% to 90%, and the rate of HIV infections decreased by almost 90% (Hutton, 2005). This initiative was a successful grassroots program started by one single man. However, Mechai notes how important it is that all sectors of the community are involved, especially long term political commitment.

While the aforementioned studies focused on some of the positive aspects of example grassroots programs, it is also crucial to analyze the limitations of small community organizations. In Catherine Campbell's (2003) text "Letting them Die: Why HIV/AIDS Intervention Programmes Fail," she examines the ineffectiveness of the Summertown, South African grassroots AIDS intervention project. The initiative used community participation and multi-stakeholder partnerships to develop a series of peer education programs. The intervention was built from the bottom-up, well financed, and run by an exceptionally dedicated staff, according to Campbell (2003). The Summertown project was evaluated longitudinally by surveys, in-depth interviews and focus groups. The

examination of the increase or decrease of sexually transmitted infections (STIs) served as outcome measures (Watkins, 2003).

Surprisingly, the assessment of this program showed an ultimate increase in STIs. Campbell (2003) noted that one of the programs most significant flaws was the existence of conflicts within the stakeholder committee: not all of the members of this committee were devoted to the goal of raising critical consciousness. Watkins (2003) makes a note that:

When the time for [program] implementation came...the representatives of the mine and miners continued with their previous biomedical and top-down approaches such as information-based health education and STI clinics with little attempt to bring these activities into the Project's integrative framework (p.737).

Other aspects of this program did not succeed due to the lack of commitment of certain program members, inappropriate intangible structure, limited capacity, an ineffective organizational infrastructure, and a lack of stakeholder accountability. However, it is important to note that the initiatives of the Summertown Project required a drastic change in individuals' cultural attitude and practices, as do all other HIV/AIDS prevention programs. Campbell (2003) states honestly, "It is likely that most intervention projects fail, at least in the short run: it is clearly very difficult to change the behavior of others" (p.183). It is unfortunate that grassroots initiative evaluations similar to Campbell's' are so rare. As flaws are discovered, solutions and alternative program measures can be fostered.

Large scale organizations

A large scale plan that has had an enormous economical effect on the HIV/AIDS pandemic in sub-Saharan Africa is President Bush's Emergency Plan for AIDS Relief (PEPFAR). The program's allocated \$15 billion is divided between 15 difference countries, 12 of which are located in Africa. The breakdown of the funding is as follows: 70% is put towards care and treatment, 20% on prevention, and 10% on supporting AIDS orphans and affected children (Smallman, 2008). PEPFAR is the largest commitment ever made for an international health initiative focused on a single disease. Medication is currently being provided to more than 1 million HIV positive Africans and assisting resources have been distributed to over 2,000 local African organizations (Smallman, 2008).

According to the Congressional Digest (2007), "the Emergency Plan strongly supports integrated prevention, treatment, and care, with the knowledge that the availability of each enhances the effect of all" (p.197). Other individuals and organizations feel differently. As Smallman (2008) notes, "critics have charge that politics rather than science drives U.S. AIDS policy, pointing to the program's favoring of treatment over prevention, which would entail engaging with politically difficult issues..." (p. 78). Brazil, in particular, holds a certain frustration with PEPFAR's policies. One of the mandates of the program is that a country receiving funds has to hold an opposition to prostitution and thus teach abstinence. Brazil, however, has shown great success in containing HIV by reaching out to populations such as sex workers and drug addicts. Also, both abstinence and fidelity are not realistic options for many at-risk women in their country. According to Smallman (2008), little to no research shows that abstinence and fidelity training decreases sexual activity. Still, the Congressional Digest

(2007) insists that both prevention and treatment initiatives are supported through PEPFAR.

PEPFAR evaluates itself by tracking and evaluating various progresses. This action plan makes its allocation decisions based on the results of its evaluation processes. All policy and program decisions are strictly based on acquired evidence and results. According to President Bush, “the United States is capitalizing on its expertise and the strengths of its partnerships with host governments, multilateral institutions, nongovernmental organizations, and the private sector to take bold action against HIV/AIDS” (Congressional Digest, 2007, p.197). The United States’ PEPFAR agencies have field sites in over 100 countries where they provide technical assistance and training to strengthen the local HIV/AIDS programs.

Programs that combine large scale program assistance and Grassroots efforts

The country of Senegal has one of the lowest HIV rates of all African nations. Although there are many reasons for this, one of the most crucial influences is the program structure set up by the government. While the first AIDS case was reported in 1986, a full-on national AIDS control program was established by 1987 and the country had a national STI control program for prostitutes and other at-risk populations since 1970 (Diop & Wade, 2003). These early-acting tactics most likely played a large role in preventing the spread of the epidemic. The AIDS control program that exists today in Senegal is active at the central, regional, and district levels; this means both grassroots community programs and large scale governmental assistance are working together to fight HIV/AIDS. Also, these programs are consistently evaluated in order to make any necessary changes and ensure their efficacy (Diop & Wade, 2003). The stable Senegalese

government made it possible for these programs to develop and receive funding. The consistent analysis of how these programs work will help less stable nations create similar initiatives likely to be effective for their communities.

A recent article by Fioramonti (2004) entitled “Analysing micro-assistance to democracy: EU support for grassroots organizations in South Africa” evaluated the success of two micro-assistance programs of the European Union. The author admitted that the majority of the funds put towards democratization were kept within the civil society organizations (CSOs) and think tanks instead of being distributed to the rural-based small organizations with limited resources (Fioramonti, 2004). A “micro-assistance to democracy” program was therefore developed to ensure that grassroots organizations were receiving the funds that they so desperately needed. After the first program was established in 1997, only project officials were interviewed to determine program success. However, the second program (lasting from 2001-2004) was followed by a direct survey of the 33 community-based organizations that were involved. Through this qualitative research, it was determined that these Grassroots Organizations (GROs) successfully distributed their funding to assist in the democratization of their region by raising awareness around issues of socio-economic rights, unfair labour practices, the welfare system, gender issues and legal empowerment (Fioramonti, 2004).

While the involved GROs were capable of providing quality information on the above issues, the majority of these initiatives put very little emphasis on legal programs directed towards good governance and democratic development. Fioramonti (2004) suggests that “given the rather limited resources available to civil society at the grassroots level and the difficulty of influencing general political outcomes, it is not surprising that these two

areas [were] neglected” (p.746). Also, even though these communities may be relatively capable of educating themselves on democratic and governmental issues, the majority of them still lack a voice in policy making and the local democratic process. A similar problem may likely occur with HIV/AIDS prevention and treatment programs of a similar caliber. Even if communities develop the capacity to educate their citizens on HIV and provide the greatest amount of medical services possible, they are still completely reliant on the NGOs to provide them with ARVs, education materials, and prevention materials. It is crucial for these small organizations to gain a say in matters that are related to their wellbeing at local and national levels.

A relatively recent study was conducted among single women aged 15-24 in 18 sub-Saharan African countries with the intentions of educating women on the abstain, be faithful, and use condoms (ABC) safe values surrounding the HIV/AIDS epidemic in Africa. This macro-level initiative called the Monitoring and Evaluation to Assess and Use Results (MEASURE) project found a substantial rise in the use of condoms, an approximate increase of 1.4% per year (Ali, 2003). One of the noteworthy results of the survey was that “at least 60% of single women who used a condom at most recent coitus did so mainly, or partly, to avoid pregnancy” (Ali, 2003, p.3). This indicates that perhaps the main reason for condom use increase is relative to birth control as opposed to HIV/AIDS awareness. Unwanted pregnancy is a much more immediate consequence for women who are sexually active, and can therefore seem more palpable than the risk of an illness that could take years to reveal symptoms.

Even though this study shows an increase in condom use, it still has many limitations. First of all, the women who completed the surveys were most likely exposed to different

levels and types of HIV/AIDS education. Further, the study spans from 1990 to 2004; a significant amount of time for cultural change and other factors outside of the MEASURE program to affect a woman's survey response. Finally, the survey results showed no specific increase in knowledge of HIV/AIDS; instead, they simply focused on condom use.

View on programs that combine large scale program resources with grassroots efforts

In 1997, Mina Silberberg of Rutgers University conducted a study of Latin American initiatives entitled "The evolution of assistance to grassroots organizations: the impact of linkage" to draw attention to how NGOs and GROs work together, both effectively and ineffectively. She described the role of an effective NGO (or assisting institution) as an organization that "can provide [grassroots organizations] with the knowledge, resources, and personnel they lack; support them politically; and help them join forces to effect changes in regional or national-level policies" (Silberberg, 1997, p.432). Unfortunately, these assisting institutions often times push too many structures and processes on smaller community programs, ultimately causing more harm than good.

In Silberberg's (1997) study, she attempted to find historical data of NGOs and GROs with emphasis on their goals, strategies, tactics, causes, and their perceptions of success and failure. To do so, 64 individuals (members of either GROs or NGOs) were interviewed while community groups and NGO meetings and activities were observed. A positive correlation was found between the nature of the linkage of the GRO and NGO and the successfulness of the GRO and NGO at completing their respective tasks. However, one specific NGO, Economic and Social Commission for Asia and the Pacific (ESCAP), proved to have an ineffective linkage structure for communicating with GROs.

It was noted that the assisting institution “lacked mechanisms for coordination and follow-through and created suspicion among the groups” (Silberberg, 1997, p.441). A different NGO, Venezuelan Union Centers of Popular Education (UVECEP) was positively noted for its coordination and collective decision making with and among GROs. UVECEP was based regionally, but still a good distance from the local programs, and therefore developed a greater focus on strengthening itself as opposed to the local groups. Even though this study does not examine GROs and NGOs working with HIV/AIDS programs in sub-Saharan Africa, it is still a useful model of how Grassroots Organizations and Large scale non-Governmental Organizations and the challenges they may face with communication, balance of power, and collaboration.

Baylies’ (2000) article “HIV/AIDS in Africa: Global and local inequalities and responsibilities” gives a general overview of what steps African governments and other organizations should take in the initiative to curtail the spread of HIV. The four main areas the author insists governments need to focus on are “[monitoring] national programs and [providing] public goods, [ensuring] behavior change among those with the riskiest behaviors, [ensuring] universal access to treatment for opportunistic infections, and [integrating] AIDS into poverty alleviation strategies” (Baylies, 2000, p.489). However, the involvement of communities is also essential. Baylies (2000) emphasizes the importance of stressing the concept of partnership between initiatives in order to produce the most effect prevention techniques and treatment programs. While governments should initiate program development, doing so without local community involvement may turn out to be futile (Baylies, 2000). Baylies (2000) indicates that each individual government and community sectors has its strengths, and should use these in

collaboration with other programs at different levels to create an overall effective approach to HIV/AIDS prevention, education, and treatment.

By examining the positive and negative attributes of large scale organizations, grassroots organizations, and programs that involve the collaboration of the two, it is now easier to develop a picture of what an ideal HIV/AIDS prevention and treatment program may look like. Doing so without first delving into weaknesses of program types would be impossible; it is necessary to weigh all strengths and weaknesses in order to create an effectively balanced program. Large-scale organizations are excellent contributors of resources such as funding and anti-retroviral treatment, yet they may have a tendency of over-stepping their boundaries and forcing unwanted structures or processes on wary communities. Grassroots organizations, on the other hand, have the advantage of a community voice and knowledge of cultural boundaries. Yet, without some sort of monetary support, they can only provide so much education and treatment. Unfortunately, even the attempt to combine these large and small-scale initiatives can be unsuccessful. It is with continual evaluation and development that HIV/AIDS prevention, education, and treatment programs in sub-Saharan Africa will become increasingly effective.

Hypothesis

This study examines and compares three different types of HIV/AIDS prevention and education programs in sub-Saharan Africa: large scale umbrella organizations, such as non-governmental organizations (NGOs), Inter-governmental organizations (IGOs), Government plans, and research organizations, small scale grassroots organizations, and initiatives that combine both large scale program assistance with grassroots efforts. As

the literature indicates, large organizations struggle with their lack of community access. On the other hand, grassroots programs often face financial or resource limitation issues since they work on a small scale. Therefore, this study intends to show that programs with a combination of both large scale organization assistance and grassroots initiatives will be the most effective in their prevention and education efforts.

Methodology

Initial contacting of potential participants

A total of eight HIV/AIDS prevention, education, and treatment programs were initially contacted for participation in this study: two grassroots programs, three large scale organizations, and three programs that combined grassroots efforts with umbrella organization assistance. Both grassroots programs were represented by key stakeholders personally known by the researcher. The combination programs to be contacted were either represented by an acquaintance of the researcher, known of due to a previous study, or encountered through a scholarly article. None of the large scale organizations contacted were connected to the researcher by personal relations, but two were recommended for study by professional social worker colleagues. The third large scale program was represented by an alumnus of Providence College so an attempt was made to reach out to this key stakeholder through alumni relations and the Biology Department.

Sampling Plan and Data Collection

The research conducted in this study was both qualitative and exploratory. Convenience sampling was used due to the limited number of potential study candidates. The data was initially intended to be gathered through phone interviews of two key stakeholders from each program type: Large scale, grassroots, and a combination of the

two. Due to unexpected limitations of international calling, it was necessary to reformat the interview questions into a qualitative survey that was sent to participants through email communication (Appendix A). Survey questions asked the program's key stakeholder to reflect on the success of the HIV/AIDS initiative, based on both professional opinion and hard data. Although the questions were open-ended, they were phrased in an attempt to evoke specific information from the interviewee.

An initial total of four programs agreed to participate, and were thus sent the informed consent form (Appendix B) prior to the qualitative survey. Three of these four programs, each one representing a different program type, followed up with a signed consent form. These three organizations were sent the qualitative survey as an emailed word document and only one key stakeholder returned a completed survey. However, the other two organizations attached information about their program that they felt was relevant and would answer the questions within the survey. The size of this study was extremely small as it examined only three programs from a single individual's point of view in each case. No personal client information was shared throughout the study, so client confidentiality did not present an issue.

Key Concepts

The key concepts addressed by this study were the effectiveness of three types of HIV/AIDS programs present in sub-Saharan Africa: grassroots programs, large scale umbrella organizations, and programs that combine both community and macro initiatives. The study was divided into these three sections, and each type of program was individually analyzed and critiqued before comparisons were made. Each section included only one case example of the program type being addressed and studied.

Data Analysis

The qualitative data gathered through email communication with key stakeholders was analyzed to determine the relative success of the programs being studied. In order to determine whether or not an HIV/AIDS prevention or treatment program was effective, it was necessary to operationalized “effectiveness.” This stud based programs’ effectiveness on the following nine categories: level of client involvement in the program, the clients’ reaction to the program, the community’s reaction to the program, the availability of funding and the provision of resources, HIV/AIDS education as a part of the program, the availability of medical treatment, the evaluation techniques used by the organization, the results of the program’s self-evaluation, and any acknowledgeable program limitations. If information on one of these categories was withheld by the participating programs, it was assumed that the organization did not provide that resource. Any information procured during the research process of this study that was not relevant to the categories listed above was not included in the results and did not have a positive or negative effect on the evaluation of an organization.

Results and Findings

Due to the limitations of this qualitative study, the results were both narrow and shallow. While contacts were made at eight international organizations, only three followed up with information, and only one was able and willing to participate in an interview. As mentioned earlier, data was gathered through email communication with key stakeholders of three programs. One key stakeholder responded directly to the survey questions while the other two programs provided relevant organization information. This

results section presents and discusses written program evaluation information on three programs: Grassroots A, Large Scale A, and Combination A.

The first program results examined were that of Grassroots A. Grassroots A is an after-school project that began in February 2008 in Umtwalume, KwaZulu-Natal. Its purpose is to empower students in various ways. The three main goals of Grassroots A related to HIV/AIDS are to decrease the number of HIV infections amongst students, educate the local community about HIV/AIDS and decrease discrimination against infected people, and to refer HIV infected people to the appropriate sources for ARV treatment with regular follow ups. The program also strives to empower and equip students to break the cycle of unemployment, poverty, and HIV/AIDS, promote school buildings as a center of care after-school, and promote the Grassroots A model for use in other schools. Grassroots A gives students information about how to protect themselves and engage in open and honest discussion around the issue of HIV. In terms of leadership and the community, Grassroots A helps students realize their responsibility to the community, empowers students to solve problems in their community without relying on large scale organizations, assists the community in becoming more sustainable by emphasizing agriculture and establishing income generation, and assists families of students with grant access and health information. Additionally, Grassroots A has approval and support from local chiefs, principals, teachers, parents, mayor, and elders.

There is a strong demonstration of client involvement in the Grassroots A program. Students not only participate in their daily school and extracurricular activities, but they also play an active role in their community. For instance, last June, students of this program organized the youth in their community in a march against Xenophobia and

Violence. While this is not directly related to HIV/AIDS, the student-run initiative still demonstrates a community action component of the program that could be very beneficial in the education and prevention of HIV/AIDS among current youth. Another positive program result is that 95% of students say that Grassroots A has made a positive influence on their lives. Additionally, 84% of students view their Grassroots A teacher as a role model.

The executive director of Grassroots A was able to answer the survey questions through email. The major goals of the program, as outlined above, are achieved by giving students something to do after school and empowering them to protect their futures. The after school program meets four to five days a week for two hours each day during the school year. The student to teacher ratio is approximately 20 to 1. The teachers are local young adults that graduated only a few years ahead of the current students. This allows for students and teachers to relate to one another in a positive and comfortable way, giving the students good role models. Through the after school program students are provided with valuable information along with life skills that are necessary to make changes in their behavior and empower them to stand up for themselves and their beliefs. In terms of treatment, a Community Assistance Coordinator works with families and individuals who are infected with HIV to help them get ARVs from the government. The Community Assistance Coordinator also teaches these individuals how to adhere to their ARV regimen. While a great deal of research was conducted on similar HIV/AIDS prevention/education programs before the development of Grassroots A to see what worked and what did not, the program itself is not modeled after any one particular

program. Grassroots A is simply trying to provide more comprehensive HIV prevention than what government-funded curriculums provide within the school day.

Grassroots A has only been in effect for one year and thus is limited in evaluative program data. However, students are asked to complete a survey at the beginning and end of the year that includes information on HIV/AIDS knowledge and behavior change. While the executive director of Grassroots A is extremely confident that improvement in HIV knowledge has occurred among most, if not all, students, the compiling of last year's data has not yet been completed. Grassroots A also evaluates its overall program by periodically asking for feedback from students and key role players in the community such as teachers, principals, and chiefs.

According to the executive director, funding for Grassroots A is extremely limited and the program struggles to stay afloat each month. Grassroots A raises their own funds from private donors through their non-profits registered in the United States and the United Kingdom. Money is also raised through income generation projects. Grassroots A works mainly with the local government schools that the after-school program is run out of. Recently, however, the program has begun to work with Africa Cooperative Action Trust (ACAT) which provides basic life training, including HIV prevention, aimed at adults. Grassroots A is working with ACAT in hopes of addressing one of their major limitations – the fact that they are currently only working with the student population. As the executive director noted,

We cannot provide too much information on HIV/AIDS to parents and teachers [because] we would be stigmatized as an AIDS Organization and would be seen as fighting culture. Long-term, this would not be worth it, so we are trying to find new

ways to reach the larger community, which is ultimately necessary in order for the youth to protect themselves (Personal communication, March 21, 2009).

Ultimately, Grassroots A hopes that ACAT will help them accomplish reaching communities outside of the student population they currently serve. While the data-based finding of Grassroots A are limited due to the fact that the program is very new, the information provided by the executive director demonstrates an overall sense of program effectiveness in terms of involving and educating the clients and providing medical treatment assistance.

Large Scale Program

The next program examined was Large Scale A. Large Scale A was created in 2002 to expand access to high quality HIV/AIDS care and treatment for all who need it, specifically in developing countries. It works in partnership with others, aiming to fill gaps or limitations of smaller programs by playing a complementary role. Main organization goals including lowering prices of drugs and tests and assisting governments to develop plans and policies for HIV/AIDS care and treatment programs. Large Scale A has found that the pace of adopting new technologies is very slow in developing countries, resulting in less efficient and effective care. Therefore the organization is currently working to develop and execute a strategy to accelerate market introduction of new products in order to reduce the distance and time required of patients to access healthcare. Also, to ensure that governments can aggressively expand sustainable access to care and treatment, Large Scale A assists in the development of healthcare policies, strengthens their management capacity, and develops cost-effective, practical systems.

Unlike Grassroots A, Large Scale A has access to sufficient funding and is therefore more likely and able to evaluate its efforts. This program has also been in effect for six years and has had more opportunities for assessment. Some concrete accomplishments that Large Scale A has made thus far in sub-Saharan Africa are as follows: secondary-line Anti-retroviral (ARV) price reductions of 30%; pediatric ARV price reductions of 60%; increase in the number of children who have access to ARVS from 1 in 40 in 2005 to 1 in 4 in 2008; and the formation of eight country-specific rural care-giving programs.

Unfortunately, these results and accomplishments do not give insight to client participation in the program's efforts. The individuals in charge of executing Large Scale A are more often than not outsiders of the community. As previous research shows, this may inhibit the program's likelihood of receiving community support. Nonetheless, the strides made by Large Scale A in treatment availability greatly surpass that of other organizations examined in this paper.

Combination Program

The last research results examined were that of Combination A. Combination A uses soccer, camaraderie, and positive role models in the fight against AIDS, providing African youth with the knowledge, skills and support they need to prevent themselves from becoming infected with HIV. One main goal of Combination A is to put 1.25 million African youth through the program by the end of 2010. The organization shares its curriculum and concept with local implementing partners, allowing them to make use of local capacity and infrastructure. Combination A also empowers local community role models and professional soccer players, youth sport coaches, teachers, and peer educators, with the tools to educate the youth in their communities. The program works

primarily in three countries, South Africa, Zambia, and Zimbabwe, but has implemented partnerships in 10 additional countries. Combination A was first established in Zimbabwe in 2003. As a winner of the Nike/Ashoka Sports for a Better World Collaborative Competition in March 2008, Combination A was selected as one of the three most innovative, effective and sustainable organizations in the Sports for Development field out of the 382 organizations entered. Program funding comes primarily from the Gates Foundation, but Combination A is still working to raise money through assistance from individuals, corporations, and foundations.

Combination A is considered a “combination” program for this study due to both its high level of community involvement and its reliance on partnerships. According to Combination A’s research and advocacy representative, “from community-based organizations to national governments, partnerships have always been essential to [Combination A’s] growth and ability to positively impact society” (Personal communication, March 19, 2009). Due to Combination A’s relatively adequate funding, the program is able to use monitoring and evaluating (M&E) tools to provide more evaluative information on the programs’ success or failure, in comparison to a program with less funding, such as Grassroots A. Combination A also has the benefit of a high level of client involvement, and thus evaluative methods are often accurately reflective of the feelings and beliefs of the client population. One aspect of program research that Combination A has done concluded that “prevention success is both achievable and affordable, provided that programs are locally owned, multi-faceted, and research-based” (Personal communication, March 19, 2009). According to Combination A’s key stakeholder, the Stanford University’s Children’s Health Council surveyed 304 students

involved with Combination A and found that the program is “a culturally appropriate, internationally suitable, creative, and effective way to educate at risk youth about HIV/AIDS and its prevention” (Personal communication, March 19, 2009). Appendix C shows various organizations’ evaluation of Combination A. Based on the positive results given in this chart, Combination A views its program’s greatest strengths as its innovative method of practice, dedicated staff, and rigorous M&E. However, the program sees its greatest weaknesses located in facilities and human resource management.

Still, this combination program successfully demonstrates the positive aspects of both a large scale program and a grassroots organization. While Combination A has a great deal of valuable interaction with the local community, it also has enough resources to fund and evaluate its services. This goes hand in hand with what was found in the literature review; programs with community access and monetary or government support tend to be successful. However, unlike Grassroots A and Large Scale A, Combination A does not appear to provide an medical or treatment related services.

Comparison of all three program types

Table 1

	Grassroots A	Large Scale A	Combination A
Client involvement	students organized the youth in their community in a march against Xenophobia and Violence	N/A	uses the power of soccer in the fight against AIDS, providing African youth with the knowledge, skills and support
Client reaction	84% of students view their Grassroots A teacher as a role	N/A	surveyed 304 students, found that the program is culturally appropriate,

	<p>model</p> <p>95% of students say that Grassroots A has made a positive influence on their lives</p>		<p>internationally suitable, creative, and effective in educating at risk youth about HIV/AIDS</p>
Community reaction	<p>has approval and support from local chiefs, principals, teachers, parents, mayor, and elders</p>	N/A	<p>great deal of valuable interaction with the local community</p>
Funding/Provision of resources	<p>raises funds from private donors through non-profits registered in the US and the UK.</p> <p>Money also raised through income generation projects</p> <p>Work with Africa Cooperative Action Trust (ACAT): provides basic life training (including HIV prevention) aimed at adults.</p>	<p>individuals in charge of executing Large Scale A are more often than not outsiders of the community</p>	<p>shares their curriculum and concept with local implementing partners, allowing them to make use of local capacity and infrastructure</p> <p>Program funding comes from the Gates Foundation and through assistance from individuals, corporations, and foundations.</p>
Education	<p>student to teacher ratio is 20 to 1</p> <p>The Community Assistance Coordinator teaches HIV+ individuals how to adhere to their</p>	N/A	<p>empower local community role models with the tools to educate the youth in their communities</p>

	ARV regimen		
Medical treatment (ARVS)	Helps families and individuals get ARVS from the government	<p>working to develop/execute a strategy to accelerate market introduction of new products (to reduce distance/time required of patients to access healthcare)</p> <p>secondary-line Anti-retroviral (ARV) price reductions of 30%</p> <p>pediatric ARV price reductions of 60%</p> <p>increase in the number of children who have access to ARVS from 1 in 40 in 2005 to 1 in 4 in 2008</p> <p>formation of eight country-specific rural care-giving programs</p>	N/A
Evaluation techniques	<p>students complete a survey at the beginning and end of the year: information on HIV/AIDS knowledge and behavior change</p> <p>asks for feedback from students and key role players in the community (teachers, principals, and chiefs)</p>	N/A due to limitation of public information	able to use monitoring and evaluating (M&E) tools in order to provide more evaluative information on the programs' success

Evaluation results	program has only been in effect for a year, so evaluative program data is limited	(see above answers)	<p>winner of the Nike/Ashoka Sports for a Better World Collaborative Competition in March 2008 (selected as one of the three most innovative, effective and sustainable organizations in the Sports for Development field)</p> <p>The percentage of students who knew where to go for help for HIV related problems increased from 47 to 76%</p> <p>percentage of students who said they would feel comfortable providing emotional support for an HIV positive classmate increased from 52% to 73%</p> <p>The percentage of students who believed condoms were effectively increased from 49% to 71%</p>
Limitations	<p>the fact that they are currently only working with the student population</p> <p>Funding</p>	the pace of adopting new technologies is very slow in developing countries, resulting in less efficient and effective care	greatest weaknesses in facilities and human resource management.

Through discussion of literature that reviewed HIV/AIDS programs, the above program aspects are essential for overall success. As table 1 demonstrates, Large Scale A is certainly the most limited in terms of client involvement, client reaction, community reaction, and education. However, Large Scale A also provides the greatest level of ARV and medical treatment in comparison to Grassroots A and Combination A. However, the lack of education and prevention tools limit Large Scale A's potential for community and client-based success.

Based on the information provided in the above table, both Grassroots A and Combination A seem to be equally successful in nearly all categories. However, since Combination A has the ability to perform relatively elaborate studies on program effectiveness, the results of these examinations hold more factual weight than the evaluative statements provided by the executive director of Grassroots A. Grassroots A is the most effective program in terms of education and prevention of HIV/AIDS in sub-Saharan Africa.

Conclusion

Limitations of the study

Unfortunately, there are many limitations to this research study. As a qualitative study, a very limited amount of information was collected to examine an exceptionally large topic. Ideally, the study would have reached at least three more organizations for a total of two program representatives for each program type. Unfortunately, the language, time, and location barriers made it difficult for this to occur. With only one examined program representing each program type, the results most likely do not yield an accurate reflection of the success and/or failure of all programs within that category. Another

limitation was the unexpected lack of evaluative program data for many sub-Saharan Africa HIV/AIDS initiatives. As a current HIV/AIDS focused Peace Corps volunteer in Senegal, Africa noted,

The sad truth is that a lot of the people we work with don't do M&E as well as they should...I work with grassroots organizations and the government and they're just not set up to do surveys or to track HIV/AIDS prevalence over time. Even the governmental health organization doesn't have the ability to do a statistically valid survey (Personal communication, March 2, 2009).

However, this Peace Corps Volunteer went on to note that programs and organizations do not necessarily have to do M&E if they base their programs off of effective ones in other countries. He stated,

Funds are limited and organizations make a choice between a) performing larger interventions of perhaps unknown efficacy, and b) performing smaller interventions and channeling funds into monitoring and evaluating those small interventions. A balance has to be struck and often that balance is 'Tanzania did M&E on their project and found it worked, so we're going to adapt it here and drop the M&E portion (Personal communication, March 2, 2009)

This decision to spend funding on program execution instead of evaluation may be wise in certain circumstances; however, it puts a limitation on this research study's ability to access evaluative program information on HIV/AIDS prevention, education, and treatment organizations in sub-Saharan Africa. Lastly, during the research process, the greatest collection of information was gathered from Grassroots A. This could perhaps result in the illusion that the grassroots program is most effective based on the fact a

greater deal of relative information was attained regarding Grassroots A in comparison to the other examined programs.

Conclusions and Implications

The numerous limitations of this study have generated a narrow set of results that only analyze a small number of HIV/AIDS prevention and education programs. Therefore, these results may not be reflective of all grassroots programs, large scale organizations, and combination programs in sub-Saharan Africa. The evaluative categories used to examine the programs discussed in the results and findings were level of client involvement in the program, the clients' reaction to the program and the community's reaction to the program along with the availability of funding and the provision of resources, HIV/AIDS education as a part of the program and the availability of medical treatment in addition to the evaluation techniques used by the organization, the results of the program's self-evaluation, and any acknowledgeable program limitations. All of the examined programs succeeded in accomplishing some of these goals in addition to others.

Overall, Grassroots A seems to be most effective in addressing all of the evaluative categories. Large scale A is certainly limited in terms of client involvement, client reaction, community reaction, and education. On the other hand, Large scale A provides the greatest level of ARV and medical treatment in comparison to Grassroots A and Combination A. However, Large Scale A's lack of education and prevention tools limit its potential for community and client-based success. Based on the information provided in the results table, both Grassroots A and Combination A are strong competitors for level of effectiveness in nearly all categories. However, it is apparent that Grassroots A

covers a broad range of issues, including HIV treatment and medication, which Combination A does not address. Therefore, this study shows that in sub-Saharan Africa the Grassroots program type was most effective in terms of HIV/AIDS education, prevention, and treatment.

These results are contradictory to both the hypothesis of this study and the concluded assumption based upon the review of relevant literature. While the literature recognized the importance of community involvement for HIV/AIDS prevention, education, and treatment programs, it also touched upon the fact that programs without access to consistent and reliable resources would not be as effective as well-funded initiatives. The literature also recognized that a program could not be effective relying on funding alone; presence within the community was extremely important. Thus, the review of pertinent literature suggested that a program with a combination of grassroots community efforts and large scale assistance would be most effective. However, as the results of this study show, it actually seems that a grassroots program has the ability to be even more successful than a combination program.

The results of this study demonstrate the great importance of community involvement in the implementation of HIV/AIDS prevention, education, and treatment programs and initiatives. Cultural traditions can play a considerable role in a community's unwillingness to accept the presence of unfamiliar or new things, especially when it comes to rarely discussed subjects such as sexual behavior. Ultimately, it is the decision of an individual to accept the resources given to him or her. Large scale organizations could spend billions of dollars a year on treatment and education, but if no one is willing to listen or come for help, the services will be futile. Thus, as this research paper has

demonstrated, program acceptance, support, and execution within a community are absolutely crucial in order for an initiative to be successful in the prevention, education, and treatment of HIV and AIDS in sub-Saharan Africa.

References

- Ali, M. and Cleland, J. (2003). Sexual abstinence, contraception, and condom use by young African women. *The Lancet*, 368. Retrieved October 5, 2008 from <http://linkinghub.elsevier.com/retrieve/pii/S0140673606697389>
- Baylies, C. (2000). Overview: HIV/AIDS in Africa: Global and local inequalities and responsibilities. *Review of African Political Economy*, 86. Retrieved October 5, 2008 from <http://www.eupjournals.com/doi/abs/10.3366/per.2005.1.2.197?cookieSet=1&journalCode=per>
- Campbell, C. (2003). *Letting them die: Why HIV/AIDS prevention programs fail*. Indiana: Indiana University Press.
- Cherian, Lily. (2005). Identifying Problems in HIV/AIDS Education in South Africa. *Journal of Family Welfare*, Vol 51 (1), 4. Retrieved Sept. 22, 2008 from medind.nic.in/jah/t05/i1/jaht05i1p35.pdf
- Congressional Digest (2007). The President's Emergency Plan for AIDS Relief; US Commitment to fighting the disease. *Congressional Digest*. Retrieved March 29, 2009 from direct.bl.uk/research/31/13/RN215351180.html
- Diop, I. and Wade, A. (2003). Senegal Monitoring and Evaluation of HIV/AIDS programs. *University of North Carolina at Chapel Hill*. Retrieved November 5, 2008 from http://www.cpc.unc.edu/measure/publications/html/sr-01-04-abstract_sn.html
- Emmelin, M. And Lugalla, J. (2004). Social, cultural, and sexual behaviors determinants of observed decline in HIV infection trends: lessons from the Kagera region, Tanzania. *Social Science and Medicine*, 59. Retrieved October 10, 2008 from <http://cat.inist.fr/?aModele=afficheN&cpsid=15656592>
- Fioramonti, L. (2004). Analysing micro-assistance to democracy: EU support for grassroots organisations in South Africa. *Development in Practice*, 14. Retrieved November 25, 2008 from <http://www.jstor.org/stable/4030019>
- Fredriksson-Bass, J. and Kanabus, A. (July 30, 2008). *HIV and AIDS in Africa*. Retrieved Sept. 22, 2008 from <http://www.avert.org/aafrica.htm>
- Home-Based Care Alliance in Africa*. Retrieved Sept. 22, 2008 from www.huairou.org/assets/download/HBC_Alliance_Flyer.pdf
- Hutton, R (Executive Producer). (2005). Rx for Survival; A global health challenge. [Television broadcast]. Boston: WGBH Educational Foundation/NOVA Science Unit.

- Jones, P.S. (2005). On a never-ending waiting list: Toward equitable access to anti-retroviral treatment? Experiences from Zambia. *Southern African Journal of HIV Medicine*, 25. Retrieved October 10, 2008, from <http://www.popline.org/docs/1753/318407.html>
- May, A. and McCabe, J. (2004). City Work in a time of AIDS: Maasai Labor Migration in Tanzania. *Africa Today*, 51. Retrieved October 10, 2008 from <http://www.popline.org/docs/301158>
- Mustonen, L. (2004). The Kagera AIDS Research Project. *School of Public Health and Social Sciences*. Retrieved October 27, 2008 from <http://www.muhas.ac.tz/kageraproject/index.html>
- NASW Delegate Assembly. (1999). NASW Code of Ethics. Retrieved Sept. 22, 2008 from <http://ncsss.cua.edu/Docs/NASWCodeofEthics.pdf>
- Silberberg, M. (1997). The evolution of assistance to grassroots organizations: The impact of linkage. *Public Productivity and Management Review*, 20. Retrieved November 25, 2008 from <http://www.jstor.org/stable/3380683>
- Smallman, S. (2008). Five years later: Judging Bush's AIDS Initiative. *NACLA Report on the Americas*. Retrieved March 29, 2009 from <http://nacla.org/node/4845>
- Stine, G. J. (2008). *AIDS Update: 2008*. New York: McGraw Hill
- Watkins, S.C. (2003). [Review of the book *Letting them die*]. *Population and Development Review*, 29. Retrieved October 10, 2008 from <http://www.jstor.org/stable/1519710>

APPENDIX A

Please answer the following questions in regards to your specific program as thoroughly as possible. Any additional information that can be provided on the evaluation of your program would be greatly appreciated. If you have any questions or concerns, feel free to contact me at Kathryn.Allison.Wood@gmail.com or by telephone at (781) 771-0129. Thank you very much for your participation.

1. Who is your target population?
2. How are your clients involved?
3. How many clients do your services reach and how do you measure this?
4. Have your clients ever shown growth in their knowledge of HIV? If so, how? How do you measure this growth, if at all?
5. From where do you receive your funding? Do you see yourself as having adequate funding?
6. What is the current growth rate of HIV cases in the region your program works in? What was the rate when your program first started?
7. What are the limitations of your services?
8. Do you work with any other organizations (larger or smaller)? Who? How does this affect your services?
9. How do you evaluate your program? Please include any results of that evaluation. If you don't, how do you know your program works?
10. Have you modeled your program off of a different program? Which one? Why?

APPENDIX B Informed Consent

Dear Participant:

I, Kathryn Wood, am a fourth year Social Work student at Providence College's Nationally Accredited Social Work Bachelors program in Providence, Rhode Island. I am conducting a research study on the success and effectiveness of HIV/AIDS prevention, education, and treatment programs in sub-Saharan Africa by comparing three types of programs: large Non-governmental (NGOs) and Governmental Organizations (IGOs), Grassroots organizations, and programs that combine grassroots initiatives with Large Scale And/or IGO support. Data gathered in this study will be reported in my bachelors' level thesis.

Research will be qualitative and collected through phone interviews with key stakeholders of the organizations being examined. These participants will be asked to verbally answer a series of 10 questions regarding the organization they represent. If verbal interviewing is not possible, written responses to the researcher's questions will be accepted. Total participation time is estimated to be between 15 and 45 minutes, but will not exceed the latter.

There are no anticipated significant risks associated with involvement in this research. No identifying information relative to any individual or program will be included in the written dissertation; all identifying information gathered through the interviews will be destroyed upon completion of the research study. It is not expected that any emotional discomfort or stress will occur due to participation in this study.

The benefit of participating in this study is the possible reward of realizing program strengths, specifically in comparison to other program types. No compensation will be provided for participation in this study.

Confidentiality of participants and programs will be protected by the researcher and academic advisor by storing collected data in a secured room only accessible to the researcher. Information provided in the interviews will be used in the dissertation without reference to individual or program names. Brief excerpts of responses may be quoted without any personal identifying information. Interviews will be tape recorded by the researcher as a means of accurate notation of the conversation. These tapes will be stored securely throughout the research process, and will be immediately destroyed upon completion of the dissertation. The researcher will adhere to any participant concerns with the electronic recording process by replacing this method with note taking. These notes will also be stored securely and destroyed upon thesis completion.

Participation in this study is voluntary. Participants may withdraw from this study up until dissertation submission and completion on March 31st, 2009. Withdrawal from the study results in no form of penalty. If you have any questions or concerns regarding the

study or this consent document, please feel free to contact me at 781-771-0129 or kathryn.allison.wood@gmail.com

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Thank you for participating in this study.

Kathryn Wood

(Print name)

(Signature)

(Date)

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

APPENDIX C

Author	Affiliate	Year	Location	Published	N	Control?	Method	Key Findings	Quotes	Implications for GRS
Bocheva and Hoffman	Children's Health Council	2004	Bulawayo, Zimbabwe	Online	304	Y	Pre, post, 5 month follow-up survey	Sig. increase in knowledge, attitudes, perceptions of social support. Improvements sustained over 5 months. Less prejudice toward PLHA.	*Culturally appropriate, internationally suitable, creative, and effective way to educate at-risk youth about HIV/AIDS and its prevention (19).	Program should be replicated
Clark et al.	UCSF	2006	Bulawayo, Zimbabwe	<i>AIDS & Behavior</i>	304	Y	Pre, post, 5 month follow-up survey	Sig. inc in belief in condom effectiveness, perceived social support, knowledge of prevention services, and reduced stigma. Control group "caught up" after 5 months. 22% reported teaching others.	"We feel that it is likely that the information from the intervention subsequently diffused to the controls via peer-to-peer interaction (6)	Diffusion effect may exist. Program may have indirect benefit to participants' peers.
Bor, J	YOHO	2006	Gaborone, Botswana	Online	342	N	Post survey	Average student educates 5.7 (4.4-6.9) others. Girls education more than boys. Knowledge primarily shared with parents, siblings, other relatives, and friends. Younger students talk w/parents; older students talk w/friends	"Diffusion is both wide and deep: over 80% of participants educated at least one person about HIV/AIDS" (7).	Evidence of the diffusion effect.
Peacock-Villada, Decelles, Banda	CARE, USAID	2006	Zambia & South Africa	<i>New Directions for Youth Development</i>	274	N	Pre/post survey and interviews	Inc in articulation of future goals and own strengths. Gender gaps are minimized. Boys make more positive decisions after program. Biggest impact on 13-14 year-olds.	"Boys and girls were better equipped to think through the consequences of making decisions and confident to make good decisions for themselves after participating in the program."	Pilot successfully improves key indicators of resiliency and life skills
Franca-Koh, AC	Sports for Life and Youth Action Kit	2007	Anbama and Oromiya, Ethiopia		72	N	In-depth interviews	Positive influence. Inc. knowledge. Realistic understanding of threat of HIV and inc sense of compassion for PLHAs. Promotes gender equality.	"Youth in both programs felt prepared to avoid HIV infection particularly through commitment to abstinence." Helped youth "create trusting relationships, discuss ideas in a productive manner, and develop a behavioral group ability to fight HIV. " "Female participants talked about feeling more equal to their male counterparts after the program."	Ethiopian program appears to have deep impact on participants beyond just knowledge and attitudes
MercyCorps	Sports for Peace & Life, Yes to Soccer	2007	Liberia & Sudan	Online	670	N	Pre/post survey (knowledge and attitudes)	Lib. 27% increase in K/A. Sud. 16%. Sport-plus vs. Plus-sport. Guidelines for implementing plus-sport.		Supports CHC findings. Partner programs also improve knowledge and attitudes. Continue to scale through partnerships.
Kaufman, Weisb, Erickson, Craig, Adams	Dartmouth College	2008	Puerto Plata, Dominican Republic	XVII International AIDS Conference	140	Y	Pre, post, 4-month follow-up interviews	Sig. increase in HIV-related knowledge, self-efficacy, interpersonal communication. Program needs greater focus on partner reduction and concurrency.	"Following participation in the FPV program, adolescents report feeling greater control in protecting themselves from HIV, while demonstrating greater knowledge about HIV transmission, testing, and risk reduction...The Grassroot Soccer curriculum could effectively become incorporated into larger-scale prevention programs in the Caribbean."	Program is also effective in a Caribbean context. Notable impact on parent-child and peer-to-peer communication (supports diffusion effect). Need more focus on partner reduction.
Gray, Betzel, Workman, Roux	University of Cape Town	2008	Western Cape, South Africa	Pending...	478	Y	Pre/post survey (biological and life skills questions)	Significant increase in biological knowledge among students who received Extra Time magazine (p<0.01)	"Exposure to the Extra Time workbook significantly improves student HIV related knowledge. It is feasible for teachers to use this workbook without extra training."	Extra Time may be valuable as a stand-alone intervention.
Kaufman, Adams, Clark, Ndlovu, Brindis	Dartmouth College	2009	Bulawayo, Zimbabwe	Pending...	246	Y	Behavioral Survey (3-5 years post intervention)	Compared to a matched group of peers, past GRS graduates were 5.7-times less likely to report sexual debut between age 12 and 15, 4.3-times less likely to report sexual activity in the last year, and roughly 8-times less likely to report ever having had more than one sexual partner. On average, GRS graduates reported significantly fewer partners (mean=0.09) than their non-graduate peers (mean=0.43).		First evidence of behavioral impact. Study has limitations but suggests that participation in GRS may significantly reduce HIV-risk behavior