

**“Vulnerability and the HIV Epidemic in
Bangladesh, Cambodia and Sri Lanka”
- The Role of Participatory Community
Assessments in Mobilising and Developing
More Effective HIV Prevention**



This report is based on the work of the following organisations:

Bangladesh

Alliance linking organisation: HIV/AIDS STD Alliance of Bangladesh (HASAB) NGO Support Programme

HASAB partner NGOs:

- Community Development Centre (CDC)
- Nari Unnayan Shakti (NUS)
- Jatiya Tarun Sangha (JTS)
- UJON Sk
- Voluntary Association for Rural Development (VARD)
- Polianpur Tarun Krishi Club (PTKC)
- Nabolok Parishad
- Community Development Foundation (CDF)
- Young Power in Social Action (YPSA)
- SHEASS – Bangladesh
- Association for Community Development (ACD)

Cambodia

Alliance linking organisation: Khmer HIV/AIDS NGO Alliance (KHANA)

KHANA partner NGOs:

- Kasekor Thmey
- National Prosperity Association (NAPA)
- Development Association of Cambodia (DAC)
- Cambodia Community Development Organisation (CCDA)
- Human Rights Protection & Rural Development Association (HURIPRUDA)
- Cambodian Children Against Starvation and Violence Agency (CCSVA)
- Rural Economic Development Association (REDA)
- Cambodian Development and Relief Centre for the Poor
- Cambodia Women's League for Development (CWLD)
- Cambodia Health Committee (CHC)
- Khmer Buddhist Association (KBA)
- Social Environment Agricultural Development Organisation (SEADO)
- Rural Family Development (RUFADe)
- Khmer Rural Development Association (KRDA)
- Battambang Women's AIDS Project (BWAP)
- United Neutral Khmer Students (UNKS)
- Indradevi Association (IDA)
- United Cambodian Community (UCC)

Sri Lanka

Alliance linking organisation: Alliance Lanka

Alliance Lanka partner NGOs:

- Seva Lanka Foundation
- Institute of Vocational Health
- Community Development Cluster

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This report benefited from the views and experiences of many different people at the International HIV/AIDS Alliance and linking organisations in Bangladesh, Cambodia and Sri Lanka. The lead author was Alan Greig.

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1. Introduction

1.1 The Alliance

The International HIV/AIDS Alliance is an international non-governmental organisation (NGO) established in 1993 to support community action on AIDS in developing countries.

Mission Statement

The mission of the International HIV/AIDS Alliance is to enable communities in developing countries to play a full and effective role in the global response to AIDS. The Alliance accomplishes this by mobilising a broad range of non-governmental and community groups, increasing their access to resources at a local level, and enhancing their technical and organisational skills. The Alliance also supports groups to share lessons learned, to collaborate with others, and to have a voice in national and international policy development. In this way, the Alliance encourages creative prevention and care efforts that respond to the real needs of communities, are owned by local people and have a sustainable impact.

In many countries, the Alliance works with and through one primary partner NGO in order to facilitate a broad response to the HIV/AIDS epidemic. These partner groups - known as “linking organisations” - facilitate collaborative planning and priority setting within the NGO sector responding to AIDS, and help other NGOs and community groups access technical, financial and management support in order to more effectively implement prevention and care initiatives.

1.2 This report

The explosive HIV epidemics in South and South-East Asia are highlighting the limitations of the current emphasis on information, education and communication (IEC) for awareness-raising. Through its work in Bangladesh, Cambodia and Sri Lanka, the Alliance recognises that more effective HIV prevention approaches depend on developing strategies that respond to the complexity and specificity of individual and community vulnerabilities to HIV infection. Community participation in all stages of project design, implementation and evaluation is critical to the quality and sustainability of such responses.

The Alliance has focused on strengthening participatory approaches to community assessment prior to project design as a critical step in the process of developing more responsive and sustainable HIV prevention strategies. The Alliance seeks to better understand community vulnerability, and in particular issues of gender, sexuality and sexual health, and to mobilise community action on the HIV epidemic. This has led the Alliance and its partners to adapt and refine a set of assessment tools and techniques to enhance and expand the participation of communities in the analysis of problems relating to HIV prevention and the design of appropriate responses. During 1997-8, The

Japanese Foundation for AIDS Prevention supported the Alliance and its partner linking organisations and NGOs in Bangladesh, Cambodia and Sri Lanka in conducting some 50 participatory community assessments with marginalised and vulnerable communities. The assessments were intended to:

- Mobilise communities;
- Strengthen links between communities and NGOs; and
- Enable NGOs, in partnership with communities, to develop effective HIV prevention strategies linked to broader issues of gender, sexuality and sexual health.

This report summarises the assessment methods and their results, comparing differing techniques and processes, and exploring the links between varied processes and the research outcomes. In synthesising their findings, the report discusses the implications of participatory community assessments for more effective HIV prevention strategies and their impact on the design, implementation and evaluation/redesign of HIV prevention projects. The report draws lessons from both the processes and outcomes of the assessments and provides recommendations for improving the effectiveness of a participatory community assessment process.

As a research study, this report is designed to be of particular interest to policy-makers and donor agencies, as well as other NGOs and agencies responding to HIV/AIDS in the Asia region and internationally.

2. Participatory Practice in Community Assessments

“People liked to work with us, we had good communication with them and the community leaders helped us to gather the people and facilitated our work.”

Cambodia Women’s League for Development

2.1 Rationale

Communities possess an understanding of themselves and a capacity to change themselves. This central premise of the Alliance’s participatory community assessment process is supported by a long history of community development practice and theories of social change. The HIV epidemic is largely a problem “of community” - of the values, structures and histories which shape relations between people in communities and which determine their vulnerability to HIV infection. It is also important to consider the impact of external factors such as economic trends, conflict and patterns of migration and mobility. The participation of communities in assessing their own HIV-related situation is essential to asking more useful questions, generating more detailed answers and mobilising communities to reflect and take action to respond to the HIV epidemic themselves.

But who is part of the community and who should take part in the assessment? Communities are not single entities, but groups representing different identities, interests and ideas. People can be part of a geographically defined community and also experience other forms of “community” – defined, for example, by gender, ethnicity, age or occupation. The participatory community assessments supported by the Alliance were sensitive to the way that power relations within communities can marginalise and silence people because of their gender, age, marital status, sexual orientation, and socio-economic class.

NGOs’ decisions on who to include in their assessments took account of the effects of these power relations. In Cambodia, each NGO divided its target community into six groupings according to a range of factors, such as gender, age, marital status and, less often, occupation. Working in ‘peer’ groups in this way helped to create a safer environment for women, especially unmarried women, to participate in discussions about sexual health, sexuality and gender relations. Some NGOs sought ways to involve community members in decisions on who to include in the assessments. In Bangladesh, for example, NGO staff identified key informants within the community who could help them identify an appropriate variety of individuals to take part in the assessment.

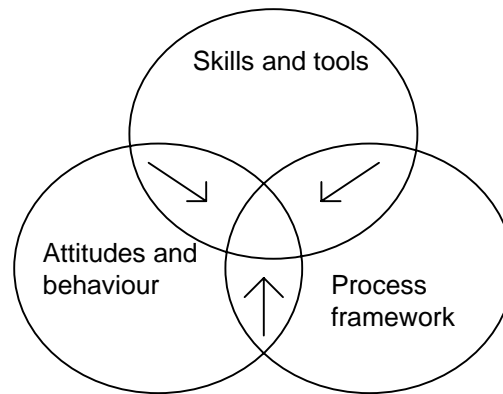


Rural women using a timeline exercise to assess patterns of community needs, behaviours and resources in Cambodia.

Through the work of its linking organisations and partner NGOs who supported and conducted participatory community assessments in Bangladesh, Cambodia and Sri Lanka, the Alliance has identified three core, interdependent, elements that are important to the success of participatory community assessment practice. These are the:

- Attitudes and behaviour of those carrying out the assessment;
- Skills and tools used in the assessment; and
- Process frameworks within which the tools are used.

Core elements of participatory community assessment practice



(Reference: Adapted from "Visit to Sri Lanka, 12-21 1997: Report on a PRA Workshop for Sexual Health Needs Assessment", International HIV/AIDS Alliance).

2.2 Attitudes and Behaviour

Drawing from the experience of the NGO staff conducting assessments in Bangladesh, Cambodia and Sri Lanka, the *attitudes* among staff that appear to be most important to promoting community participation in the assessment process include:

- A desire to build a strong relationship with the community;
- A respect for communities;
- A belief in the expertise that communities possess about their own lives; and
- A sensitivity to the power dynamics and inequalities that exist within communities and between communities and NGO staff.

For many of the NGOs concerned, the question of building a relationship with the community was made easier because they already had links through their existing work. This was true in Cambodia, where most of the NGOs selected to take part in the assessment process were already carrying out community development work in their communities. Even so, each NGO made careful preparations for the assessment by meeting with community leaders, explaining the purpose and process of the assessment, and seeking specific permission for it. These preparations were important in alleviating people's fears and suspicions. For example, the Sevalanka Foundation, working in Anuradhapura, Sri Lanka, reports that: *"There was suspicion, among some persons, at the beginning that the purpose was to suppress, through legal means, illicit taverns*

and prostitution by obtaining information about them. Nevertheless, they became enthusiastic in providing the information after the purpose was made clear by us.”



Members of the Sri Lanka Tamil Rural Women’s Network discussing community needs with Women in Nuwara Eliya District, Sri Lanka.

All of the NGOs which conducted participatory assessments took great pains to consult with communities to identify the best places for the work to be carried out. Difficulty getting community members involved was the most frequently mentioned problem in the assessment reports, and one which was usually overcome by being prepared to work late into the night in the homes and public spaces of the community. This flexibility on the part of NGO staff clearly contributed to creating the climate of trust necessary to engage community members in the assessment process. An attitude of respect toward the community was also critical. The Community Development Centre, working in Bagherhat district in Bangladesh, reported that the participatory assessment process *“has helped mobilise several groups in the village...[and] is working in this village with respect and dignity, and has created an enabling environment for working in the village.”*

In some cases, this ‘enabling environment’ was also helped by the community grounding of the NGOs. As Md. Shah Newaz Selim, a Community Educator with Association for Community Development in Bangladesh, points out: *“One important thing is that we are all ourselves from the community...not outsiders from somewhere else. Our families and peers know what we are doing.”* More commonly, however, NGO staff conducting the assessments were outsiders to the communities in which they were working. Sensitivity to the many possible facets of being an “outsider” (e.g. different educational and class backgrounds), and their implications for the assessment process is very important.

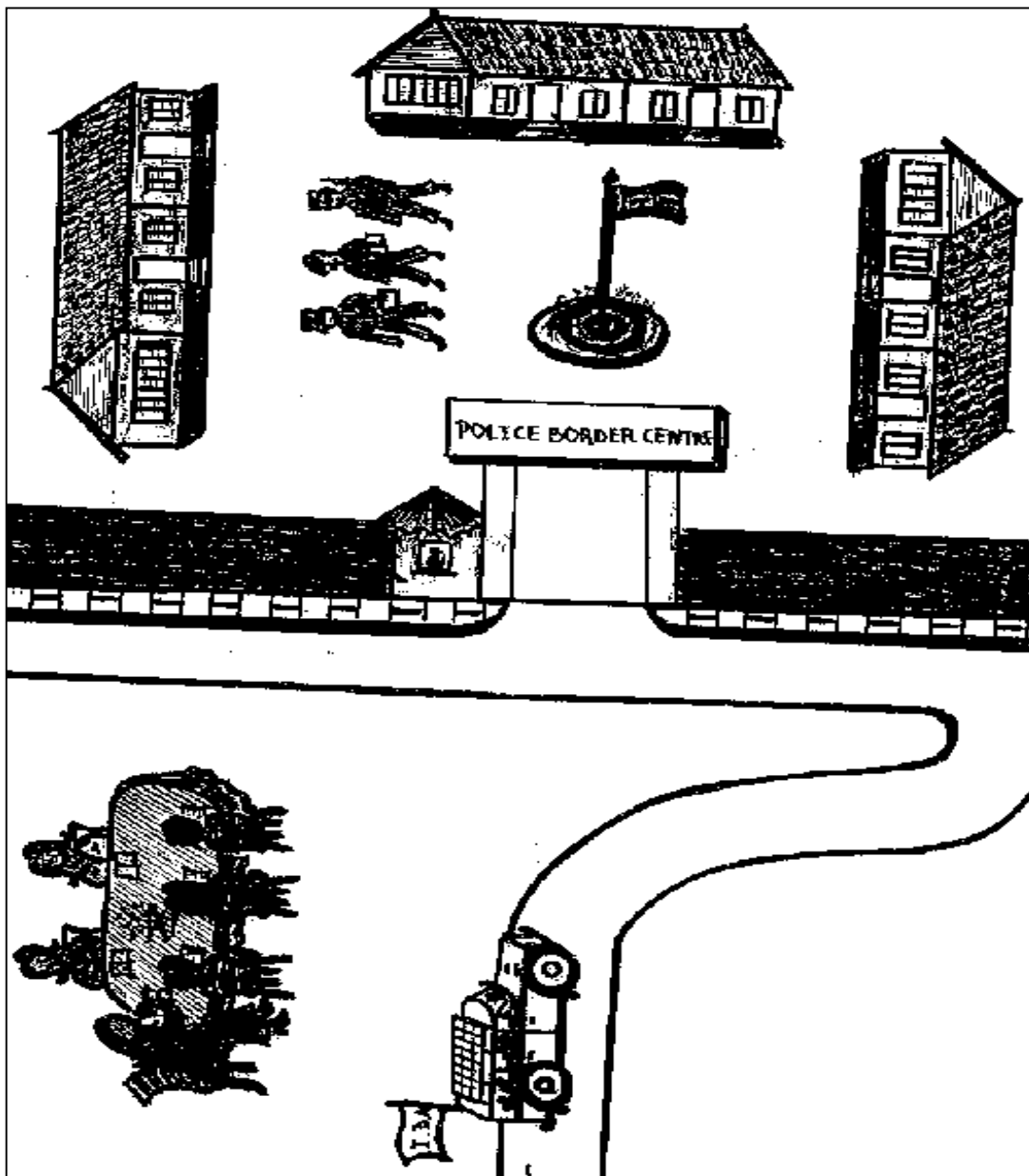


Diagram produced by the Indradevi Association, Cambodia, showing how the NGO is viewed as an outsider by the community.

Alliance technical support focused on this issue, for example by stressing the importance of non-verbal statements such as sitting in a circle at the same level as community members during the assessments. KHANA's workshop on Participatory Community Assessments for partner NGOs emphasised the 'facilitating' role that NGO staff should play; in other words, facilitating the community's own assessment of itself rather than leading the assessment from outside (and from an outsider's perspective).

Participatory Attitudes and Behaviour

In order to be able to facilitate participatory community assessments, it is sometimes necessary to “unlearn” existing attitudes. Mallika Samaranayake, Director of the Institute of Participatory Interaction in Development in Sri Lanka, described this process of unlearning at a workshop for Alliance Lanka partner NGOs:

- Sit down with the community; listen, learn, respect;
- Use your own best judgement at all times;
- Believe that the community can do their own work and can understand their own needs; and
- Relax; be humble, accept and admit your mistakes; embrace error in order to learn.

(Reference: Alliance Lanka PRA workshop for Sexual Health Needs Assessment, February 14-19 1997, Colombo, Sri Lanka).

2.3 Skills and Tools

Strengthening this facilitating role of NGOs in the participatory community assessment process was a key emphasis of the Alliance's *skill* development work. Training workshops in Sri Lanka and Cambodia, which prepared NGOs for their assessments, discussed and rehearsed facilitation skills, such as active listening, open questioning, and maximising group participation. In Cambodia, KHANA encouraged each NGO to set itself a team contract, which would stipulate key aspects of its participatory approach, and against which each NGO could assess its own performance. These contracts proved to be a valuable reminder of the participatory attitudes and skills discussed during the workshop and helped to reinforce the whole staff's commitment to implement them during the assessment.

Team Contract for Working with Community

Kasekor Thmey, an NGO working in Kampong Cham province in Cambodia, drew up the following team contract for conducting its assessment:

1. Introduce each other to the community.
2. Explain the purpose of the assessment.
3. Facilitate the assessment process.
4. Don't interrupt people while they are talking.
5. Be friendly with people.
6. Allow opportunities for people to fully express themselves.
7. Listen actively to people while they are speaking.
8. Encourage people and thank them.

The Alliance has also focused on adapting and refining a set of assessment *tools* which promote community participation. The principal method used in Bangladesh, the first country to conduct community assessments, was the semi-structured interview. Careful pre-testing of the questionnaire ensured a degree of

community contribution to the decisions on the range and types of questions to be asked.



Centre for Rural and Social Development (CRSD) using Semi-Structured Interviews during their community assessment among rickshaw pullers' wives in Sutrapur and Kotowali Thana districts of Dhaka, Bangladesh.

However, the limitations to community participation implied by the interview format became evident in these early assessments. Such a format tended to fix the roles of the NGO and community members as “providers” of information, thus reinforcing rather than challenging the separation and power imbalance between the two. The use of tape recorders and/or individual staff to take notes emphasised this imbalance (literally, in some cases, by outnumbering the interviewees.) The emphasis on recording information and then taking it away to be analysed and returned to the community as a set of conclusions also risked undermining the partnership between communities and NGOs in the assessment process and did not draw on the community’s own ability to analyse and make sense of their own experience.

For these reasons, the Alliance adapted and refined other tools – and frameworks in which to use them - which more consciously promote community participation in the assessment process. Drawn from community development work, many of these tools were initially developed for and identified with Participatory Rural Appraisal (PRA).

Why PRA?

“PRA methodologies build on existing knowledge within the community, and then use that information to identify needs and solutions. In this sense, PRA is more responsive and flexible to both immediate and changing needs. In collecting information, PRA methodologies do not focus on absolutes, but rather assess approximates. This is particularly useful in sexual health, given the fact that often there are no “right” answers and many different experiences to take into account. Often, PRA will force the development worker to go beyond their assumptions and see things from the community’s perspective.

The principles underlying PRA include: openness; assessing the reality of the situation; accepting that as development workers, we do not know nor do we have to know everything; respecting diversity within communities; identifying specific solutions from information generalised by specific communities; and assisting in the collection of data, but giving up ownership of the process and the information to the community.”

(Reference: Report on “Visit to Sri Lanka, 12-21 1997: Report on a PRA Workshop for Sexual Health Needs Assessment“, International HIV/AIDS).

The different techniques and tools which comprise PRA and which have been used by the Alliance in assessment work will be discussed in more detail in the next section, which looks at assessment of vulnerability to HIV. This section will concentrate on the ways in which PRA tools have enhanced community participation in the assessment process.

PRA’s emphasis on drawing and diagramming has proved to be effective in stimulating discussion of what can often be sensitive issues around sexual health. In part, this is because the drawings and diagrams themselves become the focus of discussion rather than group members’ own personal experiences, knowledge or views. NGOs in Cambodia worked with small groups of community members (divided by gender and marital status) to develop ‘typical person vulnerability profiles’ and found that this enabled group members to discuss issues of vulnerability to HIV in relation to people ‘like them’, without having to discuss their own experience of vulnerability and HIV-related risk behaviour.

The Alliance has also found that the process of creating diagrams and drawings can promote the sharing of community knowledge and expertise, rather than its extraction. The drawings and diagrams also provide a continuing, and accessible, record of community discussions which remain within the community and have been used by community members to educate others about the assessment process.

PRA methods have also provided structured ways for the community to assess the specific contexts in which HIV transmission takes place. Tools have been used to explore situational risks and resources, trends over time, causal relationships, differentiation by age, gender and wealth, and to rank problems

and responses. In this way, PRA tools help not only to elicit information but can also be used to facilitate its analysis by and with the community.

The accessibility and ready applicability of PRA tools were appreciated by NGO staff. During a closing evaluation of a training, one NGO staff member said that *“she had been going to workshops since 1993, but this was the first time she had been given something she could take straight back to use with her community to their benefit.”*

Community members also responded well to the PRA tools, in spite of some initial reluctance to draw and diagram, for fear that their work would not be good enough.

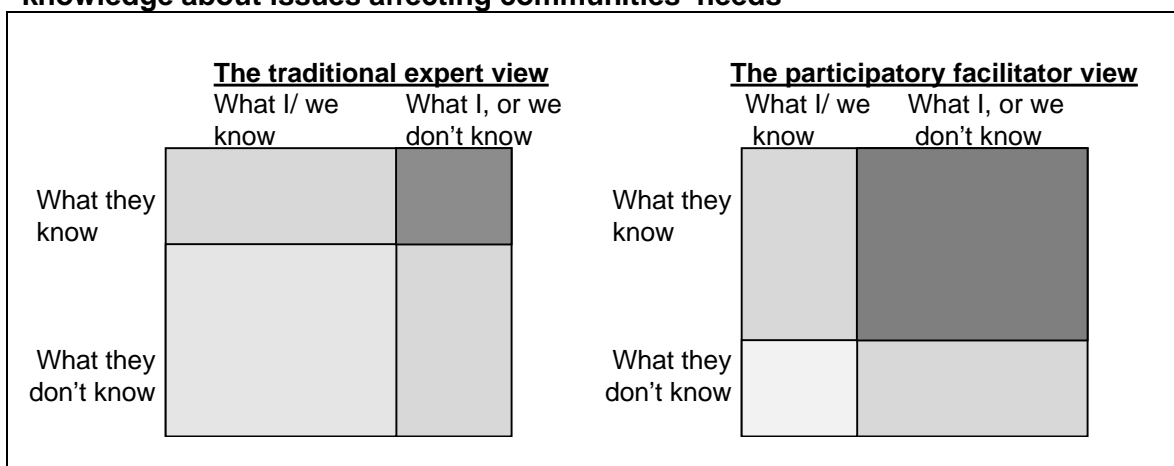


NGO Workers in Sri Lanka putting the Community Mapping Tool into Practice among Community Members.

2.4 Processes and Frameworks

As described above, the mere use of these tools in a sensitive and appropriate manner can cause shifts in perceptions as well as spark off participatory processes in different ways. However, the effectiveness of the methods themselves can also be further enhanced by adopting enabling frameworks and processes from the outset. To begin with, there is often a need to revise our own conceptual framework of who are the experts, what the role of the outsider is and whose knowledge really counts. This can be reflected in the "Johari Window", which illustrates how 'experts' in the development field have often assumed that the knowledge of development workers was greater than that of communities. For truly participatory processes to work, this view by and large needs to be reversed and the relevance of the knowledge that communities have needs to be recognised as the basis for the work.

The Johari window: a shift in framework regarding ‘who’ holds the most relevant knowledge about issues affecting communities’ needs



Within this conceptual framework, or working philosophy, there are a number of other fundamental shifts in outlook affecting how we think of the processes and frameworks defining the way we work.

These include shifting:

From:

- Outside experts
- Extracting information/data
- Local informants
- Providing conclusions for locals
- Determined end-points
- Linear process
- Reductivist analysis
- Standardised information

To:

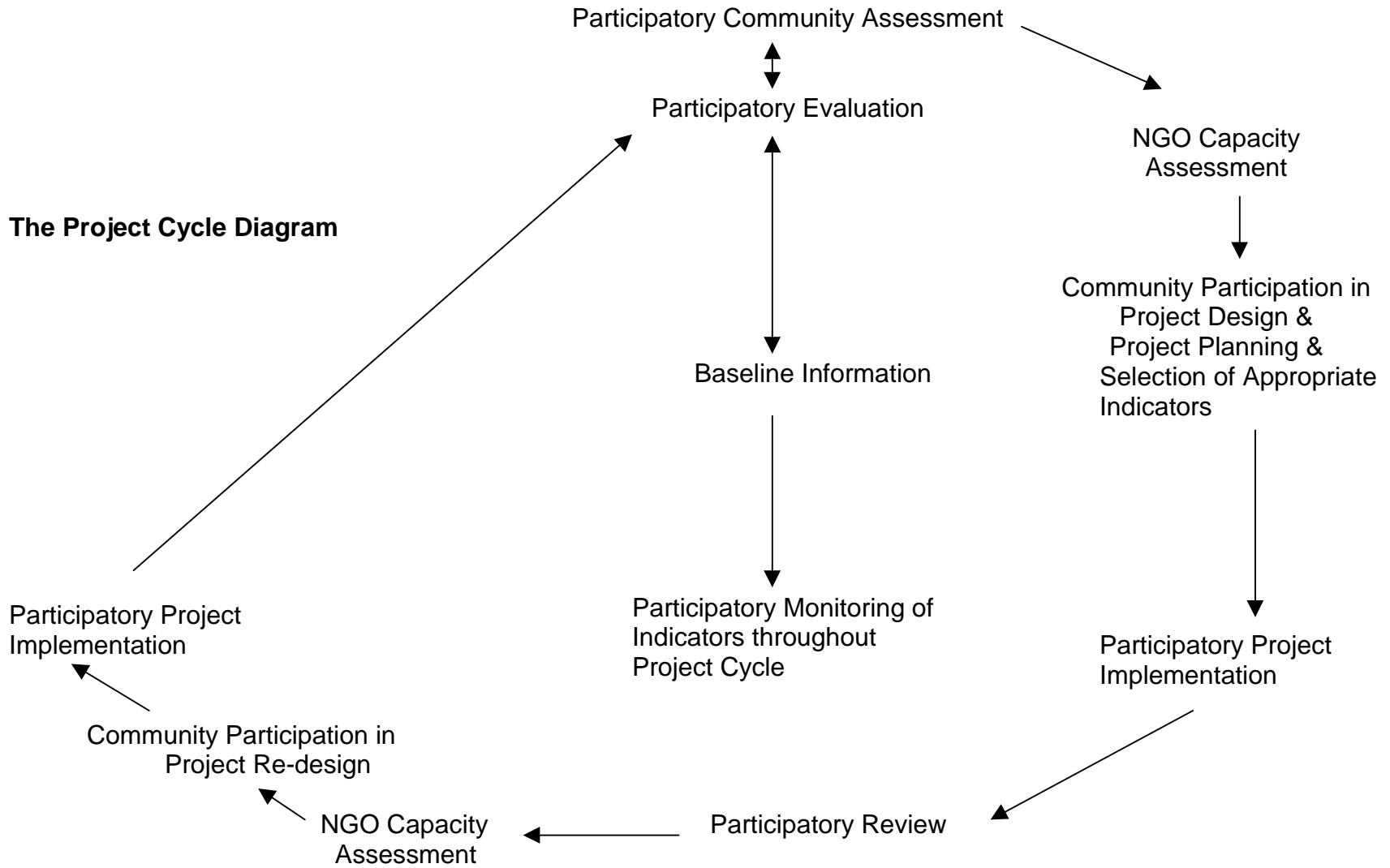
- ⇒ Local and outside facilitators
- ⇒ Giving up information ownership
- ⇒ Community analysts
- ⇒ Providing constructive questions
- ⇒ Open-ended
- ⇒ Cyclical/iterative process
- ⇒ Holistic analysis
- ⇒ Locally specific information

Rather than thinking about these community assessments simply as situation assessments prior to project design by NGOs, they often formed a starting point for longer interactive processes, where project responses were jointly identified and tried out, then reviewed in order to revise project strategies and approaches. Whilst the “Logical Framework” was a useful tool for some facilitators (in, for example helping groups turn around problem assessment trees into strategic project solutions), it was not used as a means of introducing standardised ‘indicators’ (as is often the case, in reproductive health work). Rather than providing NGOs with pre-defined objectives and indicators, linking organisations helped them work out their own objectives, as well as formulating ‘what it would mean to succeed?’ and ‘how that could be determined?’ at the local level.

In other words, the classical 'intervention project' framework (project design, followed by baseline survey, implementation, monitoring and evaluation), was set aside in favour of encouraging NGOs to work with their communities on the basis of their joint assessments, learn from their implementation, to then jointly review and revise strategies. In some cases, this could lead to more in-depth processes of evaluation in the longer term, though not necessarily. The important point was to adapt the process to the capacity and situation of the local NGOs and their communities, in order to make it appropriate and allow for effective participation. The project cycle figure, below, describes how the project cycle has evolved between HASAB and its partner NGOs in Bangladesh.

The experiences of the Alliance's partners in Bangladesh, Cambodia and Sri Lanka showed that an essential role for NGO support organisations is thus to act as an interface between the often more rigid processes and frameworks of donor organisations and the more participatory and flexible working practices needed by local NGOs and CBOs. They also hold a responsibility for minimising the sense in which the more structured frameworks and contracting cycles of donors impose rigidity and 'constraints', and instead translating that into planning participatory processes in structured and well-sequenced ways, to allow for a definition of responses from the grass-roots up.

The Project Cycle Diagram



3. Assessment of Vulnerability to HIV

3.1 Vulnerability and needs

The Alliance works with the concept of 'vulnerability' to encompass the varying factors that contribute to the spread of HIV and the range of responses that they necessitate. Prevention efforts that focus solely on individual decision-making are inadequate in the face of behaviours that result from complex interactions between individuals and their environments. The idea of vulnerability, which may be applied at the level of individuals, families or societies, seeks to illuminate the importance of these environments and the differential risk of exposure to HIV infection that they create.

The experience of the Alliance and its partners in conducting participatory assessments of community vulnerability in order to design more effective HIV prevention projects has helped to refine the traditional idea of the 'needs assessment.' In Bangladesh, the scope of the assessments was broad, asking communities about their general needs and life concerns. Assessment of these general needs was important in two ways to the elaboration of more relevant HIV prevention strategies. Firstly, it helped NGOs and communities explore the links between the HIV epidemic and the reality of people's lives, allowing for a more complex understanding of why and how HIV transmission occurs. Secondly, it highlighted the immediate and important concerns and aspirations of communities, responding to which could enhance the NGOs' credibility and relationship with their target communities.

Objectives of Assessment

The Voluntary Association for Rural Development (VARD) in Bangladesh listed the following objectives for its participatory assessment with rickshaw pullers in two villages in Sylhet:

1. To find out the way of living of the rickshaw pullers.
2. To get information about their income level, marital status and social position.
3. To identify the needs and problems of the rickshaw pullers.
4. To carry out a qualitative and participatory action research on the prevailing values, social, personal, environmental, gender issues as well as superstition, misconceptions of the rickshaw pullers.
5. To assess the health problems of the rickshaw pullers including common disease pattern and their access to health facilities.
6. To find out the behaviour pattern, including sexual behaviour pattern, of the target community.
7. To obtain information about the knowledge of the community on STDs/AIDS and condoms.

But there were problems with this approach too. Asking communities about their perceived, priority needs raised expectations that the NGOs were not able to

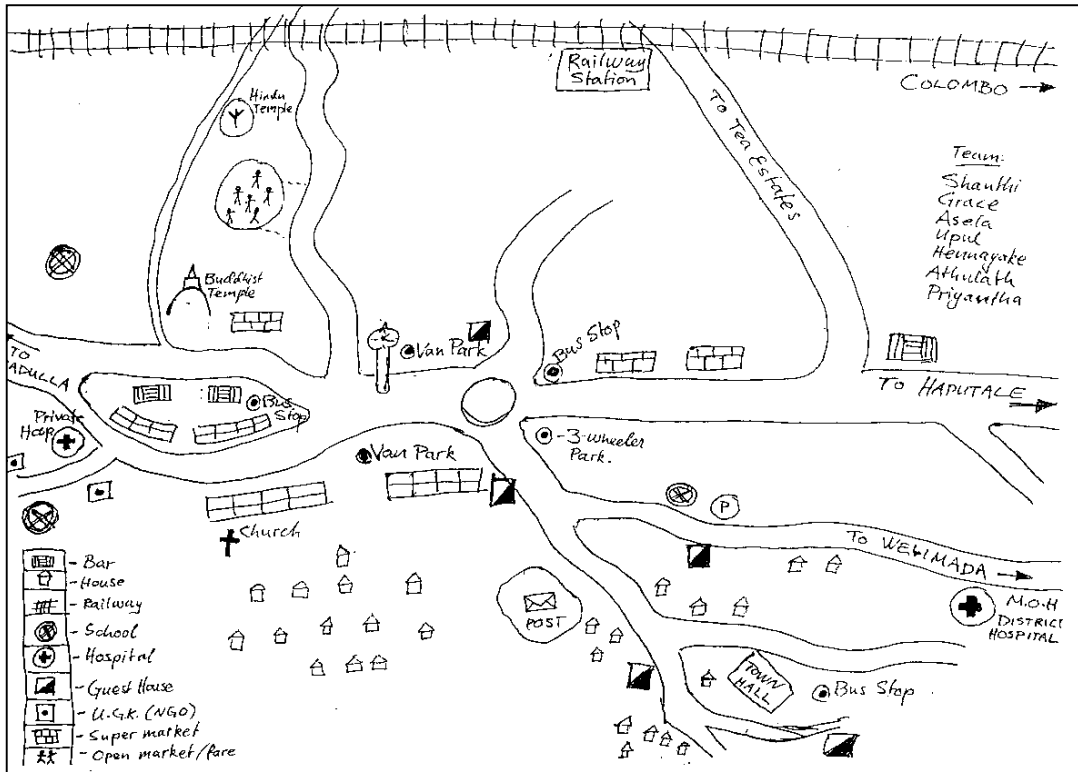
respond to. As the Voluntary Association for Rural Development, in Bangladesh, noted: *“It was a problem that the community had different expectations regarding the project activities which was solved through highlighting clearly the objective and goal of the project to them.”* The explicit HIV/AIDS funding for the projects necessarily constrained their scope and mandate. Alliance technical support now emphasises the importance of clarifying both the objectives and scope of the assessment and the expectations of communities, and of finding a “fit” between the two.

As the practice of Alliance-supported participatory community assessment has evolved, the ‘needs’ focus of the assessments has come to be defined in relation to the question: What needs to be done to reduce vulnerability to HIV infection? Typically, this has involved an exploration with communities of their perceived needs in relation to their sexual health and HIV prevention, discussion of issues relating to gender and sexuality, as well as an identification of resources and discussion of priorities. The scope of assessments has specifically related to understanding factors of vulnerability and possible responses to them. There are two aspects of the assessment process that are especially important to understanding of vulnerability:

- The type of assessment tools used; and
- The sequencing of those tools.

3.2 Type of assessment tools

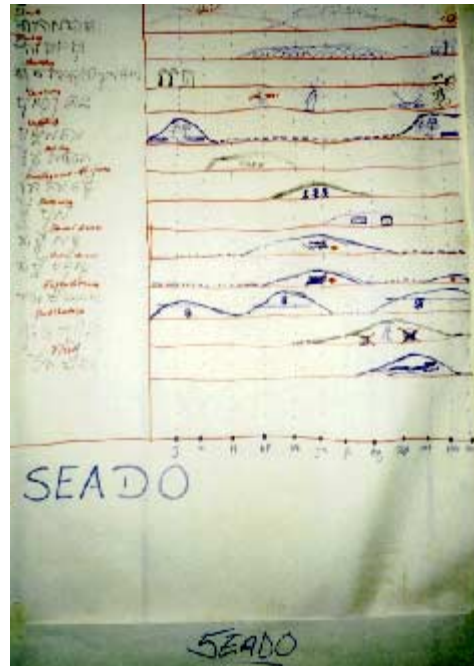
As already noted, the semi-structured interview format of the Bangladesh assessments covered a wide range of topics exploring many aspects of community life. In Sri Lanka and Cambodia, PRA methods were valuable in stimulating discussion of the local setting. Mapping was used in Sri Lanka to identify places of risk and resources in the community. While, in Cambodia, the same technique was used to look at what people liked about their community and what they wanted to change, as a way into discussing the problems they perceived as most important to them.



Map of Bandarawella Town, taken from the "Report on a PRA Workshop for Sexual Health Needs Assessment", Sri Lanka, February 1997.

Lifelines and trend diagrams were used to discuss the history of individuals and communities. In Sri Lanka, NGOs identified some sexual health trends, such as the number of unwanted pregnancies, and asked communities to plot these trends in the recent past and to discuss reasons for the trend. NGOs in Cambodia asked communities themselves which trends they considered most relevant to the HIV epidemic, and similarly asked them to plot and discuss them.

Activity charts and seasonal diagrams were useful in illustrating both times of greater and lesser risk and the best times for NGOs to work with communities. The Sevalanka Foundation in Sri Lanka noted from the seasonal diagram produced by their target community that: *"Villagers had money with them in the period July to August as it was harvest time. As such there was increased illicit sexual liaisons (visits to prostitutes) during this period."* Similarly, many of the seasonality diagrams from Cambodia clarify the links between work, income, festivals and sexual vulnerability. They also highlight the problems of access that the NGO will have to certain groups at certain times of year, for example, as a result of the seasonal out-migration of men for work.



A Seasonal Chart developed by SEADO during their training in Participatory Community Assessment.

Causal flow charts and ranking exercises helped to clarify the significant links between social norms and behaviour. Dividing their communities into groups by gender, age and marital status, NGOs in Cambodia asked each group to identify the ways in which a person in that group could protect themselves from HIV infection and then to rank these according to their degree of difficulty. Taking the most difficult, each group was then asked to list the causes and effects of this difficulty. In many cases, these exercises highlighted the links between low levels of condom use and perceptions and definitions of sexual pleasure, as something that is principally (if not entirely) by and for men. They suggest that a key factor defining vulnerability to HIV infection within Cambodia is the very different norms and values for men and women about sex.

3.3 Sequencing of assessment tools

Sequencing or using assessment tools in a logical order can make a significant contribution to the understanding of vulnerability. In general, NGOs sequenced their use of assessment questions and exercises to move from general issues to specific sexual health concerns, and from less sensitive to more sensitive issues. There were two reasons for this; to relax and involve people in the assessment process and to help people make the links between the general reality of their lives and HIV and other sexual health concerns.

In this sense, sequencing of the tools becomes a part of the analysis of the assessment. This was most apparent in the work of Cambodian NGOs whose sequence of assessment tools began with those focusing on general life contexts (such as mapping and seasonal diagrams). They then looked at trends related to the epidemic - such as labour migration or drug use - and then focused on factors of vulnerability, their causes, effects and possible responses. Finally,

these were ranked according to their potential impact and degree of difficulty in implementing. Significantly, this sequence was carried out with the same group of people. In the other countries, different exercises and questions were posed to different groups, which lost the continuity of the sequence and thus its facilitation of community analysis.

Sequencing assessment tools

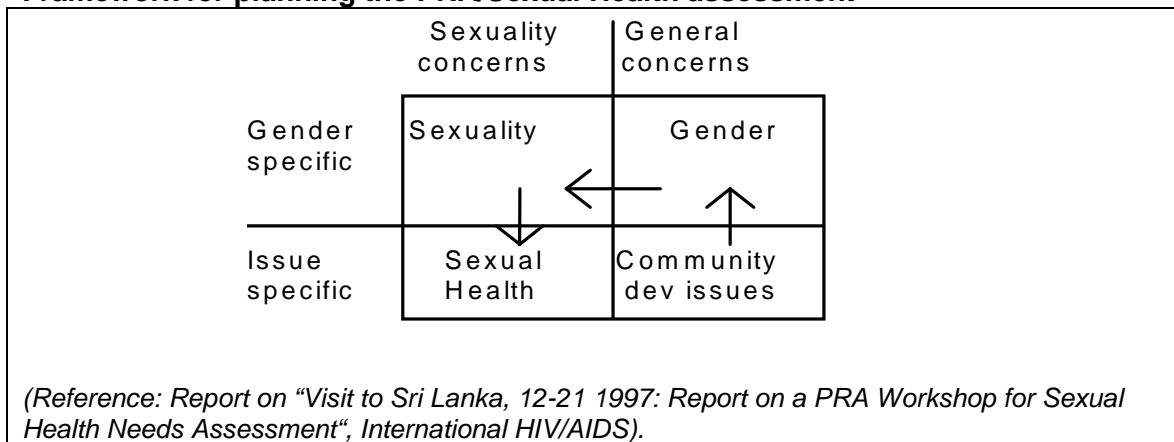
The Institute of Vocational Health (IVH) conducted an assessment with garment factory workers in the Rathmalana Industrial Zone, Sri Lanka. It used lifelines to identify the most significant events in group members' lives and to isolate those events of most concern, such as the break-up of love affairs and the delay of marriage. It then used cause/effect diagrams to explore the reasons and consequences of these events.

As the report notes: *“Young women coming to a city environment from the villages become easily involved in love affairs. ... These love affairs become transformed to sex relationships and then they easily break-up. ... The background situation concerning sex relationships of these women does not permit the recourse to the use of or demand for the use of protective devices. ... Many female workers become easily subject to mental worries and sex-related diseases as a result of such break-up prone relationships.”*

Finally, IVH used a pairwise ranking exercise to identify the most appropriate strategies for working with this community to help reduce their vulnerability to HIV.

Experiences did show that an alternative that can be effective is to start with a large group, and to gradually break it down into smaller sub-groups – especially for dealing with sensitive issues, such as gender relations. Afterwards, the large group can be reformed to assess overall community issues and perspectives.

Framework for planning the PRA/Sexual Health assessment



The importance of involving the community in not only providing information but analysing the meaning of that information was recognised by all the NGOs involved in the assessments, though it was approached differently in different places. In Bangladesh, NGOs arranged feedback sessions at which the findings

of the assessment were presented back to the community and discussed with them. In some cases, these feedback sessions served to continue and deepen the dialogue with the community about problems and appropriate responses. In Cambodia, in contrast, the use and sequencing of PRA tools encouraged communities to participate in the analysis of the information that they were sharing with the NGOs, as described above.

3.4 Improving the assessment of HIV and STD vulnerability

A critical challenge faced by many of the NGOs conducting the project design assessments was their staff's limited or non-existent experience in sexual health work. The ability of the assessment process to generate an understanding of HIV and STD vulnerability which could inform the design of a more sophisticated project response was sometimes constrained by staff's relative lack of familiarity with key concepts, such as vulnerability, social and behavioural change, and of gender and sexuality. There were several ways in which these gaps in understanding were manifest. For example:

- The inability of some NGO staff to extend or deepen a discussion with appropriate probing questions;
- A sometimes unclear understanding of what to focus on with the tools (e.g. what trends to assess? what criteria to use to rank factors of vulnerability? what to plot on the map?); and
- Difficulties in drawing meaningful connections between, and conclusions from, the tools used and the information they generated.

The graphic quality of many of the tools made them accessible to both NGO staff and community alike. There was sometimes insufficient attention to the use of questions to guide the discussion being stimulated, however. One lesson learned by the Alliance is that technical support to train NGO staff in the use of participatory assessment tools to assess HIV related vulnerability must prioritise building their conceptual understanding of vulnerability and sexual health along with developing the questioning and facilitation skills needed to effectively use many PRA tools.

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শিক্ষার অভাব	✓ •••	✓ •••	✓ •••	✓ •	✓ •••	✓ •••	✓ •••	18
জাতীয় সুরক্ষা অভাব	✓ •••	✓ •••	✓ •••	✓ •	✓ •	✓ •••	✓ •••	16
স্বাস্থ্য	✓ •••	✓ •••	✓ •••	✓ •	✓ •	✓ •••	✓ •••	18
কম আয়	✓ •••	✓ •••	✓ •••	✓ •	✓ •	✓ •••	✓ •••	15
বিশিষ্ট	✓ •••	✓ •••	✓ •••	✓ •	✓ •	✓ •••	✓ •••	20
Total	15	15	13	7	9	15	13	87

A vulnerability matrix – a Participatory Tool to Rank Vulnerability of Community Members – used by NGOs in Bangladesh.

It is also clear that the Alliance, Linking Organisations and partner NGOs must pay more attention to the analysis of information about vulnerability that comes out of the assessment process, and its implications for design of more effective responses. In part, this is a matter of connecting individuals, behaviours and contexts more meaningfully. For example, Cambodian NGOs made frequent reference to poverty (“poor living conditions”) as a factor of vulnerability but rarely described the links between poverty and increased risk of HIV infection. Without this analysis, it is hard to identify specific problems that can be addressed in the project design.

NGO staff also need to help communities think through the implications of the assessment and possible responses to the problems identified. In some cases, this may mean being able to challenge the moralism and conservatism of some communities, evident in the suggestion made by several groups in Cambodia that brothels should be abolished. This suggestion is not surprising given the frequent blaming of sex workers for the epidemic and the fact that the Cambodian government itself has periodically and publicly suggested this approach. NGO staff need skills to be able to both critique the potential effectiveness of such a response, as well as be sensitive to its human rights implications.

This does raise the question of how useful it is to simply ask communities for their solutions to the problems that are being identified by the assessment, rather than engaging in a discussion with communities about possible responses and the range of criteria by which they might be judged appropriate. This is certainly not to say that communities should not be involved in discussions and decisions on strategies and project designs, but merely to emphasise the value of enriching these discussions with the experiences and lessons that NGO staff can draw from elsewhere.

The nature of the project designs that ensued from the assessment process also suggest that the full implications of community vulnerability were not sufficiently understood or translated into strategic project responses. Most of the NGO strategies remained focused on individual behaviour change and relied on educational approaches, rather than strategies to promote social change. One reason for this is undoubtedly the limited experience and capacity of the NGOs themselves. It will be important for NGO support organisations to also support other groups which complement these educational approaches with organisation and advocacy strategies which respond to the social policy issues often raised in the assessments. Ideally, these can build and draw on the collective strength of communities, which the assessment process itself may have helped to mobilise.

4. Key Findings from the Participatory Community Assessments

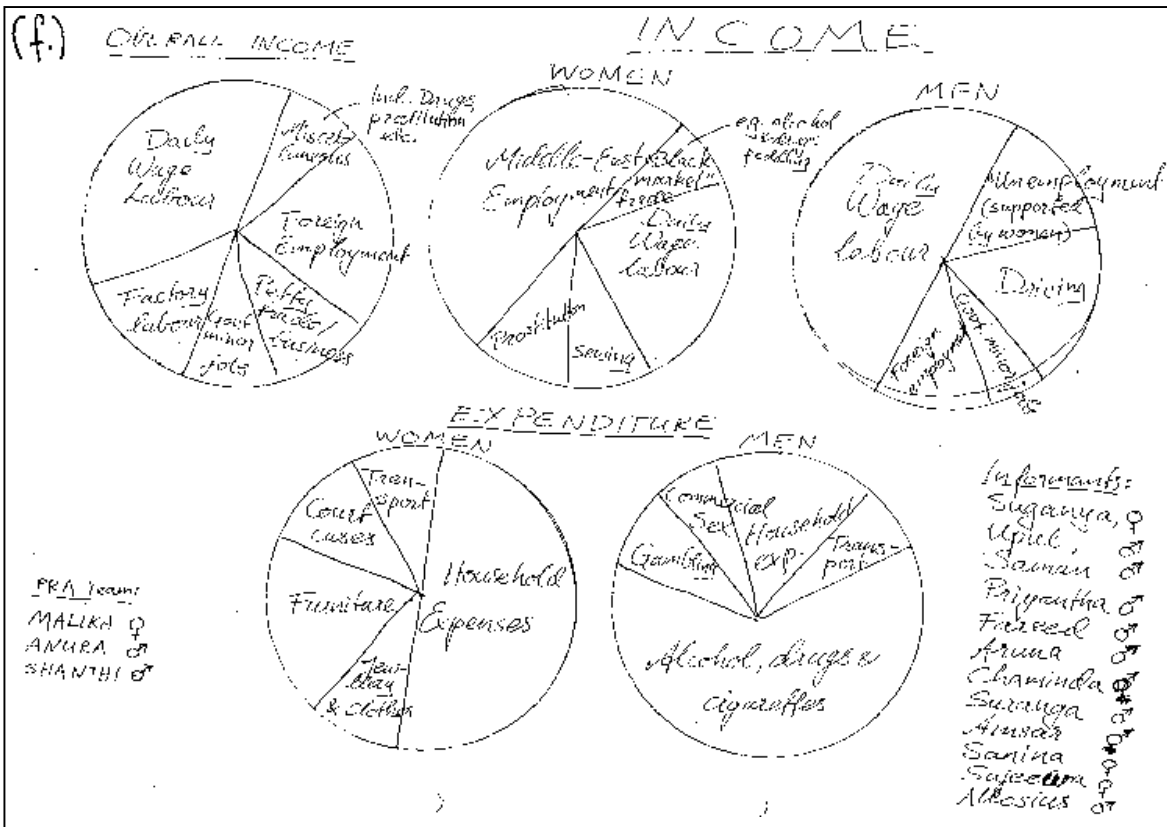
The following provides a synthesis of the key findings from the participatory community assessments in Bangladesh, Cambodia and Sri Lanka:

Key finding: HIV prevention is often not a primary concern for poor and marginalised communities.

Most of the assessments were conducted with poor communities, often lacking basic health and education services. Many communities in these assessments live with the threat of violence and conflict, as a result of continuing insurgencies in Sri Lanka and Cambodia. Living conditions are often deplorable. In Bangladesh, for example, many of the NGOs reported communities suffering inadequate shelter, over-crowding, very poor water and sanitation facilities and a range of related health problems. Incomes are low, opportunities for advancement few, and unemployment and job-related mobility and migration are frequent. These daily realities faced by communities unsurprisingly obscure their perception of the HIV epidemic as an urgent and important problem to be addressed in their lives. Furthermore, in the countries where the assessments were carried out, HIV is either of low prevalence (in Bangladesh and Sri Lanka) or still very new as a large-scale challenge (as in Cambodia).

Key finding: Vulnerability to HIV infection is linked to these realities of social, economic and political marginalisation.

In the assessments, poverty was often cited as a cause of the epidemic's spread. In the case of men, poverty forces job-seeking migration to higher prevalence areas (in towns or across borders). Among women, poverty often results in involvement in sex work.



Charts showing the income and expenditure of men and women in a community in Sri Lanka. Taken from "Report on a PRA Workshop for Sexual Health Needs Assessment", Sri Lanka, February 1997.

The assessments frequently found that lack of resources to meet people's basic health and welfare needs resulted in high levels of sexual health-related morbidity and mortality. Low literacy and low levels of education deprive people of access to sexual health information. Overcrowding can heighten vulnerability in a number of ways. IVH, working in the Rathmalana Industrial Zone in Sri Lanka, reports that: "Owing to lack of space, facilities for an unrestricted sex life are rare even for the married. This leads to lack of sexual satisfaction and related problems among the married." The frequency of married men's visits to brothels was blamed on these marital problems. In Bangladesh, CDF working with slum dwellers in Dhaka found that overcrowding affected teenage sexuality: "Several married couples live under the same roof. During the night some of these teenagers have to come outside their room while their parents are engaged in sexual relationship and make friendship with others. This in some time turned into sexual relationships."

Findings of assessment of drug dependent community, Bangladesh

"SHEASS is a local NGO working with a highly marginalised community of injecting drug users in Rajshahi, an urban area on the Bangladesh / India border. It used a participatory community assessment to re-focus its work - which had previously focused on a detoxification centre - and to develop a participatory HIV/AIDS prevention strategy based upon harm reduction.

The findings of the assessment included:

- *The drug users are marginalised. "Neighbours, relatives, near ones....nobody believes and relies on us: we are hated by everybody. We can earn money, but who will give us jobs? We have the skills but they don't trust us";*
- *The children of drug users are marginalised. Others say to them "You are the son / daughter of addicts." Some dependants have different opinions. They say "Will education make them different? The son of a rickshaw puller will be a rickshaw puller - heh! like father like son";*
- *Wives of drug users feel helpless;*
- *Drug users sell blood and sex for drug money;*
- *Drug users have no education about health;*
- *They feel ashamed even in their families;*
- *Drug users share their needles;*
- *Drug users are obsessed with addiction;*
- *They suffer social rejection. Local leaders and community people said to SHEASS: "What the hell are you people doing here? Don't you have anything to do? Do you know you are spending your time in wastage? They are addicts: they are shameless; they can do any crime; they are thieves. They are spoiling the society and you people are talking with them";*
- *Women drug users are left out. "If other people know that I use drugs then what will happen to me? Being a woman will it be possible to continue my family life? Society will push me in the street. And how can we talk to a man? Can we trust you men?"; and*
- *They don't like to use condoms."*

(Reference: Extract from a case study presented by Kabita Mahbooba, HASAB, at the Alliance Linking Organisations' Meeting in September 1997).

Key finding: One link between marginalisation and vulnerability to HIV infection is low self-esteem and a lack of a sense of being able to control decisions and actions.

The Voluntary Association for Rural Development (VARD), working with rickshaw pullers in Sylhet, Bangladesh reports: *"Most of them have no future dream. Struggle for existence is the basis of their lifestyle. Most of them have a fatalistic attitude about life, thinking that they have no control over their lives."* One result of this is a lack of sense of responsibility: *"Some of the rickshaw pullers have got the opportunity to conduct multiple sex practice as they have no particular responsibility to the society and family."* This, in turn, makes them and their partners vulnerable to HIV.

This lack of perceived, or real, control over their lives creates a fatalistic attitude toward HIV infection, and also detracts from a sense of personal and collective capacity to respond to the epidemic. This was evident to some during the assessment process. IVH in Sri Lanka notes that; *“The community was more keen on listening to lectures than participating in the methodology-related activities.”* The dangers of this passivity reinforce the importance of participatory approaches to assessment, which can help communities to know that they can make a difference.

Key finding: Women’s vulnerability is clearly linked to gender inequalities.

Several groups of married women taking part in the Cambodian assessments directly equated their vulnerability to HIV infection with the behaviour of their husbands. They had no sense of any independent ability to protect themselves, but relied solely on their husbands for their protection. Unmarried women often felt their main protection lay in ensuring that their future husband was uninfected, by conducting an HIV antibody test before marriage. Once again, there was little sense that they could negotiate their own sexual safety, whether before or during marriage, especially given the value placed on unmarried women’s sexual innocence and reticence in Khmer culture.

The vulnerability of young women was highlighted in Sri Lanka also. The Sevalanka Foundation reports that: *“In this village love affairs occur among minors in age. Formerly there were marriages among such minors. Now such marriages are not common. Sometimes the girls are left to face the situation of pregnancy without any support. On such occasions there is resort to abortions secretly...There are occasions when this leads to the death of the women.”*

Identifying how gender roles impact on sexual health:

Gender Role & Responsibility	Impact on Sexual Health
Men should be the main decision-makers in the family	Men – not couples or women – make decisions about when to have sex and whether condoms or contraception are used, while women often bear the sexual health risks of those decisions (unwanted pregnancy and STDs)
Women should be the main caretakers in the family	Women are unable to take care of their own health needs because they are too busy taking care of everyone else.
“Real men” have a lot of sexual experience. Good women are virgins and after marriage remain faithful to one man.	Many women with only one partner assume they are not at risk of infection, but their partner may have other sexual partners, women who sex outside of marriage are stigmatized and unable to access sexual health services.
Men control the economic resources in the family and community	Women have few options to leave situations where they are not able to protect their sexual health.
“Real men” should be strong and not express fear or worry.	Men and boys are not able to express the pressures they feel regarding sex, fears of STDs, talking about their feelings and protecting themselves and their partners from unwanted pregnancy and STDs.

Adapted from “Facing the challenges of HIV/AIDS/STDS: a gender-based response” KIT, SAFAIDS and WHO, 1995. Alliance Lanka training programme, October 1996.

Key finding: Male violence against women continues women’s sense of disempowerment and makes them vulnerable.

Violence against women was often reported, for example during UJON’s assessment of rickshaw pullers and CDC’s work with dock workers in Bangladesh: *“Besides the traditional forms of violence, some women identified the long stay of their spouses outside home and failure to satisfy their sexual need as [the cause of] violence against women”.*

In Sri Lanka, violence against women was often associated with the large military presence in areas affected by the Tamil insurgency. Sex workers in Cambodia reported that violence by clients, and the threat of violence, meant that they were often unable to use condoms for their own protection.

“Most of the rickshaw pullers' wives have no role in decision-making in any personal or family matters. Some rickshaw pullers beat their wives. In the time of having sex, the women have no role. Even if they have physical problem and unwillingness to have sex, they are forced to do it which hampers their sexual health...In a few cases, the husband's sexual diseases are transmitted to the wife.”

(Reference: Participatory Community Assessment report of the Voluntary Association for Rural Development (VARD), Bangladesh).

Key finding: Expectations and experiences of sexual autonomy and sexual pleasure contribute to men and women's vulnerability.

Women interviewed by the Sevalanka Foundation in Sri Lanka: *“Stated that they were not asked about their ideas before beginning intercourse...[I]t was emphatically stated that they had no notion of sexual satisfaction.”* By contrast, most men interviewed in all the assessments had clear ideas about their sexual satisfaction and expectations of getting such satisfaction.

The most frequently cited reasons given by men for not using condoms and for having multiple partners were about sexual pleasure. In the Cambodian assessments, men were frank in stating their unwillingness or inability to deny themselves their sexual desire. But the assessments also provided interesting insights into male anxiety and perceptions of female sexuality.

CDC in Bangladesh reports: *“According to the participant dock workers, most of them are unable to sexually satisfy their wives, [leading to] disruptions in family life. Women are grieved because of sexual inabilities of their husbands due to STDs and irregular intervals of sexual intercourse due to their husband's overstay at their workplace.”* Some of the women interviewed by CDC were open about their sexual desire and how they coped with their husband's absences: *“The females whose husbands stay more than weeks at a workplace said that they normally opted for masturbation.”*

In Cambodia, some married women commented on their own dislike of condoms because they took away sexual pleasure, but wanted their husbands to use them when they visited the brothel. Young women taking part in Cambodia Health Committee's (CHC) assessment in Svay Rieng province believed that “one-to-one love” was one of their best protections against HIV infection but also felt that this was difficult because of “passion”.

Key finding: Sexuality and sexual safety are influenced by the context in which sexual encounters take place.

Many assessments highlighted the role that drinking, and, in particular, rituals of male group drinking, played in heightening men's exposure to risk of infection, for example through non-use of condoms with sex workers.) Others noted how difficult it was for wives and husbands to communicate with each other about sexual safety in their hurried sexual encounters in overcrowded living conditions. IVH's assessment with garment factory workers in Sri Lanka emphasised that: *"The situational background to these non-marital relationships is not conducive to use of protective devices."*

Instances of male-to-male sex were reported, especially as experiences of adolescence and all-male occupational environments, but were not sufficiently discussed with reference to questions of sexual safety. Commenting on dock workers in Bangladesh, CDC notes that: *"A majority of them were abused in their teens by their elders. Most of them learned about sex from their friends."* While sexual abuse was rarely identified in these explicit terms, many NGOs noted that people's overcrowded living conditions led to children and young people being exposed to adult's sexual behaviour, leading them to become sexual themselves at an inappropriately early age. Some pointed out, with disapproval, young people's (especially boys') access to pornographic materials and the effects this had on their sexual development.

Adolescent Sexuality in Bangladesh

"The adolescent boys and girls spend their nights on railtracks when their elders are engaged in sexual intercourse...Most of the girls are then abused. Due to space constraint, the married elders have no other alternatives but to engage in sexual intercourse while an adolescent is lying beside them. I know several instances where brothers and sisters eventually were engaged in sexual relations as demonstrative effect of these situations."

(Reference: Statement by a female teenager from CDF's assessment of slum dwellers in Dhaka, Bangladesh).

Key finding: Communities continue to lack access to adequate sexual health information and services.

NGOs were struck, especially in Bangladesh and Sri Lanka, by people's lack of even basic information about reproduction, STDs and HIV/AIDS. Some had never heard of AIDS and had never seen a condom. NGOs in Sri Lanka used body mapping to explore people's understanding of sexual health and disease and noted the gulf that exists between local peoples' understandings and those used in conventional HIV education messages.

Awareness of HIV/AIDS was higher in Cambodia, unsurprising given its more advanced epidemic. But it is clear that misinformation persists, for example in relation to people's fear of touching someone who has HIV. Linked to this lack of adequate information was the dearth of accessible and appropriate sexual health services, including family planning, maternal/child health, STD treatment and HIV testing and counselling. Many people continued to rely on traditional treatments to treat STDs and / or self-medicated with costly treatments obtained from pharmacies.

Key finding: Fear of blood-borne HIV transmission remains high.

Avoiding contact with potentially infected blood, for example through not sharing razors, was frequently mentioned as an HIV protection strategy that people used. Many groups taking part in Cambodian assessments wanted an expansion in HIV testing facilities, in order to render blood transfusions safe.

Less discussed was the risk of HIV transmission posed by sharing of injection equipment, whether for self-administration of medicinal drugs or opiates (and to a lesser extent amphetamines.) Very few NGOs (for example JTS and CDF in Bangladesh) identified needle sharing among people injecting drugs as a significant issue for their HIV prevention programme.

(d) WAYS OF SPREADING S.T.D.s
#15 CHURCH ROAD, MATTAKULIYA, COLOMBO 15

	SEX WITH C.S.W.	UNSTERILIZED NEEDLES	MOSQUITO BITES	MIXING OF BLOOD	TOUCHING	STEPPING ON URINE	SHARING CLOTHES	score	RANK	PRA team:
SEX w/ C.S.W.	—	SEX WITH C.S.W.	SEX w/ C.S.W.	SEX w/ C.S.W.	SEX w/ C.S.W.	SEX w/ C.S.W.	SEX w/ C.S.W.	6	1 st	Vasanthi, Upul, TERENCE
UNSTERILIZED NEEDLES	—	—	MOSQUITO BITES	MIXING OF BLOOD	UNSTERILIZED NEEDLES	UNSTERILIZED NEEDLES	SHARING CLOTHES	2	4 th	INFORMANTS
MOSQUITO BITES	—	—	—	MIXING OF BLOOD	MOSQUITO BITES	MOSQUITO BITES	MOSQUITO BITES	4	3 rd	Suranga, 18 Upul, 26 Farooq, 24 Chaminda, 11 Kulathilake, 30
MIXING OF BLOOD	—	—	—	—	MIXING OF BLOOD	MIXING OF BLOOD	MIXING OF BLOOD	5	2 nd	Nazari, 23 Muzamil, 25 Ramin, 24 Arana, 21 Ajith, 24 Sanjeera, 16 Indira, 15 Alson, 20 Farooq, 20
TOUCHING	—	—	—	—	—	TOUCHING	TOUCHING	2	4 th	(All male)
STEPPING ON URINE	—	—	—	—	—	—	STEPPING ON URINE	1	5 th	
SHARING CLOTHES	—	—	—	—	—	—	—	1	5 th	

Ranking exercise showing ways of spreading STDs. Taken from "Report on a PRA Workshop for Sexual Health Needs Assessment", Sri Lanka, February 1997.

Key finding: People living with HIV/AIDS remain largely invisible.

The assessments in Bangladesh and Sri Lanka rarely, if ever, mentioned people living with HIV/AIDS. Several NGOs in Cambodia recorded people's own direct experience of the epidemic through knowing or hearing about someone who had died of AIDS. Fearful and negative attitudes towards people living with HIV/AIDS were frequently expressed during the Cambodian assessments. For example, a report by the Cambodian Development and Relief Centre for the Poor, working in Kampot province stated: *"In Prek Kres, people know that there are AIDS patients and many of them have died. Most of [the community] think they know about AIDS and they know how to [protect] themselves well - they do not go near or visit the patients because they fear infection. The villagers' fear becomes discrimination against the patients, which makes their family, parents and relatives hide the illness and beat the patients and send them from one to another, not wanting to accept or look after them. This makes the patients more desperate and more miserable physically and mentally."*

6. Strategies and Responses

To the extent that the participatory assessment process in Bangladesh, Cambodia and Sri Lanka stimulated a dialogue within communities about HIV prevention and other sexual health issues, it served to mobilise the beginnings of a community response. Many NGOs commented on people's initial reluctance to discuss issues of gender and sexuality, sex and sexual health and the transformation that took place during the assessment itself to the point where community members were actively engaged and participating in exploring not only problems, but also solutions. The sense of agency that the participatory process of the assessment generates can make a significant contribution to both the effectiveness and sustainability of community HIV prevention activities.

The participatory community assessments produced a wealth of information and analysis that helped to inform the design of strategies and projects to make them more responsive to the needs and aspirations of the communities that they were intended to serve. In this regard, it is noteworthy that the most commonly identified strategy continued to be **HIV/AIDS education**, partly because people's lack of adequate information on HIV/AIDS and sexual health more generally was frequently reported as a problem. For example, 90% of community members who took part in Cambodia Women's League for Development's assessment in Kandal province requested more education. But education strategies may also have been favoured because most NGOs are familiar with a health education response to health problems (although many of them lacked experience in sexual health work).



NGOs in Cambodia using the Findings of Community Assessments and Participatory Tools to Plan HIV/AIDS Prevention Programmes.

Some NGOs used the assessment process to determine the type of educational approaches that would be most effective. Pairwise ranking by IVH in Sri Lanka found that video shows and group discussions would be preferred by the factory workers whom they were targeting in their project. Others continued the work begun during the assessments by continuing with their participatory group discussion format, and used assessment findings to guide the selection of topics to be discussed. For example, the Khmer Buddhist Association (KBA), working in Banteay Meanchey province on the Cambodian -Thai border, found low levels of condom use and a high degree of discrimination towards people living with HIV/AIDS and thus focused on condom promotion, alleviating people's fears and exploring people's attitudes during their group work. Some, like Kasekor Thmey in Kompong Cham province, emphasised the importance of targeting their education work at men, given findings about their greater decision-making control over the potential safety of sexual situations.

Many NGOs, especially in Bangladesh and Sri Lanka, identified the need for **STD education, referral and treatment**. Strategies ranged from production of information materials on and discussion of STD prevention and management to outreach STD testing and treatment, for example at truck stops in Bangladesh and factories in Sri Lanka. Some NGOs stressed the importance of improving maternal/child health services, for instance by increasing the number of trained birth attendants.



Jatiya Tarun Sangha (JTS) used the findings of their assessment to develop a programme including STD counselling and treatments for community members in Hazaribagh, Bangladesh.

There was also a significant emphasis on expanding **condom promotion and distribution**, though there was less detailed discussion of how the barriers to condom use identified during the assessment would be addressed. Some NGOs stressed the importance of targeting men with their condom promotion, especially through all-male occupational environments such as the police or military. Others, like the Battambang Women's AIDS Project in Cambodia, focused on marital relationships and strengthening the ability of partners to negotiate their sexual safety, including condom use. KBA in Cambodia has developed a strategy to increase condom use in brothels, through working with sex workers and brothel owners to increase the availability and acceptability of condoms.



Saviya used information gathered from community members in Hikaduwa, Sri Lanka, to develop a programme for beach boys, including condom promotion and negotiation skills.

Addressing issues of **gender inequality and violence against women** was a priority for some NGOs. The Community Development Centre, in Bagherat, Bangladesh, noted that: *“Violence and abuse against women is rampant in the target area. So, the CDC consider a programme aimed at raising awareness of women rights and human rights is a vital necessity.”* Job creation, income generation and vocational training were noted as significant strategies to enhance women's economic independence, and thus it is hoped their sexual

autonomy. Working with men to explore their role in maintaining gender inequalities was recognised as a priority, but specific strategies, beyond the need for more “education”, were not described. The lack of sexual knowledge among young people, and its consequences for their current and future sexual health, had been noted as a concern in some assessments. As CDF in Bangladesh reported: *“The participants observed that they would benefit if they and their children were educated about safe sex.”*

Many NGOs recognised the importance of meeting some of their communities’ **basic needs** around water and sanitation, shelter and housing, and literacy. Community development NGOs, like DAC in Cambodia, envisaged combining their HIV education work with poverty alleviation strategies. Several NGOs in Bangladesh responded to the community’s felt need for entertainment facilities, both in order to strengthen a credible relationship with their communities and to provide an alternative to drinking and visiting brothels.

The **integration of prevention and care strategies** was specified by several NGOs in Cambodia. CDRCP and CWLD both stressed the importance of care activities and providing *“Emotional support, money and medicine to people who are living with HIV if it is possible.”* Kasekor Thmey identified counselling as an important service to be provided to people living with HIV/AIDS and CCDO targeted their counselling and care activities at the families of people living with HIV/AIDS.

One NGO in Bangladesh identified strategies **for harm reduction among injecting drug users** as a priority. SHEASS addressed this through involvement in outreach work and awareness raising on issues such as risk reduction, sexuality and STDs, and HIV/AIDS. Local leaders and members of the broader community were mobilised to help fight discrimination within the community. A drop-in centre providing a wide range of services for injecting drug users and their families - including needle exchange, condom distribution and education about general health, HIV/AIDS and harm reduction - was also established.



Members of SHEASS treating an injection wound of a community member in Rajshahi, Bangladesh.

7. Conclusions and Recommendations

“At first, we wondered why we should do a needs assessment, but the more we learned, the more we realised it was crucial. The findings were astonishing. They revealed things which were completely new to us even though we’ve been working in our community for twenty years.”

Ahmed Ilias, Al-Falah, Bangladesh

The assessment process has strengthened NGOs’ relationships with both existing and new target communities, by requiring NGOs to listen to these communities, and question their own assumptions about them, before designing their projects. Reminding NGOs that their first step should be to ask questions to assess needs, resources and priorities rather than tell people about HIV/AIDS has been a useful corrective for many organisations familiar with a didactic and prescriptive style of health education. The experience from the Alliance’s partners in Bangladesh, Cambodia and Sri Lanka suggests that the participatory process of the assessments has engaged NGOs with their communities in ways that challenge traditional notions of expertise. Rather than extracting information for analysis, the participatory assessment process has sought to integrate local people’s expertise about their own experiences and expectations.

Recommendations: ➤ NGOs developing assessments should be open to listening and learning about the reality of community needs and aspirations. Although this can provide a direct challenge to traditional NGO views and ways of working, this approach can result in a strengthened relationship between an NGO and a community. As well as being open to change, NGOs can also take practical steps to enhance this process – such as recruiting and training community members to serve as facilitators of the assessment with their peers.

Enhancing and expanding community participation in assessments prior to project design can contribute to community efforts by serving as a starting point for on-going community discussion of and action in response to the HIV epidemic. The importance of participation in this process is not to be underestimated in settings where people’s sense of agency and control over their lives is severely limited by history or contemporary political and socio-economic realities. As many of the NGOs reported, the assessment process provided a rare opportunity for members of the community they work with to discuss issues of gender, sexuality and sexual health. This kind of community dialogue helped in some cases to engender a community commitment to and ownership of the problems identified and responses planned. As the Community Development Centre, which worked with dock workers in Bagherhat, Bangladesh, reports: “A feedback meeting was organised at an elder’s house which was attended by labour leaders of the dock, interviewees, and general people. Most of them in discussions agreed to the findings, and wondered how they would resolve these problems.” Participatory processes of assessment can thus help to mobilise community concern about and action on HIV prevention.

Recommendations: ➤ The Alliance and its partners need to focus on ways to sustain the mobilisation of community concern and action initiated at the assessment phase. This could mean institutionalising community involvement in project design and subsequent projects (e.g. as staff or as an advisory body) and/or integrating the project into existing community structures (e.g. village development committees, parent-teacher associations) as well as in the evaluation of activities and outcomes.

The use of PRA tools in the assessment process has enabled greater community participation and demonstrated the potential of visualisation techniques to enrich discussion and understanding of vulnerability to HIV infection. But the real value of drawings and diagrams lies in the extent to which they are ‘interviewed’ and discussed by community members, assisted by NGO staff. Group facilitation and questioning skills and an adequate grasp of key concepts of vulnerability are critical to maximising the potential of these

assessment tools, and some NGO staff lacked this requisite skills and understanding.

- Recommendations:*
- The technical assistance needs of NGOs should be identified prior to their assessments in order that appropriate TA can be provided to improve the capacity of the NGOs to conduct their assessments.
 - Experience to date suggests that this TA will need to focus on key concepts of vulnerability (including HIV/AIDS, gender, sexuality and sexual health) and group facilitation and questioning skills.

The understandings of vulnerability generated by the assessment process were typically translated into strategic responses focusing on forms of sexual health information provision and service delivery (STD treatment and condom promotion.) This was determined less by the findings of the assessment itself than by the existing focus and capacity of the NGOs conducting the assessments. Some of the findings suggested a need for strategies such as counselling on sexuality and sexual trauma, advocacy on women's rights and campaigns against male violence but these were rarely specified by NGOs in their ensuing project designs, perhaps because of an inadequate analysis of the strategic implications of the assessment and also because of NGOs' inexperience with these types of work.

- Recommendations:*
- The Alliance must focus technical support on enabling NGOs and communities to develop strategies that respond to the broad range of factors of vulnerability identified during the assessment.
 - The Alliance and its partners should support NGOs to work in collaboration with organisations which can provide the skills and expertise to complement their own.

Participatory community assessments can play a crucial role in developing more responsive and effective strategies and projects, their role in establishing baseline information, against which project progress may be measured, has not been fully explored. Few of the NGOs referred to in this report used the assessment process to collect data which could establish a baseline against which to monitor project implementation. Some might argue that baseline data collection can only be started once projects are designed and indicators determined. But a case can be made for incorporating a greater element of standardised, quantitative data collection on basic sexual health and service delivery indicators within the community assessment process, to the extent that the former did not compromise the latter.

- Recommendations:* ➤ The Alliance and its partners should consider how to strengthen the quantitative aspects of the participatory community assessment process, perhaps by producing guidelines for suggested basic indicators and means of verification.

Conclusions from stakeholders:

After a PRA workshop for sexual health needs assessment in Sri Lanka

“Before the [PRA] workshop, I worried that the Alliance might come and force-feed us another western “teaching”, but I am pleased that the Alliance helped us find first class local experts and pleased to have learned that PRA is being used and developed in Sri Lanka by our own people. I think we can all now see how appropriate this type of participation is for helping us work with the community.”

Mr Ekanayake, Alliance Lanka Provincial Field Officer

After participatory capacity building in Cambodia

“When we first started working on HIV/AIDS with the Alliance, many of us felt like headless chickens, but now - after going through this long process together - we feel very confident and committed to working on AIDS”.

Kong Samnang, SEADO



Members of SEADO implementing their HIV/AIDS prevention programme among villagers in Banteay Meanchey.