CATHOLIC RELIEF SERVICES

CRS India PANI Evaluation

March 2008

"My husband and I are positive and we have two children age 12 and 5; they ask why we are taking medicine. The neighborhood kids won't play with our children, and they may suspect something. Their parents always chase them away."

Care and treatment client, Dimapur

Since 1943, Catholic Relief Services (CRS) has held the privilege of serving the poor and disadvantaged overseas. Without regard to race, creed or nationality, CRS provides emergency relief in the wake of natural and man-made disasters. Through development projects in fields such as education, peace and justice, agriculture, microfinance, health and HIV and AIDS, CRS works to uphold human dignity and promote better standards of living. CRS also works throughout the United States to expand the knowledge and action of Catholics and others interested in issues of international peace and justice. Our programs and resources respond to the U.S. Bishops' call to live in solidarity-as one human family-across borders, over oceans, and through differences in language, culture and economic condition.

Published in 2007 by:
Catholic Relief Services
228 West Lexington Street
Baltimore, MD 21201-3413 USA

Written by:
Shannon Senefeld, MA and Jennifer Overton, MPA.

TABLE OF CONTENTS

TABLES & FIGURES

Figures

Tables

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
APS	AIDS Prevention Society
ARV	Anti-Retroviral
ART	Anti-Retroviral Therapy
CBC	Community Based Care
CBO	Community Based Organization
CT	Counseling and Testing
CRS	Catholic Relief Services
SW	Sex Worker
DAN	Development Association of Nagaland
DFID	Department for International Development
DIC	Drop-In-Centers
DSSS	Diocesan Social Service Society
FBO	Faith-Based Organization
FGD	Focus Group Discussion
GHS	Government High School
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
IDU	Injecting Drug User
IGA	Income Generating Activity
INGO	International Non-Governmental Organization
IR	Intermediate Result
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MIS	Management Information System
MNP+	Manipur Network of Positive People
NACO	National AIDS Control Organization
NDO	Nagaland Development Outreach
NE	North East
NECHA	North East Community Health Association
NGO	Non-Governmental Organization
LSE	Life Skills Education
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PANI	Preventing AIDS in Northeast India
PCI	Project Concern International
PLHA	People Living with HIV or AIDS
PLHIV	People Living with HIV

PLWHA	People Living with HIV or AIDS
PPTCT	Prevention of Parent to Child Transmission
QOL	Quality of Life
SASO	Social Awareness Service Organization
SHG	Self Help Group
SO	State Office
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training of Trainers
UN	United Nations
VHW	Village Health Worker
ZEP	Zoram Entu Paul

ACKNOWLEDGEMENTS

The PANI project is only possible because of continued commitment by implementers and donors. Furthermore, the project would not have been possible without the excellent work of local partners in Manipur, Nagaland, Mizoram, and Assam. These partners provide the daily care and support and prevention activities to the program participants who participated in this evaluation. Without the partners, the entire PANI project would not exist. In addition, these partners worked tirelessly to participate in this evaluation in addition to their on-going work.

The CRS India PANI project is funded by CRS One World Campaign funds. Private Catholic donors continue to support the work of this project and are committed to seeing the impact that PANI has on program participants' lives. Without the continued financial and technical support from these donors, PANI could not thrive as it has.

CRS India's staff has worked tirelessly throughout the life of the project and the evaluation. Special thanks are due to the entire staff of CRS Guwahati for their endless dedication to improving the lives of the PANI program participants. The PANI staff is a very strong group and has made amazing strides in moving this project forward in such a short time.

CRS Headquarters was supportive of this evaluation and assisted with the evaluation. Jennifer Overton and Kristin Weinhauer conducted on-the-ground support throughout the evaluation. Kristin Weinhauer assisted the PANI team with planning for the evaluation, creating budgets, methodology design, survey design and final write-up. Jennifer Overton led the qualitative ground work portion of the evaluation and the qualitative write-up of the evaluation report. Shannon Senefeld served as the team leader for the design, analysis and write-up of the evaluation.

In addition, Ch. Anand Singh, CRS Guwahati, served as the team leader in the PANI project and led the PANI team through the evaluation. Dr. Shubhra Phillips and Sarah Cashore of the CRS India Program Quality Team supported this evaluation from conception through to dissemination of results, including participating in portions of the evaluation. Dr. Rajeev Mohan and Chetan Pillay of the CRS India Program Quality Team participated in the evaluation providing much needed support during the qualitative field work.

EXECUTIVE SUMMARY

Catholic Relief Services' (CRS) Preventing AIDS in Northeast India (PANI) project conducted an end-of-project evaluation to determine the project's effectiveness and impact on the lives of its program participants. At the time of the evaluation (data collection from January through May 2007, analysis from June through July and write-up in June and July 2007) the PANI project was transitioning from its first phase, three-year project to its second phase three-year project. The recommendations presented here should be addressed in the second phase of the project.

PANI's three-year project operated within four northeastern Indian states of Manipur, Nagaland, Mizoram, and Assam. PANI's goal in phase one of the project was to contribute to "Stabilized HIV prevalence among women and youth and improved health condition of IDUs and HIV and AIDS-affected and infected groups in NE India". PANI planned to achieve its goal by increasing access to care and support and prevention programming, while also increasing the capacity of local implementing and faith-based partners.

The PANI management team began planning for an evaluation in the fall of 2006. The evaluation began with on-site planning and partner consultation in October 2006. Following this, surveys and interview guides were developed in December and January 2007. Quantitative self-administered surveys were distributed to program participants from January to March 2007. Qualitative field work then began in May 2007, with analysis and write-up culminating in June and July 2007. The evaluation team was composed of CRS India staff and CRS staff from headquarters. Using both qualitative and quantitative methods, the evaluation sought to determine the effectiveness of PANI's interventions and provide concrete recommendations for future PANI interventions.

The evaluation report includes a discussion of the HIV and AIDS situation in India, as well as an overview of the PANI project. Findings from all levels of the evaluation are reported and form the substance of this report. In addition, promising practices and lessons learned that emerged during the evaluation are presented. The report concludes with recommendations from the evaluation team on future interventions for the second phase of the PANI project.

Key findings of the evaluation include:

<u>General outlook</u>

- The PANI project has been moving toward its three main objectives and should be continued in a follow-on phase of programming.
- The project has been most successful with the care and support portion of the project, and the prevention aspect of the project appears to be the weakest aspect.

- Project staff, partners and budgets are all currently overstretched. There is a clear need for additional funding or a scale-back of activities if program quality is to be ensured.

Care and treatment

- In general, clients of care services reported that their quality of care had improved over the life of the project.
- Interviewees of all groups agreed that the PANI project had significantly increased the number of clients seeking and receiving anti-retroviral therapy as well as palliative care.
- In general, beneficiaries experienced improved health and positive outlooks on life as a result of the project.

Prevention

- Stigma remains a concern in the region. PLHIV reported disclosing their status, but often confronted stigma as a result. Children especially have been subject to discrimination in school and community settings.
- There is a clear need to increase the visibility of the entire PANI project and its services.
- Project clients and caregivers noted strongly that PLHA support groups were a big success of the project.
- Prevention activities for youth (in schools and youth centers) were not standardized. The current method used to deliver prevention messages is not effective for instituting behavior change among the target population.

Partnership

- The PANI program has contributed to strengthening partners' capacity in care and treatment and prevention.
- Through the PANI program, CRS partners have reinforced ties with the local government and State AIDS Control Society, as well as with other key stakeholders. .
- Partnership was noted as one of the hallmarks of the PANI program. The majority of implementing partners consistently noted the high quality assistance provided by CRS staff as well as their level of dedication.
- Unintended benefits of the project include contributions to peace building including the bringing together of people from mixed ethnic, social and religious backgrounds.

Overall, the PANI project was well received by the project partners and program participants. The majority of partners and participants welcome PANI and applaud its efforts. Local CRS staff are also supportive of the efforts of PANI and demonstrate a real desire to continue to move the project forward and improve the quality of life of the program participants. The evaluation demonstrates there is a definite need for the project to continue in the future. While recommendations offered at this end of this report should be addressed in any follow-on phases of the project, it will also be important to continue the good work that PANI has begun, duly identified here as promising practices.

THE INDIAN CONTEXT

The National AIDS Control Organization (NACO), supported by UNAIDS and WHO, recently released estimates that indicate national adult HIV prevalence in India is approximately 0.36%, which corresponds to an estimated 2 million to 3.1 million people living with HIV (PLHIV) in the country. Overall the HIV epidemic in India has stabilized in recent years, but there is still great variation between states within the country and between certain population groups.[1]

At the same time, HIV continues to emerge in new geographic locations. The NACO 2006 surveillance data identified selected pockets of high prevalence in the northern states. Simultaneously, the 2006 surveillance figures show an increase in HIV infection among several groups at higher risk of HIV infection, such as people who inject drugs and men who have sex with men. Sero-prevalence among injecting drug users (IDU) has been found to be significantly high in metro cities of Chennai, Delhi, Mumbai and Chandigarh. Other affected areas include Orissa, Punjab, West Bengal, Uttar Pradesh and Kerala states, which also show high prevalence among IDUs. While the recent NACO data suggest that HIV prevalence levels are declining among sex workers in the southern states, overall prevalence levels among this group continue to be high.

The HIV epidemic in India had reached alarming proportions when the PANI project began. The PANI project targets the most affected areas in the Northeastern states of Manipur, Nagaland, Mizoram, and Assam. The epidemiological profile in Northeast India is unique in India in that the initial transmission vector in more than 50% of the HIV infections is attributed to needle and syringe sharing among injecting drug users (IDUs). Other factors influencing the spread of HIV from Manipur and Nagaland into the adjacent northeastern states of Mizoram, Tripura, Meghalaya, and Assam are the presence of a large, mobile population (e.g. truck drivers and army personnel) and displacement due to continued civil unrest. Intermittent insecurity brought on by internal conflicts involving insurgent groups is the principle cause of periodic displacement of rural communities which results in economic stagnation.

According to estimates, in 2003 there were more than 40,000 drug users in Manipur. Of those, 15,000-20,000 were injecting drug users. Nagaland faced a similar situation although the total number of drug users was smaller.[2] Since IDUs are often linked in tight networks that share injecting equipment, HIV spreads rapidly in these populations. Studies have shown that there has been an exponential rise in HIV sero-prevalence among IDUs in Manipur, with rates jumping from 0% in September 1989 to more than 80% in the mid-1990s. The 2002, the most recent

[1] UNAIDS. "2.5 million people in India living with HIV, according to new Estimates." July 2007.
[2] United Nations Office on Drugs and Crime, *Community Wide Demand Reduction in the North-eastern States of India*. September 25, 2003.

estimates were over 55%.[3] With young adults traveling frequently between these two states and the rest of the northeast, the potential for prevalence to jump among at-risk youth is high.

Although IDUs continue to represent the most group with the greatest risk, the rapid spread of the virus through the general population has already started. The NACO 2001 HIV Sentinel Surveillance data for Manipur estimated that 10.5% of patients who visited STD clinics and 1.8% of women who visited Antenatal Clinic (ANC) were HIV positive. The same NACO report estimated HIV prevalence for the STD and ANC groups in adjacent Nagaland at 7.4% and 1.3% respectively. One Manipur study documented an increase in HIV prevalence of non-injecting wives of male IDUs from 6% in 1991 to 45% in 1997.[4] Sexual intercourse with an infected person is estimated to account for 45% of HIV transmission in Nagaland, highlighting the need for a holistic approach to HIV prevention, including safer sexual practices, which targets broader at-risk youth populations.

A National Baseline Behavioral Surveillance (BBS) study executed by NACO in 2002 estimated that more than 50% of IDUs in Manipur were between the ages of 26 and 35.[5] In Manipur, more than 40% of IDUs reported their age below 26. The educational level of the IDUs in Manipur is relatively high with more than 20% having at least a secondary education and more than 50% having reached at least the 9th grade. The same study, however, reported an unemployment rate of IDUs at 22%. High unemployment and few income generating or career opportunities feed into the elevated rate of drug use, requiring an approach to decreasing HIV infection that incorporates livelihood promotion strategies.[6]

[3] *Epidemiological Analysis of HIV/AIDS in Manipur*. Manipur State AIDS Control Society; Dr. S. Sukumar Singh

[4] Panda et al., 2000.

[5] Sentinel cites included Mumbai, Chennai, Delhi, Kolkata and Imphal. The situation for IDUs in the surrounding states can be generally extrapolated from the same data.

[6] Extract from PANI I Proposal.

PANI

To respond to the growing injecting drug use and HIV epidemic in the North East region, CRS Guwahati State Office (SO) initiated a process of rigorous consultation with key community stakeholders, Faith-Based Organizations (FBOs), Non-Governmental Organization (NGOs) and communities infected and affected by drug use and HIV. The process resulted in identifying major gaps in the local response to the epidemic and developing key strategies to improve prevention, care and treatment services. The PANI project is made possible by the generous support of CRS from its private resources. PANI Phase II is currently funded with resources from the One World Campaign Fund.

High rates of intravenous drug use; lack of treatment, care and support for PLHIV; high stigma and discrimination; and few prevention programs targeting youth and women were some of the high priority issues which the SO identified in the process of developing the PANI proposal. While recognizing the wide spread outreach of the churches in the region, it was understood that local churches lacked the capacity to initiate HIV and AIDS programs. Hence, the strategy to bring in experienced non-church partners was adopted by the SO. A series of consultations, meetings and individual interviews with key stakeholders resulted in the adoption of the following goal and objectives.

GOAL: Stabilized HIV prevalence among women and youth and improved health condition of IDUs and HIV and AIDS-affected and infected groups in NE India[7].

The general objectives of the project are:

1) Women, youth, and IDUs in targeted communities adopt safer behaviors vis-à-vis drug use and sexual practices;
2) PLHIV, IDUs, spouses/widows of IDUs and children have improved quality of life;
3) Strengthened capacities of church, local NGOs and linkages and networking with government organizations, national, and international agencies benefit PLHIV.

The project planned to provide these services to: 7500 PLHIV, 5000 IDU, 1000 children living with HIV, and 50,000 at-risk youth and women.

Major activities planned in the project interventions include:

- Build partners capacity on the issues of HIV and AIDS, counseling, Life Skills Education (LSE), peer education, sex and sexuality, Home and

[7] Please note the evaluation is based on the strategic objectives of Phase II, but evaluates the impact of the entire PANI efforts in Phases I and II

Community Based Care, treatment education and linkages with government services.

- Exposure of partners and church leaders to relevant programs.
- State and district-level advocacy workshops and seminars organized by partners.
- Community sensitization and outreach.
- School AIDS education and school counseling.
- Provision of treatment, care and support for PLHIV through health check up, health investigations, nutritional support, opportunistic infection (OI) diagnosis and treatment, Abscess management and necessary referrals and linkages.
- Training of health care providers on HIV management and treatment education.
- Networking and linkage with educational institutions both at government and non-government sector.
- Advocacy with government agencies.
- Facilitate/strengthening PLHIV networks.
- Partners consultative meeting.
- Observation of World AIDS Day, Candlelight Memorial and other commemorations and events that bring people from diverse backgrounds together, encouraging cross learning among partners.

Objective 1: Women, youth, and IDUs in targeted communities adopt safer behaviors vis-à-vis drug use and sexual practices.

Expected Results for Objective 1:

- Increased number of church and community leaders pro-actively involved in the initiative;
- Increased number of youth reached by peer-support outreach services.
- Percent of Catholic and other private schools reached.
- Percent of at-risk youth and women who know at least 3 methods to prevent HIV transmission.
- 50,000 at risk youth and women reached.

Objective 2: PLHIV, IDUs, spouses/widows of IDUs and children have improved quality of life.

Expected Results for Objective 2

- Increased number of target participants registered for care and support services.
- 5000 IDUs provided care and support services.
- 7500 PLHIV provided care and support services.
- 1000 sex workers (SW) provided care and support services.
- 1000 orphans and vulnerable children (OVC) provided care and support services.

- Increased membership in state level PLHIV networks.
- Increase in number of household heads willing to care for a family member recovering from drug use.
- Increase in number of household heads willing to care for a family member with HIV.
- Number of self-help group (SHG) members who are able to economically sustain their livelihoods.
- Increase number of PLHIV accessing services from service centers like ART unit, prevention of parent-to-child transmission (pPTCT).

Objective 3: Strengthened capacities of church, local NGO and linkages and networking with government organizations, national, and international agencies benefit PLHIV.

Expected Results for Objective 3

- 40% of registered PLHIV linked with the free ART unit through outreach and referral.
- FBOs, NGOs and civil society jointly organize HIV and AIDS related events.
- Representatives from government, NGO and international Non-Government Organizations (INGOs) participate in PANI advisory meeting.
- 20% of PANI partners have accessed technical and financial support from other agencies.

Phase-I of PANI's five-year project operated within four northeastern Indian states of Manipur, Nagaland, Mizoram, and Assam. The plan to increase the program in Meghalaya has already been suspended under PANI phase-II. Slight changes in the project's goal and objectives have been made for phase-II of PANI. In PANI phase-II, the goal was changed "to stabilize the HIV prevalence among the general population of northeast India by 2008". The objectives to be met by the end of program now include:

1. Reduced HIV prevalence among IDUs.
2. Strengthened capacities of church, local NGO, and government social services networks.
3. Decreased stigmatization of IDUs and PLHIV.

The approach remains the same from phase one to phase two. PANI's community based, harm reduction approach, implemented through established and effective NGO networks, aim to reach at least 5,000 IDUs, 50,000 at-risk youth (particularly women), and at least 7,500 PLHIV[8].

[8] It should be noted that the PANI project, phase-I and phase-II, are extremely ambitious. It was the opinion of the evaluation team that the program encompasses an enormous geographic and programmatic scope. The PANI project is in fact several smaller projects, with multiple partners implementing care and support projects and additional partners implementing prevention programs. Each partner has developed stand alone projects which fall under the umbrella of PANI.

METHODOLOGY

The following are the evaluation objectives. This guide was developed to help organize the evaluation. The below questions were formulated to help lead the evaluation team by identifying what aspects of the project needed to be examined.

Objective 1: Measure the achievement of project goal and objectives (see above section)

- Have the project objectives and expected results been met? Why or why not?
- Were indicators realistic and relevant?
- Were the objectives realistic and relevant to priority needs of the target population?
- What have been the unintended positive and negative effects of the project?

Objective 2: Draw out the major lessons learned.

- What limitations and hindrances have been encountered?
- What hurdles did the project overcome and how?
- What are promising practices for the next phase of implementation?
- Have basic assumptions and potential solutions changed since project formulation?
- Have strategies been appropriately designed and effectively carried out?
- How have initial strategies been adapted given changing situations?

Objective 3: Determine how well needs of different groups (divided by gender, age, and target group) have been met by the project.

- Has the project responded to the needs of the participants?
- Did the project reach the intended target groups?
- Did the target groups effectively take part in the project? How?
- Which group(s) most benefited from the project? How?
- What have been the factors that have hindered participation?
- Have institution building efforts with its partners been effective?
- What are the promising practices that can be expanded in follow-on phases?

Objective 4: Determine the effectiveness of project organization and processes.

- Have the activities been effective in attaining project strategic objectives both in quantitative and qualitative terms?
- Is the resource input reasonable in relation to results (cost-benefit)?
- Has the project management and organizational structure been effective in carrying out the project?
- Are the interventions and activities appropriate in terms of cost and given the local conditions (socio-economic and environmental)?

- Have the community organization efforts been appropriate, effective and are they sustainable?
- Has CRS adequately networked with other institutions and organizations in order to ensure meeting project objectives?
- Has the project's M&E system collected appropriate, timely and accurate information? Has that information been used for project decision-making?
- Has the project been measuring quality within its interventions? How can program and intervention quality be assured?

Objective 5: Assess the accuracy of the HIV technical inputs.

- Were the implemented activities appropriate for the needs of the targeted area?
- Have there been any reports of stigma as a result of the program?
- Have the inputs of the project significantly contributed to the increased quality of life of PLHIV within the targeted region?
- Have project inputs effectively mitigated the impact of HIV and AIDS on affected families within the targeted region?

This end of project evaluation was based on a mixed-methods methodology.

Data collected came only from post-test project group, as there is no baseline data to measure against, nor is there a control group. Instead, the data only came from those who have already participated in the project. This design is necessary due to the lack of baseline data, but is feasible as the project location is situated in one geographic area (NE India). This evaluation's main focus is to obtain an initial assessment of whether the project is "working", which will guide future project interventions for phase two of PANI.

The design was based on a mixed-methods approach, triangulating data from the following sources:

- Sample of clients surveyed quantitatively;
- Focus group discussions (FGDs) and key informant interviews (KII);
- Review of secondary data, including project data and government reports;
- Site visits.

Quantitative Survey Sample[9]: The target beneficiaries in the PANI project are diverse. As such, small groups of clients were purposefully selected to participate in quantitative surveys. All participants were required to sign an informed consent before participating in the evaluation. All responses were anonymous. The surveyed groups included the following:

[9] Copies of the surveys are attached in annex.

- PLHIV: A survey was developed for PLHIV and affected families who frequent partner health services. This survey asked key questions about the client's perception of services through the project, as well as the client's perception of the impact of the project on his/her overall quality of life. Specific questions were asked for different services (i.e. testing and counseling, referrals, etc.). Over one week, all clients that frequented the selected health centers (which were chosen as a representative sample of the geographic coverage of the project) were offered the opportunity to voluntarily participate in the survey. 420 clients self-selected to participate in the survey. They were provided with the survey to complete and return to a confidential drop box. Oral administration of the survey was available to the clients, but nearly all were literate.

- Youth: The youth interventions targeted youth that were both in school settings and out-of-school youth through youth centers. As such, both in-school and out-of-school youth were asked to participate in the survey.

    - In-school youth: The evaluation randomly selected 10% of the schools where the prevention activities were conducted (as no sampling frame for the children was known to the evaluators or project implementers). Students in the target age group for the interventions (and with the appropriate consent) were asked to complete a short survey on their knowledge, attitudes and practices (KAP) related to drug use and sexual practices. A total of 684 students self-selected to participate in the survey. The survey was self-administered during school hours, after both the parents and students signed an informed consent.

    - Youth centers: The project supported six youth centers. Youth in these centers were asked to complete a short survey on their knowledge, attitudes and practices related to drug use and sexual practices. A total of 210 youth self-selected to participate in the survey. The survey was self-administered while youth visited the centers.

- Teachers: In the selected schools, all teachers of the selected classrooms were invited to complete a survey designed to elicit information on the project and their comfort in dealing with HIV and drug use issues. A total of 196 teachers self-selected to participate in the survey.

- Church leaders: Church leaders in the project area were sent a survey requesting information regarding the success of the project and future areas of possible intervention. A total of 537 leaders self-selected to participate.

- Larger FGDs and KIIs: Evaluation team members conducted semi-structured interviews with key informants and focus group discussions in order to elicit needed information for the evaluation. Key informants included local project and partner staff, community leaders, and local health workers. Other informed community members include Government officials, leaders of other NGOs and funding organizations working on HIV and AIDS issues. Key informant interviews were conducted by select evaluation team members during the fieldwork period of the evaluation. In addition, FGD were held with current beneficiary groups of IDU, PLHIV, local partner staff, families of clients, youth, women, community and church leaders and others when necessary. Each FGD was facilitated by two evaluation team members, recorded and transcribed. In total, there were 28 FGDs completed: seven with care and treatment center clients (e.g. PLHIV who receive services from PANI); nine with project staff of care and treatment and prevention; three with church leaders; three with caregivers; two with youth; one with school authorities; two with community leaders and one with CRS staff. There were 16 KIIs with the following key informants: two Bishops, two antiretroviral therapy (ART) doctors, three CRS staff; two partner project directors; two community leaders; three project directors/coordinators; one government official from the State AIDS Control Society and; one coordinator from a CRS donor.

- Review of secondary data: In order to examine partner capacity, a general interview was conducted with CRS staff to explore project key capacity issues. In addition, the project's M&E files were shared with the evaluation team for inclusion in the evaluation. A review of government documents and other public resources that were available for the target areas were examined in the secondary data review.

This design can provide some direction in terms of what the project group believes to have occurred within the project, but it will not provide precise estimates of impact. It also cannot be generalized to a wider population outside of the project group, thus the evaluation cannot comment on any potential replicability of the project to other groups.

However, this evaluation has teased out some lessons learned and promising practices that will be applicable to the second phase of the project. In addition, this evaluation has elicited information on what is currently working and how interventions can be strengthened in the future.

RESULTS

The key results from both the quantitative and qualitative portions of the evaluation are first summarized followed by the in-depth results from the qualitative and quantitative portions of the evaluation. These are summarized against the planned project objectives in the final portion of this section.

Key Results

- **Improved quality of and access to care.**
- **Improved quality of life (QOL).**
- **Stigma and Discrimination.**
- **Awareness of PANI.**
- **Support groups through health clinics.**
- **Increased partner capacity.**
- **Improved networking and linkages.**
- **Unintended benefits.**

Qualitative Results

These findings were gathered through FGD and KII with project participants including caregivers and clients, church and community leaders, partner staff, local government officials and other key actors in the project site active in the HIV sector from the 14 projects in three states (Assam, Nagaland and Manipur) under the PANI program. A compiled overview of the positive and negative aspects, as identified by all levels of beneficiaries, is provided. Following these summary discussions, more in-depth findings are presented according to the respondent groups.

- **Increased access to care and treatment:** Interviewees of all groups agreed the PANI project had significantly increased the number of clients seeking and receiving ART, as well as palliative care; prior to the project many of these same PLHIV were not open about their status and were reticent to seek care due to fear of stigmatization and/or misinformation about treatment options.
- **Improved quality of services:** Across the board participants in the survey stated that they were very happy with the services they receive and agreed that the PANI program has helped the drop-in-center (DIC) improve the quality of services offered.
- **Support groups:** Project clients and caregivers noted strongly that the support groups were a big success of the project. They stated clearly that the groups provided them with emotional support and a sense of community with other people who understood their problems. Additionally, many support groups worked on income generating projects for members who are struggling financially.
- **Increased partner capacity:** The PANI program has contributed to

strengthening partners' capacity in care and treatment and prevention. While the DICs have improved their ability to delivery high quality services, prevention partners have made strides to provide education to project beneficiaries. The government and other key stakeholders in the community recognize the work of the PANI partners and now consider them as key actors in the HIV sector.

- **Improved networking and linkages:** Through the PANI program, CRS partners have reinforced ties with the local government and State AIDS control Society, as well as with other key stakeholders. PANI partners attend regular meetings on HIV and play a strong advocacy role in their region. Moreover the PANI partners themselves have an internal network and meet quarterly to share experiences.
- **Need for OVC educational support:** Both care and treatment center clients as well as caregivers spoke of the needs for OVC, especially educational support. PLHIV who are struggling with HIV-related illnesses are often too weak to work and cannot afford school fees, but greatly value education for their children.
- **Stigma:** While interviewees agreed that the PANI projects and program interventions have contributed to a greater understanding of HIV through community mobilization, there was still a strong feeling of stigma in many communities. Across the board staff identified stigma as the greatest challenge facing the PANI project at present. Children especially have been subject to discrimination in school and community setting by other children.
- **Unintended benefits** of the project include contributions to peace building including the bringing together of people from different ethnic, social and religious background around a common theme of HIV transmission prevention, care and treatment. People from the same physical community but different backgrounds who had never worked together united under the PANI project to provide high quality services and reach project objectives.

<u>Key Points from Interviews with CRS Project Management Staff</u>

Staff repeatedly reported that staffing levels are too low to cover the project adequately and to provide technical support. CRS staff noted extremely long periods in the field due to both the increased workload as well as the difficult operating environment which leads to frequent delays in planned activities and extended travel as a result of insecurity on the roads/rail lines. Staff noted issues of burnout, stress and limited time with their families. Moreover, project staff do not uniformly possess the technical skills required to assist the complex technical nature of HIV programming. Staff commented that they look forward to more technical assistance from the CRS India Program Quality Team during the project and not just during project design and evaluation.

Staff also reported that the resources are spread too thin. The PANI project is in

fact 19 smaller projects, with 17 direct partners and seven sub-partners: seven direct and six sub-partners are implementing care and support projects and 10 direct partners are implementing prevention programs and capacity building of church organizations. One other sub-partner is working on research to assess issues related to sex work in the region. Each partner has developed their own stand alone project which falls under the umbrella called PANI. Resources are spread thinly, and as client load increases, as reported throughout the evaluation, and the budget remains the same, resources become insufficient to cover costs such as medicines for opportunistic infections for clients or additional staff to handle the increasing patient load. Moreover, several partners reported that activities and budgets were reduced from PANI Phase-I to PANI Phase-II as new partners in neighboring states were added to the PANI project. There was little explanation given to the partners for this budget decrease especially given that patient numbers were on the rise and objectives were being achieved.

Staff reported that unintended benefits of the project include contributions to peace building including the bringing together of people from mixed ethnic, social and religious background around a common theme of HIV transmission prevention, care and treatment. People from the same physical community but different backgrounds who had never worked together united under the PANI project to provide high quality services and reach project objectives.

The rough operating environment in North East India is unpredictable making project implementation and management quite challenging. There are limited INGOs operating in this region due to these issues. People do not go out after dark and police and military forces closely monitor activity in urban and rural areas at all hours of the day. There is continuously a strong military or police presence. The region is unstable with frequent "bandh" or strikes called for by opposition groups, which close down national highways, government services and communication. There are frequent explosions in marketplaces and other crowded, popular areas. In some parts of the project area, electricity is limited to only a few hours per day, and other utilities are irregular when compared to the rest of India.

Positive outcomes

By and large, PANI was deemed successful by key informants, project participants and partners. The findings of this evaluation demonstrate that the PANI program is having a positive effect at various levels. These are summarized in the table below. Please note that the table represents a shorted summary of points made by different respondent groups interviewed by the evaluation team. The shortened responses are further explained in the text below the table in the qualitative section of the report. These responses are taken directly from the interviewees, and represent their opinions on the positive outcomes of the PANI project.

Table 1: Positive Outcomes of PANI as Identified by Respondent Groups

Respondent Group	Type of Project Intervention		
	Care and treatment	***Prevention***	***Networking and Capacity –building with Partners***
Clients/ Beneficiaries/ Caregivers	▪ Increasing the number of people seeking services ▪ Emotional support ▪ Information about my treatment and side effects ▪ Finding people just like me ▪ Moral and psychosocial support ▪ OI medicines, vitamins ▪ Nutrition for children ▪ Training on HBC ▪ Home visits ▪ Lab tests	▪ Correct knowledge about infection and CT ▪ Community members come forward to help PLHIV ▪ Some people seek HIV tests and other care ▪ Own awareness levels have improved ▪ Some youth "drop-outs" have returned to school ▪ Some behavior change ▪ Increased understanding of IDU risks	▪ Increased inter-faith dialogue ▪ High quality TOT training for leaders ▪ Churches speaking about HIV prevention ▪ Less discrimination ▪ Church has policy on HIV and AIDS ▪ Greater willingness to care for PLHIV ▪ Attitude change
Project staff	▪ Enrollment has increased ▪ Patients seeking treatment for STIs and other illnesses ▪ Clients are forming SHGs ▪ Some people have more responsible behavior ▪ People feel more accepted ▪ Family members involved	▪ Community sensitization ▪ Increased community understanding about HIV ▪ More students requesting counseling ▪ Recognition of project by local authorities ▪ Students more confident	▪ School education ▪ Community sensitization ▪ Church leader training ▪ Networking with local government, NGOs ▪ More respect for FBOs ▪ Church policy ▪ Leaders talk about HIV
Site-level Key Informants	▪ Giving hope to patients ▪ Greater access to treatment ▪ OI support ▪ Pediatric work		▪ Capacity building ▪ Less ignorance ▪ Fundraising ▪ Networking

Care and Support

The project supports many care and treatment centers under the PANI projects in Mizoram, Assam, Manipur and Nagaland. As part of the qualitative evaluation, the team visited six partners in three states managing care and treatment services: Manipur Network of Positive People (MNP+), Social Awareness Service Organization (SASO), Care Foundation, Kripa Foundation, CAD Foundation and AIDS Prevention Society (APS). The team also visited Catholic Medical Center Imphal, Jawaharlal Nehru Hospital Imphal and Cradle Ridge AIDS Hospice run by Naga Mother's Association, three long-term care facilities for clients with complicated HIV-related illnesses. Most of these organizations began their work with substance abuse prevention and treatment and later added HIV services with support from CRS and other donors. Most clients in the care and treatment centers are IDUs or the spouses and children of IDUs. The care and treatment centers

offer a wide variety of services including community mobilization and prevention education, testing referral and registration for government free ARV program. In addition, the centers provide counseling for PLHIV, their spouses and family members. Staff nurses conducting home visits will often pick up monthly ARVs or draw blood for regular tests, eliminating the need to wait in long lines at the government center. The centers also provide education about ARVs, adherence, potential re-infection and HIV prevention. For the most part, these centers cater to clients who cannot pay for such services.

Quality of services

Project participants, CRS and partner staff and other stakeholders agreed that the quality of care and treatment services was very strong in the project sites. Clients were quite pleased having access to life-saving treatment and clinical staff that could help them to navigate all of the complexities of ART. Clients expressed their satisfaction with the staff and noted that the staff treated them and their family members very well, "like friends and family". Many project clients stated that the care was superior to other government and non-governmental programs. One male client noted, "I am very happy with the services. They provide everything from A-Z; I am extremely happy with the services, even the health check-ups." There was strong appreciation for home visits, which seem to be quite regular, and occur on a weekly basis, and sometimes more frequently. "Whenever somebody falls sick and is hospitalized the project staff stay with them or visit. They also come for home visit for follow up and nutritional support for children", noted one female caregiver.

> "We are more comfortable coming to the doctor, nurse, counselor here at the center than going elsewhere."
>
> *Female care and treatment client*

> "I am the only breadwinner and I need to take care of my family but I cannot work. Since I have a drug background the employers will not trust me and if they find out I'm HIV they will not hire me. Now my wife and I collect pension from the late parents to cover expenses and keep our four children in school, but what will we do when that runs out? Biggest problem is stigma and discrimination. We have opened up so that others will come out and access services…."
>
> *Male Care and treatment client*

Clients and caregivers receive training on OI management, HBC, patient education information, as well as prevention education. Clinical Staff train caregivers in small medical issues can be attended to at home and which need to be seen by a clinician. Still, several expressed the need for more training. Clients and caregivers noted that the nutrition support they receive regularly from the centers was helpful for both children and adults. In addition, many PLHIV were uncomfortable seeking care at the government centers due to the poor quality of services and lack of confidentiality. They expressed gratitude that they had an alternative for care and treatment.

Income generation

Many patients on ART, as well as some not yet eligible for ART, complained of feeling weak and therefore unable to take on full-time jobs or hard labor. This was especially true of the women. Several mothers noted that the majority of their time is now spent caring for their infected spouse and/or infected children. In some cases, they are infected as well, resulting in little time or energy for regular work. Nevertheless, they clearly explained the need for additional income and requested the project support interventions, such as SHGs and marketing training. Some women who know they are HIV positive still participate in sex work to survive as they have no other source of income. It seems as if the women could handle part-time work or full –time work which can be done from home provided that it wasn't labor intensive. The greatest challenge expressed by most clients and caregivers was financial burden in the home because they could not work.

Support groups

All care and support treatment centers offer support groups to clients and family members. Several of the centers facilitate support groups for spouses, women living with HIV, adolescents, and caregivers. Participants from the FGD who spoke with the qualitative evaluation team were immensely pleased with the support groups. Clients spoke highly of the emotional support that they received by joining the support groups; they noted that their fellow members in the support groups , who are experiencing the same issues related to their illness, understand them so much better than even their own family members. The clients also noted how much they looked forward to meeting with the support group.

> "We are 13 members in the group and we meet twice in a month here at PLC, every member contributes Rs.20/month which is later deposited in the rural bank in which we have the account. PLC staff facilitated the opening of account in the bank."
>
> *SHG Group Member, Manipur*

In some of the centers the support groups engage in income generating activities or other projects. The groups receive training in specific skills and marketing. Although support group members remarked that the income earned doesn't cover all of their costs, most clearly appreciated learning new skills, being able to be productive and earn a living. The support group members found the skills training very high quality and extremely useful. Skills training cited by the group members included raising silkworms, weaving, embroidery, tailoring, and animal husbandry. Other groups, which did not engage in such activities, recommended that the project provide this training to them. They suggested with the right skills they could start a business in pickling and making jams and jellies. At all sites, clients requested the increased support in group activities.

Cost of medical care

Many clients spoke passionately about their need for increased income to cover

additional expenses as a result of their illness. The project only covers a portion of their medical needs; therefore patients must cover the balance. Several clients spoke of the painful side effects of having hepatitis C and co-infection with HIV. Due to prohibitive costs, hepatitis C testing and treatment do not exist in the public sector. These clients are also unable to afford such services in the private sector and therefore requested support from PANI. In addition, several IDU clients spoke of the need for greater support for addiction management and requested the project provide specific and holistic services for treatment and rehabilitation[10].

Education

PLHIV face severe shortage in household income due to additional health care expenses, but healthcare is not the only area that suffers. Many participants requested educational support for children. The majority of clients and caregivers expressed a strong need for financial support to cover school fees and other school related costs. It is often the case of grandparents caring for the children orphaned by AIDS. In these instances, the grandparent has nearly exhausted their financial resources caring for their child and with limited resources remaining for the care of grandchildren who may also be living with HIV. These elderly caregivers also noted they are tired and have no resources left to care for themselves.

Throughout the evaluation, interviewees expressed the need to come up with a strategy to locate resources to cover school fees for OVC.

Nutrition

Due to resource constraints, nutritional support is provided only to children living with HIV through direct PANI funds and support from the Clinton Foundation. Nevertheless, caregivers share the nutritional support with other children in the household. Widows living with HIV and infected caregivers expressed the need for nutrition support, which is only provided minimally in some cases. In general, families caring for PLHIV in the home, whether child or adult, needed greater nutritional support for all family members mostly due to poverty related issues.

Care for OVC

In some cases, family members are finding it very difficult to support OVC. Many expressed the need for assistance and felt that creating an institution for children, such as a special orphanage, was the best alternative as a solution. In cases in which caregivers are living with HIV, the situation was even more severe. The caregiver was not able to tend to themselves, fell ill and unable to care for the family members. Widows were especially vocal about the need for additional support for their health so that they could be strong enough to care for the children.

[10] According to interviewees a holistic approach should include taking care of other medical complications associated with drug use (e.g.: HIV, HCV, abscess management, etc) and also address the long term need for economic and social sustainability of marginalized communities and their families through vocational trainings, job security and infrastructure/market access

Many women caregivers, several of whom were PLHIV spoke endlessly about the challenges faced caring for their infected children. They were worried about their children's health and welfare and were especially worried about their children's future should they die.

Child counseling

Both caregivers and clients spoke of the difficulty speaking with young children about HIV and the effects of the virus. Parents who are positive noted they were not able to tell their children they were sick, even though their children asked many questions about their medication and medical visits. Caregivers said they did not know how to tell children who are living with HIV why they need to take medicine and see the doctor more often than other children. It is particularly difficult when one child in the household is sick, while others are not. Often, children are very concerned and ask questions related to their treatment or their parents'. The team reported that a 14-year old boy found out from the kids at school that he was HIV positive, ran away and committed suicide. As one mother noted, "Another challenge is when my youngest daughter came and asked that 'people are talking about my father dying of AIDS; so what is AIDS?' it was very difficult to even think of facing such questions from my children." Some of the children are young adolescents and may already be sexually active.

Stigma

> "My husband and I are positive and we have two children age 12 and 5; they ask why we are taking medicine. The neighborhood kids won't play with our children, and they may suspect something. Their parents always chase them away."
>
> *Care and treatment client, Dimapur*

Across all six care and treatment centers and with various groups everyone discussed the high level of stigma and discrimination facing PLHIV and their family members in their community, as well as in some medical institutions, such as the ART center. Respondents spoke of neighbors excluding them from community activities. Center clients remarked that at work they experience discrimination by their employers and have even lost their jobs. Several clients talked about the deep stigma they face even in families. One woman was thrown out of her in-law's house after her husband died. She was forced to return home to her parent's homestead, which is a disgrace in the culture, to raise her children. The fear of discrimination is so high that in some cases clients are nervous to even disclose their status to their spouses and children and do not wish to have them tested for fear of the consequences. Participants in the survey mentioned that neighborhood children openly teased and in some cases beat children of PLHIV, believing that they were also infected. Several PLHIV spoke about the need for more people to be open about their status, but they are scared. Some people know they are positive but do not want to be identified or want services. Still others are unaware of the services available or the benefits of ARVs. Many suggested that

those individuals who are "hiding" should be approached by a small group of counselors so that they can feel safe and confident to seek services.

All of the FGDs requested the project enhance the community mobilization activities, to increase the awareness raising activities as a means to decrease stigma. Clients requested the projects improve the follow-up in the community after sensitization sessions to help parents and spouses come to a clearer understanding of the realities of HIV infection. They "hoped that with more understanding family members would accept them and care for them at home, instead of throwing them out".

Concerns from care and support center staff

Project management

While project staff agreed that the services offered are good quality, they noted that they are overburdened and understaffed. They spoke of the need to increase support for medicine, nutritional support and client education. Others noted that the lack of on site testing facilities makes their work more cumbersome. Many would prefer the centers were "one-stop shops", offering all services to clients while avoiding referral to other places where they were not sure of the quality of care and attention. Many remarked that referral from their center to the government center or a private lab for testing should be avoided.

Staff spoke of the difficulty managing the budget for OI medicine, as the client load increases. Some centers have staff vacancies which creates challenges to manage activities or to help ensure coordination. Also, staff noted that they require more training, such as nutritional and counseling training, especially child counseling. They would also like to see more PANI meetings to share experiences.

In Dimapur, project staff felt that they lacked a high level referral ART doctor, as compared to the level of human resources available in Manipur. Staff in all centers complained about the quality of services at the government ART center. Staff in Dimapur noted that there is a lack of hospice level care in the town; their nearest facility is far away, as villages are isolated and road networks are less developed.

Center staff are concerned about clients' poverty and advocated for more income generating activities. They noted that stigma was the greatest challenge facing PLHIV. Adherence to OI and ARV medication is also a challenge.

Partnership

Partner staff expressed a high level of satisfaction with CRS, noting that, "CRS staff are very supportive" and that "they have learned so many things". They stated that CRS helps them not only with finances, but also with technical issues, completing their reports and managing the budgets. Whenever they have

questions, CRS staff are always available by telephone and email, and come frequently for monitoring visits. CRS has helped set up documentation systems, and procedures to collect information. CRS' demand for high quality has helped them to improve.

Care and treatment partners have done an admirable job at fundraising. They have a diversified portfolio of donors including the ACS, Gates Foundation, Elton John Foundation, and Department for International Development (DFID), Project Concern International (PCI), Global Fund and Clinton Foundation. Several centers have income generating projects, for example MNP+ runs a small stationery shop from which the profits are channeled back into the organization to cover certain administrative costs.

Prevention

There are three prevention projects under the PANI program which were part of the qualitative evaluation. Two based in Manipur target in and out of school youth and community residents. One of these projects works with youth through schools and youth-friendly sports center using a Life Skills education (LSE) approach which includes some participatory activities such as cultural programs, sports tournaments, youth camps and drama. One project places counselors in school to speak with youth. Youth are trained as peer educators and youth leaders or trainers. In addition, the project works with SHGs, composed mostly of women, and literacy groups as agents of change. Both of these types of groups engage in HIV prevention education and awareness raising activities. There is one prevention project in Nagaland, implemented by the Diocese of Nagaland, which targets youth and community leaders. The project implemented a wide variety of activities including street plays, sensitization session, training for teachers, sessions with in school youth, workshops with community and church leaders and meetings with media for advocacy.

> "Also, earlier people did not give much importance to HIV / AIDS since they felt that it is something which they did not need to worry about and which is not going to affect them. However, awareness level has now improved a lot."
>
> *Community member, Assam*

Awareness

The prevention projects have made efforts to increase knowledge about HIV transmission and encourage communities and target groups to talk about HIV and related behaviors. Before the project started, many community members and youth did not have accurate information about HIV, although they had heard about the disease. But now, according to evaluation participants, they have a better understanding about HIV transmission and how to take care of people infected with HIV. Project beneficiaries agreed that the project interventions helped to spread correct knowledge about HIV in the schools and communities, clearing up many existing misconceptions. As a result of the project, "people are more comfortable

talking about HIV than they were before, but there is still far to go". Community members are more open to helping families and patients affected by HIV, and "school teachers are more aware of the disease and do not discriminate as before". According to some community members and project staff, prior to the project, youth would loiter in the streets and were likely to engage in (what they perceived were) risky activities such as substance abuse and premarital sex; however participants were please since now, with support from the PANI project, these same individuals can find refuge in youth-friendly centers to play games and talk with counselors.

In Nagaland, the project has expanded project activities to cover nine districts and has hired field animators and village health workers to work in these areas. The field animators and village health workers (VHWs) have been recruited from the outgoing Title II program and are supervised by the Catholic health dispensary in the area. The role of the field animator and VHWs is to increase HIV awareness, organize community prevention events and provide care and support services to PLHIV.

The prevention project activities have been recognized by the local authorities as contributing to the HIV prevention in the area. Key stakeholders recognize the work of the project and often invite project staff to meetings or to speak about HIV prevention at community events (Manipur). Project staff are pleased with their newly developed linkages with the government and other actors in the HIV sector.

Challenges

Despite efforts by the project, prevention efforts have met several challenges to increase HIV knowledge. Staff noted that while awareness is higher, people really don't understand the risks or consequences associated with HIV. "Awareness must continue – and it needs to be continuous, everyday not just one time." Many people still have misconceptions about HIV and its transmission, and high levels of stigma and discrimination exist.

> "Many people already know that they are positive but they still participate in high risk behavior since they need to earn money [e.g. SWs] for their kids."
>
> *Female Project Participant, Dimapur*

Several interviewees spoke about the issues surrounding prevention efforts and why it is extremely challenging. As one community member noted, "[the] major challenge is the tendency of people to hide their status. People do not reveal their status for various reasons – the society might disown them, their children might face problems in school, the schools might not accept their children. There is a fear of discrimination and stigmatization. People also do not go for testing thinking that it involves a lot of money. Also, people feel shy talking about HIV and AIDS. They feel that it is something which should not be talked about."

The prevention projects have clearly faced difficulties engaging communities on issues related to HIV prevention, especially in the rural areas outside of Dimapur. In one FGD a youth stated "…people are very conservative, and we don't talk about it [sexual behavior], we are not free to talk about it". Although the evaluation team only spoke with one group of youth, interviewees from this group stated they learn about HIV from the media and books; they know that HIV is incurable. The youth from this group were able to correctly identify the modes of transmission. Interviewees stated that many young adults still engage in sexual behavior that puts them at risk for HIV infection due to peer pressure and because they want to explore their feelings. As one participant stated, "youth are engaging in risky sexual behavior because they want to know what it feels like." Others may engage in drug abuse due to family problems. Participants agreed that some of the best ways to target youth was through the music concerts and competitions. Youth have heard the messages before but are not really listening since they don't care/bother and don't take HIV seriously. One interviewee suggested that we can convince youth that HIV is a big problem through counseling, but not through youth clubs which exist in the neighborhoods. Others suggested mixing boys and girls together to talk about sexual behavior and using religious leaders and teachers to pass messages. One participant noted, "kids want to talk about this with their parents, but parents only want to talk to other parents about it".

Future directions

Interviewees agreed that projects need to increase community mobilization and sensitization sessions. There is need for sex education, but according to many participants, parents do not discuss sex with their children. Participants agreed that encouraging parents to talk with their children is a strong prevention strategy, which can lead to behavior change. Other participants from Assam suggested using the print media more as a means to increase prevention messages. In Nagaland, religious leaders stated that they should receive more training and messages about HIV should use the bible and the church to educate.

> "Most of the youth are school dropouts who have nothing to do. This increases their vulnerability to get into risky behavior. Once they are engaged somewhere, such risks do not arise."
>
> *Religious Leader, Manipur*

> "PLHAs will not be properly treated [in our community]. If they are affected, they only know that they will die. Communities do not want to look after the PLHAs."
>
> *Religious Leader, Jalukie*

In addition, participants from all states recommended targeting youth to change their behavior. Many youth have dropped out of school for various social and economic reasons. In the states targeted under the PANI program, there is a high level of political instability which results in strikes. During these times, families keep their youth indoors and many activities (such as

schools, youth centers) are suspended for up to three days at a time. Since there is a high level of unemployment for youth and few activities for them to do after school, programs should think of ways to engage youth in productive activities or cultural programs.

In Nagaland, efforts to work with the community have been challenging. In the rural areas outside of Dimapur and Kohima, many communities are conservative and do not wish to talk about HIV since there is a strong linkage with sexual behavior. Many in these communities do not believe that HIV exists, stating they have not seen anyone with HIV and do not know of any community members who are infected. The youth laugh at prevention sessions and village residents state that "AIDS is not here in our place". As one women noted in Jalukie, "unless the community see the suffering of PLHAs with their own eyes they will not take HIV/AIDS seriously." Moreover, in the recent past the communities had some conflict with NGOs working in HIV prevention which wanted to distribute and talk about condoms. As a result of this conflict, these communities had banned HIV programs in their area (however today they are open to working with the PANI project). This history has made prevention efforts difficult. The evaluation team met very few project participants from the prevention programs and those that interacted with the team had limited experience with prevention activities. In these communities, FGD participants expressed a strong sense of stigma in the communities as well as a high level of skepticism towards HIV programs. For example, one community leader noted, "People only know that HIV is not curable. Let us stay away from them".

Project management

Project management varies from one project to another. Across the board, CRS and partner staff noted that they are overworked and do not have enough staff to tackle the myriad of prevention activities under their responsibility. They also noted that the project activities are spread too thinly across the geographic target areas. In several cases, activities were "one-time" activities with little or no follow-up. The prevention projects lacked appropriate training materials; those materials that did exist were loosely assembled and not adapted to the local context. Slide shows are in English. Trainings are conducted in a mostly "lecture" format. Project staff use "Abstinence and Be Safe" as the prevention messages in the project activities; it is not clear whether messages are adapted/altered to meet the needs of different audiences.

Care and support activities have been incorporated into prevention projects in Nagaland managed by faith-based partners. Project staff identify PLHIV in the community and refer them to local health centers. However, it is unclear how the care and support activities are integrated with prevention programming. Staff did not receive any care and support training; and the project team stated that "it is not easy to identify PLHIV".

Staff from partner organizations, as well as from CRS, noted that the project budget is not sufficient for the activities planned each month. For example, project staff shared they must use their private funds to cover transportation for themselves and for the field animator, as well as for snacks while they are traveling to a sensitization session. There is high staff turn-over. Interviewees openly commented that the salaries were too low to retain staff required to "work 12-hour days as well as consistently report for duty on the weekends, including Sunday and late evenings". In the Nagaland project, for example, the project has lost more than half of the field animators and VHWs attached to the health centers. Additionally, project staff believed that while project interventions were successful they were not targeting the populations with behaviors that put them at greatest risk, such as the rickshaw drivers (Manipur).

Partnership

The partnership between CRS and organizations working on prevention projects has been strong, but overall experiences between projects varied. While project staff appreciated the "free and frank relationship with the CRS team", they also felt the actual support received in prevention training was lacking. Both teams requested more training, especially in the area of child counseling. In addition, one of the teams noted that the level of engagement and monitoring was insufficient. Partner staff expressed a strong need for more capacity building, assistance with documentation and systems, as well as exposure visits to other successful projects in other locations.

Capacity Building of Faith-Based Organizations

Two projects under the PANI program focus on building churches' response to the HIV epidemic. These projects have trained religious leaders in HIV to raise their awareness about HIV, its impact on the community and to assist in response strategy development. One of the main partners under this objective, trained a team of trainers who in turn trained staff from 20 associations, each association is made up of many churches. The project, implemented by the development branch of the Baptist Church, has been so successful that the Baptist Church has established an HIV policy and has instructed each church to take up issues related to the care and support of PLHIV. The church council members commented, "Before people knew anything about HIV. Church leaders also didn't think it's part of their program. Now we use our pulpit to speak about HIV".

> "Earlier most leaders neglected HIV. After [the] NDO program, they have opened up their eyes. We now offer prayer and counseling."
>
> *Religious Leader, NBCC, Dimapur*

Partner staff working on the capacity building project, as well as CRS staff, noted that the change in the church leaders under the project has been remarkable. The project staff are

extremely satisfied with the results of the training and the workshops, and they believe its success is due in part to the high quality TOT and the workshops for the association's leaders. Likewise, the church leaders are satisfied with the training offered by the project. As one leader said, "It is NDO who have opened our eyes. Before NDO [the project] came, there was no work done. But after NDO, now some work is being done."

> "We want to see all churches and communities are free from HIV and AIDS. We cannot confine ourselves to the Baptists only. We also have to work with other denominations. Because they are also a part of our communities."
>
> *Church leader, NBCC, Nagaland*

The training brought about a real change in the leaders' behaviors, attitudes and practices. Church leaders stated that following the training, they had an increased capacity to communicate with local pastors and congregants. Many churches have now formed small core groups and raised funds to organize care and support activities. In addition, through support from the PANI program the projects have joined forces with other denominations. The Catholic Bishop of Kohima stated that due to his involvement in the PANI program, he has been invited by the Baptist Church to attend a seminar on peace building. In addition, FBOs, local NGOs and people from different ethnic backgrounds are coming together and working for HIV.

> "I had a relative who we knew was a PLHA. He is dead. Whenever I used to see him in the town, I would try and avoid him. Now when I think back, I feel bad. Had I known then, I would not have behaved liked that. Now after the training at NDO, I think it is a privilege to work for these people. When others feel uneasy to go and talk to the PLHAs, I take the lead."
>
> *Church leader, NBCC, Nagaland*

Project management

In all projects, staff noted the funding period was too short. Partners noted budgets and agreements were signed for a period of six months or one year. This short period gave them much concern and limited stability. Most of the time they are worried about future funding, and are writing proposals, leaving less time for project activities.

Partnership

Two partners have requested that CRS increase support and monitoring. They have been less satisfied with the relationship with CRS and feel that communication could be improved. However, these were a minority, elsewhere partnership was noted as one of the hallmarks of the PANI program. The majority of implementing partners consistently noted the high quality assistance provided by CRS staff, as well as their dedication and willingness to work as "true members of the team".

Quantitative Results

As indicated in the methodology section, this evaluation was conducted using both quantitative and qualitative data. Surveys were administered to a diverse group of PANI participants including: youth club participants, students at schools, teachers within schools, health center clients and church leaders. The following sections detail the findings from the quantitative surveys, but key highlights include:

- **Quality of health clinic services:** Respondents reported being satisfied with the services received at the clinics with 75% of respondents reporting that the services were either good (41%) or very good (34%).
- **Satisfaction with health clinic staff:** Seventy-eight percent (78%) of respondents reported being satisfied with the staff at the clinic they frequented.
- **Range of services at health clinics:** The services received at the clinics varied, but 80% of respondents reported receiving regular health care at the clinics.
- **Referral system at health clinics:** The referral systems at the health clinics appeared to be very strong with 65.5% of clients who sought health care in addition to the health clinic reporting being referred to those services by the CRS-supported clinic.
- **Support groups:** Slightly more than 63% of health clinic respondents reported having joined a support group through the health clinic. Of these respondents, 40.5% reported that the support group had improved their overall QOL.
- **Unintended positive effects:** Many clients reported that the clinics had helped them to deal with their economic status by providing free medicines (81.9%), free health check-ups (68.8%), free testing (59.5%), free lab tests (33.3%), access to SHGs (32.1%), linkages to income-generation activities (20.5%), and social linkages with other clinic members (13.6%).
- **Prevention activities:** The prevention component of the project aimed at youth, both those in school and in youth centers, is relatively weak with limited numbers of respondents indicating that they benefited from this portion of the program.
- **Satisfaction with prevention activities:** Of the teachers who reported receiving training through their schools, 34.7% rated the training as very good, 51.4% as good, and 12.5% as average. Almost half of surveyed students (47%) reported they were satisfied with prevention activities.
- **Faith-based perception of CRS activities:** In general, faith-based respondents rated the work of CRS and partners positively with only 4.1% indicating that CRS' work was below average and no respondents indicating that it was very bad.

Care and Support

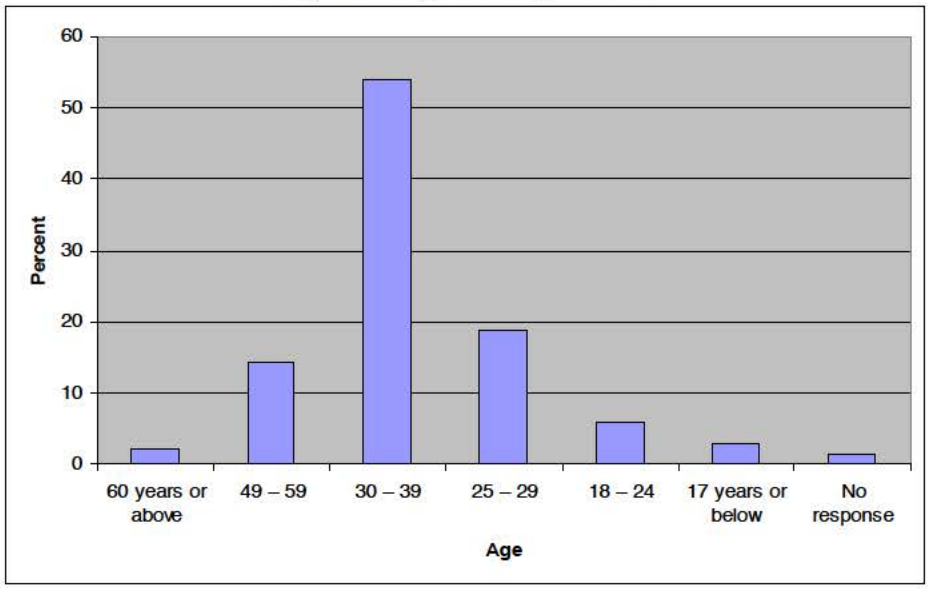
Health clinic clients were offered the opportunity to participate in the evaluation through a quantitative survey distributed on-site. Clients from the following sites self-selected to participate:

Table 2: Respondents by Site

	Frequency	Percent	Cumulative percent
APS	110	26.2	26.2
SASO	25	6.1	32.1
MNP+	100	23.8	56
Kripa Foundation Imphal	85	20.2	76.2
Care Foundation	14	3.3	79.5
Kripa Foundation Kohima	15	3.6	83.1
Development Association of Nagaland	54	12.9	96
CAD Foundation	8	1.9	97.9
Bethany Sisters	9	2.1	100
Total	420	100	

More than half (60.7%) of the client respondents were female. The majority (54%) was aged 30-39, followed by those aged 25 to 29 years (18.8%) and those aged 49-59 years (14.3%). Less than five percent were under the age of 18.

Figure 1: Age of Respondents



The majority of client respondents (44.5%) were married and living with their spouse. Nearly a quarter (24.3%) were single, and 22% were widowed. Only 3.6% were divorced, 2.6% were married but living apart from their spouse, and 1.9% were separated. The respondents were generally educated with 41.4% of the sample

having completed secondary education and 12.4% completing tertiary education. Only 8.1% had no education, and 35.2% had completed primary education.

The majority of client respondents (41.3%) reported having attended their clinic for one to two years. More than one-quarter (27.7%) reported having attended the clinic for three to five years, and 21.2% for less than one year. Only 2.8% indicated they had been attended the clinic for six years or more.

The services received at the clinics varied, but 80% of client respondents reported receiving regular health care at the clinics, 55% reported receiving counseling services, 48% reported receiving counseling and testing (CT) for HIV, 42% reported receiving treatment of STIs and OIs. Additional services reported included receiving nutritional supplements (32%), access to SHG (32%), access to peer support groups (31%), regular lab work (30%), and palliative care for family members (27%), ART (17%) and access to hotline services (7%).

In general, client respondents reported being satisfied with the services received at the clinics with 75% of respondents reporting that the services were either good (41%) or very good (34%). Ten percent reported that the services were average. Just 1% reported that the services were poor, and 1.4% reported that services were very poor. Only respondents from DAN and Kripa Imphal rated services as very poor.

Table 3: Quality of Services by Site[11]

		Quality of Services					
		Very good	Good	Average	Poor	Very Poor	Total
Site	APS	19	43	0	1	0	63
	SASO	15	8	2	0	0	25
	MNP	36	40	21	0	0	97
	Kripa Imphal	35	37	10	0	1	83
	Care Foundation	4	7	3	0	0	14
	Kripa Kohima	3	12	0	0	0	15
	DAN	24	18	4	3	5	54
	CAD	3	3	2	0	0	8
	Bethany Sisters	4	4	1	0	0	9
Total		143	172	43	4	6	368

[11] Of note, the APS data was missing a large number of respondents to the question on quality of services, as nearly 50 of the 110 respondents from APS either did not answer this question or answer inappropriately (i.e. marking more than one response). As such, these respondents are not included in the final summary of quality of services received; only valid responses are reflected in the data presented here. Only the APS site demonstrated these problems.

Likewise, 78% of client respondents reported being satisfied with the staff at the clinic they frequented with 39% saying they were very satisfied with the staff and 39% saying they were satisfied. Only 8% rated their satisfaction as average and only 2.4% rated their satisfaction as poor (1.2%) or very poor (1.2%). Unsurprisingly, satisfaction with staff was very strongly related to reported service quality ($p<0.001$). Again, APS respondents demonstrated problems with this response, with nearly 50 respondents responding inappropriately. Again, these respondents are not included in the presentation of the findings for this question.

In general, client respondents seemed to think that the quality of care at the clinics was improving over time. More than half (54.8%) reported that the quality of care at the clinic had improved a lot since their first visit. Nearly 28% reported that the quality had improved somewhat; 14.5% reported that it had remained the same. Only 1.4% reported that the quality had declined somewhat and 0.7% reported that the quality had declined drastically.

Table 4: Change in Quality of Care by Site

	Change in Quality of Care						Total
	Improved a lot	Improved somewhat	Remained the same	Declined somewhat	Declined dramatically	Missing	
APS	84	8	16	0	1	1	110
SASO	15	10	0	0	0	0	25
MNP	44	42	13	1	0	0	100
Kripa Imphal	28	30	23	3	0	1	85
Care Foundation	12	1	1	0	0	0	14
Kripa Kohima	9	5	1	0	0	0	15
DAN	26	17	6	2	2	1	54
CAD	7	1	0	0	0	0	8
Bethany Sisters	5	3	1	0	0	0	9
Total	230	117	61	6	3	3	420

Of the 52.7% of respondents who reported receiving CT from the CRS supported clinic, 27.2% reported that the quality of the services were very good; 34.3% reported the services were good and; 6.1% reported the services were average. Only 1.3% reported the services as poor and 1.6% reported the services as very poor. Again, DAN was the only clinic that received a very poor rating.

Table 5: Quality of CT services by Site

	Quality of CT services					Total
	Very Good	Good	Average	Poor	Very Poor	
APS	7	25	0	0	0	32
SASO	9	8	0	0	0	17
MNP	32	24	8	1	0	65
Kripa Imphal	14	10	1	0	0	25
Care Foundation	4	5	3	0	0	12
Kripa Kohima	4	9	2	0	0	15
DAN	9	16	5	3	4	37
CAD	2	4	0	0	0	6
Bethany Sisters	0	3	0	0	0	3
Total	81	104	19	4	4	212

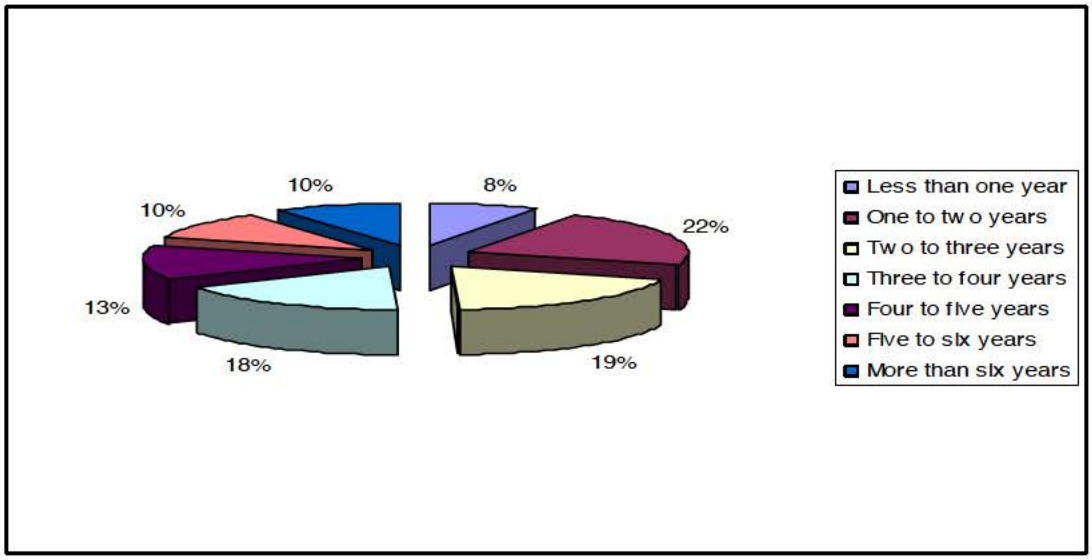
Respondents reported visiting the clinics frequently with 27% reporting visiting once in the last month, 25% twice in the last month, 12% thrice in the last month, and 18% four times or more in the last month. More than 60% of respondents reported that they had family members who frequented the same clinic.

For 82% of the respondents, the clinic was their primary source of health care. However, 70.5% reported accessing health services outside of the clinic. The external health services were primarily obtained from government hospitals (44.3%), other private clinics (25.5%), government clinics (16.7%), and private hospitals (13.8%). Of those who did seek health services outside of the CRS supported clinic, 65.5% reported being referred to those services by the CRS supported clinic.

Not surprisingly then, 49.9% of respondents reported that the clinic had very good referral services; 31.5% reported that the referral services were good, meaning the clinic referred appropriately. Only 8.2% reported that the referral services were average, and only 1.7% and 0.7% reported that the referral services were below average or very poor, respectively.

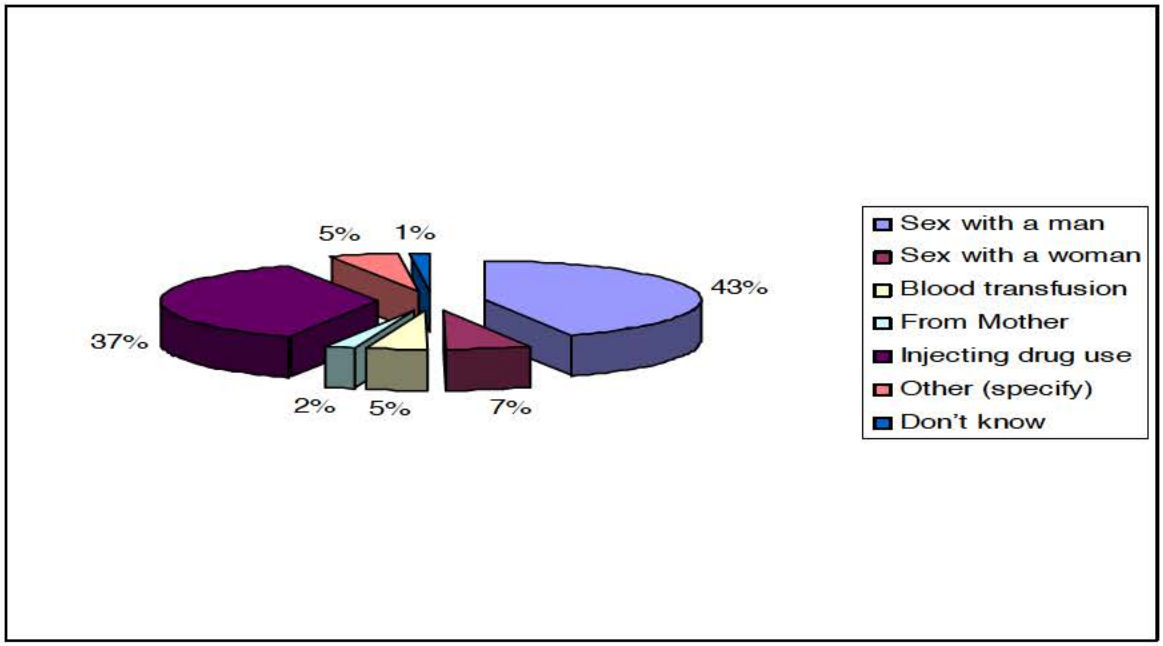
The majority of respondents (68.8%) reported being HIV positive. Just fewer than 16% reported that they were not HIV positive, and 15% of respondents did not respond to this question. Of those who reported being positive, the amount of time since they tested positive ranged from less than one year (8%) to more than six years (10%).

Figure 2: Time since Tested Positive



Those who reported being HIV positive also reported being infected in a variety of ways. The most common modes of transmission reported were sex with a man (43%), IDU (37%), and sex with a woman (7%). Only 1% reported not knowing how they were infected. Men most frequently reported being infected via IDU whereas women most frequently reported being infected via sex with a man. Only three male respondents reported being infected through sex with another man.

Figure 3: Mode of HIV Infection



Of the 289 respondents who reported being HIV positive, 180 (or 62%) reported

currently taking ART. Of those who were not taking ART, 71% reported they did not currently need ART, 12% reported they could not afford ART, and less than 1% reported the medication made them ill or was too complicated to remember to take the medication.

Respondents who reported being HIV positive were asked whether they had shared their status with those around them. In many cases, respondents chose not to answer this question. In general, respondents reported disclosing their status to someone.

Table 6: Disclosed Status with Support Systems

	Yes	No	No response
Spouse	161	19	109
Family	251	19	19
Friends	192	39	58
Peers	226	13	50

While it appears alarming that 109 respondents reported "no response" to whether they had disclosed their status to their spouse, in fact the majority of respondents who had spouses had disclosed their status. When examining disclosure against marital status, respondents who reported being married and living with their partners overwhelmingly reported disclosing to their spouses with 97% of these respondents indicating that they had disclosed their status. The high rate of no response to the spousal disclosure question is likely due to the fact that many respondents did not have spouses to whom they could disclose (i.e. were single, widowed, etc.). The below table demonstrates this.

Table 7: Marital Status by Shared Status with Spouse

		Shared status with spouse		Total
		Yes	No	
Marital Status	Single	7	6	13
	Married and Living Together	103	3	106
	Married but Living Apart	5	0	5
	Separated	2	1	3
	Divorced	2	2	4
	Widowed	42	7	49
Total		161	19	180

In general respondents who had disclosed their status reported that others had been supportive of them. More than 50% reported that others had supported them;

23.8% reported that others had then talked to them about their status. Only 6.7% reported that others then acted afraid of them and only 7.4% reported that others had then avoided them.

Slightly more than 63% of respondents reported having joined a support group through the health clinic. Of these respondents, 40.5% reported that the support group had improved their overall QOL. Other positive benefits associated with being part of the support group included making the respondent feel like part of a larger community (37.4%), helped respondent to overcome stigma (34.3%), helped respondent to solve problems (33.3%), improved some aspects of respondent's life (32.4%), created lasting friendships (31.4%), helped respondent to deal with family and friends (29.8%), and provided a safe forum for the respondent (24.5%). Only 1.2% reported that the support groups did not help, and 1% reported that joining the support group hurt the respondent, but no details were provided on why this outcome was linked to the support group.

Respondents reported that the clinics had also helped them to deal with their economic status by providing free medicines (81.9%), free health check-ups (68.8%), free testing (59.5%), free lab tests (33.3%), access to SHGs (32.1%), linkages to income-generation activities (20.5%), and social linkages with other clinic members (13.6%).

In general, respondents indicated that their health was positive with 6.9% reporting excellent health, 27.4% reporting very good health, and 37.4% reporting good health. 13.3% reported fair health, and only 3.8% reported poor health. The majority of respondents also indicated that their health had improved over the past year with 37.6% reporting that their health was much better now than one year ago, and 29.3% reporting that it was somewhat better now than one year ago. Less than 8% reported that their health was worse now than one year ago. Slightly less than 10% reported that their health had stayed the same over the past year.

Overall summary quality of life means were calculated for the project. There were no significant differences among respondents in terms of quality of life in regards to gender, location, health center or disclosure. The highest average domains of quality of life were in bodily pain, indicating that there was relatively low reported levels of bodily pain, and social functioning, with those clients who had disclosed their status reporting higher means in this domain. Physical functioning had the lowest mean, but also had a large standard deviation. Emotional wellbeing had the highest standard deviations, with a mean of 48.77, but a standard deviation exceeding 40. Overall, the physical and mental health measures of quality of life for client respondents was relatively high. This measure provides a baseline for future comparison.

Table 8: Quality of Life Summary Measures[12]

Domain	Mean	SD	Summary Measure
Physical Functioning	39.70	31.23	Physical Health
Role-Physical	47.34	39.32	
Bodily Pain	68.02	22.42	52.39
General health	54.26	16.79	
Vitality (Energy)	52.99	20.36	Mental Health
Emotional Well-being/Role	48.77	41.79	54.96
Social Functioning	61.06	20.12	
Cognitive Functioning	57.89	18.45	

Prevention

The main prevention activities within the project focus on youth clubs and school-based HIV education. The project originally aimed to influence youth in targeted communities to adopt safer behaviors vis-à-vis drug use and sexual practices. As such, both in-school and out-of-school youth were asked to participate in the survey. Surveys were administered to youth in both locations, as well as teachers in the targeted schools. Youth within these schools that are in the target age group for the interventions (and with the appropriate consent) were asked to complete a short survey on their knowledge, attitudes and practices (KAP) related to drug use and sexual practices (n=684). In the selected schools, teachers of the selected classrooms were also requested to complete a survey designed to elicit information on the project and their own comfort in dealing with HIV and drug use issues (n=196). The project also supported six youth centers. Youth within these centers that were within the target age group for the prevention interventions were asked to complete a short survey on their knowledge, attitudes and practices related to drug use and sexual practices (n=210).

Students in School

The 684 student respondents came from a variety of schools. The majority of students (61.9%) were in grades 9 to 11, but respondents also included students from grades 6 to 8 (19.4%) and grade 12 (4.8%). The majority of students (59.6%) reported being aged 13 to 15. Other age groups included ages 16 to 18 (23%), 10 to 12 (11.2%) and 19 or older (1.8%). Slightly more than half (51.9%) were female.

[12] As mentioned earlier, there were apparent data errors from the APS dataset. In the QOL section of the survey, more than two-thirds of respondents were disqualified from analysis due to inappropriate responses. As such, the QOL report does not include the APS respondents, reducing the total number of observations to 310.

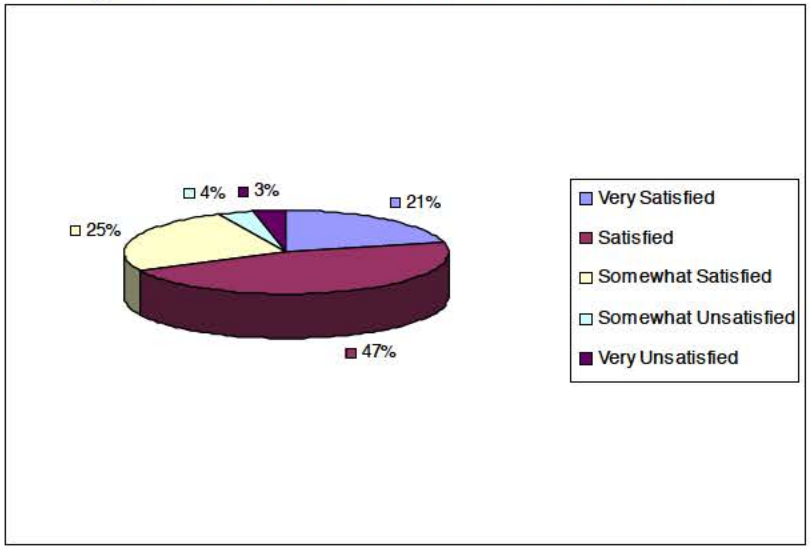
Table 9: Respondents by School

School	Frequency	Percentage
Kiddies Corner School	28	4.1
Brighter English Academy	31	4.5
Camps English School	30	4.4
Grace Academy	29	4.2
South Point School	30	4.4
M.M. Higher Secondary School	32	4.7
St. Xavier School	43	6.3
Government High School (GHS)	58	8.5
Monfort School	95	13.9
St. Clare	121	17.6
St. Mary	95	13.9
Holy Cross School	92	13.5
Total	**684**	**100**

The majority of students (85.7%) reported having received HIV education. However, only 53.3% reported that this education had come through their school. Students cited television/radio (19.2%), family (8.7%), community organizations (7.9%), friends (7.5%) and health clinics (3.4%) as other sources of HIV education.

Students were asked to rate their satisfaction with the HIV education if they had received this education through the schools. Of those who responded, 47% reported that they were satisfied, 21% were very satisfied, 25% were somewhat satisfied, and only 7% were somewhat unsatisfied or very unsatisfied.

Figure 4: Satisfaction with HIV Education in School



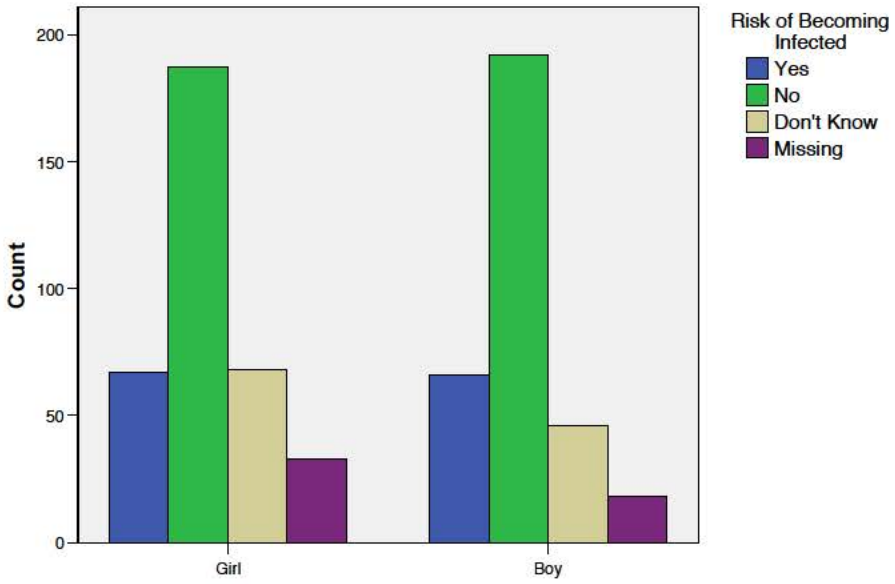
Some schools clearly had a higher percentage of their students reporting dissatisfaction with their HIV education than others. For example, Grace Academy had 17.2% of respondents indicating they were very unsatisfied with the training. Similarly, Monfort School had 11.6% of respondents indicating they were very unsatisfied with the training.

Table 10: Satisfaction with HIV Education by School

		Satisfaction with HIV education						Total
		Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Very unsatisfied	No response	
School	Kiddies Corner School	9	14	5	0	0	0	28
	Brighter English Academy	4	14	10	2	1	0	31
	Camps English School	6	10	4	2	0	8	30
	Grace Academy	4	8	10	1	5	1	29
	South Point School	4	20	4	1	1	0	30
	M.M. Higher Secondary School	8	8	4	6	0	6	32
	St. Xavier	2	8	16	4	1	12	43
	Government High School (GHS)	11	15	22	0	1	9	58
	Monfort School	28	19	9	2	11	26	95
	St. Clare	23	75	20	0	0	3	121
	St. Mary	13	35	42	3	0	2	95
	Holy Cross School	17	59	9	1	0	6	92
Total		129	285	155	22	20	73	684

Despite the high levels of satisfaction, 70% of youth reported they still needed additional information on HIV. Nearly one-fifth (19.6%) reported they felt they were at risk of becoming infected with HIV. Boys and girls equally reported their perceived risk of becoming infected with no significant difference between the genders.

Figure 5: Risk of Becoming Infected with HIV by Gender



Students were asked whether they knew how to protect themselves from HIV. The majority of students (71.8%) reported that they knew how to protect themselves from HIV and 65.9% reported they felt they had the ability to protect themselves from contracting HIV. Some students did list correct ways to protect themselves from HIV infection including condom use (15.6%), avoiding IDU (11.8%), abstaining from sex (9.7%), being faithful to one partner (9.5%) and limiting the number of sexual partners (4.4%). However, these are very low percentages of accurate knowledge compared to the belief of the students that they can protect themselves from HIV. In addition, students listed incorrect ways to protect themselves from HIV infection including avoiding kissing (2.9%), avoiding mosquito bites (1.7%) and seeking protection from traditional healers (0.8%). Slightly more than 12% of students indicated that there was no way to avoid HIV transmission to the baby if a mother was infected, and 6.9% of students reported that there was a cure for AIDS.

Students indicated a variety of reasons why a person would get an HIV test including marriage (21.6%), planning for the future (19.2%), protecting sexual partner (18.5%), protecting child (13.7%), due to illness (9.7%), family planning (9.6%), and for insurance (2.8%). Conversely, students also listed multiple reasons not to get an HIV test including fear of knowing (33.8%), lose partner (17.1%), stigma (14.5%), lose job (8.2%), lose terminal benefits (5.8%), and lose pension (5%). The majority of students (94.8%) did know where to go for an HIV test and indicated they would go to a hospital (44.3%), a health clinic (23.1%) or a CT center

(27.4%). Students were asked who should go for an HIV test. Responses varied and were relatively low, especially for some of the high-risk groups where one would expect to see students indicating testing is needed. Students were asked to select all that applied.

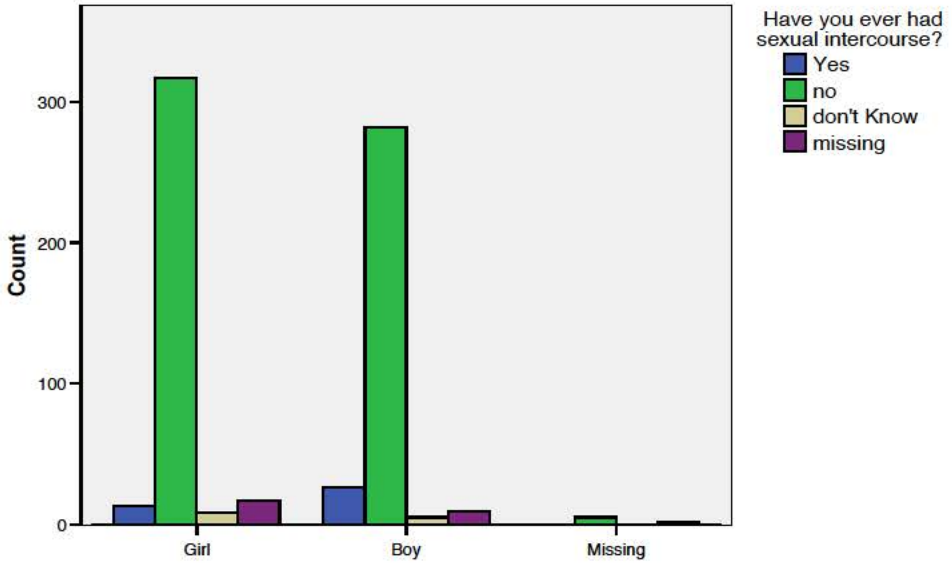
Table 11: Who Should Go for an HIV Test

Who	f	%
Anyone at risk	234	15.4
Sex Workers	232	15.3
Anyone sexually active	197	13.1
Those with multiple partners	187	12.3
Those getting married	164	10.8
Users of sex workers	154	10.3
Truckers Drivers, Soldier, Traveling sales persons, etc.	146	9.6
Those who are sick	82	5.4
Don't Know	59	3.9
No response at all	59	3.9

Only 5.7% of students reported they had ever had sexual intercourse. Boys were more likely to report having had sexual intercourse than girls; however girls were more likely to not answer the question.

Of the small number who reported having had sexual intercourse, 25.6% reported they last had sex days ago and 17.9% reported it was weeks ago. Slightly more than one-fifth (20.5%) reported it was months ago, and 23.1% reported it was years ago. 82% of sexually active youth reported that they had engaged in sexual intercourse during the past year. Of the sexually active youth, 30.8% reported having had sex with one partner, 12.8% with two partners, 7.7% with three partners, and 28.2% with four or more partners. Slightly more than 20% reported that they did not know how many people they had sexual intercourse with. Less than half (47.8%) of sexually active youth reported that they felt they were at risk of becoming infected with HIV, yet only 59% reported using a condom the last time they had sexual intercourse.

Figure 6: Student Reported Sexual Intercourse by Gender



Stigma was relatively high among the students with only 58.3% indicating that they would be willing to care for an HIV positive, sick relative in their household. Slightly more (59.2%) reported that an HIV positive teacher who isn't sick should be allowed to continue teaching in school, while only 57.5% reported they would play with another child who has HIV. Only 38.7% stated that they would buy food from an HIV positive vendor, the acceptance rate dropped to 38.7%.

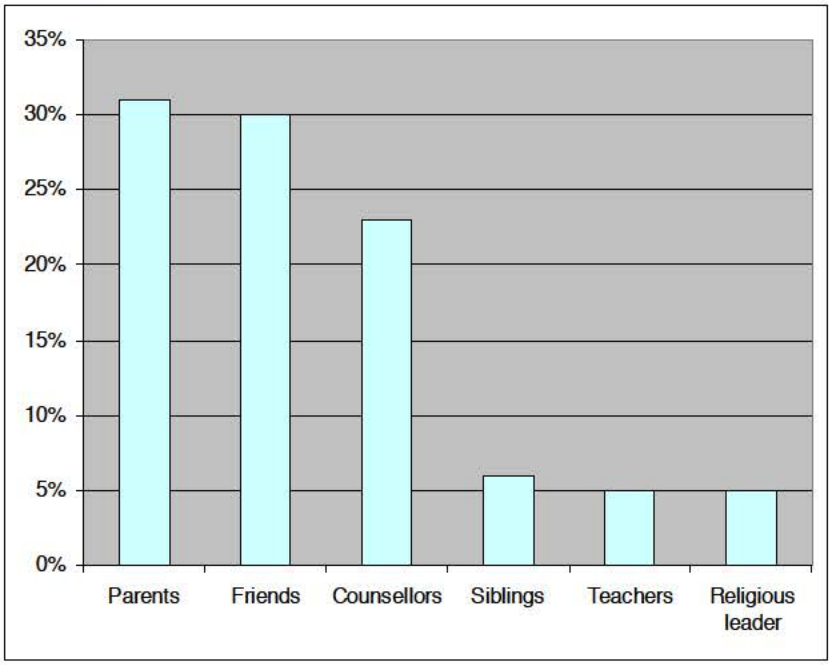
The majority of students (79.7%) reported they would share their status with their family if they were HIV positive, but only 42.4% indicated they would share their status with their friends. Only 32.6% would share their status with their peers. The majority of students (60.7%) reported that their friends at school had received HIV education and prevention information. Slightly more than half (53.2%) reported that they had spoken to their friends about HIV prevention. Of these, approximately half (49.5%) reported they had spoken with five or more friends.

Only a small percentage (14.5%) believed that their friends were engaged in behavior that might put them at risk of contracting HIV. Within this percentage, the specific behaviors their friends were thought to be engaged in IDU (31.7%), recreational sex (21.2%), alcohol use (19.9%), other drug use (15.4%), and transactional sex (11.8%). 42.4% of the students reported that their friends had received information about these risky behaviors and HIV, 29% of these students

reported that their friends received this information through the school and that quality of the information was very good (26.8% stated the quality of the information was good).

Only 23.8% of youth reported that there was someone in their school who could help them with a sex-related problem. Slightly more (25.1%) reported they had access to a counselor to discuss any issues or concerns they might have, and the majority (57.6%) reported the counselor was available to them weekly, while 26.1% reported the counselor was available daily. Although 51.8% of students reported their teacher had discussed HIV prevention with their class, only 15.6% reported that the teacher had discussed HIV prevention with them individually. Approximately 39.3% of students reported that they had discussed HIV with their parents or guardians. Students indicated there were multiple sources from which they could seek advice or assistance if they were being pressured to have sex.

Figure 7: Sources of Advice When Pressured to Have Sex



However, there were varying degrees of comfort reported by students when seeking advice from the sources mentioned previously. The most commonly cited source of advice in terms of comfort level was friends, with 18.2% of students saying they would be very comfortable seeking advice from their friends. Students reported the most discomfort when seeking advice from religious leaders.

Table 12: Comfort Level by Source of HIV Advice (Percentage)

Comfort Level	Parents	Siblings	Friends	Teachers/Counselors	Religious Leaders
Very comfortable	9.8	5.7	18.2	7.6	3.5
Comfortable	12.6	9.4	13.7	8.6	3.7
Sometimes comfortable	7.7	6.1	7.7	9.2	7.5
Uncomfortable	4.7	5	0.7	4.8	4.1
Very uncomfortable	6	1.3	1.3	4.2	7.5
Multiple Responses	2.5	1.8	2.3	2.3	1.9
No Response	56.7	70.7	56.1	63.3	71.8
Total	100	100	100	100	100

Slightly more than half (53.8%) of students reported receiving education on drug abuse prevention and only 33.5% reported receiving this education through their school. Satisfaction with the school-based programs varied with 9.6% of students reporting being very satisfied, 32.2% being satisfied, 15.6% being somewhat satisfied, 4.4% somewhat unsatisfied and 6.1% very unsatisfied. More than half (50.4%) reported that they needed more information. Slightly less than half (49.3%) reported having spoken to friends about drug abuse prevention. As with HIV, nearly half of those (47.4%) reported speaking to five or more friends.

Only 10.1% of students reported having taken drugs themselves, but 40.6% of these reported that they had just taken drugs once in experimentation, and 42.1% reported that they hardly ever took drugs of any kind. Only 1.4% reported taking drugs daily, and 2.9% reported taking drugs weekly. However, 3.5% of students reported injecting drugs with a syringe in the past.

Students reported that if they were being pressured to use drugs, they would seek advice or assistance from parents (40.1%), friends (23.8%), counselors (18.6%), siblings (7.6%), teachers (7.6%) and religious leaders (2.3%). As with HIV, the comfort level varied by source of advice with friends being reported by 17.3% of students. Similarly, religious leaders were cited as the most uncomfortable source of advice.

Table 13: Comfort Level by Source of Drug Advice (Percentage)

Comfort Level	Parents	Siblings	Friends	Teachers/Counselors	Religious Leaders
Very comfortable	15.2	9.8	17.3	8.9	5.1
Comfortable	12.6	9.9	12.3	9.5	13
Sometimes comfortable	5.6	6.0	7.6	9.1	5.6
Uncomfortable	4.8	2.1	1.7	2.7	3.1
Very uncomfortable	3.5	1.6	1.7	3.7	4.4
Multiple Responses	2.0	1.2	1.5	1.8	1.2
No Response	56.3	69.4	57.9	64.3	67.6
Total	100	100	100	100	100

Teachers in School

Teachers in the selected classrooms where the student survey was administered were invited to participate in a survey directed at measuring teacher awareness of and comfort teaching about HIV and drug abuse. A total of 196 teachers self-selected to participate from the following schools.

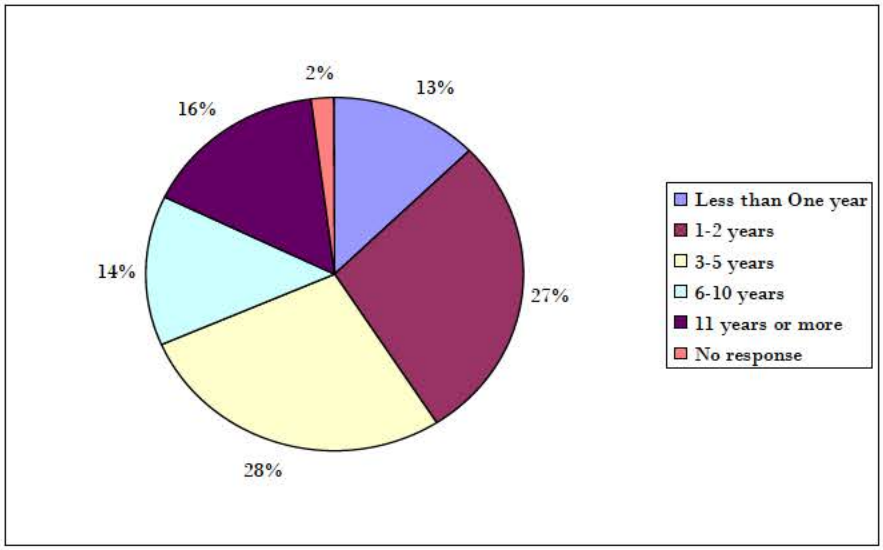
Table 14: Teachers by School

School	f	%
Kiddies Corner School, Imphal	15	7.7
Brighter English Academy, Imphal	16	8.1
Camps English School, Imphal	13	6.6
Grace Academy, Imphal	15	7.7
South Point School, Imphal	15	7.7
M.M. Higher Secondary School, Imphal	16	8.2
St. Xavier School, Nagaland	16	8.2
Government High School (GHS), Nagaland	8	4.1
Monfort School, Nagaland	16	8.2
GCKA, Nagaland	12	6.1
UCHSS, Nagaland	26	13.2
Zoram Entu Paul (ZEP), Aizawl	28	14.2
Total	**196**	**100**

The time spent teaching at the school varied with 13% of teachers having been at

the school less than one year to 16% having been at the school for 11 years or more.

Figure 8: Time Spent Teaching at the Surveyed School



Slightly more than 19% reported teaching grades 6 to 7, 13% reported teaching grades 8 to 9, 11.7% reported teaching grades 10 to 11, 5.1% reported teaching grade 12, and 39.3% reported teaching more than one grade. The majority of teachers (76.5%) reported teaching their current grade for at least one year.

Slightly more than two-thirds (66.8%) reported receiving training in HIV education. Of these, only 38.5% reported receiving this training through the school in which they teach. This is a surprisingly low number, given the focus of the PANI objective and related interventions. Of those that received training through their schools, the majority rated the training as "good" or "very good" (34.7% and 51.4%, respectively), and 12.5% as average. However, more than half (56.1%) reported that they needed more information on HIV beyond what they received in their training.

Only 17.9% of teachers reported they were at risk of becoming infected with HIV, and 85.6% reported that they knew how to protect themselves from HIV infection. When asked how to protect one's self from HIV infection, only 13.5% of teachers indicated condom use, 12.5% indicated avoiding sexual intercourse with people who inject drugs, 12.4% indicated fidelity to one partner, 12.4% indicated avoiding sex with sex workers. Only 6.6% indicated that one should limit the number of sexual partners, and only 6.1% reported that one should abstain from sex. 1.1% indicated that one should seek protection from traditional healers, and 0.6% reported that one should avoid mosquito bites. Twenty-seven percent of teachers indicated that if a mother is infected with HIV, there is no way to avoid transmission to the baby. Additionally, 6.1% indicated that a person with AIDS can be cured. Of those who

believed that AIDS can be cured, one person reported that they had received HIV training through their school systems.

More than half (55.6%) indicated that a person can find out if s/he is HIV positive by going for a test. More than 81% had heard of HIV CT service center. Reasons cited for seeking an HIV test included marriage (23.2%), protecting partner (18.9%), protecting child (18.8%), planning for the future (17.4%), due to illness (7.6%), and family planning (6.2%). There were also numerous reasons cited for not getting an HIV test including fear of knowing (54.1%), stigma (35.7%), lose partner (19.4%), lose terminal benefits (8.7%), lose job (8.2%) and lose pension (4.1%).

More than 40% of teachers indicated that they would go to a hospital if they wanted an HIV test. Other responses included CT center (28.7%), health clinic (16.5%), and a community organization (9.2%). Teachers were asked who should go for an HIV test. The most commonly cited people were sex workers (18.3%), those with multiple partners (14.9%), anyone at risk (14.2%), users of sex workers (13.9%), truck drivers (13.2%), anyone sexually active (9.6%), those getting married (8.3%), and those who are sick (5.8%).

Only 4.6% of teachers (9) responded that they had been tested for HIV. Of these, only 55.6% (5) reported that they actually received their results.

Stigma was still high among teachers with only 70.4% reporting they would care for a relative who was sick with an AIDS-related illness. Only 79.1% reported that a teacher with HIV who is not sick should be allowed to continue teaching in school, and 6.6% indicated that they would not be willing to teach a child with HIV. More than 13% reported that they would not buy food from a vendor who is HIV positive.

The majority of teachers (82.7%) reported they would tell their families if they were HIV positive, but only 40.8% reported that they would tell their friends. Stigma appeared higher in the work setting, with only 36.2% reporting that they would tell their co-workers.

Just over 69% reported that the students at their schools had received HIV education and prevention information through the school. Of these, 22.8% rated the quality of the education as very good, and 50% rated it as good. Only 1.5% rated it as very poor. Slightly more than 61% reported that they had personally spoken to their students about HIV prevention, but only 38.8% reported engaging their students on issues around HIV prevention and drug abuse outside of the school setting. The number of times that the teachers had facilitated HIV sessions on their own for students varied from none (35.7%) to four or more times (10.2%).

Table 15: Number of Times Teachers Facilitated HIV Sessions for Students

Number of Times	f	%
None	70	35.7
One	27	13.8
Two	30	15.3
Three	8	4.1
Four or more	20	10.2
No response	41	20.9
Total	**196**	**100**

Only 17.3% of teachers reported that they believed that their students were engaged in behavior that might put them at risk for HIV. Of those that reported that their students were engaged in risk taking behavior, 37.7% reported this behavior included IDU, 25.9% other drug use, 21.2% transactional sex, and 15.2% alcohol use. Nearly half (49%) reported that their students had received information about these risk behaviors and HIV, although the frequency of this information varied greatly from daily (1%) to less than once every three years (10.4%).

Table 16: Frequency with which Students Receive Information on Risky Behaviors and HIV, as Reported by Teachers

Indicator	f	%
Daily	1	1.0
Weekly	17	17.7
Monthly	10	10.4
Quarterly	5	5.2
Annually	33	34.4
Every two years	5	5.2
Less than once every three years	10	10.4
Multiple Responses where multiple responses are not suitable	1	1.0
No response	14	14.7
Total	**96**	**100**

In general, teachers seemed to believe that the quality of the HIV information was high with 19.8% rating the quality as very good, 38.5% as good, 30.2% as average and only 2.1% as poor and 2.1% as very poor. However, 77% reported that their students needed additional information about HIV.

More than 45% of teachers indicated that students had access to a counselor to discuss any issues or concerns that they might have. Of those with access, 18.9% of teachers indicated that the counselor was available daily for the students (30% reported the counselor was available weekly, and 23.3% reported that the counselor was available monthly). More than 17% of teachers reported that they referred students they suspected of engaging in risk behavior to the counselor. Slightly more

than 20% reported that they themselves talked to the students, but 7.7% reported they did nothing.

Nearly 44% of teachers reported that they needed additional tools to enable them to better educate and empower their students to protect themselves from HIV. The most commonly reported tools needed include additional training for their students (30.2%), additional training for themselves (25.1%), referral information for care (24.7%) and printed materials for the students (20%).

Out of School Youth

In addition to the school-based prevention programs, the PANI project targets youth clubs that cater to out-of-school youth. All six centers were included in the evaluation with 35 youth from each center participating in the survey.

Table 17: Youth Centers Participating in the Survey

Center	f	%
Don Bosco Youth Centre 1	35	16.7
Don Bosco Youth Centre 2	35	16.7
Imphal East	35	16.7
Imphal West	35	16.7
Thoubal District	35	16.7
Bishnupur District	35	16.7
Total	**210**	**100**

The majority of the youth (64.3%) reported having been attending the center for one to two years. More than one-fifth (21.8%) had been attending their center for less than one year. The youth at the youth centers were slightly older than the students that participated in the school-based survey with 86.2% reporting they were 18 or 19 years old (9.5% were 16 to 17 years old; 2.3% were 14 to 15 years old; and 1% were 12 to 13 years old.). Unlike the school-based survey, more respondents from the youth centers were male (59.5%) with 40% female respondents (compared to 51% of school-based respondents).

The majority (95.7%) reported having received HIV education. However, only 33.88% reported receiving this education through their youth clubs. Other sources included television/radio (27.38%), friends (21.81%), community organizations (7.38%), family (6.13%) and health clinics (3.42%). Near two-thirds of youth who reported receiving education through the youth centers reported being satisfied with the quality of the education. However, 76.2% reported that they needed more information on HIV beyond what they received at the sessions at the youth clinic.

Table 18: Satisfaction with Center-Based HIV Education

Satisfaction Level	f	%
Very Satisfied	35	18.6
Satisfied	81	43.1
Somewhat Satisfied	66	35.2
Somewhat Unsatisfied	1	0.5
Very Unsatisfied	1	0.5
No Response	4	2.1
Total	**188**	**100**

Some youth centers clearly saw higher satisfaction scores than others. While there were no extremely low scorers among the centers, the satisfaction scores seemed most ambivalent in the Imphal centers.

Table 19: Satisfaction Level by Center

		Satisfaction level						Total
		Very satisfied	Satisfied	Somewhat satisfied	Somewhat unsatisfied	Very unsatisfied	Don't Know	
Center	Don Bosco 1	9	8	5	1	0	1	24
	Don Bosco 2	12	12	2	1	1	0	28
	Imphal East	2	8	24	0	0	1	35
	Imphal West	2	4	28	1	0	0	35
	Thoubal District	6	27	0	0	0	2	35
	Bishnupur District	5	23	7	0	0	0	35
Total		36	82	66	3	1	4	192

Slightly more than one-fifth (21.4%) of youth reported that they felt they were at risk of becoming infected with HIV. However, 95.2% reported that they knew how to protect themselves from HIV when asked if they knew how to protect themselves from HIV, and 94.8% reported they were able to protect themselves from HIV.

Some youth did list correct ways to protect themselves from HIV infection including condom use (15.01%), avoiding sex with SW (13.80%), abstaining from sex (5.33%), being faithful to one partner (13.39%) and limiting the number of

sexual partners (7.68%). However, these are relatively low percentages of accurate knowledge compared to the overwhelming belief held by the youth that they know how to protect themselves from HIV.

Only a few youth listed incorrect ways to protect themselves from HIV infection including avoiding kissing (0.96%), avoiding mosquito bites (0.48%) and seeking protection from traditional healers (0.33%). Slightly more than 2% of youth indicated that there was no way to avoid HIV transmission to the baby if a mother was infected and 1.4% reported that there was a cure for AIDS.

Youth indicated a variety of reasons why a person would get an HIV test including marriage (24.82%), planning for the future (13.15%), protecting sexual partner (23.17%), protecting child (22.42%), due to illness (4.78%), family planning (4.48%), and for insurance (7.03%). Conversely, youth also listed multiple reasons not to get an HIV test including stigma (35.2%), fear of knowing (30.71%), lose partner (19.95%), lose job (7.4%), lose terminal benefits (4.5%), and lose pension (0.89%). The majority of youth (98%) did know where to go for an HIV test and indicated they would go to a CT center (56.12%), hospital (34.01%), or a health clinic (8.16%). Youth were asked who should go for an HIV test and asked to select all responses that applied. Responses varied and were relatively low, especially for some of the high-risk groups where one would expect to see students indicating testing is needed.

Table 20: Who Should Go for an HIV Test

Indicator	f	%
Sex Workers	169	18.2
Anyone at risk	164	17.6
Truckers Drivers, Soldier, Traveling Sales Persons, etc.	149	16.0
Users of sex workers	133	14.3
Those with multiple partners	129	13.9
Those getting married	93	10.0
Anyone sexually active	67	7.2
Those who are sick	26	2.8

Similar to the students, only 8.6% of youth reported that they had ever had sexual intercourse. Boys were more likely to report having had sexual intercourse than girls. Of those that reported previous sexual intercourse, 22.2% reported that their last sexual intercourse was days ago, 11.1% that it was weeks ago, 33.3% that it was months ago, and 33.3% that it was years ago. More than 77% of sexually active youth reported that they had sexual intercourse in the past year. Of these, 50% reported only one sexual partner, 16.67% reported two sexual partners,

11.11% reported three sexual partners, and 22.2% reported four or more sexual partners. Of all sexually active youth, only 61.1% reported that they had used a condom the last time they had sexual intercourse.

Stigma was lower among the older out-of school youth than among students, with 91.9% of out-of-school youth indicating they would care for a relative who became sick with an AIDS-related illness. Slightly more, 94.8%, reported that an HIV positive teacher who isn't sick should be allowed to continue teaching in school, and 95.7% reported they would play with another child who has HIV. When asked if they would buy food from an HIV positive vendor, the acceptance rate dropped only slightly to 93.8%.

The majority of youth (93.3%) reported they would share their status with their family if they were HIV positive, but only 65.7% indicated they would share their status with their friends. Only 72.4% would share their status with their peers.

The majority of youth (87.2%) reported that their friends had received HIV education and prevention information. Nearly 90% reported that they had spoken to their friends about HIV prevention. Of these, 81.8% reported they had spoken with five or more friends.

Slightly less than half (47.1%) believed that their friends were engaged in risk behavior that might put them at risk of contracting HIV. Within this percentage, the specific behaviors their friends were engaged in included recreational sex (32.1%), IDU (23.7%), alcohol use (19.6%), other drug use (15.6%), and transactional sex (8.9%).

Eighty-six percent of the youth reported that their friends had received information about risk behaviors and HIV, and 86.19% reported that their friends received this information through the youth center. Of these, 16% reported the quality of the HIV information was very good. 42.5% stated the quality was good and only 1.1% reported that the quality was poor).

Eighty percent of youth reported that there was someone they could turn to who could help them with a sex-related problem. The majority (61.4%) reported that they had discussed HIV with their parents or guardians. Youth indicated there were multiple sources from which they could seek advice or assistance if they were being pressured to have sex.

Table 21: Sources of Assistance for You when Pressured to Have Sex

Indicator	f	%
Counselors	165	43.7
Friends	128	33.9
Siblings	41	10.9
Parents	21	5.6
Teachers	19	5.0
Religious leader	4	1.1

However, there were varying degrees of comfort by source of assistance. Youth reported feeling most comfortable seeking advice from friends (63.9%) and teachers or counselors (31.9%). Interestingly, the third most cited group was religious leaders, with 23.8%. Youth reported being most uncomfortable seeking advice from their parents, with 7.1% saying they would be very uncomfortable and 13.8% saying they would be uncomfortable seeking advice from their parents.

Table 22: Comfort Level by Source of Advice (Percentage)

Comfort Level	Parents	Siblings	Friends	Teachers/Counselors	Religious Leaders
Very comfortable	7.6	9.5	62.9	31.9	23.8
Comfortable	12.9	24.8	17.6	16.7	16.7
Sometimes comfortable	26.2	23.8	3.3	16.2	8.6
Uncomfortable	13.8	6.7	1.4	4.8	6.2
Very uncomfortable	7.1	1.0	1.0	0.5	3.3
No Response	32.4	33.8	13.8	30	41.4
Total	100	100	100	100	100

The majority (89.5%) reported having received education on drug abuse prevention. The most commonly cited source of this education was through the youth clubs (37.4%), followed by television/radio (27.1%), friends (18.2%), community organization (8.5%), family (6%) and health clinics (2.9%). Of those who had received the education through their youth center, 12.2% reported they were very satisfied with the education, 40.3% were satisfied, 42.0% were somewhat satisfied, and 1.7% were somewhat unsatisfied. More than 72% of youth reported that they needed more information on drug abuse than what they received at the youth centers.

Despite the reported need for additional information, 81.9% reported they had spoken to their friends about drug abuse prevention, and 79.1% reported they had

spoken to five or more friends about the topic. Only 9% of youth (19 youth) admitted taking drugs. Of these, 3 youths reported taking drugs daily, 1 youth reported taking drugs weekly, and 1 youth reported taking drugs monthly. The majority reported hardly ever taking drugs (31.6%) or just once in experimentation (36.7%). Only 2.4% reported that they had ever injected drugs with a syringe.

Youth indicated there were multiple sources from which they could seek advice or assistance if they were being pressured to take drugs.

Table 23: Sources of Assistance for You when Pressured to Take Drugs

Indicator	f	%
Counselors	181	35.1
Friends	124	24.0
Parents	73	14.2
Teachers	64	12.4
Siblings	56	10.9
Religious leader	18	3.4

However, there were varying degrees of comfort by source of assistance. Youth reported feeling most comfortable seeking advice from friends (63.8%) and teachers or counselors (31.4%). Youth reported being most uncomfortable seeking advice from religious leaders, with 4.8% saying they would be very uncomfortable and 7.6% saying they would be uncomfortable seeking advice from their religious leaders. Parents followed closely as a second uncomfortable source of advice.

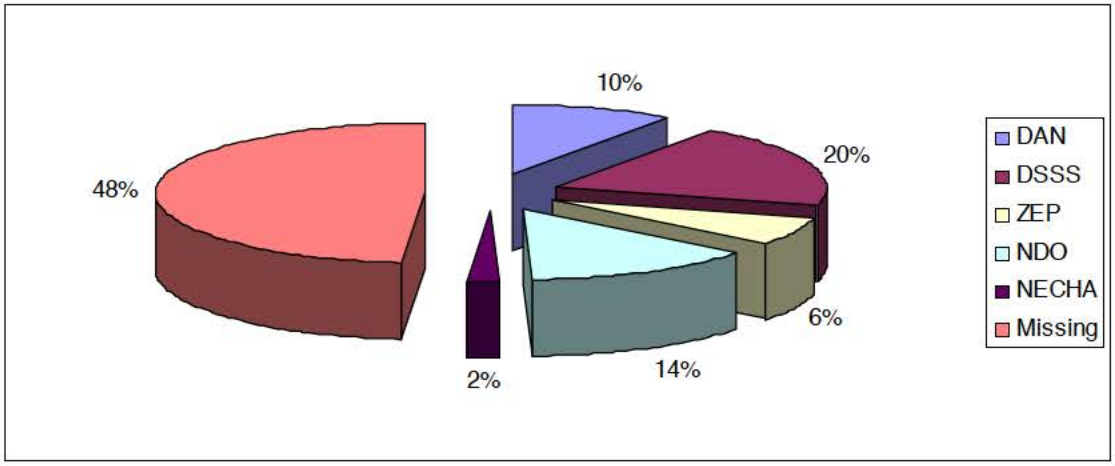
Table 24: Comfort Level by Source of Advice (Percentage)

Comfort Level	Parents	Siblings	Friends	Teachers/Counselors	Religious Leaders
Very comfortable	8.1	11.9	63.8	31.4	20
Comfortable	22.4	29	18.1	19.5	19.5
Sometimes comfortable	26.2	18.6	5.7	16.7	12.9
Uncomfortable	8.1	4.3	0	2.9	7.6
Very uncomfortable	4.3	0.5	0.5	1	4.8
No Response	30.5	34.8	11.9	28.6	35.2

Capacity Building of Faith-Based Organizations

As one of PANI's objectives is to increase the capacity of local church partners, surveys were sent to church leaders throughout the project site to elicit information from church leaders on the effectiveness of the PANI project. A total of 537 respondents replied to the survey. Although asked to indicate which organization currently worked with, approximately half (48.6%) did not indicate an organization.

Figure 9 : Respondents' Associated Organizations



Respondents included priests (1.7%), pastors (14.3%), nuns (3.4%), other clergy (47.1%), administrators (9.9%) and laymen/laity (5.4%). The majority of respondents (57.2%) reported having received HIV-related training from CRS or partner organizations. Of those, 11.4% reported having received the training within the last six months, 38.8% within the last year, 36.8% within the last two years, and 4.9% more than two years in the past. Those who had not previously attended CRS supported training were asked if they were planning on attending such training in the future. More than 66% indicated that they were planning to attend such training, but 22.1% indicated they were not sure if they would attend or not.

Respondents were asked how long their church or community had been working with CRS and partner organizations. A significant percentage (37.4%) did not respond. However, 12.1% indicated they had been working with CRS and partners for less than one year, 24% indicated one to two years, 13.8% reported a timeframe of two to three years, and 12.7% reported more than three years.

In general, respondents rated the work of CRS and partners in a positively with only 4.1% indicating that CRS' work was below average (note: 22% did not respond to this question).

Table 25: Respondents rate the work that the CRS and Partner NGOs is doing in the PANI project

Indicator	f	%
Extremely high quality	25	4.7
High quality	161	30.0
Average	205	38.2
Below average	22	4.1
Very bad	-	-
Do not know	4	0.7
No response	120	22.3
Total	537	100

Slightly more than one-fifth of respondents (20.1%) reported that their organization had a program for the care and support of PLHIV and 20.2% reported that they had dedicated resources for the care and support of PLHIV. Of those that reported being involved in the care and support of PLHIV, 27.8% reported being involved for less than one year, 34.3% for one to two years, 8.3% for two to three years and 15.7% for more than three years.

Respondents were also asked whether they had an official department within their church for HIV and AIDS specific activities and programs. Only 9.9% of respondents reported having an active department for HIV and AIDS, but an additional 17.1% reported that they planned to start such a department. Only 6.9% reported having an active department for responding to the drug abuse problems in the area and an additional 18.4% reported plans to start such a department. Respondents were asked how many full-time staff they had working on HIV and/or drug prevention programming. Less than 10% responded that there was one full-time person, 4.3% reported there were two to three full time people, 1.6% reported there were four to five full time people, and 7.4% reported six or more full time staff.

Some hesitancy in programming for groups with high risk behavior emerged when respondents were asked how open their church was to caring and supporting injecting drug users and/or sex workers who were affected by HIV. Only 13.6% indicated their church was very open, and 26.3% indicated it was somewhat open. 26.6% were unsure, and 14.9% reported their church was somewhat closed, while 3.9% reported their church was very closed.

Those with existing programs in HIV and/or drug prevention were asked to specify where their programs focused. The majority focused on prevention of HIV (28.3%)

and prevention of drug use (16.3%).

Table 26: Programmatic Focus

Indicator	f	%
Prevention of HIV	205	28.3
Prevention of drug use	117	16.3
Reduction of risky behavior	106	14.7
Care for people living with HIV	83	11.5
Promotion of abstinence	58	8.0
Care for the children whose parents have/had HIV	41	5.7
Support for families affected by HIV	33	4.6
Rehabilitation of injecting drug users	31	4.3
Treatment of sexually transmitted infections	25	3.5
Promotion of fidelity	23	3.1
Total	722	100

Respondents were asked how their programs worked to prevent HIV. The majority of respondents (42.1%) reported they focused on education. Other common programs included encouraging CT (23.6%), instituting behavioral change campaigns (22.7%), encouraging preventing of mother-to-child transmission (11.5%), implementing LSE (9.7%), and providing or linking to treatment for STIs (6.9%) or to ART (5.2%). The majority (72.1%) reported that they did not operate any health centers directly. Of those with direct health care center, 52.5% reported integrating HIV care into overall health care, and an additional 21.4% reported plans to begin integrating HIV care within the next year.

The majority of respondents (66.3%) reported they were not involved in any advocacy work around HIV. Only 18.2% reported being engaged in HIV advocacy work. Those who are engaged in advocacy report primarily engaging in community mobilization (84.7%), giving voice to HIV issues outside the NE region (9.2%), and lobbying the state regarding the existing HIV policies (6.1%).

Two-thirds of respondents (69.4%) reported they did not work in any communities or groups related to HIV. Of those 14.2% who did report working in groups, the majority (37.7%) identified the primary group as a community based organization. Others indicated they also worked with interdenominational groups (14.5%), state groups (12.6%), hospital groups (12.6%), other international organizations (6.9%), city groups (5.5%), parish networks (4.8%), and other Catholic networks (4.8%).

Respondents were asked to rate their church's level of participation in the HIV response. Overall, respondents indicated that there was still much work to be done,

with more than 50% of respondents replying that their church had not done enough.

Table 27: Your church's level of participation in the fight against HIV overall

Indicator	f	%
Very strong, we're doing everything possible we can	19	3.6
Strong, we're doing a lot, but there's more we could do	49	9.1
Average, we're doing some things, but not enough	152	28.3
Poor, we've not done enough	143	26.6
Very poor, we have not been actively engaged to any degree	81	15.1
Multiple response where multiple responses are not suitable	4	0.7
No response	89	16.6
Total	537	100

Overall, respondents felt that their church was strongest in prevention (42.5%). Respondents also identified care and support for PLHIV (11%) and advocacy (10.8%) as areas of strength. In contrast respondents indicated that their church was weakest in care and support for PLHIV (37.4%), advocacy (15.5%) and prevention (11.9%).

Discussion

While the results of this evaluation cannot extend to measuring the impact of the actual project on quality of life, changed behaviors or capacity levels, there is general information than can be culled for each of these objectives. The following sections reports on the achievement toward each of the project objectives.

Care and Support

Objective: PLHIV, IDUs, spouses/widows of IDUs and children have improved quality of life

The care and support activities have achieved their objective of increasing PLHIV access to services, and the clients are pleased with the support they receive from the partner staff. Many clients told stories about the extent to which the project staff and services have helped them, and 78% indicated that they were very satisfied with the staff at the clinics. With more than two-thirds of the clients reporting that the clinics were their primary health care provider and more than half reporting benefiting from the clinics beyond health care (i.e. nutrition supplements, access to support groups, etc.), it is apparent that these centers are having a positive impact on the QOL of the clients.

The care and support partners/projects have been able to dramatically respond to the increasing number of clients seeking care and have expanded the number accessing free ART. The partners for the most part use a DIC model and link with the closest government ART center, usually at the local civil hospital for the provision of ARVs. CRS partners have a full complement of staff at most DICs including an ART physician, nurse(s), counselors, outreach workers and peer educators. Although the capacity exists at these centers to handle all ART services, for the most part they do not handle the basic diagnostic and prognostic laboratory services such as CD4, liver function test, and other blood work, but refer to the government hospitals, for CD4, since these tests are provided for free or send out blood samples to other labs to carry out the necessary test. In addition, the distribution of ARVs is provided through the government centers, although often project staff accompany clients to pick up their medications or help facilitate this process. However, the team does handle all OI management, management of other HIV related illnesses, management of ARV side effects, patient adherence education and psycho-social services including nutritional support, SHGs or support groups and home visits as well as training for caregivers. It should be noted that capacity and services offered vary greatly from one health clinic to the next, and increased standardization and quality control of services will need to be built into any follow-on phases of the project.

In addition, health clinic clients report their family members frequent the same

clinic, which is indicative of strong internal referral networks. Health clinic clients also report appropriate referral to external sources of care and support, which indicates a strong external referral network. These networks ensure that coverage is extended to family members in need of support, as well as ensuring that clients are able to access needed services.

Support groups appear to be a very strong element of the care and support projects. Clients and staff alike praised these activities and claimed they provided emotional support to group members as well as financial support during difficult times. The groups also voluntarily spread the word about HIV transmission and prevention and in some cases provide testimony as to their own situation, which was found to be a very effective prevention education strategy as well as a good way to encourage others to seeking testing and treatment services. Members report that the groups have improved their quality of life. Many participants reported that they are engaged in income-generation activities through their support groups, although few groups reported earning any significant income as a result. The project will need to ensure that the support groups are functioning according to their mandates and provide training in organizational skills or in small enterprise development. Support groups are generally formed to provide emotional support for their members. At times, these groups evolve to address other common group concerns (i.e. economic status, advocacy work, etc.). PANI will need to ensure that the partners have the capacity to support such support group evolution in the future, while still supporting those group members who want only to belong to an emotional support group.

It appears that the PANI project has been successful in moving toward its first objective despite the fact that there are many challenges. One of the main challenges around this objective is the difficulty in accessing treatment for PLHIV. The services at the government hospital actually discourage people from coming for their ART due to the poor quality of service, which in turns leads to irregular adherence and increased chance of developing resistance. The ART centers are overcrowded and short-staffed. In addition, due to the limited number of ART centers in the area, some people must come from very far, up to 100 miles. Since the wait at the hospital is so long sometimes clients have to spend the night in town spending money they don't have. As a result many people do not return for their monthly check-ups to pick up their medications after the first few initial visits. This presents a problem of adherence to the health clinic staff and will be a persistent problem through the remainder of the project, as long as the government centers continue to operate in this way.

Additionally, clients report not seeking testing until late in their illness. PANI will need to determine how best to encourage people to get tested early and seek services earlier in their illness to ensure the best clinical outcomes possible. Increasing testing services at new locations would help achieve this objective, as well as using

creative community mobilization approaches. Community mobilization activities should be scaled up (as in PANI I) since stigma is still widely prevalent; increasing community acceptance will also help individuals to come forward sooner and get tested [earlier] since many people presently do not even want to know their status.

Based on the care and support projects under the PANI umbrella, which consists of seven direct and six sub-partners in four states (some partners have multiple activities or projects), there are several challenges facing access to services:

- Lack of adequate availability of CT and ART services;
- Clients come for care and support services very late in their illness;
- Private physicians are not up to date on appropriate ART and HIV care management;
- High Stigma in targeted communities;
- Client financial constraints ;
- Burn out of caregivers and project staff.

Despite these challenges, the PANI project is addressing care and support and providing high quality care given the limits of the government ART roll-out and the resources the project receives from CRS.

Prevention

Objective: Prevention: Women, youth, and IDUs in targeted communities adopt safer behaviors vis-à-vis drug use and sexual practices

The prevention activities consist of sensitizing youth, school teachers and community leaders on HIV in order to raise awareness about how the virus is spread to 1) reduce the risk of transmission and 2) decrease stigma and discrimination. Many of the qualitative questions posed to those who participate in the prevention activities centered on their opinion of the impact of the project and the HIV situation in their community. However, certain questions were raised in order to better understand their level of awareness, what they learned and how they were using their new knowledge. In addition, the quantitative portions of the surveys asked questions about basic knowledge, attitudes and practices to provide a baseline against which the project can measure progress in the future.

In general, the prevention component of the project appears to be the weakest portion of the entire project. While the objective includes target groups of women, youth and IDUs, the majority of the reported activities have occurred only with youth, and even the number of activities with youth are fewer than would be expected at this point in the project.

While the evaluation team spoke to fewer project beneficiaries participating in pure prevention activities than care and support activities in the qualitative portion of

the evaluation (it should be noted that there are secondary prevention activities in the care and support projects), it seemed clear that the level of awareness of the project and of HIV in general were lower than would be expected at this point in the PANI program. This was substantiated by the quantitative portions of the evaluation.

Furthermore those that were aware of modes of transmission did not attribute their learning to the PANI interventions; in addition, while some youth participants cited the basic modes of transmission and prevention when prompted to do so, it seemed as if a real understanding of the issues was missing (e.g. they were unable to speak about risks and behavior as it relates to HIV). In addition, when speaking with adults who had participated in prevention activities, participants did not provide modes of transmission or prevention efforts related to sexual transmission as part of their answers when specifically asked about prevention strategies. This was confirmed by other stakeholders as well as partner staff themselves. On several occasions the evaluation team was told by teachers and community leaders that youth "are aware of HIV but don't really understand it". These findings seem to conclude that while prevention activities have taken place, the quantity and the quality of these activities have had limited effects on improving knowledge and practices, and have most likely not contributed significantly to prevention of HIV transmission.

This was proven to be the case in the quantitative portion of the surveys, where the knowledge levels were repeatedly low among students and teachers. At the same time, stigma was still very high among these groups, with large percentages of students reporting poor attitudes relating to HIV. For example, stigma was still relatively high among the students with only 58.3% indicating that they would be willing to care for an HIV positive, sick relative in their household. Only 57.5% reported they would play with another child who has HIV. When asked if they would buy food from an HIV positive vendor, the acceptance rate dropped to 38.7%. Interestingly, quantitative surveys revealed lower levels of stigma among out-of-school youth targeted for prevention activities. The practices of youth (both students and youth in youth-centers) were largely protective with low levels of self-reported high-risk behavior. Nevertheless, youth did report experimentation with select high-risk behaviors [5.7% of students and 8.6% of youth from youth centers reported having had sex; and 10.1% (students) and 9% (youth) reported having taken drugs], which indicates the possibility of increased transmission in the future, especially given the low knowledge levels.

What is more troublesome is the fact that youth overwhelmingly reported that they knew how to protect themselves from HIV, but consistently answered basic HIV transmission questions incorrectly. This false sense of protection, as noted by the discrepancy between knowledge and practice, is extremely worrisome, as youth may believe they are protected even when they are not. This is apparent in the practices

portion of the survey when youth report sexual activity with multiple partners without condom use. While knowledge alone does not result in behavior change, the current knowledge levels are below acceptable in a targeted group of youth who should have been benefiting from HIV education and prevention messages and cannot feasibly be linked to any changed behavior or attitudes as a result of the project.

Faith-based partners responsible for the prevention activities were also interviewed; their level of knowledge about HIV and deeper appreciation for the greater impact of the epidemic was limited. For example the partner staff were not up to date on the latest information on HIV transmission, prevention, and treatment and related issues e.g. hepatitis C, while civil society (secular) partners were well aware of international guidelines and industry standards for care, treatment and prevention. This was worrisome since in almost all cases, the partner staff are conducting the prevention trainings or the sensitization sessions. In the surveys, the disparity between schools in terms of knowledge and satisfaction with trainings was evident, suggesting a need for greater quality control and monitoring of the trainings throughout the project.

Both recipients of the sensitization sessions and the partners themselves were extremely shy to discuss the transmission of HIV through needle sharing and sexual activity. In many cases, people were visibly uncomfortable talking about sexual transmission and spoke about this mode of transmission using euphemisms. When pressed to explain what messages they tell youth about sexual modes of transmission, partner staff stated they told them to lead a "morally upright lifestyle", "to be safe" or "careful" with no additional information or explanation. Yet when pressed further on what "being safe or careful" meant, some participants were unable to state what this meant and others seemed uncomfortable responding or could not answer. To confirm what messages were being transmitted as part of the education sessions and sensitization activities, evaluation team members requested to review the training manuals being used. However, the evaluation team was unable to find any training manuals for any activities. In only one case did a partner show the evaluation team a few pages downloaded from the UNAIDS and ILO on various topics, several of which were not appropriate for the local audience.

This reticent approach to discussing sexual transmission of HIV was perpetuated among youth themselves and by their teachers. In the quantitative surveys, fewer than 40% of teachers reported receiving HIV training at the school where they are teaching. In the qualitative field work teachers interviewed stated they had not received any HIV education or training in how to deliver HIV messages. It seems clear, therefore, that the teachers cannot be expected to pass on accurate information to the students or youth. Teachers are not currently empowered to openly discuss these sensitive issues with their students, and many reported consistently inaccurate knowledge, inappropriate attitudes or beliefs. In addition,

only slightly more than half the students reported they had discussed HIV with their peers, which is indicative of the need for additional peer education programs. Youth at the youth centers were more likely to have spoken to their peers about HIV and drug use, but while the knowledge rates were higher among this group than the youth at school, many misconceptions and attitudes still existed and an unacceptably high number reported not having received HIV education through their youth centers.

Moreover when asked what methods and approaches they use to share the HIV messages, both participants from the prevention activities and partners carrying out the prevention activities stated that for the most part they are using lecture method coupled with a power-point presentation on the laptop. In all cases, participants indicated that the awareness sessions were done in English while the majority of the community members, especially women and youth grades 5 to 8, are not fluent in written or spoken English. There was no evidence of any training materials in the local language at either the high schools or in the community. Teachers reported they needed additional print materials to use to disseminate prevention messages at the schools and to use in trainings.

One the positive side, the DAN project sponsored a successful theater approach to HIV education and used community volunteers as educators. A core group of youth was trained by a theater group from Varanasi. The actors are called upon by the DAN staff to perform in schools and communities and are provided a stipend each time. This activity seems to have been well received, according to observations made by project staff, but researchers did not speak with any community members and youth who attended the play. The project staff do not seem fully aware of how best to promote this type of innovative learning for HIV awareness and stigma reduction. Based on feedback from the project staff as to how well communities and youth accepted the skits, this form of education should be highly encouraged and the theater groups should be supported to take ownership of the intervention. When asked which part of the PANI project was most successful, several of the DAN staff spoke about the community volunteers. Volunteers help with various activities including awareness raising and organizing education sessions in the community. These volunteers seemed to have been scaled back in PANI II, the reason of which is unclear.

Throughout the KIIs and FGDs, the team did not hear reference to "ABC" (Abstinence, Be Faithful or Use a Condom) which is fairly common in other countries. Moreover, there was almost no reference to *full and accurate information* about condoms; any references to condoms were made only to explain how the community used to condemn condom use. According to project participants who were interviewed for the evaluation, there is no discussion about condoms at all, even as a prevention method for HIV. This was particularly true in Nagaland where the society appears to be more conservative. It should be noted as well that

local CRS staff are not fully aware of CRS' policy on providing full and accurate information about condoms for prevention of sexually transmitted HIV.

There was no focus on high risk groups in the prevention activities. Furthermore, it was not clear what prevention strategy partners adopted in their approach to raising awareness. It appeared to the evaluation team that the activities were a series of information sessions that were limited to one-time experiences, with very limited follow-up for any feedback or twice in a school year for 1.5 hours each visit. Partners admitted that monitoring had been very weak after these sessions. Moreover, the groups trained did not have a plan as to how they were going to use the information learned, nor did the partner have any thought as to what the participants might do with the information learned. One partner noted that the community leaders were to train others, but this did not emerge during the FGDs or interviews. There was no schedule of training sessions at the partner level or at the community level according to those who had been trained. There was no measure of the impact of the sessions to evaluate if participants had increased knowledge of effective prevention methods.

Capacity-Building of Faith-Based Organizations

Objective: Strengthened capacities of church, local NGO and linkages and networking with government organizations, national, and international agencies benefit PLHIV

The PANI program has supported several projects which aim to raise awareness about HIV among church leaders and increase the involvement of FBOs in the sector. These projects have been very successful to date, moving many church leaders from denial to acceptance and concern. For example, in one Diocese where a Bishop once stated he would never have a PLHIV in his hospital, he now has dedicated a wing of 20 beds to HIV in-patient care. In the Baptist church, leaders have moved from rejecting PLHIV from their church pews to developing an HIV and AIDS policy which mandates care, support and love for those with HIV.

Yet work towards this objective still needs to be done. One Bishop stated that priests in his diocese still do "not take HIV" seriously. Several Catholic Bishops in the region have not at all embraced HIV education and prevention the way that the other Bishops have, stating that "it is not a priority for our communities". Only 10% of surveyed partners reported that they had a full-time dedicated staff for HIV, and more than 13% indicated that their church was still closed to working with high-risk groups.

CRS not only has a role in training the clergy and other religious in these states but also helping FBOs determine their niche. It seems clear that the churches are more comfortable with moral messages about HIV and therefore may not be best placed to handle prevention activities. Both Catholic and Baptist church leaders expressed

a desire to scale-up their activities in care and support. Lessons can be learned from the Baptist church in Nagaland, which has developed a training program that is training a cadre of trainers and developing a training manual. CRS could also support exchange visits between Bishops and priests and hold workshops using the TOT approach with a formal training curriculum, including lesson plans, specific learning objectives for each session, etc, format which proved successful.

Networking, another activity under this objective, has been also very fruitful. In Imphal for example, the PANI partners hold regular meetings to share experiences and discuss the project. Partners participate in government level meetings and interact with other NGOs as a direct result of CRS' efforts. In fact, some of the partners have noted that the greatest impact of the PANI program has been this inter-church dialogue; they spoke positively about the effects of bringing church and non-church partners together in such a forum.

Partnership was noted as one of the hallmarks of the PANI program. The majority of implementing partners consistently noted the high quality assistance provided by CRS staff, as well as their level of dedication and willingness to work as "true members of the team".

Specific recommendations for each of the objectives and other cross-cutting themes are discussed in the following section.

RECOMMENDATIONS

Overall, program participants of the PANI project are clearly benefiting from the project. In addition, as more than 80% of the PANI health care clients rely primarily on PANI supported health clinics, it is apparent that PANI fills a key gap in the communities, ensuring that no duplication of activities occurs with other organizations.

PANI implementers are successful overall in meeting the key objectives of the project. The project should continue in the same direction, but should reinforce some key aspects of the project in Phase II.

General Recommendations

1. **Resources and training:** While the diversity of the states and the interventions call for program flexibility to accurately respond to the needs of the program participants, there is also a need for some standardization, especially within the prevention activities. A couple of the trainings had curricula while the majority did not. It was assumed by most partners that all staff doing training knew the content of the trainings. There was limited effort placed on training staff as trainers prior to conducting any training for project participants. With the exception of healthcare trainings for families which were based on the needs of the families, all trainings including the self help groups should have had curriculums.

2. **Monitoring Quality Interventions (including M&E):** PANI needs to increase monitoring of interventions throughout the project site.

Under PANI's Phase I, two of the prevention trainings gave participants pre- and post- tests on information learned during the training. The other trainings did not. Neither of the two partners with the tests analyzed the results to improve the training. One partner never calculated the results. One partner calculated the results after the training was over, but no changes were made to any training curricula as a result of these test results.

- The one year evaluation carried out by CRS Guwahati staff includes recommendations for change, but doesn't include the method used to evaluate or the findings that were found prior to making recommendations.
- The MIS or master database is kept at the CRS Guwahati office. The quarterly reports that are sent in by the partners and then entered into this database were not readily available at the CRS Guwahati office for the pre-evaluation team. One might find one or two quarterly reports for a partner, but the majority of the reports were collected when meeting with the partners.

- Data collection is not standardized between partners. Partners have never seen each others data collection forms. On a positive note, each partner had tools or templates for collecting information. It does appear that there is a form being filled out for each intervention that takes place for prevention, care and support and church level activities.
- Overall the project is not tracking key, industry-wide standardized indicators on a regular basis across all activities projects which could be used for internal and external comparison and reporting purposes, as well as fundraising.

3. **CRS Staffing:** Staffing at the CRS Guwahati office includes one program coordinator for the PANI project with support from the Partner Support Officers (PSOs). The PSOs are responsible for all of CRS' programs with that partner. In a state where the PANI project has 7 partners and the staff is based in Guwahati, staffing levels are inadequate to work with each partner and ensure high quality programming. Staff complained of burn out, stress, and time away from their families due to extended travel to the field. Staffing should be examined and increased to respond to the true needs of a project of this scope. PANI should hire two more PSOs who are HIV professionals and place each of the three project officers in the state capitals of Manipur, Nagaland and Mizoram. Once the staffing levels increase, the staff could more adequately respond to the monitoring needs of the project and the technical capacity building needs of the partners.

4. **Funding:** There is concern among staff and partners that the project is overstretched financially. Indeed, the project currently cares for more clients than planned. While it is admirable that the project does not want to turn away needy clients, eventually program quality will be compromised if the project continues to serve so many clients and implement so many interventions on a limited budget. CRS should make efforts to secure additional funding for the project or be prepared to scale down portions of the interventions with the current budget. Although a complete financial analysis was not included as part of this evaluation, resources appear to be spread very thinly. One recommendation might be to either reduce the geographic scope of the program and/or reduce the programmatic coverage (i.e. fewer intervention areas), or simply only serve the number of clients budgeted. Due to input costs, the project cannot currently continue to serve the growing number of clients. [13]

[13] While the PANI project needs additional funding, it must be noted that CRS' contribution in the NE region in tackling HIV/AIDS issues is well recognized and acknowledge by other stakeholders, Government and civil societies. Moreover, CRS has diversified its resources and leveraged additional support for the PANI project through the Clinton Foundation and Government State AIDS Control Societies.

5. **Increase visibility:** The PANI project is doing some fantastic work, but the knowledge of this work in circles outside of the project is mixed. As such, any follow-on programming should diligently work to increase the visibility of the PANI project and its interventions.

6. **Increase collaboration:** While the project has created a strong referral network, there is still a need to increase collaboration with other stakeholders and meet more frequently with care and support projects, especially those in the project area supported by the Clinton Foundation. This collaboration will enable the project to strengthen its interventions and remain keyed into larger initiatives that may affect the project participants and interventions.

7. **Scale up existing services:** While funding is currently limited, there is a need for program expansion, particularly to the remote and needy areas where people do not have access to services. Given the current budget constraint, existing funds should not be diverted to this scale-up, but additional funds from external resources should be explored to meet this need.

8. **Scale up OVC program:** In the current project design, OVC are addressed under the care and support objective. However, this has meant that their needs have not been fully explored. If CRS is successful in expanding the PANI funding base, the project should consider scaling up the OVC component of its work and exploring the unique needs of OVC. In addition to child counseling, the project may wish to explore the educational needs of OVC, as well as a specific HIV prevention strategies aimed at OVC. The project should also explore establishing support groups for OVC and their caregivers and responding to their overall livelihood needs, while remaining cognizant of the need to combat stigma related to children and HIV in the area.

9. **Increase advocacy work:** There is a clear need to continue and to increase the advocacy work related to HIV. Very few of the partners are currently engaged in this component, and it will be increasingly difficult to accomplish the project's objectives without some attention to this area. In particular, additional advocacy work with government is needed to:
    - Influence policy
    - Ensure implementation of existing policy and law
    - Help access funds for local partners
    - Increase access to second line ARVs
    - Increase hepatitis C testing and treatment

Specific Recommendations by Objective

Care and Support

Increased quality control: While the majority of clients reported being satisfied with the services received at clinics, there was great disparity among the clinics in client satisfaction and services offered. With so many clients relying on the health centers as their primary health care provider, the PANI project will need to institute standard quality control measures within health care clinics. By incorporating quality control measures, the project will be better placed to respond immediately to any issues in care. This seems to be especially true for those partners that are sub-grantees to a main partner, as they consistently had lower satisfaction ratings. In the next phase of the project, these partners should be explicitly targeted with increased quality control measures.

Early testing: More work needs to be done to mobilize people to be tested early and seek services earlier. Increasing testing at new locations would help achieve this objective, as well as using creative community mobilization approaches. Lessons can be learned from partners in India and other countries to reach more people sooner.

Stigma: Community mobilization activities should be scaled up, as stigma is still prevalent; increasing community acceptance will help individuals to come forward sooner and get tested since many people presently do not want to know their status.

Support Groups: While the support groups are functioning well, they seem to have been formed for a dual purpose of providing support to members and generating income. However, very few groups are actually generating income. Support groups without any specific income function are extremely useful and should be maintained and expanded. Those support groups that wish to expand their mission to include income generation will need additional support in the areas of skills training, marketing training and business development training so that clients can earn a sustainable income through a low-intensity project (like tailoring or making foods at home). CRS as an agency is supporting a new model which focuses on savings and group formation and organization.

Decentralization of ART services: As the low quality of care provided at government-run health facilities can discourage patients enrollment which may lead to decreased adherence and thus increased resistance to ART, CRS and its partners could help decentralize ART services closer to the communities that need them as in other countries. If the DICs could be recognized as ART centers, then clients would be able to come for a "one-stop-shopping" with the OI management, check-up and counseling as well as ARVs all at one location. This would ease the burden for caregivers and PLHIV.

Reinforce Prevention of Parent-to-Child-Transmission (pPTCT): While pPTCT is not a focus of the current project, it fits into the main objectives and should be included as a programmatic area in the future. To accomplish this, PANI will need to work with local partners to increase their technical capacity and understanding of pPTCT. At the same time, the earlier recommendation for increased early testing will need to be implemented in order for mothers to come forward for testing services.

Institute child counseling training and activities: The growing number of children affected by HIV and AIDS in NE India has highlighted a gap in programming. There is a clear need to institute child counseling within the project. The local partners will need training in order to increase their capacity in this area and may need to increase staffing levels, i.e. adding social workers, to address the current gap in services.

Standardize training for caregivers: As mentioned in the general recommendations section, there is a need for standardized curricula. This includes training for caregivers. Caregivers suffer from great burnout and overwork and need to be trained regularly and appropriately. By creating and instituting regular, standardized training for caregivers, the project will be better able to respond to the needs of PLHIV.

Use volunteer[14] peer educators: There is currently a tension as to whether to pay peer educators or just use volunteers. In some projects, volunteers are used successfully as peer educators, i.e. CT projects, while other projects pay staff to conduct this work. The project needs to examine the responsibilities of the paid workers to ensure that they have a complete job description with more responsibilities than a typical volunteer. When using volunteers, the project should ensure that there should be less work for the volunteers, but monthly meetings to support the volunteers and follow-up on their activities. The project should explore some incentives for the volunteers (i.e. t-shirts, annual thank-you dinner, etc.). This model could be especially effective in a situation like NE India where there are many highly motivated HIV positive individuals who have expressed an interest in volunteering their time to care for others and to provide prevention education. Small incentives serve as recognition of their efforts and dedication.

Increase technical support to health center staff: While the health centers are doing an immense amount of work, they need additional technical support and reinforcement. Training and capacity building plans should be developed for each of the health centers. During the evaluation, clear needs emerged around understanding nutrition and HIV, improving existing nutritional supplements,

[14] Volunteers are unpaid but could be provided with incentives and "thank-you's" to show appreciation for their contributions. Successful strategies have shown that PLHIV make excellent volunteer candidates.

child counseling, counseling for PLHIV, enhancing treatment education for adherence, and ART training for health center staff.

Prevention

Prevention strategy development: The current prevention strategy seems to be haphazard education sessions for youth. However, the implementation of these sessions varies dramatically from partner and site. It is widely accepted that knowledge alone does not equal behavior change. In order to truly work toward the objective of preventing new HIV infections, the project will need to look at how the education can be translated into behavior and attitudinal change. There is need for clear methodology for prevention. The project should explore the use of standardized LSE and peer-education methodologies. Of course, at the moment, even the knowledge portion of the project appears to be very low, so this will also need to be included under the strategy development, but should be seen as only one part of a prevention strategy.

Curriculum development: As mentioned under the general recommendations, there is a clear need for a standard HIV education and prevention curriculum to be used within the project. Consistently, the program participants reported that they were using disparate curricula and materials. Standard, proven curriculums should be adapted to the situation in NE India and used across partners for the same target groups.

Targeted prevention: The prevention objective is very large currently, but only work with the youth is really being carried out. There were very few activities targeted to women and IDU that emerged from the project. Given the numerous issues with the prevention portion of the program in the youth population, it would be best for the project to rework and scale-back certain prevention component of the project so that it is targeted only on one population in future interventions. In this way, the project can focus on delivering quality prevention interventions as opposed to spreading its focus too diffusely.

Teacher training: In many cases, the teachers are the front line for HIV education. They currently exhibit low knowledge and attitude levels and are uncomfortable talking to their students about HIV. Given this, it is worrisome that there are many teachers who provide information to their students, as this information may not be correct. There is a clear need for additional training for teachers. Teachers have requested additional printed materials for their students. These materials should be made available to all teachers and classrooms within the targeted schools.

Additional sessions for youth: Both youth in the schools and the youth centers overwhelmingly stated that they needed additional information on HIV. A surprisingly low percentage reported having benefited from HIV education through existing schools or youth centers. As part of the HIV prevention strategy, PANI

should institute a clear schedule for HIV education and training for all targeted schools and youth centers, which should be shared with youth. These sessions should cover topics such as sex and drug use, as these are commonly reported high-risk behaviors among this age group.

Quality control: Currently training is of poor quality with poor content and delivery methods. A prevention strategy and curriculum development can solve many of these issues. However, there will still be a need for regular monitoring of the quality of the implementation. Satisfaction levels among youth, students and teachers varied greatly by site. There should be consistent monitoring of the effectiveness of the training. The prevention strategy should include a timeline for how often the program participants will receive the trainings, and the implementation of this timeline should be tracked. The one-time sessions at schools will likely be ineffective without standard quality control of both the content of the trainings and the frequency in which they are held. Partners should be encouraged to monitor the impact of their trainings. Regular KAP surveys can easily be administered to youth who participate in the trainings. In addition, results of pre- and post-test surveys can easily be incorporated into the training plans/curricula.

Build on partners' strengths: Some partners are carrying out programs which do not maximize their strengths. Some FBO partners report being uncomfortable talking about sexual transmission of HIV. In this case, other partners should fill this gap. Across the board, the partners lack capacity to carry out the prevention activities and have not received sufficient training to do so. Additional training for existing partners on prevention will be needed if this objective is to be successful in the future.

Correct information: While there is no mandate on how much each partner must supply in terms of information about HIV, it is possible that incorrect information can be harmful to targeted communities. Misinformation about HIV transmission, prevention and treatment may be doing more harm than good. Residents in the communities in NE India have a have a strong respect for authority, especially religious leaders, due to cultural traditions and will follow their advice. All CRS partners should only be giving correct information. This is a basic quality issue. Regular monitoring should be instituted to ensure that this is happening. There are still reportedly low levels of knowledge and comfort among many of the PANI faith-based partners. Additional trainings will need to be held for these groups.

Capacity Building

Update CRS and project staff on the latest HIV information: As mentioned previously, the basic knowledge among CRS staff and partners on HIV is low. There is need for additional training for these initial trainers to ensure correct information trickles down to all the program participants. This includes educating CRS staff and partners on CRS' position on condoms, and the HIV and AIDS policy

of the Catholic Indian Bishops Conference of India. All staff and partners should clearly understand these policies and their implications for programming.

Technical Capacity Building: The main form of assistance from the CRS Guwahati office to partners consists of financial assistance, monitoring of activities being carried out as outlined in the proposal, quarterly reports and a one year evaluation. Capacity building for partners for technical programming is lacking. More technical trainings need to occur. Training topics include, but are not limited to:

- ART management for health center staff;
- Child counseling techniques;
- HIV prevention methodologies;
- Nutrition education and counseling for health center staff;
- HIV education for faith-based institutions and schools.

Regular training for FBOs: The majority of surveyed FBOs indicated they would benefit from additional trainings, but the trainings to date seem to be organized in an ad hoc manner. Future trainings should be conducted on a more regular and frequent schedule. Standard curriculums should be used whenever possible. One successful TOT with the Baptist church leaders in Nagaland stood out as a promising practice which could be emulated by other projects.

Faith-based organization staffing: Staffing at FBOs is very uneven and minimal. Only a small percentage report that they have dedicated staff for working on HIV issues. Once these partners find their programming niche, they will need to increase staff to respond appropriately. Obviously, the first step is to assist these partners to understand how they are relevant to HIV and to examine staffing levels by partner. Small-scale organizations may not need dedicated staff, but this should be examined by organization to ensure that the needs are being met.

Sub-grantee capacity: In general, sub-grantee organizations received lower scores than clinics that were directly linked with CRS. In phase two, CRS will need to more closely monitor the quality of services provided through the care and support partners' sub-grantees. These organizations should also be seen as partners and investment in capacity building is needed.

Stigma reduction: Even within the faith-based partners and organizations, there was a high level of reported stigma and discomfort in dealing with HIV and high-risk groups. Future programming should explore how to hold regular sessions with faith-based partners to encourage open dialogue around these sensitive issues.

Exchange visits: CRS could support exchange visits between Bishops and priests and hold workshops on similar issues of concern. These exchange visits can occur internally, but could also include cross learning from other Bishops' conferences that have confronted HIV, i.e. the Southern African Catholic Bishops' Conference.

Increased partner meetings: While the PANI partners stress that the networking opportunities among PANI partners has been extremely beneficial, these meetings between the PANI partners should be much more frequent with an initial recommendation that the project explore holding these meetings at least quarterly.

Expanded networking: While church partners have begun to interact with actors in the NGO and government sector, such efforts need to be sustained and expanded. The government for example would like to have CRS and its partners participate more frequently at the district level AIDS Coordination meetings, training, and workshops. Being present will allow CRS and its partners to enhance its networking and learn of new programs, resources and funding initiatives. CRS has been requested by the government to be present at these meetings. If CRS improves its participation in these meetings and in facilitating other meetings and workshops, it should help raise the profile of the PANI partners and CRS' good work in India.

CONCLUSIONS

While it is not possible to quantify the overall impact of PANI on program participants' quality of life or whether PANI actually contributed to a stabilization of HIV prevalence in the region, it is clear that PANI is contributing to the improvement of the quality of life of program participants in the targeted states, especially through its care and support interventions. Program participants and partners both report that the project is effective and moving in the right direction.

There are obviously some areas that will need improvement in a follow-on phase of the project. These areas are highlighted in the recommendations section of the report. Program participants that are served by PANI report that the project is beneficial to their overall well-being. A follow-on phase of this project would be beneficial to the targeted program participants, as well as to the project partners.

While the follow-on phase has already begun, there is a need to integrate the recommendations from this report into the existing and future programming. The project should undoubtedly continue to focus on increasing partner capacity, as well as the ability of local organizations to care for PLHIV, while linking to other wrap-around service providers in the targeted geographical areas. The project should explore the usefulness of the youth prevention interventions and revamp those interventions considerably in any follow-on phases.

In sum, PANI definitely made progress toward its goal and strategic objectives. A follow-on phase of the project would enable greater impact and the opportunity to focus on sustainable interventions, while continuing to improve the overall care and quality of life of program participants in the targeted states.

ANNEX 1: CAREGIVER FGD

Caregivers

Moderator: "My name is ……I would like to ask for your permission to discuss important issues in your community with you. The information that we obtain from this discussion will be used to guide Catholic Relief Services and its partners on its work with health clinics and HIV programming.

We will not use the information that you provide to identify you in any way. All the information that you provide will be kept confidential. This means that no one will know that you provided this information. The information gathered here will not be linked to your name at any time. However, I would like to record this conversation, so that I can ensure that I've heard all of you accurately. I will use these tapes for note-taking only and will destroy them after I am finished with my work. Do you have any questions about this?

This will probably take about 1.5 hours for this discussion.

You are not required to answer any question that you do not wish to answer. Some questions may be sensitive, but I would appreciate your honest answers whenever possible.

Is there anyone who would like to leave and does not wish to participate?"

Be sure to obtain consent from all present to participate.

Ice breaker: Moderator should start by making reference to a recent event like soccer, village festival, etc. Something to get the participants talking among themselves, then explain the rules of the discussion, one person at a time, no good or bad opinion, opinions from every person is equally important, etc. (5 minutes).

1.) I understand that you are currently caring for someone who is living with HIV or a child whose parents have been infected with HIV. Can you share with me what is involved with the care that you provide?

- Probe: what sorts of care is required? If HIV+, are ARVs available? If OVC, what sorts of challenges?

Moderators: 10 - 15 minutes for discussing the care.

2.) What challenges do people living with HIV here face?

- Probe: stigma in the community, among the health center staff, modes of transmission of the clients, continued risky behaviors
- Probe: for economic situation of HIV+ and problems with reintegration in the communities

- Probe: for rehabilitation aspects related to cessation of drug use, alternative income avenues for CSWs, etc.
- Probe: for widows and OVC, what are the unique challenges and responses

Moderator: 20 - 25 minutes for HIV.

3.) What do you think of the quality of the services you receive to assist you with this care?

- Probe: for staffing levels, medication stocks, confidentiality, wrap around services, linkages with other relevant institutions, etc.
- Probe: What would you like to see improved about the project and the services you receive?

Moderator: 10 - 15 minutes for quality of services.

4.) How has the project impacted your life?

- Probe: the impact of the project on participating stakeholder's assets (focusing on human, financial, social and political), their ability to deal with the shocks, the impact of the project on SYSTEMS and STRUCTURES related to HIV and AIDS
- Probe: significant changes have the CRS supported project brought into the life of you and your family members
- Probe: How would you manage without the project?

Moderator: 20-25 minutes for the impact of the project.

5.) What has been the most meaningful support you received from the project? Why do you say that it was the most meaningful?

Moderator: 15 minutes.

Thank them for their participation.

ANNEX 2: HEALTH CLINIC CLIENT FGD

Health Clinic Clients

Moderator: "My name is ……I would like to ask for your permission to discuss important issues in your community with you. The information that we obtain from this discussion will be used to guide Catholic Relief Services and its partners on its work with health clinics and HIV programming.

We will not use the information that you provide to identify you in any way. All the information that you provide will be kept confidential. This means that no one will know that you provided this information. The information gathered here will not be linked to your name at any time. However, I would like to record this conversation, so that I can ensure that I've heard all of you accurately. I will use these tapes for note-taking only and will destroy them after I am finished with my work. Do you have any questions about this?

This will probably take about 1.5 hours for this discussion.

You are not required to answer any question that you do not wish to answer. Some questions may be sensitive, but I would appreciate your honest answers whenever possible.

Is there anyone who would like to leave and does not wish to participate?"

Be sure to obtain consent from all present to participate.

Ice breaker: Moderator should start by making reference to a recent event like soccer, village festival, etc. Something to get the participants talking among themselves, then explain the rules of the discussion, one person at a time, no good or bad opinion, opinions from every person is equally important, etc. (5 minutes).

1.) Can someone tell us about the health clinic here? What sorts of services do they provide?

- Probe: who pays for the services, types of services, are the services only health-related or do they offer support groups, linkages to credit, etc.

Moderators: 10 - 15 minutes for discussing the services.

2.) What do you think of the quality of the services here?

- Probe: for staffing levels, medication stocks, confidentiality, wrap around services, linkages with other relevant institutions, etc.

Moderator: 10 - 15 minutes for quality of services.

3.) CRS finances portions of the health center specific to HIV. Let's talk about HIV in particular for a minute. Are there people attending this center who are openly HIV positive? What challenges do they face?

- Probe: for attendance of those who are openly positive, stigma in the community, among the health center staff, modes of transmission of the clients, continued risky behaviors
- Probe: for economic situation of HIV+ and problems with reintegration in the communities
- Probe: for rehabilitation aspects related to cessation of drug use, alternative income avenues for CSWs, etc.
- Probe: for widows and OVC, what are the unique challenges and responses
- Probe: How has the health center impacted the lives of the clients with HIV?

Moderator: 20 - 25 minutes for HIV.

4.) How can the health clinic best respond to HIV?

- Probe: For treatment, testing, but also for prevention (reducing risky behaviors, sero discordant couples, etc.), as well as care and support; see if there are any trainings for caregivers, etc.
- Probe: who else responds? What else is needed?

Moderator: 10 - 15 minutes for responding to HIV.

5.) How has the project impacted your life?

- Probe: the impact of the project on participating stakeholder's assets (focusing on human, financial, social and political), their ability to deal with the shocks, the impact of the project on SYSTEMS and STRUCTURES related to HIV and AIDS
- Probe: significant changes have the CRS supported project brought into the life of you and your family members

Moderator: 10 minutes for the impact of the project.

6.) What has been the most meaningful support you received from the clinic? Why do you say that it was the most meaningful?

Moderator: 10 minutes.

Thank them for their participation.

ANNEX 3: HEALTH CLINIC STAFF FGD

Moderator: "My name is ……I would like to ask for your permission to discuss important issues in your community with you. The information that we obtain from this discussion will be used to guide Catholic Relief Services and its partners on its work with health clinics and HIV programming.

We will not use the information that you provide to identify you in any way. All the information that you provide will be kept confidential. This means that no one will know that you provided this information. The information gathered here will not be linked to your name at any time. However, I would like to record this conversation, so that I can ensure that I've heard all of you accurately. I will use these tapes for note-taking only and will destroy them after I am finished with my work. Do you have any questions about this?

This will probably take about 1.5 hours for this discussion.

You are not required to answer any question that you do not wish to answer. Some questions may be sensitive, but I would appreciate your honest answers whenever possible.

Is there anyone who would like to leave and does not wish to participate?"

Be sure to obtain consent from all present to participate.

Ice breaker: Moderator should start by making reference to a recent event like soccer, village festival, etc. Something to get the participants talking among themselves, then explain the rules of the discussion, one person at a time, no good or bad opinion, opinions from every person is equally important, etc. (5 minutes).

1.) Can someone tell us about the health clinic here? What sorts of services do they provide?

- Probe: who pays for the services, types of services, are the services only health-related or do they offer support groups, linkages to credit, etc.
- Probe: linkages to other services and government institutions

Moderators: 10 - 15 minutes for discussing the services.

2.) What do you think of the quality of the services provided here?

- Probe: for staffing levels, medication stocks, confidentiality, wrap around services, linkages with other relevant institutions, etc.
- Probe: are there management issues? Does the clinic receive any outside technical support from CRS or partners? What types? What's missing?

Moderator: 10 - 15 minutes for quality of services.

3.) CRS finances portions of the health center specific to HIV. Let's talk about HIV in particular for a minute. Are there people attending this center who are openly HIV positive? What challenges do they face?

- Probe: for modes of transmission of the clients, continued risky behaviors
- Probe: for economic situation of HIV+ and problems with reintegration in the communities
- Probe: for rehabilitation aspects related to cessation of drug use, alternative income avenues for CSWs, etc.
- Probe: for widows and OVC, what are the unique challenges and responses

Moderator: 20 - 25 minutes for HIV.

4.) How can the health clinic best respond to HIV?

- Probe: For treatment, testing, but also for prevention (reducing risky behaviors, sero discordant couples, etc.), as well as care and support; see if there are any trainings for caregivers, etc.
- Probe: who else responds? What else is needed?

Moderator: 10 - 15 minutes for responding to HIV.

5.) How has the project impacted the lives of the clients?

- Probe: the impact of the project on participating stakeholders' assets (focusing on human, financial, social and political), their ability to deal with the shocks, the impact of the project on SYSTEMS and STRUCTURES related to HIV and AIDS
- Probe: significant changes have the CRS supported project brought into the life of clients and their family members
- Probe: What has been the most meaningful support the clinic provides to its clients? Why do you say that it was the most meaningful?

Moderator: 15 minutes for the impact of the project.

Thank them for their participation.

ANNEX 4: YOUTH FGD

Moderator: "My name is ……I would like to ask for your permission to discuss important issues in your community with you. The information that we obtain from this discussion will be used to guide Catholic Relief Services and its partners on its work with youth and prevention programming.

We will not use the information that you provide to identify you in any way. All the information that you provide will be kept confidential. This means that no one will know that you provided this information. The information gathered here will not be linked to your name at any time. However, I would like to record this conversation, so that I can ensure that I've heard all of you accurately. I will use these tapes for note-taking only and will destroy them after I am finished with my work. Do you have any questions about this?

This will probably take about 1.5 hours for this discussion.

You are not required to answer any question that you do not wish to answer. Some questions may be sensitive, but I would appreciate your honest answers whenever possible.

Is there anyone who would like to leave and does not wish to participate?"

Be sure to obtain consent from all present to participate.

Ice breaker: Moderator should start by making reference to a recent event like soccer, village festival, etc. Something to get the kids talking among themselves, then explain the rules of the discussion, one person at a time, no good or bad opinion, opinions from every kid is equally important, etc. (5 minutes).

1.) Can someone tell us about favorite school activities in this community? What kids like to participate in and those that they do not like that much-- educational trips, school debates, class assignments, texts; etc

- Probe: who pays for school fees, involvement of relatives, guardian, volunteers, external support, role of teachers in students' lives, frequency of school attendance in general

Moderators: 10 - 15 minutes for discussing education.

2.) Let us now discuss a topic that kids your age are often shy about. But we want you to talk freely because we are only interested in the opinions of kids your age not any particular person here. Do kids your age talk about sexual issues among themselves?

- Probe: for sexual behaviors of youth, accepted cultural norms, standard sexual practice among youth, etc.

Moderator: 10 - 15 minutes for knowledge of modes of transmitting HIV.

3.) Do kids your age receive information about HIV and other sexually transmitted infections?

- Probe: for all modes of transmission of HIV, and how to prevent them. For where education occurs, quality of education, etc.

Moderator: 10 - 15 minutes for knowledge of HIV.

4.) Do kids your age receive information about drug use and preventing drug abuse?

- Probe: For frequency and acceptability of drug use. For where education occurs, quality of education, etc.

Moderator: 10 - 15 minutes for drug use and abuse discussion.

5.) Even though kids your age know how HIV is transmitted and that drug use is dangerous, they often still engage in risky behavior (i.e. unprotected sex, injecting drug use, etc.). Why do you think this happens?

- Probe: for why youth think they aren't at risk themselves, their ability to control their own sexual actions and fate, peer pressure, etc.

Moderator: 10 - 15 minutes.

6.) What role the youths should be playing in building a healthier society? What are the gaps and challenges in scaling up youth involvements in prevention of social issues like drug use, HIV, corruption, unemployment, etc.?

- Probe: for societal constraints, community attitudes, youth motivation, etc.

Moderator: 10 - 15 minutes. Warn them that the discussion will end in two minutes.

Thank them for their participation.

ANNEX 5: PARTNER KEY INFORMANT INTERVIEW GUIDE

Questions for Key Informants in Partner Organizations

There are approximately 25 questions to be used in these sessions. Each interview should take approximately 1.5 hours. While this questionnaire serves as a guide for this interview, each interviewer should feel free to ask follow-up questions if needed.

Interviewer: Please ensure that each informant understands the purpose of the interview and that their answers will be used to improve the next phase of PANI. Please ensure them of the confidentiality of their answers and that their answers will not impact their participation in the overall project or their funding levels.

Questions:

1.) Please tell me about how your organization has worked with the PANI project over the past years?

2.) How is your organization structured? (Probe for management structure, financial set-up, M&E, etc.)

3.) What are the major hurdles that your organization faces? (Probe for management issues, finance and reporting, etc.)

4.) Looking back, how did the project change over time from what you first envisioned? (Probe to see how beneficiaries were included in project design and adaptation over time.)

5.) Please explain your partnership with CRS. (Probe for frequency of visits, technical assistance, trainings, networking opportunities, etc.)

a. If CRS provided trainings (even if not directly), how would you describe the quality of these trainings?

6.) How can CRS best assist you with the next phase of your project?

7.) What limitations have you faced in the implementation of your project? (Probe for external limitations such as stigma in the community and internal limitations such as staffing issues at the partner level)

8.) Have there been any unintended positive or negative effects of the project? (Probe for unplanned events such as community becoming more involved, resentment of those in the project, etc.)

9.) Are there any gaps in the project? How could those be filled?

10.) What are the strengths of the project and why are those portions working so well?

11.) How are you linking to other organizations? (Probe for government linkages, funding from other sources, etc.)

12.) If you had unlimited funding, would you change anything in the project? Please explain. (Probe to see if there are clear gaps in the current program that impact the quality or if there would just be an increase in scope, etc.)

Any additional information from the interview:

ANNEX 6: TEACHER SURVEY

Questions	Responses
What is the name of the school in which you teach?	(Include a list of schools here
How long have you been teaching in this school?	1.) LESS THAN 1 YEAR 2.) 1-2 YEARS 3.) 3-5 YEARS 4.) 6-10 YEARS 5.) 11 YEARS OR MORE
What grade do you currently teach?	1.) 6th 2.) 7th 3.) 8th 4.) 9th 5.) 10th 6.) 11th 7.) 12th
How long have you been teaching this grade?	1.) LESS THAN 1 YEAR 2.) 1-2 YEARS 3.) 3-5 YEARS 4.) 6-10 YEARS 5.) 11 YEARS OR MORE
Have you received training in HIV education?	YES.....1 NO.....2 DON'T KNOW 8
If so, where did you receive this training? ***(Please circle all that apply.)***	1.) THROUGH THE SCHOOL IN WHICH I TEACH 2.) HEALTH CLINIC 3.) COMMUNITY ORGANIZATION 4.) TELEVISION/RADIO 5.) FRIENDS 6.) FAMILY 7.) OTHER_____
If you received training through the school in which you currently teach, please rate the training.	1.) VERY GOOD 2.) GOOD 3.) AVERAGE 4.) POOR 5.) VERY POOR
Do you feel that you need more information on HIV beyond what you received in your training?	YES.....1 NO.....2 DON'T KNOW 8
If so, what additional information would you like to receive?	_____
Do you feel that you are at risk of becoming infected with HIV yourself?	YES.....1 NO.....2 DON'T KNOW 8
Do you know how to protect yourself from HIV infection?	YES.....1 NO.....2 DON'T KNOW 8
How can a person protect himself from HIV infection? ***(Please circle all that apply.)***	1.) ABSTAIN FROM SEX 2.) BE FAITHFUL TO ONE PARTNER 3.) LIMIT NUMBER OF SEXUAL PARTNERS 4.) AVOID MOSQUITO BITES 5.) USE CONDOMS 6.) AVOID KISSING 7.) AVOID SEX WITH PROSTITUTES 8.) AVOID SEXUAL INTERCOURSE WITH PEOPLE WHO INJECT DRUGS 9.) AVOID BLOOD TRANSFUSIONS 10.) AVOID SEX WITH PERSONS OF THE SAME SEX 11.) AVOID INJECTION DRUGS 12.) AVOID SHARING RAZORS AND BLADES 13.) SEEK PROTECTION FROM TRADITIONAL HEALERS 14.) OTHER (SPECIFY):_____

If a mother is infected with the AIDS virus, is there any way to avoid transmission to the baby?	YES .....1 NO .....2 DON'T KNOW 8
Can a person who has AIDS be cured?	YES .....1 NO .....2 DON'T KNOW 8
How can a person find out if he or she has HIV (the virus that causes AIDS)?	GO FOR TEST ..... A GO TO HEALTH FACILITY..... B GO TO COUNSELLING/TESTING FACILITY C OTHER_____D (SPECIFY) DON'T KNOW ..... E
Have you heard of an HIV/AIDS counseling and testing service center?	YES .....1 NO .....2 DON'T KNOW 8
What do you think are the reasons to get an HIV test? ***(Please circle all that apply.)***	MARRIAGE .....1 FAMILY PLANNING .....2 INSURANCE .....3 PLAN FOR THE FUTURE .....4 PROTECT PARTNER.....5 PROTECT CHILD.....6 IF I M SICK .....7 OTHER_____8 (SPECIFY) DON'T KNOW 9
What would be reasons <u>not</u> to get an HIV test? ***(Please circle all that apply.)***	LOSE JOB.....1 LOSE TERMINAL BENEFITS.....2 LOSE PENSION.....3 LOSE PARTNER.....4 FEAR OF KNOWING.....5 STIGMA.....6 OTHER_____7 (SPECIFY) DON'T KNOW 8
If you wanted an HIV test, where would you go? ***(Please circle all that apply.)***	HOSPITAL.....1 HEALTH CLINIC.....2 COMMUNITY ORGANIZATION…….3 VCT CENTER.....4 OTHER_____.....5 (SPECIFY) DON'T KNOW 6

Who should go for an HIV test? ***(Please circle all that apply.)***		SEX WORKERS.....1 USERS OF SEX WORKERS.....2 DRIVERS, SOLDIERS, TRAVELLING SALES PERSONS, ETC. 3 ANYONE AT-RISK .....4 THOSE WITH MULTIPLE PARTNERS5 ANYONE SEXUALLY ACTIVE .....6 THOSE WHO ARE SICK.....7 THOSE GETTING MARRIED .....8 OTHER_____9 (SPECIFY) DON'T KNOW 10
Have you ever been tested for HIV?		YES.....1 NO.....2 DON'T KNOW 8
Please don't share the actual results of your HIV test, but did you receive the results?		YES.....1 NO.....2 DON'T KNOW 8
If a relative of yours became sick with the AIDS virus would you be willing to care for him or her in your own household?		YES.....1 NO.....2 DON'T KNOW 8
If a teacher has the AIDS virus, but is not sick, should he or she be allowed to continue teaching in school?		YES.....1 NO.....2 DON'T KNOW 8
Would you teach a child who has HIV?		YES.....1 NO.....2 DON'T KNOW 8
Would you buy foods from a vendor who is HIV positive?		YES.....1 NO.....2 DON'T KNOW 8
If you were HIV positive, would you tell…	Your family?	YES.....1 NO.....2 DON'T KNOW 8
	Your friends?	YES.....1 NO.....2 DON'T KNOW 8
	Your co-workers?	YES.....1 NO.....2 DON'T KNOW 8
Have your students received HIV education and prevention information at your school?		YES.....1 NO.....2 DON'T KNOW 8
If so, how would you rate the quality of the education and information that they have received?		1.) VERY GOOD 2.) GOOD 3.) AVERAGE 4.) POOR 5.) VERY POOR
Have you ever spoken to your students about HIV prevention?		YES.....1 NO.....2 DON'T KNOW 8
Have you ever engaged your students on issues around HIV prevention and drug abuse outside of the school setting?		YES.....1 NO.....2 DON'T KNOW 8
How many times have you facilitated HIV sessions on your own for students?		1.) NONE 2.) ONE 3.) TWO 4.) THREE 5.) FOUR OR MORE

Do you believe that any of your students are engaged in risky behavior that might put them at risk of contracting HIV? ***(Please do not name any individual students.)***	YES.....1 NO.....2 DON'T KNOW 8
If so, what are these behaviors? ***(Please circle all that apply.)***	1.) ALCOHOL USE 2.) INJECTING DRUG USE 3.) OTHER DRUG USE 4.) TRANSACTIONAL SEX (RECEIVING GOODS OR SERVICES FOR SEX) 5.) RECREATIONAL SEX 6.) OTHER (SPECIFY): _____
Have the students received information about these risky behaviors and HIV?	YES.....1 NO.....2 DON'T KNOW 8
If so, how often do they receive such information?	1.) DAILY 2.) WEEKLY 3.) MONTHLY 4.) QUARTERLY 5.) ANNUALLY 6.) EVERY TWO YEARS 7.) LESS THAN ONCE EVERY THREE YEARS
How would you rate the quality of the information that they receive?	1.) VERY GOOD 2.) GOOD 3.) AVERAGE 4.) POOR 5.) VERY POOR
Do you think that your students need additional information about HIV?	YES.....1 NO.....2 DON'T KNOW 8
Do your students have access to a counselor to discuss any issues or concerns they might have?	YES.....1 NO.....2 DON'T KNOW 8
If so, how often is the counselor available for the students?	1.) DAILY 2.) WEEKLY 3.) MONTHLY 4.) OTHER:_____
In the cases where you suspected your students were engaged in such risky behavior, what did you do?	1.) NOTHING 2.) TALK TO THE STUDENTS 3.) TALK TO THE STUDENTS' PARENTS 4.) CONDUCT A TRAINING FOR THE CLASS 5.) REFER THE STUDENT TO THE COUNSELOR 6.) OTHER (Specify):_____
Are there any tools that would enable you to better educate and empower your students to protect themselves from HIV infection?	YES.....1 NO.....2 DON'T KNOW 8
If so, what tools do you need? ***(Please circle all that apply.)***	1.) ADDITIONAL TRAINING FOR MYSELF 2.) ADDITIONAL TRAINING FOR MY STUDENTS 3.) PRINTED MATERIALS FOR THE STUDENTS 4.) REFERRAL INFORMATION FOR CARE 5.) OTHER:_____

Do you have any additional comments regarding the HIV prevention program?

ANNEX 7: CHURCH SURVEY

With which Church/religious community are you working?

_____

What is your role within this Church?

1.) Priest
2.) Pastor
3.) Sister
4.) Other clergy
5.) Administrator

Have you received HIV-related training from CRS or partners (DSSS, ZEP, NDO, DAN)?

1.) Yes
2.) No
3.) Not sure

If so, when did you receive the training? (Please circle all that apply.)

1.) Within the last six months
2.) Within the last year
3.) Within the last two years
4.) More than two years ago
5.) Don't remember

If not, do you plan to attend a CRS-supported training in the future containing information about HIV and AIDS?

1.) Yes
2.) No
3.) Not sure

Please indicate which, if any, organizations with whom you currently work.

1.) DAN
2.) DSSS
3.) ZEP
4.) NDO

How long has your Church or community been working with CRS?

1.) Less than one year

2.) 1-2 years -
3.) 2-3 years -
4.) More than 3 years -

How would you rate the work that CRS is doing in the PANI project?

1.) Extremely high quality
2.) High Quality
3.) Average
4.) Below Average
5.) Very bad

Do you have a program for the care and support of people living with HIV or AIDS?

1.) Yes
2.) No
3.) Don't Know

Do you have dedicated resources for caring and supporting people living with HIV or AIDS?

1.) Yes
2.) No
3.) Don't Know

If so, how long have you been involved in care and support programs for people living with HIV or AIDS?

1.) Less than 1 year
2.) 1-2 years
3.) 2-3 years
4.) More than 3 years
5.)

Do you have an official department within your Church for HIV and AIDS?

1.) Yes, we have an active department
2.) No, but we plan to start a department
3.) No, and we have no plans to establish a separate department
4.) Don't Know

Do you have a separate department in your Church for drug prevention?

1.) Yes, we have an active department
2.) No, but we plan to start a department
3.) No, and we have no plans to establish a separate department
4.) Don't Know

If you are working on HIV and/or drug prevention programming, how many staff do you have who are working full-time on these programs?

1.) One -
2.) 2-3 -
3.) 4-5 -
4.) 6 or more -

What do your programs focus on? (Circle all that apply)

1.) Prevention of HIV
2.) Reduction of risky behavior
3.) Promotion of abstinence
4.) Promotion of fidelity
5.) Prevention of drug use
6.) Care for people living with HIV
7.) Care for children whose parents have/had HIV
8.) Support for families affected by HIV
9.) Rehabilitation of injecting drug users
10.)Treatment of sexually transmitted infections
11.)Other (Specify):_____

How open is your Church to caring and supporting injecting drug users and/or commercial sex workers who are affected by HIV?

1.) Very open
2.) Somewhat open
3.) Unsure
4.) Somewhat closed
5.) Very closed

How do your programs work to prevent HIV? (Circle all that apply)

1.) Education
2.) Behavior change campaigns
3.) Life skills education
4.) Encourage counseling and testing
5.) Encourage prevention of mother-to-child transmission
6.) Provide or link to treatment (ART)
7.) Provide or link to treatment of sexually transmitted infections
8.) Other (specify):_____

Do you operate any health centers?

1.) Yes
2.) No
3.) Don't know

If so, have you integrated HIV care into those centers?

1.) Yes, we are currently integrating HIV care into overall health care

2.) No, but we plan to begin integrating HIV within the next year -
3.) No, but we plan to explore integrating HIV in the future -
4.) No, and we do not plan to begin integrating HIV -
5.) Don't know -

Are you involved in any advocacy work around HIV?

1.) Yes
2.) No
3.) Don't Know

If so, what types of advocacy work have you engaged in?

1.) Community mobilization
2.) Lobbying the state regarding existing policy
3.) Given voice to NE's HIV issues externally
4.) Other (specify):_____

If you have been successful in any of your HIV advocacy work, could you please write a few sentences here to highlight that success?

Do you work in any committees or groups related to HIV?

1.) Yes
2.) No
3.) Don't Know

If so, please circle all that apply. -

1.) Interdenominational groups
2.) Caritas network
3.) Parish networks
4.) Other Catholic networks
5.) State groups
6.) City groups
7.) Hospital groups
8.) Community-based organization groups (outside of CRS)
9.) Other international organizations
10.)Other (specify):_____

How would you rate your Church's level of participation in the fight against HIV overall?

1.) Very strong, we're doing everything we possibly can
2.) Strong, we're doing a lot, but there's more we could do
3.) Average, we're doing some things, but not enough
4.) Poor, we've not done enough
5.) Very poor, we have not been actively engaged to any degree

Where is your Church the strongest in the fight against HIV?

1.) Prevention
2.) Care and support for people living with HIV
3.) Advocacy

Where is your Church the weakest in the fight against HIV?

1.) Prevention
2.) Care and support for people living with HIV
3.) Advocacy

Is there anything else that you would like to tell us?

ANNEX 8: HEALTH CLINIC CLIENT SURVEY

	What is your gender?	1.) MALE 2.) FEMALE
	What is your age?	1.) 60 YEARS OR ABOVE 2.) 40-59 YEARS 3.) 30-39 YEARS 4.) 25-29 YEARS 5.) 18-24 YEARS 6.) 17 YEARS OR BELOW
	What is your marital status?	1.) SINGLE 2.) MARRIED AND LIVING TOGETHER 3.) MARRIED, BUT LIVING APART 4.) SEPARATED 5.) DIVORCED 6.) WIDOWED
	What is the highest education level you completed?	1.) NONE 2.) PRIMARY 3.) SECONDARY 4.) TERTIARY
	What is the name of the clinic you attend?	(Include a list of clinics here) 1) Kripa Foundation Imphal 2) Social Awareness Service Organization (SASO) 3) Manipur Network of Positive People (MNP+) 4) Kripa Foundation Kohima (Kekhrie Foundation) 5) Cradle Ridge (NMA) 6) Mizoram Network of Positive People (MPlus) 7) AIDS Prevention Society (APS)
	How long have you been attending this clinic?	6.) LESS THAN 1 YEAR 7.) 1-2 YEARS 8.) 3-5 YEARS 9.) 6-10 YEARS 10.) 11 YEARS OR MORE
	What services have you obtained at this clinic? ***PLEASE CIRCLE ALL THAT APPLY.***	1.) REGULAR HEALTHCARE 2.) COUNSELING AND TESTING OF HIV 3.) TREATMENT OF STIs AND OIs 4.) HOTLINE SERVICES 5.) PEER SUPPORT GROUPS 6.) NUTRITION SUPPLEMENTS 7.) ART 8.) REGULAR LAB WORK 9.) PALLIATIVE CARE FOR FAMILY MEMBERS 10.) COUNSELING SERVICES 11.) ACCESS TO SELF HELP GROUP 12.) OTHER (SPECIFY):_____
	In general, how would you rate the quality of the services that you receive at this clinic?	6.) VERY GOOD 7.) GOOD 8.) AVERAGE 9.) POOR 5.) VERY POOR
	How many times have you visited this clinic in the last month?	1.) ONCE 2.) TWICE 3.) THREE TIMES 4.) FOUR TIMES OR MORE
	How satisfied are you with the staff at this clinic?	1.) VERY GOOD 2.) GOOD 3.) AVERAGE 4.) POOR 5.) VERY POOR
	Do any of your family members frequent this clinic as well?	1.) YES 2.) NO 3.) DON'T KNOW

	How do you think the quality of care at this clinic has changed during the time since you first visited it?	1.) IMPROVED A LOT 2.) IMPROVED SOMEWHAT 3.) REMAINED THE SAME 4.) DECLINED SOMEWHAT 5.) DECLINED DRAMATICALLY
	Is this clinic your primary source of health care?	1.) YES 2.) NO 3.) DON'T KNOW
	Do you access health services outside of this clinic?	1.) YES 2.) NO 3.) DON'T KNOW
	If so, what other services do you access?	1.) OTHER PRIVATE CLINIC 2.) PRIVATE HOSPITALS 3.) GOVERNMENT CLINIC 4.) GOVERNMENT HOSPITALS 5.) OTHER (SPECIFY)_____
	If you visit any other health care institutions outside of this clinic, were you referred to those institutions by this clinic?	1.) YES 2.) NO 3.) DON'T KNOW
	How would you rate the referral services at this clinic?	1.) VERY GOOD-THEY ALWAYS REFER APPROPRIATELY 2.) GOOD-THEY OFTEN REFER APPROPRIATELY 3.) AVERAGE-THEY SOMETIMES REFER APPROPRIATELY 4.) BELOW AVERAGE-THEY RARELY REFER APPROPRIATELY 5.) VERY POOR-THEY NEVER REFER APPROPRIATELY
	Are you HIV positive? (If no, skip to question X)	1.) YES 2.) NO 3.) DON'T KNOW 4.) DON'T WISH TO SAY
	If so, how long has it been since you tested positive for HIV?	1.) LESS THAN ONE YEAR 2.) ONE TO TWO YEARS 3.) TWO TO THREE YEARS 4.) THREE TO FOUR YEARS 5.) FOUR TO FIVE YEARS 6.) FIVE TO SIX YEARS 7.) MORE THAN SIX YEARS
	If you are HIV positive, what year do you think you were infected?	____----------
	If you are HIV positive, how do you think you were infected?	1.) SEX WITH A MAN 2.) SEX WITH A WOMAN 3.) BLOOD TRANSFUSION 4.) FROM MOTHER 5.) INJECTING DRUG USE 6.) OTHER (SPECIFY):_____ 7.) DON'T KNOW
	Have you ever received HIV testing and counseling from this health clinic?	1.) YES 2.) NO 3.) DON'T KNOW
	If so, how would you rate the quality of the testing and counseling that you received?	1.) VERY GOOD 2.) GOOD 3.) AVERAGE 4.) POOR 5.) VERY POOR
	Did you receive counseling before getting tested?	1.) YES 2.) NO 3.) DON'T KNOW

	Did you receive counseling after getting your results?	1.) YES 2.) NO 3.) DON'T KNOW
	If you are HIV positive, are you currently taking ART?	1.) YES 2.) NO 3.) DON'T KNOW
	If not, why are you not taking ART?	1.) DON'T NEED ART 2.) CANNOT AFFORD ART 3.) THE MEDICATION MAKES ME ILL 4.) TOO COMPLICATED TO REMEMBER TO TAKE MEDICATION 5.) OTHER (SPECIFY):_____
	If you are HIV positive, have you shared your status with….	
	Your spouse?	1.) YES 2.) NO
	Your family?	1.) YES 2.) NO
	Your friends?	1.) YES 2.) NO
	Your peers?	1.) YES 2.) NO
	If you've shared your status with others, how have they reacted?	1.) SUPPORTED ME 2.) TALKED TO ME ABOUT MY STATUS 3.) ACTED AFRAID OF ME 4.) AVOIDED ME 5.) OTHER (specify):_____
	Have you joined a support group through the health clinic?	1.) YES 2.) NO
	If so, how has this support group affected your life? ***Circle all that apply.***	1.) IMPROVED OVERALL QUALITY OF LIFE 2.) IMPROVED SOME ASPECTS OF MY LIFE 3.) MADE ME FEEL LIKE A PART OF A LARGER COMMUNITY 4.) CREATED LASTING FRIENDSHIPS 5.) PROVIDED A SAFE FORUM FOR ME 6.) HELPED ME TO SOLVE PROBLEMS IN MY LIFE 7.) HELPED ME TO DEAL WITH MY FAMILY AND FRIENDS 8.) HELPED ME TO OVERCOME STIGMA 9.) DID NOT HELP ME MUCH 10.) DID NOT HELP ME AT ALL 11.) JOINING THIS GROUP HURT ME (PLEASE PROVIDE EXPLANATION):_____
	How has this clinic helped with dealing with your economic status? ***Circle all that apply.***	1.) PROVIDED FREE MEDICINES 2.) PROVIDED FREE TESTING 3.) PROVIDED FREE HEALTH CHECK-UPS 4.) PROVIDED FREE LAB TESTS 5.) PROVIDED ACCESS TO SELF HELP GROUPS 6.) FACILITATED LINKAGES TO INCOME-GENERATING ACTIVITIES 7.) PROVIDED SOCIAL LINKAGES WITH OTHER CLINIC MEMBERS
	In general would you say your health is:	1.) EXCELLENT 2.) VERY GOOD 3.) GOOD 4.) FAIR 5.) POOR

	Compared to one year ago, how would you rate your health **now** in general?	1.) MUCH BETTER NOW THAN ONE YEAR AGO 2.) SOMEWHAT BETTER NOW THAN ONE YEAR AGO 3.) ABOUT THE SAME 4.) SOMEWHAT WORSE THAN ONE YEAR AGO 5.) MUCH WORSE NOW THAN ONE YEAR AGO		
	The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? ***Circle only one number on each line.***			
		Yes, Limited a Lot	Yes, Limited a Little	No, Not limited at All
	Vigorous activities: such as running, lifting heavy objects, participating in strenuous sports	1	2	3
	Moderate activities: such as moving a table, pushing a vacuum cleaner	1	2	3
	Lifting or carrying groceries	1	2	3
	Climbing several flights of stairs	1	2	3
	Climbing one flight of stairs	1	2	3
	Bending, kneeling or stooping	1	2	3
	Walking more than a mile	1	2	3
	Walking several blocks	1	2	3
	Walking one block	1	2	3
	Bathing or dressing yourself	1	2	3
	During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?			
		Yes	No	
	Cut down the amount of time you spent on work or other activities	1	2	
	Accomplished less than you would like	1	2	
	Were limited in the kind of work or other activities	1	2	
	Had difficulty performing the work or other activities (for example, it took extra effort to do your work)	1	2	
	During the last **four weeks**, have you had any of the following problems with your work or other regular daily activities as a result of any **emotional problems** (such as feeling sad or depressed)?			
		Yes	No	
	Cut down on the amount of time you spent on work or other activities	1	2	
	Accomplished less than you would like	1	2	
	Didn't do work or other activities as carefully as usual	1	2	
	During the last four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?	1.) NOT AT ALL 2.) SLIGHTLY 3.) MODERATELY 4.) QUITE A BIT 5.) EXTREMELY		
	How much bodily pain have you had during the past 4 weeks?	1.) NONE 2.) VERY MILD 3.) MILD 4.) MODERATE 5.) SEVERE 6.) VERY SEVERE		

	During the last 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	1.) NOT AT ALL 2.) A LITTLE BIT 3.) MODERATELY 4.) QUITE A BIT 5.) EXTREMELY
	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	1.) ALL OF THE TIME 2.) MOST OF THE TIME 3.) SOME OF THE TIME 4.) A LITTLE OF THE TIME 5.) NONE OF THE TIME

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks….

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
Did you feel full of pep and energy?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so sad that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt sad and depressed?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired	1	2	3	4	5	6

How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sicker a little easier than most people	1	2	3	4	5
I am as healthy as anybody I know	1	2	3	4	5

I expect my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5

Do you have anything else that you'd like to share with me regarding the care and support that you receive through this clinic?

ANNEX 9: STUDENT SURVEY

Student Survey

Questions	**Responses**
What is the name of the school you attend?	(Include a list of schools here)
How long have you been attending this school?	11.) LESS THAN 1 YEAR 12.) 1-2 YEARS 13.) 3-5 YEARS 14.) 6-10 YEARS 15.) 11 YEARS OR MORE
What grade do you currently attend?	8.) 6th 9.) 7th 10.) 8th 11.) 9th 12.) 10th 13.) 11th 14.) 12th
How old are you?	15.) 9 years or younger 16.) 10 17.) 11 18.) 12 19.) 13 20.) 14 21.) 15 22.) 16 23.) 17 24.) 18 25.) 19 or older
Are you a boy or a girl?	1.) GIRL 2.) BOY
Have you received education on HIV?	YES.....1 NO.....2 DON'T KNOW 8
If so, where did you receive this education? ***(Please circle all that apply.)***	1.) THROUGH THE SCHOOL I ATTEND 2.) HEALTH CLINIC 3.) COMMUNITY ORGANIZATION 4.) TELEVISION/RADIO 5.) FRIENDS 6.) FAMILY 7.) OTHER _____
If you received HIV education through the school which you currently attend, please rate how satisfied you were with this education.	1.) VERY SATISFIED 2.) SATISFIED 3.) SOMEWHAT SATISFIED 4.) SOMEWHAT UNSATISFIED 5.) VERY UNSATISFIED
Do you feel that you need more information on HIV beyond what you received in your session at the school?	YES.....1 NO.....2 DON'T KNOW 8
If so, what additional information would you like to receive?	_____
Do you feel that you are at risk of becoming infected with HIV yourself?	YES.....1 NO.....2 DON'T KNOW 8
Do you know how to protect yourself from HIV infection?	YES.....1 NO.....2 DON'T KNOW 8

How can a person protect him or herself from HIV infection? ***(Please circle all that apply.)***	1.) ABSTAIN FROM SEX 2.) BE FAITHFUL TO ONE PARTNER 3.) LIMIT NUMBER OF SEXUAL PARTNERS 4.) AVOID MOSQUITO BITES 5.) USE CONDOMS 6.) AVOID KISSING 7.) AVOID SEX WITH PROSTITUTES 8.) AVOID SEXUAL INTERCOURSE WITH PEOPLE WHO INJECT DRUGS 9.) AVOID BLOOD TRANSFUSIONS 10.) AVOID SEX WITH PERSONS OF THE SAME SEX 11.) AVOID INJECTION DRUGS 12.) AVOID SHARING RAZORS AND BLADES 13.) SEEK PROTECTION FROM TRADITIONAL HEALERS 14.) OTHER (SPECIFY):_____
If a mother is infected with the AIDS virus, is there any way to avoid transmission to the baby?	YES .....1 NO.....2 DON'T KNOW 8
Can a person who has AIDS be cured?	YES .....1 NO.....2 DON'T KNOW 8
What do you think are the reasons to get an HIV test? ***(Please circle all that apply.)***	MARRIAGE .....1 FAMILY PLANNING .....2 INSURANCE .....3 PLAN FOR THE FUTURE .....4 PROTECT PARTNER.....5 PROTECT CHILD.....6 IF I M SICK .....7 OTHER_____8 (SPECIFY) DON'T KNOW 9
What would be reasons <u>not</u> to get an HIV test? ***(Please circle all that apply.)***	LOSE JOB.....1 LOSE TERMINAL BENEFITS.....2 LOSE PENSION.....3 LOSE PARTNER.....4 FEAR OF KNOWING.....5 STIGMA.....6 OTHER_____7 (SPECIFY) DON'T KNOW 8
If you wanted an HIV test, where would you go? ***(Please circle all that apply.)***	HOSPITAL.....1 HEALTH CLINIC.....2 VCT CENTER.....3 OTHER_____.....4 (SPECIFY) DON'T KNOW 5

Who should go for an HIV test? ***(Please circle all that apply.)***	SEX WORKERS.....1 USERS OF SEX WORKERS.....2 DRIVERS, SOLDIERS, TRAVELLING SALES PERSONS, ETC. 3 ANYONE AT-RISK .....4 THOSE WITH MULTIPLE PARTNERS5 ANYONE SEXUALLY ACTIVE .....6 THOSE WHO ARE SICK.....7 THOSE GETTING MARRIED .....8 OTHER_____9 (SPECIFY) DON'T KNOW 10
Have you ever had sexual intercourse?	YES.....1 NO.....2 DON'T KNOW 8
When was the last time that you had sexual intercourse?	DAYS AGO..... 1 WEEKS AGO..... 2 MONTHS AGO ..... 3 YEARS AGO ..... 4 NEVER HAD SEX.....9
Have you had sexual intercourse in the past year?	YES.....1 NO.....2 DON'T KNOW 8
If so, how many people have you had sexual intercourse with?	1.) One 2.) Two 3.) Three 4.) Four or More 5.) Don't Know
Did you use a condom the last time that you had sexual intercourse?	YES.....1 NO.....2 DON'T KNOW.....8
If a relative of yours became sick with the AIDS virus would you be willing to care for him or her in your own household?	YES.....1 NO.....2 DON'T KNOW 8
If a teacher has the AIDS virus, but is not sick, should he or she be allowed to continue teaching in school?	YES.....1 NO.....2 DON'T KNOW 8
Would you play with a child who has HIV?	YES.....1 NO.....2 DON'T KNOW 8
Would you buy foods from a vendor who is HIV positive?	YES.....1 NO.....2 DON'T KNOW 8
If you were HIV positive, would you tell…	
Your family?	YES.....1 NO.....2 DON'T KNOW 8
Your friends?	YES.....1 NO.....2 DON'T KNOW 8
Your peers?	YES.....1 NO.....2 DON'T KNOW 8
Have your friends at school received HIV education and prevention information?	YES.....1 NO.....2 DON'T KNOW 8
Have you ever spoken to your friends about HIV prevention?	YES.....1 NO.....2 DON'T KNOW 8

If so, with how many of your friends have you spoken about HIV prevention?	1.) 1 2.) 2 3.) 3 4.) 4 5.) 5 or more 6.) None
Do you believe that any of your friends are engaged in risky behavior that might put them at risk of contracting HIV? ***(Please do not name any individual students.)***	YES.....1 NO.....2 DON'T KNOW 8
If so, what are these behaviors? ***(Please circle all that apply.)***	7.) ALCOHOL USE 8.) INJECTING DRUG USE 9.) OTHER DRUG USE 10.) TRANSACTIONAL SEX (RECEIVING GOODS OR SERVICES FOR SEX) 11.) RECREATIONAL SEX 12.) OTHER (SPECIFY): _____
Have your friends received information about these risky behaviors and HIV?	YES.....1 NO.....2 DON'T KNOW 8
If so, how often do they receive such information?	8.) DAILY 9.) WEEKLY 10.) MONTHLY 11.) QUARTERLY 12.) ANNUALLY 13.) EVERY TWO YEARS 14.) LESS THAN ONCE EVERY THREE YEARS
If your friends at school receive information about risky behaviors and HIV through your school, how would you rate the quality of this information?	10.) VERY GOOD 11.) GOOD 12.) AVERAGE 13.) POOR 14.) VERY POOR
Do you think that you need additional information about HIV?	YES.....1 NO.....2 DON'T KNOW 8
Do you think you have the ability to prevent yourself from becoming infected with HIV?	YES.....1 NO.....2 DON'T KNOW 8
In case you are confronted with a sex-related problem, is there anybody in your school who can help you with your problem?	YES.....1 NO.....2 DON'T KNOW 8
Do you have access to a counselor to discuss any issues or concerns you might have?	YES.....1 NO.....2 DON'T KNOW 8
If so, how often is the counselor available for you?	5.) DAILY 6.) WEEKLY 7.) MONTHLY 8.) OTHER:_____
Has your teacher discussed HIV prevention with you individually?	YES.....1 NO.....2 DON'T KNOW 8
Has your teacher discussed HIV prevention with your class?	YES.....1 NO.....2 DON'T KNOW 8
Have you ever discussed HIV with your parents or guardians?	YES.....1 NO.....2 DON'T KNOW 8

If you were being pressured to have sex, who would you seek advice or assistance from? (Please circle all that apply.)	1.) Parents 2.) Siblings 3.) Friends 4.) Teachers 5.) Counselors 6.) Religious leader 7.) Other (specify):_____
How comfortable are you with talking to the following people about HIV?	Very comfortable / Comfortable / Sometimes comfortable / Uncomfortable / Very uncomfortable
Parents	1 2 3 4 5
Siblings	1 2 3 4 5
Friends	1 2 3 4 5
Teachers Counselors	1 2 3 4 5
Religious Leaders	1 2 3 4 5
Other (specify)_____	1 2 3 4 5
Have you received education on drug abuse prevention?	YES.....1 NO.....2 DON'T KNOW 8
If so, where did you receive this education? ***(Please circle all that apply.)***	1.) THROUGH THE SCHOOL IN WHICH I ATTEND 2.) HEALTH CLINIC 3.) COMMUNITY ORGANIZATION 4.) TELEVISION/RADIO 5.) FRIENDS 6.) FAMILY 7.) OTHER_____
If you received drug use education through the school which you currently attend, please rate how satisfied you were with this education.	1.) VERY SATISFIED 2.) SATISFIED 3.) SOMEWHAT SATISFIED 4.) SOMEWHAT UNSATISFIED 5.) VERY UNSATISFIED
Do you feel that you need more information on drug abuse beyond what you received in your session at the school?	YES.....1 NO.....2 DON'T KNOW 8
If so, what additional information would you like to receive?	_
Have you ever spoken to your friends about drug abuse prevention?	YES.....1 NO.....2 DON'T KNOW 8
If so, with how many of your friends have you spoken about drug use prevention?	7.) 1 8.) 2 9.) 3 10.) 4 11.) 5 or more 12.) None
Have you ever taken drugs?	YES.....1 NO.....2 DON'T KNOW.....8
If so, how often do you take drugs?	1.) Daily 2.) Weekly 3.) Monthly 4.) Hardly ever 5.) Just once in experimentation
Have you ever injected drugs using a syringe?	YES.....1 NO.....2 DON'T KNOW.....8

If you were being pressured to use drugs, who would you seek advice or assistance from?	1.) Parents 2.) Siblings 3.) Friends 4.) Teachers 5.) Counselors 6.) Religious leader 7.) Other (specify):_____
How comfortable are you with talking to the following people about drug use?	Very comfortable / Comfortable / Sometimes comfortable / Uncomfortable / Very uncomfortable
Parents	1 2 3 4 5
Siblings	1 2 3 4 5
Friends	1 2 3 4 5
Teachers Counselors	1 2 3 4 5
Religious Leaders	1 2 3 4 5
Other (specify)_____	1 2 3 4 5
Do you know any local service organizations?	YES.....1 NO.....2 DON'T KNOW 8
Could you please list those that you know?	_____
Do you have any additional comments regarding the HIV and drug prevention program?	

ANNEX 10: YOUTH SURVEY

Questions	Responses
What is the name of the youth center/club you attend?	(Include a list of centers here)
How long have you been attending this center/club?	16.) LESS THAN 1 YEAR 17.) 1-2 YEARS 18.) 3-5 YEARS 19.) 6-10 YEARS 20.) 11 YEARS OR MORE
How old are you?	26.) 9 years or younger 27.) 10 28.) 11 29.) 12 30.) 13 31.) 14 32.) 15 33.) 16 34.) 17 35.) 18 36.) 19 or older
Are you a boy or a girl?	3.) GIRL 4.) BOY
Have you received education on HIV?	YES.....1 NO.....2 DON'T KNOW 8
If so, where did you receive this education? ***(Please circle all that apply.)***	1.) THROUGH THE YOUTH CLUB I ATTEND 2.) HEALTH CLINIC 3.) COMMUNITY ORGANIZATION 4.) TELEVISION/RADIO 5.) FRIENDS 6.) FAMILY 7.) OTHER _____
If you received HIV education through the youth club which you currently attend, please rate how satisfied you were with this education.	1.) VERY SATISFIED 2.) SATISFIED 3.) SOMEWHAT SATISFIED 4.) SOMEWHAT UNSATISFIED 5.) VERY UNSATISFIED
Do you feel that you need more information on HIV beyond what you received in your session at the youth club?	YES.....1 NO.....2 DON'T KNOW 8
If so, what additional information would you like to receive?	_____
Do you feel that you are at risk of becoming infected with HIV yourself?	YES.....1 NO.....2 DON'T KNOW 8
Do you know how to protect yourself from HIV infection?	YES.....1 NO.....2 DON'T KNOW 8
How can a person protect him or herself from HIV infection? ***(Please circle all that apply.)***	1.) ABSTAIN FROM SEX 2.) BE FAITHFUL TO ONE PARTNER 3.) LIMIT NUMBER OF SEXUAL PARTNERS 4.) AVOID MOSQUITO BITES 5.) USE CONDOMS 6.) AVOID KISSING 7.) AVOID SEX WITH PROSTITUTES 8.) AVOID SEXUAL INTERCOURSE WITH PEOPLE WHO INJECT DRUGS 9.) AVOID BLOOD TRANSFUSIONS 10.) AVOID SEX WITH PERSONS OF THE SAME SEX 11.) AVOID INJECTION DRUGS 12.) AVOID SHARING RAZORS AND BLADES 13.) SEEK PROTECTION FROM TRADITIONAL HEALERS 14.) OTHER (SPECIFY):_____

If a mother is infected with the AIDS virus, is there any way to avoid transmission to the baby?	YES .....1 NO .....2 DON'T KNOW 8
Can a person who has AIDS be cured?	YES .....1 NO .....2 DON'T KNOW 8
What do you think are the reasons to get an HIV test? ***(Please circle all that apply.)***	MARRIAGE .....1 FAMILY PLANNING .....2 INSURANCE .....3 PLAN FOR THE FUTURE .....4 PROTECT PARTNER.....5 PROTECT CHILD.....6 IF I M SICK .....7 OTHER_____8 (SPECIFY) DON'T KNOW 9
What would be reasons <u>not</u> to get an HIV test? ***(Please circle all that apply.)***	LOSE JOB.....1 LOSE TERMINAL BENEFITS.....2 LOSE PENSION.....3 LOSE PARTNER.....4 FEAR OF KNOWING.....5 STIGMA.....6 OTHER_____7 (SPECIFY) DON'T KNOW 8
If you wanted an HIV test, where would you go? ***(Please circle all that apply.)***	HOSPITAL.....1 HEALTH CLINIC.....2 VCT CENTER.....3 OTHER_____.....4 (SPECIFY) DON'T KNOW 5
Who should go for an HIV test? ***(Please circle all that apply.)***	SEX WORKERS.....1 USERS OF SEX WORKERS.....2 DRIVERS, SOLDIERS, TRAVELLING SALES PERSONS, ETC. 3 ANYONE AT-RISK .....4 THOSE WITH MULTIPLE PARTNERS5 ANYONE SEXUALLY ACTIVE .....6 THOSE WHO ARE SICK.....7 THOSE GETTING MARRIED .....8 OTHER_____9 (SPECIFY) DON'T KNOW 10
Have you ever had sexual intercourse?	YES .....1 NO .....2 DON'T KNOW 8
When was the last time that you had sexual intercourse?	DAYS AGO..... 1 WEEKS AGO..... 2 MONTHS AGO..... 3 YEARS AGO ..... 4 NEVER HAD SEX.....9

Have you had sexual intercourse in the past year?	YES.....1 NO.....2 DON'T KNOW 8
If so, how many people have you had sexual intercourse with?	6.) One 7.) Two 8.) Three 9.) Four or More 10.) Don't Know
Did you use a condom the last time that you had sexual intercourse?	YES.....1 NO.....2 DON'T KNOW.....8
If a relative of yours became sick with the AIDS virus would you be willing to care for him or her in your own household?	YES.....1 NO.....2 DON'T KNOW 8
If a teacher has the AIDS virus, but is not sick, should he or she be allowed to continue teaching in school?	YES.....1 NO.....2 DON'T KNOW 8
Would you play with a child who has HIV?	YES.....1 NO.....2 DON'T KNOW 8
Would you buy foods from a vendor who is HIV positive?	YES.....1 NO.....2 DON'T KNOW 8
If you were HIV positive, would you tell…	
Your family?	YES.....1 NO.....2 DON'T KNOW 8
Your friends?	YES.....1 NO.....2 DON'T KNOW 8
Your peers?	YES.....1 NO.....2 DON'T KNOW 8
Have your friends received HIV education and prevention information?	YES.....1 NO.....2 DON'T KNOW 8
Have you ever spoken to your friends about HIV prevention?	YES.....1 NO.....2 DON'T KNOW 8
If so, with how many of your friends have you spoken about HIV prevention?	13.) 1 14.) 2 15.) 3 16.) 4 17.) 5 or more 18.) None
Do you believe that any of your friends are engaged in risky behavior that might put them at risk of contracting HIV? ***(Please do not name any individual students.)***	YES.....1 NO.....2 DON'T KNOW 8
If so, what are these behaviors? ***(Please circle all that apply.)***	13.) ALCOHOL USE 14.) INJECTING DRUG USE 15.) OTHER DRUG USE 16.) TRANSACTIONAL SEX (RECEIVING GOODS OR SERVICES FOR SEX) 17.) RECREATIONAL SEX 18.) OTHER (SPECIFY): _____
Have your friends received information about these risky behaviors and HIV?	YES.....1 NO.....2 DON'T KNOW 8

If so, how often do they receive such information?	15.) DAILY 16.) WEEKLY 17.) MONTHLY 18.) QUARTERLY 19.) ANNUALLY 20.) EVERY TWO YEARS 21.) LESS THAN ONCE EVERY THREE YEARS
If your friends receive information about risky behaviors and HIV through your youth center, how would you rate the quality of this information?	15.) VERY GOOD 16.) GOOD 17.) AVERAGE 18.) POOR 19.) VERY POOR
Do you think that you need additional information about HIV?	YES.....1 NO.....2 DON'T KNOW 8
Do you think you have the ability to prevent yourself from becoming infected with HIV?	YES.....1 NO.....2 DON'T KNOW 8
In case you are confronted with a sex-related problem, is there anybody who can help you with your problem?	YES.....1 NO.....2 DON'T KNOW 8
Have you ever discussed HIV with your parents or guardians?	YES.....1 NO.....2 DON'T KNOW 8
If you were being pressured to have sex, who would you seek advice or assistance from? (Please circle all that apply.)	8.) Parents 9.) Siblings 10.) Friends 11.) Teachers 12.) Counselors 13.) Religious leader 14.) Other (specify):_____
How comfortable are you with talking to the following people about HIV?	Very comfortable / Comfortable / Sometimes comfortable / Uncomfortable / Very uncomfortable
Parents	1 2 3 4 5
Siblings	1 2 3 4 5
Friends	1 2 3 4 5
Teachers Counselors	1 2 3 4 5
Religious Leaders	1 2 3 4 5
Other (specify)_____	1 2 3 4 5
Have you received education on drug abuse prevention?	YES.....1 NO.....2 DON'T KNOW 8
If so, where did you receive this education? ***(Please circle all that apply.)***	1.) THROUGH THE YOUTH CENTER 2.) HEALTH CLINIC 3.) COMMUNITY ORGANIZATION 4.) TELEVISION/RADIO 5.) FRIENDS 6.) FAMILY 7.) OTHER _____
If you received drug use education through the youth center which you currently attend, please rate how satisfied you were with this education.	1.) VERY SATISFIED 2.) SATISFIED 3.) SOMEWHAT SATISFIED 4.) SOMEWHAT UNSATISFIED 5.) VERY UNSATISFIED
Do you feel that you need more information on drug abuse beyond what you received in your session at the youth center?	YES.....1 NO.....2 DON'T KNOW 8
If so, what additional information would you like to receive?	_

Have you ever spoken to your friends about drug abuse prevention?	YES.....1 NO.....2 DON'T KNOW 8
If so, with how many of your friends have you spoken about drug use prevention?	19.) 1 20.) 2 21.) 3 22.) 4 23.) 5 or more 24.) None
Have you ever taken drugs?	YES.....1 NO.....2 DON'T KNOW.....8
If so, how often do you take drugs?	6.) Daily 7.) Weekly 8.) Monthly 9.) Hardly ever 10.) Just once in experimentation
Have you ever injected drugs using a syringe?	YES.....1 NO.....2 DON'T KNOW.....8
If you were being pressured to use drugs, who would you seek advice or assistance from?	8.) Parents 9.) Siblings 10.) Friends 11.) Teachers 12.) Counselors 13.) Religious leader 14.) Other (specify):_____
How comfortable are you with talking to the following people about drug use?	Very comfortable / Comfortable / Sometimes comfortable / Uncomfortable / Very uncomfortable
Parents	1 2 3 4 5
Siblings	1 2 3 4 5
Friends	1 2 3 4 5
Teachers Counselors	1 2 3 4 5
Religious Leaders	1 2 3 4 5
Other (specify)_____	1 2 3 4 5
Do you know any local service organizations?	YES.....1 NO.....2 DON'T KNOW 8
Could you please list those that you know?	_____

Do you have any additional comments regarding the HIV and drug prevention program?

ANNEX 11: KEY INFORMANT INTERVIEWS WITH PROJECT STAFF

There are approximately 25 questions to be used in these sessions. Each interview should take approximately 1.5 hours. While this questionnaire serves as a guide for this interview, each interviewer should feel free to ask follow-up questions if needed.

Interviewer: Please ensure that each informant understands the purpose of the interview and that their answers will be used to improve the next phase of PANI. Please ensure them of the confidentiality of their answers and that their answers will not be shared with their supervisors in any way that can be linked back to them.

Questions:

13.) Please tell me about your involvement with the PANI project over the past years?

14.) What do you think about how CRS is structured for the PANI project? (Probe for management structure, financial set-up, M&E, enough staffing, etc.)

15.) What are the major hurdles that PANI faces? (Probe for management issues, finance and reporting, etc.)

16.) Looking back, how did the project change over time from what you first envisioned? (Probe to see how partners were included in project design and adaptation over time.)

17.) Are the objectives and goal of PANI II realistic considering your current resource levels (i.e. financial and human)?

18.) Describe the partnership of CRS with its PANI partners. (Probe for frequency of visits, technical assistance, trainings, networking opportunities, etc.)

    i. If CRS provided trainings (even if not directly), how would you describe the quality of these trainings?

19.) Where should CRS focus its efforts for improving PANI over the next phase of the project?

20.) What limitations have you faced in the implementation of PANI? (Probe for external limitations such as stigma in the community and internal limitations such as staffing issues at CRS or the partner level)

21.) Have there been any unintended positive or negative effects of the project? (Probe for unplanned events such as community becoming more involved, resentment of those in the project, etc.)

22.) Are there any gaps in the project? How could those be filled?

23.) What are the strengths of the project and why are those portions working so well?

24.) Are there any portions of the program that are more sustainable over time than others? (Probe for any sustainability planning or exit strategies.)

25.) If you had unlimited funding, would you change anything in the project? Please explain. (Probe to see if there are clear gaps in the current program that impact the quality or if there would just be an increase in scope, etc.)

Any Additional Information from the Interview: