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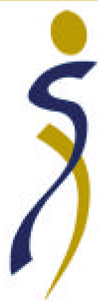

SOCIAL DEVELOPMENT NOTES

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REPORT CARDS AS A TOOL FOR EMPOWERING COMMUNITIES IN THE FIGHT AGAINST HIV/AIDS IN CAMEROON: A WORK IN PROGRESS

The use of report cards in a HIV/AIDS prevention program in Cameroon appears to be a promising tool for galvanizing community interest, discussion and action. Local HIV/AIDS committee members are evaluated by communities who vote on the effectiveness of committee activities. As a result of the report cards, most communities replaced some of the members of the local HIV/AIDS committee and the content of the action plans to fight HIV/AIDS. The report card tool also facilitates discussions on a very sensitive and previously forbidden topic. Printed report cards are now available in 6,000 communities who could use the report cards to evaluate other activities or community services.

Introduction

One of the greatest challenges facing societies threatened with the spread of HIV/AIDS is to find ways to motivate people to change their behavior to prevent contracting the virus. Building this motivation entails the kind of communication which generates awareness so that people understand the dangers posed by the disease and what can be done to avoid infection. The key is to inspire people to act on their own behalf. This is the ultimate aim of the report card approach being implemented as part of the Multisectoral AIDS Program (MAP) in Cameroon.

To empower people in the fight against HIV/AIDS, thousands of community grants under the MAP need to be effectively managed at the community level through participatory processes that enhance the accountability of local HIV/AIDS committees to their communities. Most HIV/AIDS operations conduct random supervision of community action plans and annual audits of 10 to 20 percent of the communities. In 2003, the National AIDS Committee in Cameroon (CNLS) decided to test self-evaluation tools that would entrust the communities to monitor activities and evaluate them. The objective is to transfer responsibility for local- level monitoring and evaluation (M&E) to the beneficiaries.

To the best of our knowledge, it is the only large-scale application of the report card approach to HIV/AIDS in the world. Elsewhere, report cards have been used largely as "citizen report cards" to provide feedback on client satisfaction with delivery of water, health, education, electricity and other services. In the MAP, report cards are being used both for community self-evaluation and for communities to evaluate program performance at the local level.

The report card approach in Cameroon shows early signs of success. It creates a forum for public discussion on a very sensitive topic, increases awareness of the disease, and, most importantly, instills a sense of responsibility among the people – a realization that they are the ones who can and must act to prevent themselves from being infected by HIV/AIDS. It encourages the community assembly to tell the truth, to recognize that AIDS is still progressing or that affected family members with AIDS are still rejected. It increases project staff accountability to the people, provides feedback by ordinary people on the effectiveness of the local

community action plan to fight HIV/AIDS, and supports community evaluation and decision-making processes. Still, this approach is in its infancy. Report cards are experiencing growing pains as they begin to take hold.

Genesis of the Report Cards

The use of report cards in the MAP began as part of an effort to reach out and involve people at the community level, and to improve the effectiveness and governance of community grants in fighting HIV/AIDS. CNLS used MAP funds to provide grants to the communities to stimulate local actions to fight AIDS. NGOs sensitized communities and assisted them in setting up a Local Committee against AIDS. Each committee worked with the community to prepare an action plan. Each community received a small grant (a maximum of $2,000 per year) to implement its action plan. These grants are managed by the committees. The MAP quickly scaled-up: it began with 866 communities in 2002, was reaching 3,000 communities by the end of 2003, and expanded to 6000 communities in 2005.

This was the first time in Cameroon that grants were used at the community level on such a massive scale. CNLS gave communities significant discretion in the activities they could undertake based on identification of local factors affecting propagation of AIDS and access to treatment. However, CNLS came under criticism for misuse of funds at the community level with stories of some individuals using funds for small allowances. Project management became concerned about the soundness of committee management and about monitoring the large sums of grant money being administered by the communities. CNLS did not want to spend scarce resources to monitor or control community grants.

The World Bank task team played its "knowledge bank" role and informed CNLS that Care International was using report cards at the community level in Malawi. The news triggered interest in Cameroon. CARE Malawi could not send an experienced team to Cameroon, so the Bank task team leader helped CNLS design its own report card approach based on his previous experience as an extension officer. He recruited social development specialists to support this effort.[1]

The report cards were introduced in 2003 as a tool to help with the local management of the MAP. The report cards were not seen so much as an M&E instrument but as a capacity building activity to empower the communities to control and improve their action plans. The first year was spent largely on design and on finding a place in the MAP agency to house this novel approach. CNLS decided to give responsibility for the report cards to the Local Response Unit of CNLS. In April 2004, report cards were included, along with quantitative evaluation, as part of a community self-evaluation system led by local program administrators known as Municipality Focal Points (MFPs). Report cards are now a mandatory component of the participatory assessment process that takes place every six months prior to requests for new six-month allocations.

The Report Card Methodology

The report card approach in Cameroon adopted its current features during a February 2004 workshop. Report cards are the second of the following three stages.

The first stage, quantitative evaluation, now called monitoring, records and assesses the progress of each planned activity in terms of actual achievements.

The second stage, qualitative evaluation, assesses the impact of program activities at the community level as perceived by community residents. Report cards are used to determine people's level of awareness about HIV/AIDS and to assess the effectiveness of actions against HIV/AIDS by tracing changes from year to year. The questions

[1] We gratefully acknowledge the support received from the Norwegian and Finnish Trust Fund for Environmentally and Socially Sustainable Development to assist with the design and early implementation phase of the report card initiative from 2003 to 2005.

can vary from one community to another but they generally follow guidelines prepared by CNLS. They cover the disease itself, how to prevent it, and how well the committee is helping to prevent it.

Four groups of ten persons each – girls, boys, women and men who are not members of the committee and who are not involved in the implementation of the action plan – are purposively selected to represent the diverse ethnic groups, socioeconomic strata, and neighborhoods of the community. The total sample size of 40 respondents represents about 5 to 10 per cent of the average community. Three cards, color-coded for each of the four demographic groups (yellow for girls, green for boys, pink for women and blue for men), are used to provide responses on each of the following 12 questions on nine HIV/AIDS-related issues.

1. Knowledge of AIDS
    - Do you know how HIV is transmitted?
    - Is there HIV/AIDS in your community?
2. Awareness of HIV/AIDS danger/risk
    - Have you changed your behavior due to HIV/AIDS?
3. Quality of services provided
    - Does anyone visit your community as part of the fight against HIV/AIDS?
    - If so, are you satisfied with these visits?
4. Promotion and use of condoms
    - Do you have access to condoms?
    - Do you use condoms during casual sexual encounters?
5. Voluntary blood-testing
    - Do the members of your community undertake voluntary blood tests?
6. Access to treatment
    - Do people in your community infected with HIV have access to treatment?
7. Stigma
    - Are people with HIV rejected by their families or by the community?
8. Management of financial resources for the fight against HIV/AIDS
    - Is the money that is meant to be used for the fight against HIV/AIDS well spent?
9. Role of the local HIV/AIDS committee
    - Are you satisfied with the work of the local HIV/AIDS committee?

The three cards depict one, two, or three stars. The community representative votes one of the three cards, choosing the number of stars to quantitatively represent a qualitative response. For example, regarding the second theme, awareness of danger and risk associated with HIV/AIDS, the associated question is: "Have you changed your behavior due to HIV/AIDS?" If the person votes with a one star card, that means he or she has changed behavior only slightly or not at all. If a three star card is selected, that denotes major behavior change. A hat is passed around to collect the cards, which are placed face-down to assure confidentiality of responses.

The third stage, analysis of the quantitative and qualitative evaluation results, is performed jointly by project staff and community members. They complete the revision of the community's 'problem tree' and 'vulnerability map'. Ideally, this final phase of the process entails a period of group discussion based on the results of the monitoring and report card voting. This phase should enable community members to gain a full appreciation of the degree to which they have met planned goals for each of the identified activities related to HIV/AIDS prevention so that they can better identify further action to satisfy perceived needs.

Implementation of the Report Card Approach

As of early 2005, after one year of implementing the report card approach, it had been applied in 858 communities in all ten of Cameroon's provinces, with the majority (55 percent) of communities in the Southern Province. The distribution of the 858 communities among the ten provinces is as follows:

- South – 469
- South West – 122
- Center – 63
- West – 60
- North West – 55
- Littoral – 30
- Adamaoua – 25

- East – 15
- North – 14
- Extreme North – 5

The total number was expected to increase significantly during 2005 as self-evaluation becomes standardized as part of all community action plans. By October 2005, CNLS had produced 6,000 sets of cards and guidelines on how to use the cards, and disseminated them to the communities.

Thirty people have received basic training in report card techniques: five managers from the Local Response Unit, 20 heads of provincial units, and five MFPs. The objective of this training was to enhance the effectiveness of the application of the report card tool at the community level.

Observations on the Report Card Process

In early 2005, a team of World Bank consultants visited three communities in the Southern province, two rural and one peri-urban, during the meetings to vote on the topics covered by the report cards. In each community, discussion was lively and keen interest was shown by many of those present. There were a number of apparent problems. There were also some clearly positive features.

The most glaring shortcoming was the low level of community participation in the report card activity. Initially, there were relatively few community participants not on the HIV/AIDS committee. Committee members voted and failed to mobilize the community to vote. In one community, only nine people voted, and all were members of the committee. CNLS quickly corrected this situation as committee members are not allowed to vote on their own performance. In all of the communities, it took so long to collect the cards, count them, and present results after each vote, that many people simply lost interest. CNLS tried to correct this problem by asking the facilitators to do the voting quickly, playing it like a social game, and to pay more attention to the third stage, the analysis of the quantitative and qualitative evaluation results.

Another problem is the risk that the report card process will become more of an end in itself than a means for action. During the community meetings, there was a brief discussion following the presentation of results, but little or no group discussion when the results to all 12 questions were tabulated. While the discrete findings on each of the report card topics are important, just as important is the opportunity for reflection by community members on what these findings mean and what actions might be taken to remedy the situation, assigning responsibility wherever possible. Report cards are a platform for group deliberation and decision-making, a tool for governance and empowerment, far more than a mere survey instrument.

The strengths of the approach outweighed these drawbacks. In some way, this game of cards – on a topic which is associated with fear, shame, and sadness – was able to attract people's attention and raise their awareness in ways that might have been far more difficult with a lecture by a health professional. The use of report cards seemed to lighten up and make more accessible a heavy, formerly forbidden, subject. Several people in these communities said words to the effect of "Before these meetings I did not know what HIV/AIDS was. Now, thanks to coming together in this way, I do."

Equally as important, the report card voting sessions provided a forum where community members could openly address HIV/AIDS-related issues together, thereby developing communication with peers, family members and other age groups on an issue that is difficult to discuss. For example, communities often discuss closing bars at an earlier hour, sexual relations between teachers and students, and taking actions to influence local factors associated with HIV/AIDS. Communities developed collective responsibility for action to mitigate the risks involved and assist those affected by the disease.

The most stimulating exchange that took place in these communities concerned the issue of stigma (topic 7) regarding the care of orphans in the community. One man disagreed with the results of the votes which indicated that most people were caring for affected community members. He

asserted that people in the village only cared for their own families and no one else. Many others hotly contested this. It turned out that there were five orphans of AIDS-infected parents who were receiving community support. The heated discussion appeared to galvanize the people's will to increase their collective responsibility and assistance to orphans and others affected by the disease.

Refining the Report Card Approach

After the first year of using the report card, it became clear that several issues were not being sufficiently illuminated by using only yes/no questions. Accordingly, a short, qualitative interview guide was added to address these issues.

1. Voluntary blood testing (theme 5)
   - Do members of your group get blood tests?
   - If not, why are people reluctant to be tested?
2. Actions undertaken by the community to reduce HIV/AIDS prevalence (theme 2)
   - Describe the nature of these actions and how the members of the community participated in realizing them.
3. Role of the local committee (theme 9)
   - What are the reasons the community is satisfied or dissatisfied with the actions of the local HIV/AIDS committee?

This short interview guide was to be administered by the Municipality Focal Point (MFP) to three members of each of the four aforementioned demographic groups not previously selected for the report card voting, thus expanding the total number of persons reached by the qualitative evaluation to 52 per community. Each interview was expected to take ten to fifteen minutes.

Beyond the issue of yes/no questions, there were a number of other aspects of the report card approach which were problematic during this first year or so of experience.

- MAP managers responsible for oversight of the report card methodology needed to become more familiar with the approach.
- The self-evaluation approach generally needed further adaptation to the Cameroon context so that communities could better understand it.
- The questions needed simplification and good translation into the local vernacular.
- The report card tool needed proper administration by the MFPs during the self-evaluation sessions.
- Other key actors needed to be included – MFPs, committee members, and peer educators (*pairs educateurs*) – along with community members as evaluators.

Much of the refinement of the report card approach comes down to improved training for the MFPs, the persons primarily responsible for implementing the program in each community. MFPs need to select participants for the report card activity who are not members of the HIV/AIDS committees and who fairly represent the diversity of the community, animate the self-evaluation sessions, manage the voting expeditiously, keep the community members present at the evaluation sessions informed about results on an ongoing basis, and express the questions correctly in the local language. Proper training of local MAP staff (the MFPs) charged with administering the report card program is clearly a major need that was underestimated during the program's conception. Problems encountered during observation of the report card meetings in the communities have generally been resolved satisfactorily as follows:

- HIV/AIDS committees are seeking increased community participation in the meetings and are aware that they should not take part in the voting themselves.
- Community meetings are prepared in advance to ensure sufficiently broad representation (by locale, ethnicity, socioeconomic level, etc.), and meeting times are set to maximize community attendance.
- Vote results are now presented in large enough letters to be read throughout the assembly hall.
- The MFP, who leads the meetings, is trained to accurately translate the voting procedures and topics into the local vernacular.

Suggestions for Improving the Program

Beyond refining the report card approach itself, other issues are now being addressed to improve the program. These may be organized around two broad themes: recognition and integration.

Recognition

HIV/AIDS does not lend itself to open, free discourse. The topic is too intimate, private, and potentially embarrassing and judgmental. To induce constructive dialogue about HIV/AIDS, careful thought should be given to some sort of material inducement or recognition. Two opportunities for such recognition are the peer educators (*pairs educateurs)* and the report card meetings.

The educators are the foot soldiers, the local itinerant teachers, of the HIV/AIDS health profession. They go door to door in the villages (where they reside) talking to people about the meaning of HIV/AIDS: the nature of the disease, risks associated with it, prevention strategies, and so on. They are the key source of information, especially about what the HIV/AIDS committees are doing. They motivate people to attend the community meetings. At present, they receive no remuneration. Given that they are drawn from the villages, they are relatively poor. Many have had to resign from this service due to the high opportunity cost of the time they spend on this voluntary educator role. Their precious time is needed to earn income for their families. Opinion was unanimous in the villages visited, as well as among the representatives of partner donor agencies (GTZ, UNAIDS, UNDP), that the peer educators should receive some remuneration, both to retain them in this important function and to give them the recognition they deserve.

The other opportunity for granting recognition as an incentive for engagement on HIV/AIDS is the semi-annual meeting at which report card voting takes place. In many parts of Africa, certainly in the south of Cameroon, community gatherings traditionally are occasions where food and drink are provided. This refreshment not only encourages people to attend the event but also demonstrates respect for their attendance. Critics might say that if refreshments are served people will attend primarily for that reason. The analogy may be children who receive school lunches. They are more apt to go to school, but while there they will also go to class and learn. Similarly, providing modest refreshments may draw people to the report card sessions, but once they are there they will participate in the discussions that should enhance their wellbeing.

Integration

Propagating messages aimed at changing peoples' behavior to reduce the prevalence of HIV/AIDS is not easy. To do so effectively requires all the help available: to strengthen communication in whatever way possible, but also to enhance the transmission and acceptability of the message. The message itself, to be palatable among ordinary persons, may best be cloaked as part of a holistic, multi-sectoral development program rather than as an isolated HIV/AIDS intervention. Stronger communication can come from forging strong links between the HIV/AIDS community program, including the self-evaluation with its report card component, and local government. This strengthening can also entail sound analysis with proper use of qualitative and quantitative research techniques.

In one community, during the report card voting procedure, the local mayor made an unannounced visit. He had heard of the meeting and wanted to come and lend his support to the cause of fighting HIV/AIDS. This was an articulate, hands-on, respected mayor. When he spoke about the importance of the HIV/AIDS program, people listened. After he left, people were more attentive to the proceedings than before he came. Clearly, collaboration between local government authorities and the HIV/AIDS program is one way to strengthen its effectiveness.

Perhaps more basic and obvious than this inter-institutional integration is the need for closer collaboration between the Local Response Unit (LRU) and the Operations Unit within the Central Technical Group (CTG) of the National HIV/AIDS committee (CNLS). The CTG has a monitoring and evaluation unit which, until now, has been disassociated from the LRU, so there is

very little analytical basis upon which to assess progress and identify areas needing improvement.

Taking just one example among many, a key issue facing the community members, especially in the outlying rural areas, was the cost of transport to the city where the blood-testing facility was located. People were said to generally accept the need for testing but many did not go because of the cost of two trips, one for the test and a later one for the results. The people of one community said they had found a solution to this problem by convincing the government to drive a mobile testing unit to their community. Sound, comprehensive analysis of peoples' willingness and ability to pay for transport to testing centers, and of the cost of bringing testing units to villages, would be most useful to policy formation regarding blood testing. The institutional integration recommended here may well soon happen as one of the next steps for the report card component is to transfer it to the monitoring and evaluation unit of the CTG.

The final recommended integration may well be the most important. Common sense tells us that people feel uncomfortable discussing HIV/AIDS. The topic is just too personal and, increasingly, too painful, as loved ones die of this disease. It is likely that a significant number of people do not participate in meetings on HIV/AIDS because of this discomfort and embarrassment. The report card approach for self-evaluation may well play a useful role in all development sectors – health, education, agriculture, etc. This integration would make sense because all sectors are affected by HIV/AIDS but also because, presented as part of a development package, people would likely feel less timid addressing issues associated with the disease. Consideration is being given to incorporating HIV/AIDS issues in this manner into a Bank-supported community-driven development (CDD) program in the near future.

Conclusion: The Potential of Report Cards for HIV/AIDS Prevention

Overall, the self-evaluation process and its report card instrument have been well received by the communities, the municipalities and CNLS. People appreciate this process whereby local HIV/AIDS committee members report to them on program activities. Those entrusted to manage the program are made accountable to the people who, after all, must be the key actors in avoiding infection from this pandemic. Where this self-evaluation has taken place, community members now claim that they are better informed and better understand the use of funds employed in the fight against HIV/AIDS.

Social monitoring is also well received. People are empowered by participating and being consulted on the main issues of the HIV/AIDS program. Shortly after the first self-evaluation sessions had taken place in 2004, a number of local HIV/AIDS committees were replaced as a result of communities expressing dissatisfaction with them. The main reason was the embezzlement of funds targeted for HIV/AIDS prevention activities. Generally, the self-evaluation process is becoming accepted and a part of community life.

It is difficult to provide any definitive assessment of the effectiveness of an innovation like report cards when it is little more than a year old. This difficulty is compounded by the lack of qualitative and quantitative analysis done on the program to date. What can be said in this progress report is that the report card approach does seem to be making positive, noteworthy contributions to HIV/AIDS prevention in communities where it has been applied. This is a promising form of social accountability at the community level.

People seem to appreciate and to be drawn into engagement in the difficult discourse on HIV/AIDS by the innocence and even fun of the report card game. They appear to enjoy seeing immediate feedback on their responses to questions. Awareness of the disease has increased as has community mobilization to take collective remedial action. The people have gained ownership of their own self-evaluation work. They feel a sense of power by influencing actions on HIV/AIDS and judging the quality of health and support services. With the corrective measures recommended above – relating to preparation of the communities, training of the

meeting leaders (MFPs), better use of the local vernacular, recognition, and integration – it appears that this report card approach may well be internalized in the HIV/AIDS program of Cameroon in such a way that it will provide a sustainable contribution to the prevention of this disease.

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