Capacity-building for knowledge generation: Experiences in the context of health and development

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Preface

Capacity-building is key to sustainable development efforts. For all the right reasons, over the past decades it has also enjoyed considerable attention in the field of health and development. However, perspectives on what capacity-building means, what it intends to achieve and which strategies are most effective differ, depending on the context and the perspectives of a variety of stakeholders. This book aims to contribute to conceptual reflection but mostly to share experiences regarding a range of capacity-building approaches in different contexts that have in common that they are situated outside formal lecture hall settings and intend to contribute to knowledge generation.

The idea to produce this book stems from experiences with the multi-country programme for social science research on HIV and AIDS that was hosted by the Royal Tropical Institute (KIT) from 2004 until 2009 and the aftermath of this programme. A range of institutions from five African countries from across the continent participated in this programme, with the central focus of building capacity in the fields of research, knowledge management and monitoring and evaluation, while linking and strategizing between and within countries. One of the outcomes of this process was the establishment of national platforms for coordination and implementation of HIV-related research. Towards the end of the programme, the focus became more regionally oriented, resulting in the birth of the so-called Great Lakes applied research consortium. (For reflections on the multi-country programme and the consortium, see Chapters 6 and 7.)

Originally, the editors aimed to present the different studies conducted under the umbrella of the multi-country programme and the consortium. Hence, the book dwells on some of the outcomes and lessons learned from those initiatives. However, along the way the editors took up the challenge of expanding the book's scope by including the views of other colleagues working in the field of capacity-building for health and development. They were asked to describe the different capacity-building processes they are or were involved in and to reflect on their experiences with these processes. Their encouraging responses made it possible to produce this book.

I am pleased to be able to present this book containing seven chapters that share experiences with different strategies for capacity-building, ranging from empowerment, writeshops and strengthening of research capacity to stakeholder analysis, knowledge management and mind mapping. KIT, as an independent knowledge centre, has been involved in such strategies for capacity-building for health and development in Africa and Asia for many decades. While we recognize the added value of partnering with other institutions, especially in the global South, and invited co-authors from several of these institutions to contribute, this book also constitutes an opportunity to share the breadth and wealth of KIT's collective experience with capacity-building for health and development.

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Finally, we would like to thank Jon Stacey of The Write Effect for the English editing of the book.

The editors

Abbreviations and acronyms

AAP	Purchaser agency
AIDS	Acquired immune deficiency syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal care
ASACO	*Association de Santé Communautaire* (Mali) (Community health association)
DHMT	District health management team
DMHIS	District mutual health insurance scheme
DRC	Democratic Republic of Congo
FGD	Focus group discussion
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLARC	Great Lakes Applied Research Centre
HIV	Human immunodeficiency virus
HQ	Head quarters
HSS	Health systems strengthening
KIT	Royal Tropical Institute
M&E	Monitoring and evaluation
MAP	Multi-Country HIV/AIDS Program (World Bank)
MCP	Multi-Country Programme (for Social Science Research on HIV and AIDS)
MDG	Millennium Development Goal
mhealth	Mobile health
MOH	Ministry of Health
NGO	Non-governmental organization
PBF	Performance-based financing
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
RAWOO	Netherlands Advisory Council on Development Research
RBF	Results-based financing
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SIEC	*Système d'Information Essentielle pour la Commune* (Community essential information system)
SNV	Netherlands Development Organization
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
SWOT	Strengths, weakness, opportunities and threats
TASO	The AIDS Support Organization (Uganda)
TB	Tuberculosis
TBA	Traditional birth attendant
TSF	Technical Support Facility (UNAIDS)

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VLC	Virtual learning community
WHO	World Health Organization

Introduction

Creative pathways: From capacity development to action learning

Anke van der Kwaak, Annemiek Richters and Hermen Ormel

> *'If you can't fly then run, if you can't run then walk, if you can't walk then crawl, but whatever you do you have to keep moving forward.'*
> Martin Luther King

This book is about capacity-building for knowledge generation in a diversity of settings, especially in Africa. The programmes presented throughout the book aimed to support this capacity-building process, and each created its own context-driven pathway to reach its own specific goals. In this introduction to the book and its chapters we present and discuss the different definitions and models of capacity-building and action learning and the framework that has guided our work. We conclude with a brief overview of the content of the seven chapters.

Formal and informal forms of education

On the verge of the new millennium the participants of the World Conference on Higher Education (5–9 October 1998), assembled at the United Nations Educational, Scientific and Cultural Organization (UNESCO) Headquarters in Paris, stated in their *World Declaration on Higher Education for the Twenty-first Century* their conviction 'that education is a fundamental pillar of human rights, democracy, sustainable development and peace, and shall therefore become accessible to all throughout life and that measures are required to ensure co-ordination and co-operation across and between the various sectors, particularly between general, technical and professional secondary and post-secondary education as well as between universities, colleges and technical institutions.' They further emphasized that higher education systems 'should enhance their capacity to live with uncertainty, to change and bring about change, and to address social needs and to promote solidarity and equity; should preserve and exercise scientific rigour and originality, in a spirit of impartiality, as a basic prerequisite for attaining and sustaining an indispensable level of quality; and should place students at the centre of their concerns, within a lifelong perspective, so as to allow their full integration into the global knowledge society of the coming century' (World Conference on Higher Education 2008).

According to the preamble to the Declaration, higher education includes 'all types of studies, training or training for research at the post-secondary level, provided by universities or other educational establishments that are approved as institutions of higher education by the competent state authorities. Everywhere higher education is faced with great challenges and difficulties related to financing, equity of conditions at access into and during the course of studies, improved staff development, skills-based training, enhancement and preservation of quality in teaching, research and services, relevance of programmes, employability of graduates, establishment of efficient co-operation agreements and equitable access to the benefits of international co-operation' (Ibid.).

Reflecting on the above as it regards the field of health and development, we found that in many parts of the world there is indeed ample training in medicine, epidemiology, statistics and quantitative research and analysis, but, as the chapters in this book demonstrate, a real need exists for capacity-building in a range of complementary methodological approaches and theories, especially in the fields of (medical) anthropology, public health, health systems research, health economics, community health, applied statistics, philosophy and ethics and other health-related subjects. In addition to the work in this field of complementary approaches carried out in formal educational settings such as universities, polytechnic institutes, colleges and schools, a lot of training takes place outside these settings, especially within development programmes in partnerships with governmental and non-governmental organizations and knowledge institutes (see, for instance, King et al. 2010).

This book touches on training and other forms of capacity-building that take place outside traditional school settings where hierarchical teacher–pupil relationships dominate. In contrast to this, we present processes taking place in settings where a variety of actors exchange, learn and study to, in the words of Martin Luther King, move their work forward. Before we present the different tools and approaches used in such informal, fluid learning practices we first share some ideas and concepts about capacity-building.

Definition and models of capacity-building

There is a wide body of literature on capacity-building and capacity development. The term capacity development emerged in the lexicon of international development during the 1990s. The question is what is the difference between capacity-building and capacity development? The United Nations Development Programme (UNDP) (2009) defines capacity development as the process taking place at different levels, through which individuals, organizations and societies obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time. Capacity development is a process of change, and hence is about managing transformations. The various levels it involves are interlinked and interdependent. An investment in capacity development must design and account for impact at these multiple levels. *Capacity development* used to be seen as a process ‘from within’, while *capacity-building* was seen as a process ‘driven from the outside’. Today, these different definitions have blurred, and “capacity-building” and “capacity development” are used interchangeably and included as a goal in the programmes of most international organizations that work in development, including the United Nations (UN), the World Bank and a host of international non-governmental organizations (NGOs). UNDP (2009) sees capacity-building as a long-term continual process of development that involves all stakeholders; including ministries, local authorities, NGOs, professionals, community members, scholars and others. Capacity-building uses a country’s human, scientific, technological, organizational, institutional and resource capabilities. The goal of capacity-building is to tackle problems related to policy and methods of development, while considering the potential, limits and needs of the people of the country concerned. We have chosen to include capacity-building in the title of this book as defined by UNDP (2009), but also use the term capacity development as synonymous, as do other authors in this book.

Global initiatives

The World Bank's *Capacity Development in Practice* initiative (2011) takes as a starting point that, to gain sustainable results, it is critical to strengthen stakeholder ownership and address the efficiency of policy instruments and the effectiveness of organizational arrangements. In each of the World Bank's thematic programmes a mix of four main business lines are used to address a country's development needs. The first is innovation: platforms are offered for nurturing and sharing innovative practical solutions to development challenges. The second deals with knowledge exchange, which includes just-in-time sharing of information and experiences among development practitioners and leaders, debates about various options for policy reform, topic-specific field visits between developing countries, or dialogues among various development stakeholders as a way of building consensus and coalitions for reform, such as global dialogues on the economic crises. The third line is leadership, whereby the World Bank offers customized support to high- and mid-level decision-makers and emerging leaders at the national and subnational levels who are looking for innovative solutions to tough development challenges, whether in fragile states and post-conflict situations or in major reform initiatives such as decentralization. The last key issue is structured learning, consisting of providing training courses, workshops and conferences that help clients (government officials, private-sector managers and civil society organizations) develop skills and address capacity constraints in priority sectors or disciplines. The World Bank offers a range of frameworks, strategies and documents to support its capacity development strategy.

What we can learn from this is that capacity development can never be a vertical approach targeting only one level or group of professionals, clients or others, but has to be also a horizontal and mainstreamed process which reaches out to different groups of stakeholders at the same time.

When we look at NGOs there is a wide range of approaches and philosophies in terms of capacity development. The Dutch NGO Oxfam Novib (2011), for instance, states that it has contributed a lot to capacity development in the past, such as with HIV and AIDS workplace policies, but that it wants to strengthen this process more systematically from 2012 onwards. It intends to undertake capacity assessments with its partner organizations using a tool to map and monitor capacities by asking 20 questions that help identify an organization's capacity regarding five core capabilities, as presented by Heider (n.d., see below). Similar processes seem to take place within other NGOs. There are a large number of documents, guidelines and training tools all focusing on the capacity development or capacity-building of NGOs. Important questions which are asked, such as 'who builds whose capacity?' (Eade 1997), still seem valid.

In this context, Sanyal (2006) underlines that an important reason for the inability of NGOs to bring sustainable impact has been their failure to establish the right linkages between local imperatives and global systems. She then points to a new type of NGO that aims to create linkages between local issues and global institutions. These NGOs have been variously termed as "intermediary NGOs", "bridging organizations" and "support organizations or half-way houses". They have two different features: they are located at the centre of several constituencies – local groups, national bodies and international institutions – and their activities include innovative programmes such as organizational capacity-building, training, staff development, research, advocacy, collection and dissemination of information, and networking, all of which are not considered traditional NGO activities. These features enable such organizations to establish the "bridging ties" between civil society groups and organizations and the institutional structures at the national and global level. In her article Sanyal focuses on the Indian NGO, the Society for Participatory Research in Asia (PRIA). Her analysis of the governance issues related to this NGO's work is interesting for this chapter, as she shows the paradox related to the Society being sandwiched in between international and national agencies on the one hand and local communities on the other. Although the model seemed to work well in terms of local responsiveness and legitimacy, the Society's influence at the global level decreased while the NGOS also missed out actual contact with the communities themselves.

Competencies, capabilities and capacity

The current thinking on capacity-building looks at how capacity emerges and how it is sustained. Heider (n.d.) makes a distinction between the development of:

- individual competences (the mind sets, skills and motivations of individuals);
- collective capabilities (the capacity of a system to carry out a particular function or process); and
- overall capacity (the overall ability of an organization or system to create public value).

She underlines that in capacity development the capacities of these three levels need to have the following five capabilities:

- to commit and engage (volition, empowerment, motivation, confidence);
- to carry out technical tasks (directed at the implementation of mandated goals);
- to relate, attract resources and support (manage relationships, resource mobilization, networking, legitimacy building);
- to adapt and self-renew (learning, strategizing, adaptation, repositioning); and
- to balance coherence and diversity (encourage innovation and stability).

One of the current definitions of capacity development is building abilities, relationships and values that enable organizations, groups and individuals to improve their performance and achieve their development objectives (Ulleberg 2009). This is nothing new, but also here the concept of change or transformation is essential. If capacity development is defined as initiating and sustaining a process of individual and organizational change that can equally refer to change within a state, civil society or the private sector, it is also meant as creating change in processes that enhance cooperation between different groups of society (Ibid.). This definition emphasizes three aspects: (i) capacity-building as the catalyst and constant fuel for a process of change, (ii) the importance of building institutional capacity and (iii) the involvement of a wide range of groups in society. Here the importance of a more participatory learning process becomes clear, whereby all stakeholders – clients and programmers – are involved (Ibid.).

What we have seen so far is that there is an overlap in many of the approaches and definitions. As editors and authors of the current book we see some challenges: capacity development is mostly assumed to automatically contribute to positive change, ignoring that some aspects may be less desirable depending on who's in charge, who's involved and what are tangible benefits for staff and end-users. Then there is attention to context, but cultural specificities are hardly mentioned in the writing about capacity development other than a call for local appropriateness or responsiveness.

To start with the first challenge: in literature, besides the assumed benefits of capacity-building, there is growing concern that 'often it does not lead to lasting organizational improvement, and can even cause organizations harm' (Blumenthal 2001: 1) or even the idea that the wrong capacities of the wrong people are strengthened (Ebrahim 2003). In a paper about the capacity development of voluntary and community organizations in the UK the authors underline that because there are so many possible reasons for building capacity and so many possible ways of achieving capacity, capacity-building is a reflection of the ideological, theoretical and conceptual confusion surrounding it (Cairns et al., 2005). Is it organizational change, training, organizational development, organizational performance, strategic review or business planning we are talking about or a key building block in developing civil society and improving the lot of disadvantaged groups – a means to achieve radical social and economic change? Organizations and NGOs might indeed be totally confused about what they are offered or are supposed to do from the perspective of funders or others with whom they have a dependency relationship. Cairns et al. (2005), therefore, propose the term "action learning" which refers to the idea of achieving organizational change and performance improvement through peer reflection and critical review of working practices. Action learning is advocated as a means to build capacity by several writers (Schofield et al. 1995, Jones 2001) especially those who take an empowerment approach. Fowler (2007), referring specifically to NGOs, argues that action learning is a key means by which an organization can 'gain mastery of itself'.

Kaplan (1997) argues in this context that to be effective facilitators of capacity-building in developing areas, NGOs must participate in organizational capacity-building first. Steps to building organizational capacity include: developing a conceptual framework, establishing an organizational attitude, developing a vision and strategy, developing an organizational structure and acquiring skills and resources. He also argues that NGOs who focus on developing a conceptual framework, an organizational attitude, vision and strategy are more adept at being self-reflective and critical, two qualities that enable more effective capacity-building.

Thus, action learning could be the right term, but what about the second challenge: the accountability to culture and context? Ebrahim (2003) has presented several frameworks of capacity-building and summarizes lessons learned, namely that simple training programmes can achieve little on their own, that effective capacity-building 'is rarely confined to addressing only one of the elements in isolation', the greater contexts need to be examined, analysed and addressed, and capacity-building is a long-term process that requires patience. That is indeed useful, but until now culture is missing. For this we have to turn to the topic of cultural competence.

In the field of cultural competence a wide variety of definitions is to be found. Cross (1988) defines it as a set of congruent behaviours, attitudes and policies that come together in a system, agency or professional and enable that system, agency or professional to work effectively in cross-cultural situations. He proposes a continuum that ranges from cultural destructiveness, cultural inability and cultural blindness to cultural pre-competence and advanced cultural competence.

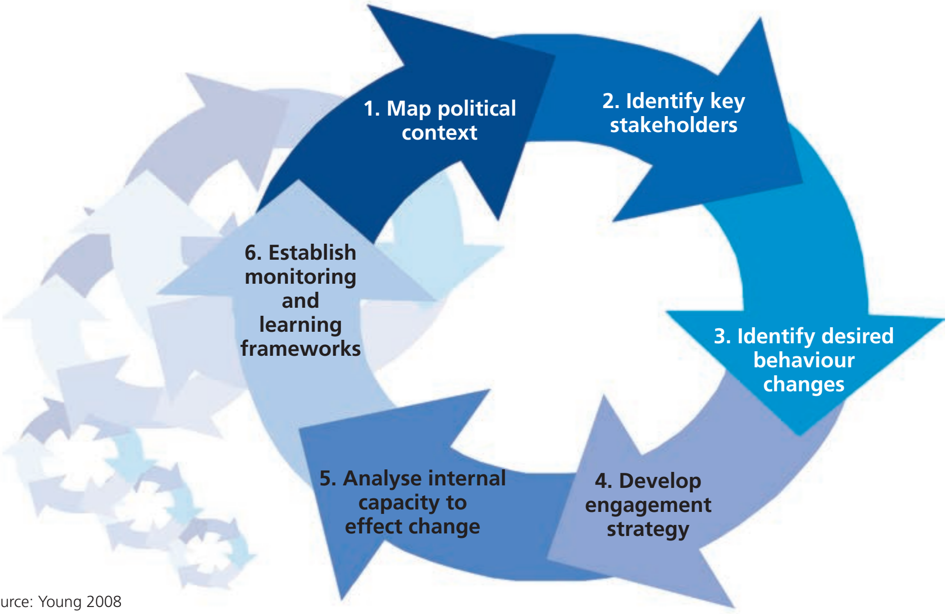
Within the realm of cultural competence there is an emphasis on communication and the ability to be aware of one's own cultural background, biases and behaviour, the ability to pay respect and be open to other cultural behaviours and backgrounds, knowledge on basic cultural issues, recognition of basis difference and skills in terms of verbal and non-verbal communication (Teal and Street 2009). However, it seems that this cultural competence needs to be integrated into the different approaches to capacity-building or action learning to be effective. This means often that stakeholders have to be involved in action learning processes from the start. Needs assessments and involvement of policymakers, implementers and especially end-users, clients and target audiences are a way to do this. This book presents case studies in which these circumstances were often present. Another aspect related to cultural competence is that involving those who matter means actually sharing the outcomes of the action learning process. In the next section we, therefore, focus on knowledge translation.

Knowledge brokering

Evidence-based policy can be defined as government(s) 'mak[ing] well-informed decisions about policies, programmes and projects by putting the best available evidence from research at the heart of policy development and implementation' (Davies 1999a, as quoted by Davies 2004). Policies, programmes and interventions aiming at improving health and well-being are more effective if they are based on sound evidence (i) regarding the nature of the problem and related influencing factors, and (ii) regarding what works, and what doesn't, to achieve results and impact. Regrettably, action learning findings often do not find their way into new and adapted policies and programmes. This can be due to a lack of understanding, of advocacy skills and empowerment to become recognized contributors to the policy development and monitoring processes or to advocate effectively for social science research to inform policies and programmes. Simultaneously, policymakers and end-users may not be trained to access, digest and apply action learning findings. From the various models representing the "translation" process from research findings to policy and programme application, Figure 1 visualises the knowledge translation process and has inspired this book. Once new or adapted knowledge has been produced through research, a number of steps are needed for it to find its way into policies, programmes and, ultimately, practice.

Special attention in this process goes to dialogue and communication between action learners, researchers, policymakers and other stakeholders, from the early stages of capacity development or action learning processes, from topic prioritization and design, as donors and the research community alike increasingly recognize that it is essential to address the gap between research findings and their uptake. Knowledge brokering is a

Figure 1 Knowledge translation process



Source: Young 2008

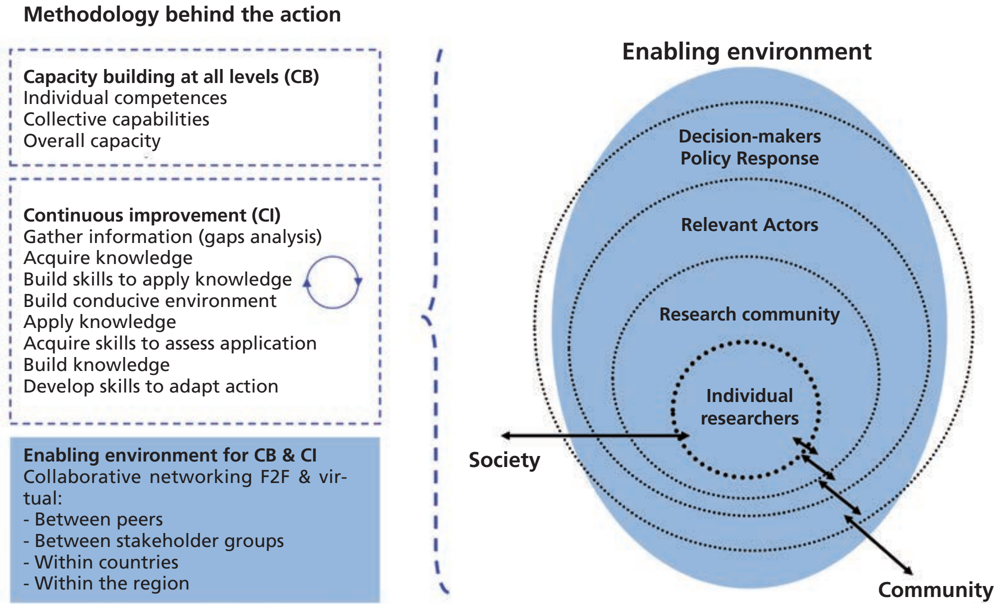
strategy to close the gap and foster greater use of research findings and evidence in policy-making. The "flow model" presented in Figure 1 takes the researcher and important stakeholders through six steps that build on each other and include: mapping the political context, identifying key stakeholders, identifying desired behaviour changes, developing engagement strategies, analysing internal capacity to effect change and establish monitoring and learning frameworks (Young 2008). This means that this process has to take place at the beginning of any capacity development process or action learning initiative.

Our framework

It is now time to present the framework used for this book and the case studies it contains. The capacity-building and action learning processes described in this book have engaged the research and NGO communities in diverse settings including African countries as well as global constellations. All processes described are aiming to strengthen intellectual engagement and the culture of enquiry (see Figure 1). This means that not only knowledge institutes and researchers participated but also problem owners, policymakers, interventionists, advocates and other end-users of research.

Capacity-building from our perspective is a way of action learning including building capacity to coordinate, network and translate knowledge to ensure that research is relevant to inform policy and practices. It indeed focuses on three levels: the individual, the collective and the overall capacity. The process also strongly invests in the continuous improvement of aspects of enabling environments as shown in Figure 2.

Figure 2 Broad-based capacity development or action learning



Source: the authors

The content of the book chapters

Each chapter in this book presents one of more cases of action learning or capacity development. All chapters have at least one author who actually works or used to work at KIT. KIT is an independent, not-for-profit organization and knowledge centre, founded in 1910, which is involved in international development projects and cultural initiatives in more than 60 countries around the world. KIT development researchers and advisors all have a combination of field, academic and teaching experience. KIT advisors are also involved in operational research projects on what works, why and for whom, particularly in Asia and Africa. The joint action learning programmes of KIT and its partners produce a growing evidence base for innovative problem-solving approaches. Capacity development is central to KIT's approach: we aim to build capacity development components into all the work we do. We emphasize sharing knowledge and exchanging ideas through networks, meetings, writeshops and publications. The co-authors of the different chapters are often researchers or professors from other universities and knowledge institutes or work at the NGOs with whom KIT collaborates.

In Chapter 1, *Pam Baatsen* and *Barend Gerretsen* take us into the world of online capacity development within the e-learning module on health systems strengthening (HSS) and HIV responses. They argue that the success of scaling up responses to HIV and AIDS in part depends on improvements in the structures and functioning of the broader health system and that experts dealing with HIV need to be empowered with health system competences. The chapter describes the virtual learning concept and approach and how the individual capacities of 49 consultants – regularly working for the UNAIDS Technical Support Facilities – from African, Asian and Latin American countries were enhanced.

Chapter 2 contains a case study looking into the strengthening of collective capabilities under the title ‘Young people living with HIV: Life skills, self-esteem and social media in Kibera, Nairobi’. *Anke van der Kwaak, Hermen Ormel, Francis Obare* and *Tobias Ouma* present a small knowledge translation process that followed an action research project among young people living with HIV. The dissemination of the study went hand in hand with mind mapping skills, expressing ideas and initiating a virtual community. Bridging and bonding by building capacities is the central focus of this chapter.

Chapter 3 presents two research training processes carried out with, respectively, the African Medical and Research Foundation (AMREF) and The AIDS Support Organization (TASO) in Eastern Africa using a participatory approach, starting with identifying research problems and leading up to dissemination of the studies in books and journals*. Anke van der Kwaak, Betty Kwagala, Josephine Birungi, John Nduba, Liezel Wolmarans* and *Gerard Baltissen* show how capacities were developed at three levels in the organizations: individual professionals were trained, the collective was strengthened, as there were multidisciplinary regional and national teams doing research, and at the end the overall capacity of the organization and its stakeholders was strengthened. The chapter shows that leadership and an enabling environment are key to this process.

Lucie Blok, David Plummer, Georges Tiendrebeogo and *Françoise Jenniskens* reflect in Chapter 4 on the methodological challenges in studying complex systems. The chapter entitled ‘Impact of HIV programmes on health systems strengthening in five African countries: Methodological challenges in studying complex systems’ explores the experience of research designed to study the impact of HIV programmes on health systems in Burkina Faso, the Democratic Republic of Congo, Ghana, Madagascar and Malawi. It reflects on the methodological challenges and research innovations within a regional approach of action learning.

Chapter 5 takes us into the field of results-based financing and shows how proper preparation prevents poor performance. *Bertram van der Wal* and *Jurrien Toonen* share with us the interesting ins and outs of implementation processes of results-based financing in Mali and Ghana. The chapter shows that a one-size-fits-one approach led to two different models whereby capacity development, involving local communities and mobilizing resourcefulness were key. The dynamic approach and need for continuous improvement and contextualization are very strongly presented.

In Chapter 6 *Rob van Poelje* takes us back to the beginning of action learning, namely multi-stakeholder process and analysis. He presents the so-called Multi-Country Programme (MCP) in five African countries, focusing on social science research on HIV and AIDS. He shows that stakeholder and peer processes can start to lead a life of their own, that regional approaches do not come naturally and that systems, teams, peers and countries need to be motivated and taught how to share their competencies and how to collaborate to come to more effective outcomes and outputs.

In the last chapter of the book the follow-up of the process presented in Chapter 6 is described – namely the case for a Great Lakes Applied Research Centre. The authors, *Annemiek Richters, Hermen Ormel* and *Anke van der Kwaak*, reflect on a rich process of action learning on vulnerabilities and agency among institutes working in a regional network.

One can argue that the books ends on a negative note, as the research centre never materialized. However, it is stressed that the development of networks and research alliances is very possible, but that without funding and leadership it will not be viable. The processes described in this chapter – as in the rest of the book – show that capacity development cannot be a goal in itself but that it should be part of an existing financed programme. Only then will a multi-level strengthening of capacities and capabilities be realized. Creative collaboration, critical reflection and contextualization prove to be key within a dynamic process moving forward.

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KIT staff discussing activities on the virtual learning community platform (Photo: Anke van der Kwaak, KIT)

1 Online capacity development 2.0: Using virtual learning communities

Pam Baatsen and Barend Gerretsen

'The whole event was very useful. It was a platform for all the professionals in the region to interact and share new innovations and practices in the health systems.'
Participant, virtual learning community on health system strengthening and HIV responses

Abstract

The success of scaling up responses to HIV and AIDS in part depends on improvements in the structures and functioning of the broader health system. However, experts dealing with HIV do not necessarily have health system competences. To address this, 49 consultants from African, Asian and Latin American countries regularly working for the UNAIDS Technical Support Facilities were brought together in virtual learning communities (VLCs) for capacity-building on health systems strengthening (HSS) and HIV responses. This chapter describes the VLC concept and approach, as well as the process followed to develop these specific VLCs and the contents dealt with.

In their evaluations at the end of the VLCs and one year later, participants indicated that the learning was relevant and based on real life situations and needs, and that it enhanced their appreciation for different perspectives on health system issues. They were able to use their own and each other's experiences, and build on these through reflection. These results endorse the view that VLCs are a good avenue for competence-based learning strategies. The evaluations also demonstrated that participants perceived an increase in their capacity to work on HSS and HIV responses and that many of them continue to apply the knowledge and skills gained in their daily work.

1.1 Introduction

After the HIV epidemic manifested itself in the 1980s, the reaction in many countries was to initiate and sustain specific programmes that could deliver effective and equitable responses to this new and threatening disease, addressing prevention, counselling and testing, and treatment, care and support, among others. However, three decades later these disease-specific programmes have performed less well than expected (Atun et al. 2008, Grepin 2011). The sheer size and complexity of the epidemic require new approaches.

Over the past years, discussions around the need to scale up the HIV responses led to the realization that national health systems need to be strengthened to improve the impact of the HIV-specific programmes (WHO 2007). The care and support programmes, in particular, often use the same service delivery apparatus (health facilities, health workers, management and supply chain structures) as other health services. As a result, there has been a rapid increase in the demand for experts with competences to improve the structures and functioning of the broader health system to facilitate scaling up HIV responses.

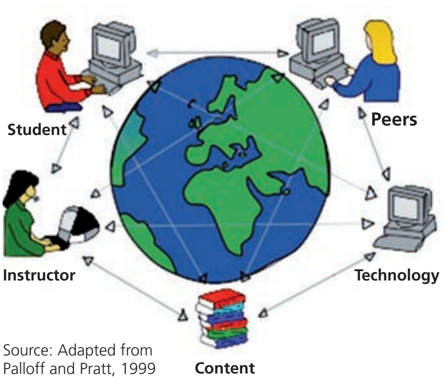
Against this background, the Amsterdam-based Royal Tropical Institute (KIT), in collaboration with the UNAIDS Technical Support Facilities (TSFs), piloted two courses on HSS and HIV responses in 2010 using a VLC as a learning environment. The participants were 49 consultants from African, Asian and Latin American countries, working regularly for the TSFs, who were brought together to meet and connect on a web-based platform in an interactive and dynamic manner. They were offered this learning experience free of cost. The purpose of this chapter is, first, to describe the VLC concept and its specific approach, the process followed to develop the specific VLCs, the content dealt with and some of the products developed by the VLC members; second, it provides an analysis of the capacity built as a result of the VLC approach.

1.2 What is a virtual learning community?

A VLC has been defined as 'a gathering of people, in an online "space" on the internet, whereby people are joined together by mutual interest to intensively and interactively examine a particular theme. By doing so, they are able to learn together in a dynamic and purposeful way and exchange existing knowledge and work on aspects of problem solving together' (Boetcher et al. 2002).

Figure 3 Virtual learning communities

The learning Web



Source: Adapted from Palloff and Pratt, 1999

Various types of VLCs can exist – for instance, spontaneously formed communities around a common interest, or communities facilitated by a contracted facilitator, a so-called "managed VLC" (Lewis and Alan 2005). They can exist for shorter or longer periods of time, depending on their aims. The VLCs on HSS and HIV responses discussed in this chapter were both managed VLCs, purposefully created for shorter periods of time. The first was directly managed and facilitated by KIT staff, while the other was managed by the UNAIDS TSF for South Asia with backstopping support from KIT.

While in theory any online space could be used for a VLC, for more formalized VLCs such as the ones we used it is important to ensure that the learners and moderators can work in a well-structured environment that facilitates learning interaction and the development of learning products that then are shared. These learning products can be short papers, presentations, newspaper-type articles, multiple choice questions and statements for debate, but also audio and video recordings. After uploading draft products to the VLC platform, fellow participants are asked to provide constructive feedback, on the basis of which the learning products can be improved. For the two VLCs on HSS and HIV responses, Virtual Action Learning software, developed by the Dutch company Citowoz, was used (see www.citowoz.nl).

1.3 Why use a virtual learning community?

In the first VLC managed and facilitated by KIT, 24 experienced consultants from three continents took part in early 2010; the second VLC involved 25 participants from South and East Asia and the Pacific in the second half of that year. All participants had completed higher education, were mainly male and had at least three to five years working experience. Flying people in from all over the world for several weeks of training would have been much more costly, while the costs now remained limited to "renting" the Virtual Action Learning software, for which we paid a few hundred Euro for a three-month period, and the time investment of the facilitators for preparation and tuition. In addition, the consultants are all very busy people with limited time for learning. By using a VLC approach, these consultants could identify the most convenient time for them to work on the learning products, throughout the seven-week duration of the VLC.

Taking into account the characteristics of the target group, the VLC should be able to meet adult educational principles: self-directed learning and building on experience with a problem-solving approach (Honebein 1996). The organizers considered the VLC a convenient learning environment for applying these principles. By using this approach, learners are motivated to apply their knowledge to complete assignments, to build on their own experiences and to review and reflect on each other's work by giving each other and receiving feedback. The feedback process increases mutual learning, where necessary assisted by the moderators. In this way, participants strengthened competences considered essential for carrying out tasks they have as consultants.

To supplement the a-synchronic learning, two or three short, real-time Skype sessions for participants, facilitators and experts were organized, to provide additional opportunities to raise issues or obtain feedback. Also, all consultants and facilitators were asked to upload a photo and a short description of themselves to the platform. All this helped to increase the sense of a "community".

Adult education and competence-based learning are also used as complementary approaches in KIT's other educational activities, including its Masters courses in Public and International Health. Thus, moderating a VLC fits the existing teaching skills within KIT's faculty.

1.4 What did the virtual learning community aim to achieve?

As mentioned above, the two VLCs were developed to increase health systems-related competences among experts dealing with scaling up HIV responses. Scaling up HIV responses to achieve the goal of universal access to comprehensive HIV prevention, treatment, care and support programmes was agreed upon by the UN General Assembly in 2006. The General Assembly also agreed that major obstacles to achieving universal access, including weak health systems and inadequate human capacity, would need to be addressed (UNAIDS 2006).

The VLCs aimed to contribute to achieving universal access by enhancing the capacity of the participants to (i) analyse and evaluate which components and functions of a health system require strengthening to scale up HIV and AIDS responses, and to develop concrete recommendations for improvements; and (ii) identify, analyse and utilize opportunities presented within HIV and AIDS programmes to establish synergies between the health sector response to HIV and AIDS and efforts to strengthen the existing health system – for instance, through the integration of stand-alone voluntary counselling and testing services for HIV within the existing health system.

UNAIDS TSFs were requested to identify interested consultants from their databases who met the following criteria:

- a special interest in and/or some experience with the topic;
- a reasonable level of written English;
- committed to participate and invest three to four hours per week and complete the full course;
- having internet access to use the VLC platform; and
- ideally having participated in or followed the online (D-group) discussion on HSS and HIV responses prior to the VLC.

This online discussion platform had been set up by KIT towards the end of 2009 to facilitate exchange on various aspects of HSS and HIV responses among approximately 150 UNAIDS TSF consultants and UNAIDS country partners in Africa, Asia and Latin America. Recruitment of participants for both VLCs took about two weeks.

1.5 How did the virtual learning community achieve its objectives?

Following a brief introduction session on the use of the VLC virtual environment using Skype and the GoTo-meeting teleconferencing platforms, the participants were asked to gradually complete six “learning arrangements”. In this particular VLC platform, a learning arrangement is an assignment that leads to an individually produced draft learning product, which is then uploaded to the VLC. Participants are requested to provide feedback on their peers’ learning products; therefore, a participant can improve his/her product and upload it again for a second round of feedback and improvement. While the first learning arrangement was relatively easy, subsequent learning arrangements became gradually more complex and challenging. One participant following the VLC mentioned in this regard:

> *‘While the start was relatively easy, towards the end I was sometimes really doubting whether I would be able to do it. However, as it was so interesting, I really could not give up on it, even though I was working on a challenging consultancy at the same time.’*

During the development of the VLC, care was taken to ensure that the learning arrangements produced a mix of learning products, as shown in the table below which provides an overview of the learning arrangements used during the VLC, linked to the matching learning objectives and products expected.

After having acquainted themselves in learning arrangement 0 with the VLC environment itself, in *learning arrangement 1* participants reviewed a video on health systems and the WHO document *Everybody's business: Strengthening health systems to improve health outcomes; WHO's framework for action* (2007). Subsequently, their first product took the form of a short text in which they described the health system they were working in, identified one critical health system component that required strengthening, justified that selection and developed a strategy to strengthen this particular health system component. After uploading the draft text to the VLC, they reviewed the draft products developed by two of their fellow participants and specifically addressed the strategies developed on the different health systems components and how they impacted on these different components.

In *learning arrangement 2*, participants produced and uploaded a draft paper in which they described the evolution of the vertical–horizontal debate for HIV programmes and analysed which approach their own country or a country of their choice had taken, possible changes over time and reasons for this, and main strengths, weaknesses, opportunities and threats (SWOT) of the current organizational approach.

In *learning arrangement 3*, participants were asked to review two of their colleagues' SWOT analyses and develop recommendations on how the response to HIV and AIDS could be strengthened; this was then also uploaded to the VLC. In turn, they were also expected to reflect on the recommendations made about their own SWOT analysis.

Table 1 VLC summary curriculum

Time frame	Learning arrangements (LA)	Specific learning objectives *After completing this learning arrangement the learner will be able to:*	Product expected
Week 1 - Day 1	LA 0 Using the VLC	• Employ some of the functionalities of the VLC	• A message on the platform • Your own personal profile and your photo uploaded
Week 1	LA 1 Health systems and their components	• Identify the key components and objectives of a health system • Identify the actors involved in a health system • Identify and explain key strategies for strengthening health system components • Analyse the relationships and interdependencies between health system components	• Presentation of a definition of a health system • Short (max. 1 page) paper with description of your own role within the health system you are working in or have worked in

Week 2	LA 2 Horizontal and vertical approaches	• Understand and explain the comparative advantages and disadvantages of "vertical" and "horizontal" (integrated) approaches in the context of HIV and AIDS	• A paper with strategies for strengthening different health system components; and • An analysis of relationships and interdependencies between different health system components
Week 3	LA 3 Horizontal and vertical approaches	• Recognize strengths and weaknesses of different organizational approaches to HIV and AIDS service delivery • Develop strategies for optimizing the organizational structures of HIV and AIDS responses in different contexts	• A paper describing the evolution of the vertical–horizontal debate for HIV and AIDS; including • A SWOT[1] analysis of the organizational structure of a current HIV and AIDS response
Week 4	LA 4 Scaling up AIDS responses and health systems (strengthening)	• Identify how scaling up HIV and AIDS responses depends on particular health system elements or functions • Explain how HIV and AIDS responses impact on health systems • Analyse which functions in a health system need strengthening to scale up HIV and AIDS responses	• A paper with recommendations for optimizing the organizational structure of HIV and AIDS responses
Week 5	LA 5 Scaling up AIDS responses and health systems (strengthening)	• Analyse strengths and weaknesses of indicators for health systems strengthening in relation to scaling up HIV and AIDS responses	• A paper with the formulation of 4 research questions related to scaling up HIV and AIDS responses and health systems (strengthening); with • A rationale for the selection of these 4 questions
Week 6	LA 6 Community systems strengthening	• Understand and identify the core components of a functioning community system • Identify community systems strengthening needs in the context of AIDS responses • Provide recommendations on community systems strengthening	• A paper with a formulation of 3 indicators related to measuring the impact of HIV scale-up on health systems • Voting for the top three indicators and discussion of strengths and weaknesses of these indicators
Week 7	Evaluation		• Online evaluation completed

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[1] SWOT analysis: analysing (internal) strengths and weaknesses and (external) opportunities and threats.

In *learning arrangement 4*, the VLC members reviewed a successful HSS-HIV Global Fund Round 9 proposal, identified two interventions that would have the greatest impact on the health system of that country and explained the expected impact. After sharing their draft documents on the platform, all were asked to comment on two fellow participants' draft products and to discuss whether they should revise their own draft product on the basis of the comments provided and received.

Learning arrangement 5 tasked the participants with formulating three indicators for measuring the impact of scaling up the HIV response on the health system and providing the rationale, strengths and weaknesses of each of the indicators. Subsequently, participants were invited to cast a vote for the strongest indicators developed by all participants and to provide a rationale for their vote. An example of one participant's work related to learning arrangement 5 is presented in Box 1.

Box 1 Example of product shared on the VLC

Learning arrangement 5 – Scaling up AIDS responses and health systems (strengthening)
Expected product:

- Formulation of research questions
- Providing rationale for the selection of these questions

Service delivery, organization and management

Research question: How has HIV scale-up affected the health system's ability to accommodate the special needs of vulnerable populations?

Indicator: Existence of an up-to-date national health strategy defining vulnerable populations, service provision, stakeholder relationships and accountability mechanisms to meet the needs of vulnerable populations.

Strengths: An evidence-based national health strategy defines vulnerable populations and outlines the services required to meet the health needs of vulnerable populations. That is: type and location of services, service cost, appropriateness, acceptability and quality of services. A national monitoring and evaluation framework is included in the strategy. The strategy should include key stakeholder relationships outside the health system, which will assist the health and wellness of vulnerable populations such as social security providers.

Weaknesses: A national health strategy to meet the needs of vulnerable populations may be in place but not used in practice. Data collection systems to monitor if vulnerable people's needs are met at the service level (for example: attendance at services, register of results, client record reviews, client satisfaction surveys, exit interviews, outreach service data) may not be in place, resourced or used.

Leadership and governance

Research question: Have public–private partnerships in the area of HIV influenced the accountability of the government to the public?

Indicator: Increase in number of non-HIV civil society organizations from year x to y with effective mechanisms for people to express their views to government organizations.

Strengths: Tracks the number of effective civil society organizations that have emerged since HIV/AIDS private–public relationships began until 2010. The systems of non-HIV/AIDS civil society organizations can be measured to assess if they enable/empower people to express their views to government (for example accessible, timely, consistent, transparent systems). A qualitative process could assess if HIV/AIDS private–public relationships influenced the establishment of the non-HIV/AIDS civil society organizations.

Weaknesses: It may be difficult to gauge whether civil society developments are primarily influenced by HIV/AIDS public–private relationships or whether these developments can be attributed to something else. Also civil society organizations in some countries are not permitted and/or acknowledged.

For *learning arrangement 6* the participants selected and reviewed an HIV grant proposal and, on the basis of the Global Fund community systems strengthening framework (GFATM 2010), identified what strategies described in the proposal focused on strengthening community systems. Following that, they provided constructive feedback on each other's work.

1.6 Results

1.6.1 Participation

The first group started with 24 participants, of which 12 (50 per cent) successfully completed all learning arrangements. Of the second group 20 out of 25 (80 per cent) participants were successful in completing the VLC. A lesson learnt from the first VLC was that not everyone was clear about the time investment needed. In response to this, members of the second group were asked to sign a declaration form in which they committed to participate and complete the VLC. The form also clearly spelled out the time investment needed to successfully do so.

The level of participation in the VLC and the enthusiasm expressed by the participants was very high.

Participants commented:

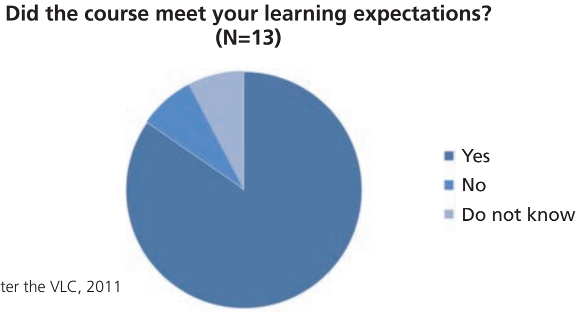
> *'It was the first time that I was participating in a web-based learning course, and I found it very interesting, especially the ability to interact with others in other time zones…'*
>
> *'I enjoyed it; it helped me focus my knowledge and identified my gaps too.'*

The two end-of-VLC evaluations (response: 13 out of 32) showed that those having stopped at the onset or mid-way mostly did so because of time-consuming consultancy assignments, but in some cases also because of internet connection problems. However, nearly all drop-outs indicated being interested in participating in the VLC if it were provided again.

1.6.2 Learning expectations

A year after the VLC, the large majority of the respondents said that it had met their expectations. Comments made included the following:

Figure 4 Evaluation of learning expectations, one year after VLC



Source: Evaluation one year after the VLC, 2011

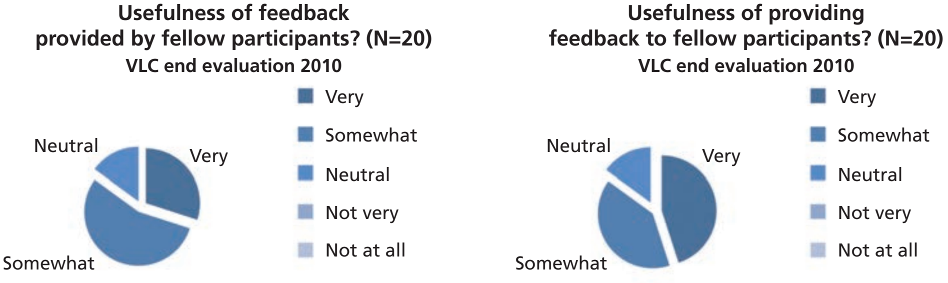
> *'Yes, it did push me to think more comprehensively.'*
>
> *'The training made me a national consultant for HSS.'*
>
> *'It helped me to understand the interaction between the HIV programmes and the health system.'*

The one person who responded negatively to this question justified his answer by saying, '*I wanted to get some professional feedback on my articles/impressions so that in future I can correct myself.' While* the set-up of the VLC was to have participants interact as professionals with each other, they felt a need to get feedback on their products from VLC moderators or other experts as well. For a next VLC this might be dealt with by informing participants that they do not receive feedback from moderators, thereby managing participants' expectations better, or by ensuring that such feedback will in fact be made available.

1.6.3 Learning from each other

Interestingly, in the evaluations at the end of the VLC (as opposed to the evaluations a year later), receiving feedback from fellow participants was seen as somewhat less valuable than providing feedback to other participants. Participants mentioned that some comments were excellent, some average and some unintelligible. Some mentioned that the comments from fellow participants provided guidance, helped to address doubts, helped to decide what should not or ought to be included in the products, and helped to understand different facts and perspectives, as well as commonalities.

Figure 5 Evaluation results regarding usefulness of feedback



Usefulness of feedback provided by fellow participants? (N=20)
VLC end evaluation 2010

Usefulness of providing feedback to fellow participants? (N=20)
VLC end evaluation 2010

Source: VLC end evaluation, 2010

The perceived advantage of having to provide feedback to others was, among others, to be able to learn from fellow participants by reviewing their work, as '*some participants were very focused and experienced in the area'*, and '*insight could be obtained'* by going through their products. One person remarked '*It taught me to be diplomatic and at the same time also learn that different viewpoints can also make absolute sense.'* One person said that for a person to provide relevant feedback '*too much knowledge is needed, which at times was lacking in participants, so instead they restricted their feedback to compliments.'* Also others remarked that some participants were more focused on providing compliments rather than constructive feedback. This again contributed to the desire to also obtain feedback from the VLC facilitators.

Box 2 Example of feedback provided by one of the participants on the work of colleagues

'I think the best way to interpret your analysis of the Ethiopian story is to describe it as an organic approach. As the environment changed, so did the approach. The community health extension workers are a fantastic innovation and something that we have tried implementing in South Africa. The biggest strength is by far the political leadership which has worked well in shaping the response. Finally the biggest vulnerability is the reliance on donor funding. How will changes in donor commitment affect the response in Ethiopia?'

'Firstly, the approach used in India, if I understand you correctly, is vertically managed. Does this mean that the surveillance, planning etc. happen on a national and sub-national manner? Secondly, by "horizontally implemented" do you mean that treatment, care, prevention are implemented as part of primary healthcare? If I understand you correctly, I think this is a phenomenal approach as it would open access and decrease stigma. However, I have difficulty understanding the funding. Why fund vertically when you implement horizontally? How are budgets ring-fenced for HIV in this environment and how are they spent? Secondly, how are human resources managed? More specifically are there specific HIV-trained healthcare workers or are all healthcare workers trained in a multipurpose manner?'

Source: VLC on HSS and HIV, 2010

1.6.4 Applicability of the VLC learning for work purposes

The end-of-VLC evaluations indicated that the majority of the participants highly rated the VLC in terms of usefulness for their work. This corroborated the finding of the one-year-after tracking survey, in which 75 per cent of the evaluation respondents indicated they still used the knowledge and skills gained in their daily work.

The participants provided different examples of how they bring the learning into practice, one year after the VLC:

> *'The links of HSS and HIV gave me a deeper understanding which I am using overall in my consulting work. It especially helped me to increase my system's thinking skills.'*
>
> *'I use the building blocks of HSS to implement the HIV programme in my country.'*
>
> *'My work involves working with the government, so I can see how a particular strategy would influence the functioning of the system.'*
>
> *'I use it in real-world, day-to-day issues in consulting for the Global Fund, where HSS is the reason for programme ineffectiveness.'*

Some also remarked that while they do not work specially on HSS or the HIV response, they are still able to make use of the learning:

> 'I always use the gained knowledge, especially formulating recommendations for programmes.'
>
> *'I am using it in my work, though not specifically in HIV, but it increased my depth of knowledge on generic socio-medical issues also.'*

The majority of the respondents said they had no problems using the knowledge and skills gained. One said, '*My work is mostly academic, and I can apply these concepts in my research'*, while another observed: *'I have met with people who were open and willing to* *work towards HSS.'* One person remarked that it was neither a yes nor a no: '*Challenges are inevitable and not directly tied to the inability to apply the new or old knowledge and or skills*.'

1.6.5 Follow-on contact

The majority of the respondents said they are still in touch with other VLC participants, mostly through social media, such as Facebook, and email; a few also interacted on Skype. These contacts are more incidental and seem to be more of a social nature rather than work-related.

Meanwhile, quite a number of participants indicated being willing to play a role in developing or moderating a later edition of this VLC.

1.6.6 From direct facilitation to backstopping

While the first VLC on HSS and HIV responses was directly moderated by KIT, the second was moderated by the UNAIDS TSF South Asia with backstopping from KIT. To support the latter and to support further use of the VLC by UNAIDS in general, KIT produced a guide on how to develop a VLC (Gerretsen et al. 2010). To ensure increased capacity in the South Asian region, a consultant who had participated in the first VLC was contracted to jointly moderate the VLC together with the TSF South Asian Capacity Manager, who had also participated in the first VLC. KIT's role was to provide backstopping and coaching support in relation to the moderation. For this VLC, KIT and the TSF South Asia adapted the learning arrangements slightly, based on insights from the first VLC, and included a new learning arrangement on community systems strengthening. This arrangement worked well. The second VLC was successfully implemented, and the experience gained contributed to increased capacity within the Asia region to implement subsequent VLCs without backstopping.

1.6.7 Scope for improvement

Although high levels of satisfaction were expressed in relation to the VLC's content and applicability, some suggestions for improvements were also made, such as more interaction over the content between VLC facilitators and participants:

> *'I understand that the model of learning is peer-led and -based. However, I think that there should be some more interaction with the trainers/instructors in occasional classroom sessions.'*
>
> *'Feedback from peers tends to be diplomatic. It would have been good to receive feedback from the HSS specialists themselves for critical appraisal.'*

Other remarks related to the time investment, whereby some expressed the idea that the VLC should be extended over a longer period of time, and others that it should be shortened. However, the majority indicated that the allocated time was acceptable. Other suggestions made were to use more videos or a real-time chat forum, where people can discuss assignments once they are available.

1.7 Discussion and conclusion

Although in the past few years KIT has organized and facilitated a range of VLCs as a learning approach complementary to classroom sessions, the VLCs described were the first stand-alone VLCs, i.e. organized without any face-to-face classroom interaction with the VLC members. Important lessons learnt from these first experiences are that:

- VLCs can work if face-to-face classroom interaction cannot take place. This is shown by the success rate of 50 to 80 per cent of participants completing the VLC, and the overall positive feedback. However, proactive facilitation, matched with the use of other communication methods such as Skype and other teleconferencing platforms, chat sessions, online presentations (webinars) and the use of different learning strategies, are key to this success.
- Providing clear information on the VLC's requirements (minimum time investment per week, the need for participants to complete assignments according to the time schedule although at their own convenience, and internet/computer requirements/skills) before participants sign up contributes to avoiding drop-out. Having participants sign a contract in which they state that they have understood these requirements possibly helps to increase their commitment.
- The end-of-VLC evaluation shows that participants feel that the VLC has been able to increase their knowledge and skills. Many of the participants stated that they are still benefiting from the knowledge and skills gained through the VLC in relation to their daily work. Even some of those not working on the topic covered by the VLC are able to use some of the generic skills acquired or apply the increased understanding to other areas of work.
- In addition to feedback from fellow participants, even when these have quite significant experience on the topic, participants voiced the opinion that they also expected to obtain feedback from subject specialists; this should be addressed in future VLCs.

Review of the products uploaded by the VLC participants shows that they - in line with adult learning and competence-based learning approaches – were able to use their own experiences and build on them by reflecting on their own and each other's work. The end-of-VLC and also the one-year-after evaluation show that the participants recognize that the learning was relevant, based on real-life situations and needs and enhanced their appreciation for different perspectives. This further endorses the view that VLCs are a good avenue for competence-based learning strategies. A lesson learnt for future VLCs, however, is that, to be able to track which and how much competence has been built, the competence-related objectives need to be made more explicit and translated into measurable indicators prior to the event, to the event.

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Mind-mapping exercise during the workshop with Young Positives in Kibera, Nairobi, October 2010 (Photo: Hermen Ormel, KIT)

2 Young people living with HIV: Life skills, self-esteem and social media in Kibera, Nairobi

Anke van der Kwaak, Hermen Ormel, Tobias Ouma and Francis Obare

Abstract

This article presents some of the contents and outcomes of a workshop that took place in Kibera, Nairobi, in October 2010 (Van der Kwaak et al. 2011). The workshop was a follow-up of the 2009 study “Access to sexual and reproductive health information and services among adolescents living with HIV in Kenya”. The initial aim and starting point of the workshop was to disseminate the research findings among young people who participated in the study. It was then decided to offer this group of young people living with HIV a follow-up in line with the study’s recommendations, i.e. to enhance their self-esteem and life skills and strengthen “bonding” activities among themselves and with other young positives and “bridging” efforts with other groups such as parents, other adolescents and service providers. The workshop used highly interactive approaches to facilitate life skills training for young people living with HIV in Kenya, including the use of mobile communication and social media, mind-mapping and social commentary posters. These proved to be exciting ways of attracting and engaging young people in topics such as HIV prevention and care, power and self-esteem, positive living, quality of life and exercising rights. It became clear once more that there is an urgent need for additional efforts to strengthen knowledge and information about sexuality and HIV-related issues among young people living with HIV. Mobile technology and social media were shown to have a highly motivational quality for them and are potentially effective ways to channel information, address self-reflection, improve accountability and build community and mutual support.

2.1 Study results and recommendations: Young positives’ access to information and services

The study “Access to sexual and reproductive health information and services among adolescents living with HIV in Kenya” (Obare et al. 2010) was conducted in Nairobi and Nyanza provinces, Kenya, between September and November 2009 by Plan Kenya, the Royal Tropical Institute (KIT, Netherlands), and Plan Netherlands through funding made available by Plan Netherlands, KIT, and the Dutch Ministry of Foreign Affairs.

The objective of this study was to assess the sexual and reproductive health (SRH) needs of adolescents aged 15–19 years, who are living with HIV in Kenya, and to identify and develop interventions that integrate these needs into the existing HIV and AIDS treatment, care and support programmes in the country. It involved a survey among 606 young people living with HIV ("Young Positives") aged 15–19 years and four focus group discussions (comprising eight participants each) with adolescents living with HIV aged 18–19 years.

Study participants were identified and recruited through HIV treatment centres with the help of counsellors, community health workers and social health workers. Female respondents comprised 78 per cent of the sample, in line with the high numbers of their enrolment in health facilities. The findings showed that:

- more than four in five (84 per cent) of the adolescents living with HIV have ever had sex (73 per cent of the males and 88 per cent of the females);
- 79 per cent of those who have ever had sex reported current condom use (93 per cent of males and 76 per cent of females);
- among those who were in a relationship, 74 per cent had disclosed their HIV status to their partners (63 per cent of the males and 76 per cent of the females);
- among those who were in a relationship and knew the HIV status of the partner, 21 per cent were in discordant relationships (45 per cent of the males and 16 per cent of the females);
- more than two-thirds (68 per cent) of female respondents who have ever had sex had been pregnant at least once, with three in four of the pregnancies (75 per cent) being unintended;
- whereas 86 per cent of the pregnant adolescents received antenatal care (ANC), prevention of mother-to-child transmission (PMTCT) of HIV services were received for 71 per cent of the pregnancies; and
- more than three in four (76 per cent) of the adolescents living with HIV intend to have children in the future (90 per cent of the males and 73 per cent of the females).

(Obare et al. 2010)

While some HIV and AIDS treatment, care and support programmes have incorporated counselling of children and adolescents, it most often falls short of mentioning sexuality, social, empowerment and rights issues (Van der Kwaak et al. 2010). Service providers may be unaware of their clients' sexuality, but in general they seem neither interested nor motivated or prepared to find out whether these clients are dating and are sexually active. Also, adolescents living with HIV seem to be treated as patients, while most are not ill most of the time and all are active, young people living with a chronic disease who have multiple aspirations in life. The different identities (such as being young, being a mother or father, being a pupil, being HIV positive etc.) are not recognized by the programmes and services. More girls living with HIV are registered at treatment centres than boys (Obare et al. 2010, Birungi et al. 2010). This is due to girls' higher susceptibility to HIV and other infections and stronger health-seeking behaviour, among others.

From the study it became clear that more girls are out of school than their male peers; however, both groups want to have boyfriends or girlfriends, whether HIV-positive or HIV-negative, and to date, fall in love and have sex, and both groups plan to have children. However, they mostly receive services from these centres in line with their HIV status and related illnesses, and they are not empowered with the necessary information to enable them to balance rights and responsibilities, make informed decisions about their lives and achieve a higher quality of life in general. Girls fail to access PMTCT services in time, and boys seem to fall off the attention radar of the programmes totally. Involvement of young men and new or enhanced social programmes addressing Young Positives' aspirations and rights, in a context of chronic illness and often poverty, seems a necessary next step. Based on the findings of this study (Obare et al. 2010), the recommendations for programmatic actions included:

- *Update existing counselling and support packages to include sexual and reproductive health information and services:* Updating the counselling and support packages to include counselling on SRH will equip service providers, including counsellors, with a tool to systematically assess the SRH information and service needs of HIV-positive adolescents, and to address such needs in time or make appropriate referral.
- *Encourage and strengthen support groups for adolescents living with HIV:* Although support groups for people living with HIV have been shown to be a source of peer and psychosocial support, life skills training and potential avenues for channelling SRH information, many Young Positives do not belong to such groups. Thus, HIV and AIDS programmes in the country need to encourage the formation of support groups for young people living with HIV and to strengthen the existing ones.
- *Strengthen life skills training for Young Positives:* Most of the adolescents living with HIV are vulnerable on several levels, including their young age coupled with the fact that they are living with a chronic illness, many have lost one or both parents, and the majority are out of school. HIV and AIDS programmes, therefore, need to strengthen life skills training to enable them to make informed choices and to balance responsibility with sexual and reproductive desires.

2.2 New opportunities to engage young people: Social media and mobile phones

The recommendations regarding the need to improve knowledge and strengthen mutual support and life skills brought about reflections on innovative strategies to engage young people and improve communication with and among them. Recent literature from the field of health communication brought our attention to social media. These have been described as means for social interaction that, due to easily accessible communication techniques, have a substantial capacity to change the way organizations, communities and individuals communicate (Wikipedia 2011). Social media are seen by many as gateways to democratizing knowledge and information. Web-based technologies are thus used for creation and exchange of user-generated content. Common examples are the popular social networking sites such as Facebook and MySpace but also include YouTube, Flickr, Twitter, Wikipedia, blogging platforms, chat sites and others. Social media are increasingly used for public health and social development purposes, by embedding them in specific, interactive websites and web-based networks.

However, computer-based web access is still limited for most people in developing countries, especially outside urban areas, due to limited bandwidth and prohibitive cost. Yet mobile phone access and coverage is rapidly expanding nearly everywhere – standard phones at least have voice, voicemail and text (sms) and often a camera for photos/video and multimedia sharing (mms), while smart phones also have email and web access. In recent years, mobile communication and multimedia technology have increasingly been used for public health and well-being ("mhealth"). Expectations for mhealth are high, in terms of increasing access to information and services, improving quality of services and lowering their costs, among others. Mobile phones have also rapidly become a popular tool in the broader field of development-related communication and social networking. KIT has entered the mhealth field with intervention research in Sierra Leone on mobile applications aimed at improving maternal and new-born health through enhancing provider–provider communication, client-initiated communication with providers and provider-initiated monitoring of clients (Magbity et al. 2011). KIT has also used mobile phones to produce short, project-related documentaries, and as an awareness and skills development tool for young people.

Mobile technology and social media have both proven themselves to be "exciting" ways to attract and engage young people with "serious" topics such as HIV prevention and care but also the rights-based development of self-esteem and life skills. This was confirmed by Mechael et al. (2010) in their review of present approaches in mhealth. They conclude that 'the mobile technologies when applied to addressing health issues...are beginning to gain traction and show positive, albeit mixed results,' and that for the 'programs to succeed, an enabling well informed policy and business environment that engages all relevant public and private health and [information technology] stakeholders to drive scale and sustainability is needed.'

2.3 Research follow-up: Workshop with Young Positives

The need to disseminate the findings of the above-mentioned study among its participants, the wish to initiate a follow-up to the recommendations and the recognition of the added value of using social media for interventions with young people led to the proposal for a workshop on life skills, self-esteem and social media for young people living with HIV.

Efforts were undertaken to identify any Kenyan organizations with the interest, capacity and funding to establish a post-research follow-up programme and engage these Young Positives both face to face and virtually. As part of this process and as a first step, a two-day workshop was organized in the Kibera slum in Nairobi, Kenya, in October 2010 to provide a forum for exploring the young people's desires and dreams in terms of social relations and bonding, aspects of positive living and quality of life, and rights and social responsibilities. The workshop used mobile technology and social media as exciting ways of attracting and engaging these young people in topics such as HIV prevention and care, as well as rights-based development of self-esteem.

The objectives of the workshop were to increase participants' self-esteem and life skills and strengthen "bonding" activities (among the workshop participants and with like-minded Young Positives) and "bridging" efforts (with other groups such as parents, non-positives and service providers) to improve positive living, quality of life and exercising rights.

More specifically, the workshop envisaged enabling participants to:
- express their expectations;
- discuss their desires and dreams in terms of social relations, bonding and bridging; positive living and quality of life; exercise of rights; information use and social responsibilities;
- discuss options, benefits and personal interests regarding the use of mobile phones and social media;
- better understand and improve their skills to use social media; and
- develop and implement small ideas for using mobile phones and other media to turn dreams into reality.

2.4 Preparations

The workshop was facilitated by the authors, as a collaborative event involving KIT and Nairobits, a local non-governmental organization (NGO) involved in work with youth and social media. Methods used were mainly participatory learning approaches in the form of participatory group tasks, interactive plenary sessions with presentations and activities, and skills practising exercises.

Through Kenyan liaisons, in the weeks prior to the two-day weekend workshop, invitations were distributed to approximately 50 of the young people (15–19 years old) in Nairobi who had previously participated in the research, with the understanding that they would have access to a mobile phone. More than 50 participants (a maximum in view of the available space, logistics and envisaged group dynamics) turned up for the workshop on the Saturday morning; in the end several had to be turned away due to lack of space in the already cramped classroom.

With the aim of linking the workshop initiative – and the young people participating – with community-based and other organizations active in Kibera, invitations were also distributed to the African Medical and Research Foundation (AMREF) Kenya, the Foundation of People living with HIV and AIDS in Kenya (FOPHAK) and Plan Kenya; the first two organizations sent representatives to participate. Also, mobilizers of HIV treatment centres who had been involved in the original study and in the recruitment of participants for this workshop were present.

2.5 Texting and Facebook

Anticipating the use of *text messaging* prior to and during the workshop, registered participants were asked to share their mobile phone number in advance. Frontline sms software was used to generate a database of mobile numbers to which messages could be sent. Even before the workshop it was anticipated that many of the participants would not use their own phone but a phone borrowed from a family member or friend instead. Therefore, message contents would have to be “neutral” about the exact nature of the workshop, its participants and activities to ensure confidentiality for the participants.

On the evening before the workshop, a group text message was sent out to all known mobile numbers to remind the participants in neutral terms of the workshop they had registered for.

During the first day, it turned out that most but not all participants had access to a mobile phone; the majority of those who did have access did not have their own phone but had borrowed (mostly) a relative's or (some) a friend's phone for the occasion. Many indicated that lack of money was the main reason why they did not use a mobile phone as much as they would like to do.

On the evening of the first day, all participants received a message thanking them for their participation during the first day, asking them what they liked about it and whether they had suggestions for the second day's programme. A small amount of top-up money was sent to each number to allow participants to reply without incurring costs. About 23 participants (over 50 per cent of those participants with known numbers) replied to the message; some of the responses are shown in Table 2.

Table 2 Sample of text messages received from workshop participants after day 1 (unedited)

I think 2day's workshop was lively and educativ, expecially how each and every 1participated effectively. I also appriciat our facilitators 4 making us learn more new things.gdnite. Time: 16/10/2010 22:44:09
I lkd how we as a group came out with a theme 2 creat a tree in mind mapping &also da food. Time: 16/10/2010 22:31:3
How ican mind map idea bysharing with others in slum in oder 2enpower youth doing positive things. Time: 16/10/2010 23:26:07
OK, i liked the skills u used for bonding us together in the training and the facilitation itself. Thanks. Time: 16/10/2010 23:33:45
I like how the facilitotars were teaching n explaing for al of us to undustand. N also food was delicious.n how the group work was done was excellent coz. Time: 16/10/2010 23:37:37
Thanks 4 ur msg What I liked most abt da training was da facilitation on communication as it touched on modern 'n' advanced ways of comm. like facebook, camera taking etc which I'm quite interested in & looking forward 2 learning more especially da practical part of it 2day. Time: 18/10/2010 07:12:19

These text messages were used as an evaluation of the first day and showed that participants enjoyed it for various reasons; some indicated why they were looking forward to the second day.

Also, a Facebook page (with high levels of security so as to avoid access by "outsiders") was set up to which participants could connect if they had established their own Facebook page first. The idea was to share photos and other workshop materials, and possibly offer a platform for a "community" that could be established among the participants.

A selection of photos taken during the first day was uploaded to the Facebook page, as well as other outputs of day 1 activities: four mind maps and eight poster representations related to self-esteem. These outputs and photos were shown in plenary to the participants during the second day, as part of the session on social media and explaining why Facebook was being used, including examples of "communities" of people with similar interests or challenges.

It was motivating to the participants; however, few (less than five) of them already owned a Facebook page. While the session showed the steps to establish one, this proved too big a step to be used for communication during or immediately after the workshop. Hence, the plan to use Facebook to establish a "community" of young people living with HIV was not feasible.

2.6 Day 1 – Bonding, bridging and communicating

Participants were asked to share their expectations for the workshop; the summary of the top 10 is presented in Box 3. These expectations largely coincided with the workshop's objectives and programme.

Box 3 Summary of main participant expectations

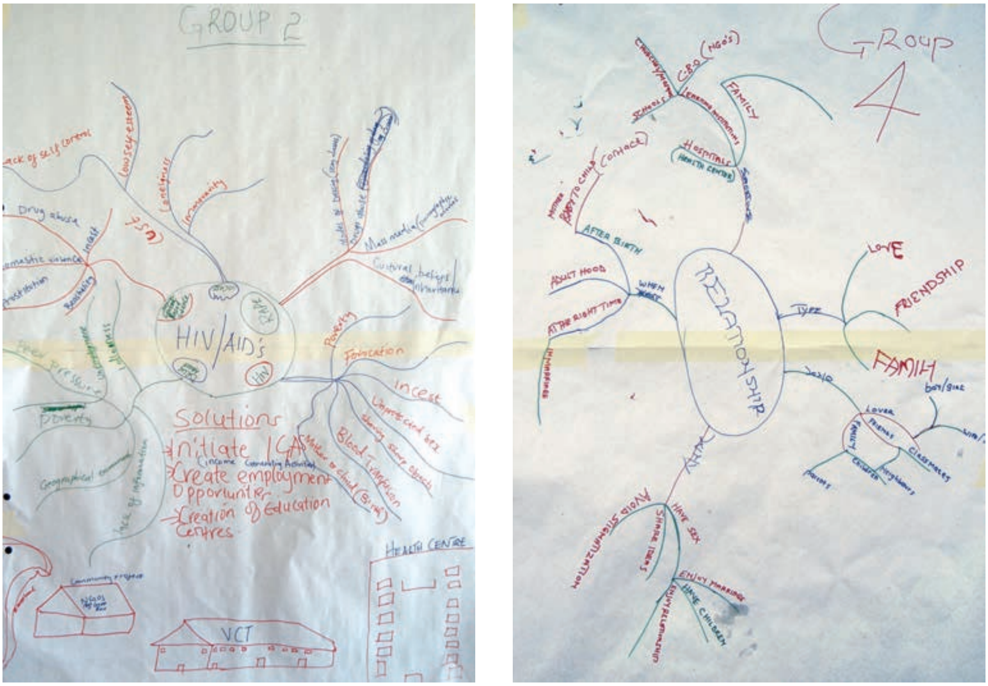
1. To learn something new; to gain knowledge; get new ideas
2. To share ideas with others; use my talents; get skills for my business
3. To learn how to protect yourself from HIV; to know about HIV, AIDS, prevention; abstain from sex; self-esteem; behaviour change; sexual and reproductive health
4. To know why men rape children; how a woman can respect her husband; why HIV has spread to married couples and what can be done
5. To be informed about internet, mobile phones
6. To be able to communicate with each other and support each other; help young people to live free of discrimination
7. To find out if there is support for me; how someone with HIV can live in the community
8. To be social, make friends
9. To be able to teach others about what I have learned; be a peer educator
10. Certificates; lunch; allowance

After the opening and introductions, a summary of the findings of the study *"Access to sexual and reproductive health information and services among adolescents living with HIV in Kenya"* (Obare et al. 2010), in which the participants had been respondents, was presented. Participants were encouraged to ask questions, and several took the opportunity to do so.

The film *We are one in a million* was shown, about a woman living with HIV and supported by her family. Participants discussed the film and most appreciated it, since it was inspirational and gave a message of hope and support.

The relationship concepts of bonding (with friends and other people one feels close to) and bridging (with others that can offer support such as service providers) were introduced. The participants brainstormed on the meaning of the two concepts from their perspectives, with a view to reaching a common understanding. For the mind-mapping exercise, that served to initiate or strengthen bonding and reflect on bridging, the participants were divided into four groups. Each addressed one of the four topics chosen during a brainstorm session, i.e. sexually transmitted infections (STIs), HIV and AIDS, sports and relationships. The group process that followed was very dynamic, and the various groups came up with very different and interesting maps – which they explained to each other during a "gallery walk" (see Figure 6 for two of the four mind maps).

Figure 6 Selected mind maps



Source: Kibera workshop, October 2010 (photos: KIT)

Participants found this exercise interesting, as it asked them to use their creativity and at the same time discuss and reach a certain group consensus on how to translate their ideas on the topic into a map.

Media and communication

Being able to communicate and "understand" how others communicate is a key skill for anyone, and even more so for young people. The group of participants brainstormed on how to define "communication" and what it entails (sender, receiver, message contents) and was then led to acknowledge the difference between two important ways of communicating: verbal and non-verbal. They worked in pairs to identify what channels of communication they themselves use and what other channels they know.

In plenary, "old" (face to face, letters, fixed-line phone) and "new" communication media were discussed. The latter included mobile phones (voice, sms/text, photos/video/mms) and internet (email, browsing, MSM, Yahoo Messenger, Skype (chat, voice call, video call), Facebook), although both evidently overlap – for example, internet access for many in East Africa is via mobile phone. However, those few participants that used the internet did so mostly in one of the internet cafés in Kibera.

In summary, of the around 50 participants:
- most had access to a phone (this was a requirement for the workshop);
- fewer than a quarter owned a phone; another quarter would regularly use another person's phone, while around half would not usually have access to a phone;
- fewer than 10 brought a phone with a camera;
- fewer than 10 had experience with surfing the internet;
- fewer than five had a Facebook page;
- only three had access to a phone with internet access; and
- none had ever used Skype.

It, therefore, became apparent that it was not feasible to use the workshop's methods as planned in relation to multimedia and social media – i.e. having participants make and share photos and let them use their Facebook profile to establish a community among themselves on a shared Facebook page was not realistic. While participants were very eager to learn more about the new media, internet browsing and what it can be used for was still a revelation to most. Many stated that in the short run, lack of money (to use internet cafés or smart phones) would prevent them from using web-based tools. In the end, group messaging was the main social media used during the workshop (see above and table 2).

The participants discussed the advantages and disadvantages of old and new media. Advantages of new media mentioned were that distances no longer seem to matter, that these media are fast and save time and energy, and that they connect both information and people. Perceived disadvantages mentioned were that they are expensive (phones, airtime, internet access), that they require literacy, and that morality may be compromised. Lack of access to technology and/or funds to use the technology were identified as major obstacles to using the new media.

During a second session, participants in plenary explored the actual dimensions and applications of the internet in terms of Google web browsing, maps and images, Yahoo Messenger chat, Skype video calling and Facebook. As stated earlier, participants were extremely interested in increasing their web-related and virtual communication skills as well as access to the new media; and many requested that this should become a priority during a follow-up workshop.

2.7 Day 2 – Power, self-esteem and image-building: Posters

The second day, after a recap and reflecting on the exchange of text messages the evening before, continued with a session on "power" (i.e. types of power: having power over, having power to, having power with, and having power within) and what type the participants like or do not like, and why. This led to discussions of self-esteem, image-building and one's identity as a person. Participants were then asked to work in groups to produce a poster on "self-esteem and communication", in relation to their identity as a person, including their lives with HIV. They selected cut-outs (words, photos and images from magazines and newspapers) that they identified with the topic and glued them onto a flipchart to tell a story which was expected to be both attractive and informative. After considerable work, eight posters entered a poster competition, with one winning the prize for Best Poster (see Figure 7 for a sample of two posters).

Figure 7 Selected posters

Source: Kibera workshop, October 2010 (photos: KIT)

2.8 Mystery questions box

People – and, in particular, young people – often have questions related to sexuality, HIV and reproductive health that they would rather not ask in public. A mystery questions box was, therefore, placed in the classroom, where participants could drop a note with their anonymous query. The collection of queries was answered in plenary towards the end of the second day. Questions related to:

- whether and how an HIV-discordant couple can get an HIV-negative baby;
- the HIV prevalence among adolescents in Kenya;
- steps taken to get the government and NGOs interested in dealing with HIV and AIDS issues;
- how one can know whether their partner is enjoying sex;
- what kind of sex is "sweeter", with or without a condom;

- under what circumstances blood contact can lead to HIV infection;
- why people say that women who wear a certain dress are "asking to be raped"; and
- whether and how one can "read" someone else's emotions.

2.9 Learning and suggestions for a next time

Participants were asked to share what they felt they had learned during the two days and whether they had any suggestions for the programme of a next workshop. Their responses are summarized in Table 3.

Table 3 Workshop evaluation on current and future learning

Current learning	Suggestions for next workshop
• Young people are creative and active, but need more skills "to go anywhere" • Web browsing, how to open a Facebook profile • More information on HIV, especially female condoms, and new interventions • The study summary and outcomes • Power over and power within • Dreaming, dating and desires • Mind-mapping and making posters	• More on HIV contents, sex, myths and reality • More and accessible youth-friendly services • Knowledge about and access to prevention of mother-to-child infection of HIV • HIV and relationships • Tips on how to become empowered, be productive, self-employed • Provide access to internet, social media • Technological (dis)advantages • To disclose or not to disclose one's HIV status • School enrolment and being young and HIV-positive

2.10 To conclude

The workshop's objectives were found to be somewhat ambitious. The first two of the envisaged outputs were achieved to a large extent so that participants' self-esteem and life skills were addressed and bonding activities undertaken with peers. However, the last two envisaged outputs seemed to be too optimistic. Current understanding and skills regarding multimedia and social media were not at the minimum required level, and the workshop was too short to establish the basics. To make a difference and actually strengthen positive living, quality of life and exercising rights, more is needed than a single two-day workshop. This is why the workshop was deemed to be the first of a series. For such as series to happen, other key stakeholders were identified and engaged, potentially including AMREF Kenya, Plan Kenya, Liverpool VCT, the Kenyan government and service providers and other NGOs and community-based organizations working with HIV-positive adolescents. Together these stakeholders would be able to ensure enough continuity to responsibly initiate a series of workshops and other initiatives to respond to these young people's rights and needs. Two specific actions that could help towards empowering the Young Positives in Kibera include:

- mapping of services, interventions and other skills-building programmes that are in place in Kibera; and
- interventions that are aimed at involving Young Positives in Nairobi and connecting them better among themselves and with services, skills training and education, including a skills- and network-building programme with a continuous learning component.

These two activities would respond to the urgent need made evident once more by the workshop: to ensure and strengthen knowledge and information about sexuality and HIV-related issues among young people who live with HIV, and especially including young women in view of their particular needs regarding sexuality and pregnancy. It also became clear that mobile technology, the internet and social media have a highly motivational quality for young people and are potentially effective assets for channelling information, addressing self-reflection, improving accountability and building community and mutual support.

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Session on prioritisation of health problems, Maasai Magadi area, Kenya (Photo: Anke van der Kwaak, KIT)

3 Greener pastures? Implementing a participatory research training model in Eastern Africa

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Abstract

Few models have been effective or comprehensive enough to facilitate capacity development in social science research appropriate for health research in general or HIV research in particular. This chapter reflects on two capacity-building initiatives which were implemented within two research alliances – namely, one among the Royal Tropical Institute (KIT) of the Netherlands, Makerere University and The AIDS Support Organization (TASO) in Uganda and the other among KIT and African Medical Research Foundation Head Quarters (AMREF HQ) and AMREF Netherlands. Both have spanned three to four years.

The process engaged service providers and managers of TASO and AMREF in a series of participatory capacity-building workshops. Comprehensive and user-friendly health systems research modules were used as a guide and a resource. The capacity development approach used was important because it fundamentally embedded the study of health issues by service providers in their on-going programme implementation. Research by service providers has a high potential to contribute to improving services.

The capacity development process adopted a participatory approach to enhance learning and maximize the benefits of research. The sequential workshops addressed developing proposals and research instruments, ethical review, data collection and analysis, report-writing, and dissemination of findings. This chapter reflects on the research process, the challenges faced during the research, the sequence of workshops and the writeshops. Giving participants hands-on training in mixed-methods research with an emphasis on qualitative techniques furnished them with tools to address sensitive topics around sexual and reproductive health and HIV.

3.1 Introduction

Since the late 1980s, capacity development has become a popular concept which reflects many ideas and lessons from past development activities. It can also be applied to research, whereby research capacity development constitutes a process of building and enhancing the competencies of individuals and creating a supportive and enabling environment in organizations, aiming to bring about a greater ability to perform relevant and excellent research.

The need for capacity-building in social science research, to facilitate research on health in general and on sexual and reproductive health and rights, including HIV and AIDS, in particular, is well recognized, but there are few comprehensive, effective and affordable models available. According to Langsan and Rodolfo (2004), research capacity-building in developing countries remains one of the world's unmet challenges. Many questions have been raised internationally about the ways to build, develop and strengthen capacities, and several approaches to capacity-building are presented in the introduction to this book.

As we have seen, there are usually three aspects of capacity development: (i) capacity-building as the catalyst and constant fuel for a process of change; (ii) the importance of building institutional capacity; and (iii) the involvement of a wide range of groups in society (Ulleberg 2009). Here we reflect on the participatory learning process whereby all stakeholders – in the case of TASO and AMREF: clients and programme staff – were involved.

In the case of TASO, KIT and Makerere University had engaged in various informal partnerships involving research, planning interventions and dissemination of promising practices to stakeholders and HIV clients. Interest in qualitative research capacity development started with the research on sexuality counselling at TASO entitled *Gathering evidence to promote sexual health in Uganda* (Kwagala et al. 2008). The findings raised significant interest, particularly regarding the possibility of contributing to developing the organization's capacity to conduct research that would improve services. Key recommendations from the studies referred to the need to strengthen a client-responsive system and to the benefits of research capacity development that would enable staff to not only identify priority areas for research but also conduct research to inform programming. After this, TASO and KIT expressed a mutual desire for partnership in capacity development in research and knowledge management with respect to priority problems within the context of HIV and AIDS counselling, treatment and care in Uganda. The research findings would be used to inform TASO's policy and programmes as well as those of other organizations around the country.

Based on the example of the process implemented with TASO Uganda, AMREF HQ and KIT decided on a similar process with providers and programme managers within the AMREF Nomadic Youth project.

In both cases, the *Health systems research training series* (Varkevisser et al. 2003) was used. It provides a comprehensive model of research capacity-building that encompasses the entire research process from proposal development and ethical clearance to conducting research, analysing findings and disseminating results. It is user-friendly for participants with limited research experience.

In this chapter we reflect on the effectiveness and replicability of a capacity-building processes implemented within the last few years with TASO and AMREF in Eastern Africa. After describing the research capacity development process, the two cases will be presented. Subsequently, commonalities and challenges will be discussed, and the added value of also doing writeshops with the mid-level career professional is presented. We address the feasibility of nurturing researchers and writers out of development practitioners and discuss the relevance of this capacity development process for both non-governmental organizations (NGOs) and their staff and clients.

3.2 The research capacity development process

Facilitation methods were mainly participatory, empowering learning approaches in the form of participatory group assignments, role plays and presentations, demonstrations, interactive plenary sessions, and a limited number of lecture sessions. Field activities for pre-testing instruments were organized. Participants mainly worked in regional teams within Uganda in the case of TASO and in country teams in the case of AMREF throughout the capacity development activities. Most of the workshops were out of station and residential in nature, to avoid disruption. The main resources, i.e. reference books and additional references on topical issues, were provided by the facilitators.

The training modules were tailored to context-specific research capacity needs. Although mixed research methods were emphasized, capacity development in qualitative methods received more attention, since most of the participants already had adequate skills in quantitative methods. Additionally, qualitative methods proved advantageous in researching sensitive issues, which is often the case for services for young people or people living with HIV. Although qualitative, bottom-up research does not readily attract as much funding as clinical trials, it is essential for fostering a responsive service. The research capacity development programme emphasized developing both institutional and individual research capacities.

3.3 The case of TASO

The participants were TASO staff selected from the 11 TASO centres across the country and TASO headquarters, with varying educational and professional backgrounds. These included directors and programme personnel associated with research and the relevant services such as counselling, clinical care and training; facility managers; medical officers; information management officers; and counselling coordinators. Their educational backgrounds included counselling and psychology, education, social sciences, statistics, nursing, medicine and public health. Most of the participants had a Bachelor’s or Master’s degree. The few staff without a Bachelor’s degree had extensive experience with TASO programmes, and their participation was deemed beneficial to the programme. Numbers ranged from 30 to 44 participants per workshop. Although TASO is an organization of which clients become a member and at each and every occasion the clients are part and parcel of the process, this was not the case during the research process. However, they were actively involved during the drafting of the research instruments, practical exercises and pre-testing.

Five workshops were conducted, covering developing proposals and research instruments, ethical review, data collection and analysis, and report-writing. The sixth workshop, addressing the use of research findings for advocacy and to inform policy, is planned to take place in the near future.

The process commenced by identifying research priorities. The priority-setting exercises involved each of the participants – and, later, regional teams – identifying two priority areas of research based on their observations and experiences while working with people living with HIV at TASO. Participants were asked to think about the relevance of selected areas following the criteria for rating research topics, namely: relevance, avoidance of duplication, urgency, political acceptability, feasibility, applicability, and ethical acceptability (Varkevisser et al. 2003). Priority areas were presented and discussed in plenary. Each team presented two key problems, and these were discussed in a plenary session.

After the final selection of priority problems (all addressing HIV and AIDS), each region started the proposal development process. Areas of interest included: gender-based violence; adolescent-friendly services; lost to follow-up in conflict areas; and infant feeding practices of people living with HIV (TASO clients). To ensure that research findings inform TASO programmes and policy, the last objective of each of the research proposals focused on recommendations (based on research findings for interventions), with the ultimate aim of improving services.

To ensure proper coordination of the research process, two principal investigators were selected for each of the studies, and regional research coordinators were selected by the teams. These were responsible for coordination within the teams and quality control, and were expected to report to the officer in charge of research at TASO.

The third meeting entailed developing and pre-testing data collection instruments. This involved peer testing of instruments, after which the instruments for the various data collection techniques were pre-tested. The pre-testing exercise was jointly organized by the TASO research programme officer and carried out at TASO's Jinja centre and the paediatrics section of Jinja regional referral hospital. The exercise involved identifying respondents, building rapport, obtaining consent from respondents, interviewing, note-taking, transcription and reporting back in plenary about the whole process. Facilitators worked closely with the various groups. The exercise generated a lot of interest among the participants, some of whom were experiencing field research for the first time.

Through the pre-test, participants learned that, with appropriate research techniques and interview skills, people living with HIV can easily open up to discuss issues of concern. They also realized the need to eliminate hierarchies in research, i.e. the need for the researcher to be a learner and not a "knower". In essence, the need to recognize the difference between communicating with clients as providers and interviewing them as researchers was appreciated. Participants realized that posing the right questions in the right order and not asking leading questions are valuable interviewing skills. Some of the key issues that were presented and discussed included differentiating between reimbursements and incentives in research and whether (and when) to use incentives; the issues of maintaining anonymity when a respondent has to sign a consent form; challenges of interviewing busy key informants; and comprehensive note-taking.

The fourth workshop focused on data analysis and an introduction to report-writing. It entailed an update on how data were collected and the types of data collected. Both qualitative and quantitative data were collected. Participants were introduced to qualitative and quantitative data analysis, with a special emphasis on qualitative data analysis. The sessions included demonstrations of examples of analysis using Excel spread sheets, Word files and ATLAS.ti programs. Participants acquired the know-how and were able to commence data analysis thereafter. Some of the teams had already started capturing quantitative data. Participants were introduced to drafting research reports and developing catchy or attractive titles for their reports.

Five proposals were developed, covering a variety of topics as shown in Table 4.

Table 4 Titles of proposals by region

Headquarters	*Gender-based violence and HIV: Their co-existence in people living with HIV. A case study of TASO clients*
Central region	*Provider–client perspectives on the friendliness of TASO adolescent HIV/AIDS services*
Northern region	*"They prayed for peace and walked away from ART": Lost to follow-up clients in the post conflict area of Northern Ugandan*
Eastern region	*Two become one: Accessing HIV & AIDS services as a couple in rural Eastern Uganda*
Western region	*Assessment of factors influencing infant feeding options among TASO HIV-positive mothers: A case study of TASO western region*

Additionally, the workshop focused on inductive and deductive research paradigms, grounded theory and the difference between conceptual and analytical frameworks. Slides representing the life of a goldfish in a fish bowl were used to start the discussion addressing the different paradigms of deductive and inductive thinking. Different frameworks and their application for conceptual thinking or for analysis, including social determinants of health and the three delay model, were presented and discussed. Ample time was dedicated to demonstrations and hands-on practice of data analysis. Participants realized the importance of pre-testing instruments, proper training of research assistants and close supervision of and support to research assistants, if high-quality data were to be collected; flexibility regarding techniques, sources of data, locating of respondents in qualitative research; and use of appropriate national and international guidelines in setting the framework for analysis.

The last workshop was mainly dedicated to developing the capacity of participants to disseminate research findings in the form of publications (in this case, scientific articles) and case studies. An initial avenue for publication (the *Exchange* magazine published by Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) and KIT), a journal widely read by SRHR and HIV practitioners, was identified. Participants were also encouraged to publish in peer-reviewed journals.

Apart from the main training workshops, follow-up of the proposal development, research and writing activities was done through electronic communication in consultation with facilitators and by key TASO research personnel. The training workshops were organized in partnership with the programme officer in charge of research.

Evaluation of the programme

Evaluations were done in writing and verbally at the end of all workshops. Several participants wanted to have more time allocated to capacity development in terms of increasing the duration or number of training workshops to ensure that participants with no or limited research training and experience are accommodated. A few participants initially struggled with understanding the strengths of qualitative methods, since they were already grounded in quantitative research. After the training workshops and fieldwork, qualitative research was appreciated. An evaluation of the analysis workshop, for example, described qualitative data analysis as an eye-opener:

> *'I have been involved in research and analysis of quantitative data more than qualitative, and this has really opened my eyes. I am looking forward to completion of the report and publications.'* (female participant with a statistics background)

> *'Now I feel that I am not only able to develop a proposal and conduct research using qualitative methods but also train others.'* (male medical practitioner)

Participants reported that they valued the approaches to facilitation and contents of the workshops and said they plan to apply this tool in other organizational programme areas. The priority-setting approach, being an open space technology whereby people define priorities and share them with others in random groups and gallery walks, was particularly valued for its easy, fast and yet comprehensive approach to selecting priority research problems.

The data collection process was an eye-opener to errors in record-keeping. One of the teams discovered areas for improvement in its records which informed its approach to service provision, meaning that the insights of the study on the views of young clients and lactating women living with HIV made them aware of their own prejudicial attitudes. There were errors in recording clients that were lost to follow-up. The research established that clients that had been recorded as lost to follow-up were actually consistently coming to use the services. As a result, the relevant centres made efforts to review the data collection process to prevent recurrence. Findings of another study are already being used to improve services: research among adolescent clients living with HIV in the Central region revealed that 70 per cent preferred to have clinics separate from adults. This has been implemented at Entebbe TASO centre, where adolescent clients now have a separate clinic.

The research teams demonstrated keen interest in and commitment throughout the capacity development process. The programme highlighted the need to disseminate information, mentor other staff at TASO and strengthen the network of TASO researchers and the partnership between KIT and TASO. The members of senior management at TASO and institutions such as the medical school were also recommended to share their skills with colleagues.

The institutional approach which includes strategic involvement of key resource persons at national and regional (centre) levels within the organization, tailoring the programme to the organization's identified capacity development and research priorities, is expected to ensure continuity and sustainability. It is envisaged that trained resource persons will eventually train other relevant staff. Institutionalization of research at TASO involved establishing a department for research with a designated programme officer and an ethics review committee, and the research projects developed under the programme were managed by the research department. Institutional capacity development can hardly be effected without addressing individual capacities. This not only enhances overall institutional performance but also serves as an incentive for the staff members involved, since the skills could be widely applied. One of the participants made the following comment: 'The programme is relevant for my current work and future career plans.'

Participation in the programme is viewed as a key motivation for participants; to some, research was a new area. Many of the participants had only been engaged in service delivery. The participatory approach through which the teams were supported to identify their own research priorities has resulted in ownership of the research agenda. This is also shown by the additional studies that have been initiated by TASO centres. Furthermore, abstracts have been written and submitted to international and national conferences.

After the training, the research teams subsequently involved other colleagues in their research. Further institutionalization and mainstreaming of research is reflected in the establishment of research committees. These committees of seven to 10 members are mandated to oversee research activities and also guide other staff in identifying the research priorities for each TASO centre. Meetings take place monthly, and reports are forwarded to TASO headquarters.

The programme has multiplier effects in terms of inspiring participants to initiate research. In addition to the studies designed under the capacity development programme, so far, for instance, three studies have been initiated by the research committees of the Central region, addressing issues of HIV and disability, tuberculosis and toxoplasmosis.

Partnership in human, financial and material resource mobilization by TASO and KIT has been key to sustaining the process. The capacity-building process addressed the issue of mobilizing resources for research, including applying for research grants. TASO was able to make budget allocations for research activities including co-financing training workshops and funding the actual research activities. For instance, some of the funds used to co-finance training workshops were provided by the University of British Columbia. Additionally, owing to the research capacity development and associated partnerships, TASO has been able to successfully develop proposals and has obtained funding from the European and Developing Countries Clinical Trials Partnership to support the TASO Institution Review Committee.

3.4 The case of AMREF

A survey conducted by Nduba and Kamenderi (2010) points out that nomadic pastoralists, including both semi-pastoralists and nomadic populations, are among the poorest subpopulations living in remote areas in Eastern Africa (Kenya, Tanzania and Ethiopia), often with an underdeveloped health infrastructure coupled with challenges in access to reproductive and maternal health services. In terms of maternal health, nomadic pastoralists rarely seem to use the services of professional midwives and other reproductive health care providers, which may result in many undesirable pregnancy outcomes.

It further transpired that reproductive health trends among nomadic youth exhibited undesirable outcomes. Geographical variability was noticed, with nomadic youth in Ethiopia presenting poorer outcomes than those in Kenya and Tanzania. Generally, nomadic youth were characterized by early sexual debut, early marriage, low contraceptive use, low access to reproductive health services and a high prevalence of female genital cutting. Literacy levels were low, with very few nomadic youth accessing formal schools. Widespread provider-based barriers were noted: service providers showed inadequate reproductive health knowledge, and there was a lack of youth-friendly services. Traditional healers/herbalists and traditional birth attendants (TBAs) were shown to play a pivotal role in providing reproductive health services, thereby providing a strong basis for interventions addressing their role in remote and hard-to-reach nomadic settings. The situation on the ground shows little evidence of comprehensive, high-quality reproductive health care widely implemented in primary health care systems (Nduba and Kamenderi 2010).

Against this backdrop of a lack of evidence and a strong need for reproductive health interventions in nomadic settings, AMREF – with support from the Dutch Ministry of Foreign Affairs – started to implement a four-year regional programme (2007–2010) on the reproductive health care needs and rights of the nomadic youth in Ethiopia, Kenya and Tanzania. The resulting Nomadic Youth Reproductive Health programme was designed to address the poor reproductive health of the nomadic population, specifically of adolescents, with the objectives of contributing to the reduction of:

- HIV and AIDS, sexually transmitted infections (STIs) and unwanted pregnancies;
- maternal and childhood mortality; and
- female genital cutting among young girls.

The starting premise was that the programme's objectives could be achieved if the reproductive health knowledge and access to health services for the targeted 135,000 nomadic people were substantially improved. A two-pronged approach was followed: supporting services for nomadic communities by focusing on better qualified health workers and placing infrastructure in line with the key opportunities mentioned earlier; and generating evidence on the needs of nomadic youth in terms of sexual and reproductive health (SRH), to understand the challenges in meeting these needs and identify the opportunities to address and improve the identified needs.

During the first two years of the programme (2007–2008), the AMREF International Training Centre organized several meetings with local stakeholders, programme staff and researchers to identify programme-related research priorities and questions. A regional baseline study was conducted in the three programme countries to identify emerging problems in the context of reproductive health. A persistent need existed for more substantial operational and action research to describe and understand these emerging problems and to provide recommendations to improve the health of nomadic youth. This need, coupled with low research output in the programme after two years of implementation, called for greater efforts to support and channel energies into research. AMREF partnered with KIT to address this. Over a two-year time period (2009–2010), a capacity development process involving KIT took place.

3.4.1 The process for capacity development

Preparation phase

Workshop participants were identified jointly by AMREF and KIT, using criteria such as experience in research, monitoring, evaluation, proposal writing and knowledge of programmatic content. This resulted in 40 prospective participants for the first workshop: six from each country (Tanzania, Ethiopia and Kenya) and representatives from the regional water and sanitation programme and both AMREF HQ and AMREF Netherlands. For further workshops, the number of participants stabilized at around 15 active participants – more or less five per country.

In June 2009 the first capacity development workshop was carried out, during which research proposals were written. The workshop was facilitated by two KIT staff members and one AMREF representative. This workshop was the start of a series of further workshops in the capacity-building process (see Figure 8), namely:

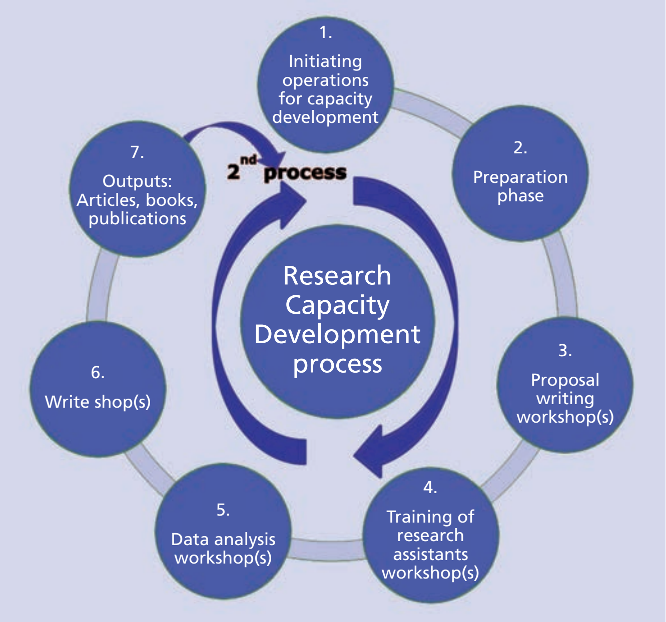
- two proposal-writing workshops (June and November 2009) to refine proposals (including development of tools);
- research assistants training workshops, one in each country to provide guidance on implementation before the start of the studies carried out from November 2009 to January 2010;
- two data analysis workshops (May and July 2010) to analyse data; and
- two writeshops (September and December 2010) for writing articles and book chapters.

Proposal-writing workshops (June and November 2009)

The objectives for the first research capacity development workshop (June 2009) in Naivasha, Kenya, were to enhance the capacity of the participants to develop and implement research proposals aiming to solve priority problems to improve the reproductive health care for nomadic youth in Kenya, Ethiopia and Tanzania.

A second workshop, building on the first, took place in Lumuru, Kenya (November 2009), with the aim of finalizing proposals by including and refining budgets, research tables (including tools), quality assurance mechanisms and a framework of analysis, and to agree on planning and timelines for implementation and next steps. Methods used included, but

Figure 8 The process for research capacity development



Source: own elaboration

were not limited to, participatory learning approaches in the form of participatory group tasks, presentations, interactive plenary sessions and limited lecture sessions.

Ample time was spent on prioritizing research topics, using the following seven criteria: relevance, no duplication, urgency, political acceptability, feasibility, applicability of results, ethical acceptability, and realistic budget. In addition it was agreed to keep a check on other related studies carried out or under way. Studies were found to be under way on female genital cutting and on TBAs; therefore, they were not prioritized for this research. A further exclusion concerned studies on HIV, as this did not fall within the mandate of the nomadic youth programme.

The proposals developed during the workshop and finalized in the months thereafter concerned the following topics:

- Ethiopia, Tanzania and Kenya: male involvement in SRH;
- Ethiopia: reasons for low utilization of reproductive health services in Afar;
- Tanzania: factors influencing uptake of family planning methods and maternal health services; and
- Kenya: community determinants of high levels of maternal mortality.

Training of research assistants workshops **(between November 2009 and January 2010)**
To complete the capacity-building process within the timeframe of 18 months, research training workshops for assistants took place in each of the three countries concurrent to

submission and approval of proposals for ethical clearance. This workshop prepared local research teams consisting of AMREF staff and between three and six recruited research assistants per country to conduct the research.

The aim of these workshops was to identify and discuss the most important points to be considered when planning for data collection and to identify the resources needed to carry out the research and assess their availability. Participants described typical problems that they experienced during data collection:

- The research teams were often seen by respondents as representing the service providers, given that AMREF staff lead and were part of the research teams. Questions dealing with the services, quality of care, delays and competencies of the providers were barely answered. In some cases where there were no services in operation, respondents used the interviews to mainly complain about the lack of services, instead of focusing on the study questions.
- Some of the study respondents who refused to take part mentioned reasons such as a lack of time to participate or unwillingness to share sensitive information.
- The research teams felt that findings should be synthesized with existing and other AMREF research, as findings were often not shared within and between country teams. This was addressed by organizing regional research meetings nested in the next cycle of a similar capacity development process.

There were also context-specific challenges; for instance, the following issues were encountered during the study implementation in the Afar region in Ethiopia:

- The distance to the respondents and services was a real problem. Nomadic people are living at great distances from each other, and the few health workers, facilities and extension workers are also scattered over a large area.
- The language barrier was problematic, not just as far as the use of the research tools was concerned, but also in relation to communication with health workers at the health facilities. Not all researchers and health workers were fluent in Afar, and this was complicated further by the Afar people being unfamiliar with Amharic or Tigrinya.
- Although accomplished, the system of translation and back-translation of the research tools required specific skills and was time- and resource-intensive and expensive.

Data analysis workshops **(May and July 2010)**

After the studies were implemented and data were collected, advice was provided through email and the internet on how to do the first cleaning and categorizing of data, which included sorting data, consistency checks, out-of-range values, missing data and general processing of data.

Subsequently, analysis workshops were held in May and July 2010 with the aim of describing how to analyse and interpret data, based on the research objectives and variables of the study, and following the plan for data analysis (including data master sheets, dummy and research tables) formulated during the research proposal phase.

For the quantitative data analysis, EpiData (Lauritsen and Bruus 2004) was used to develop and test data entry screens based on the final version of the research tools developed during proposal writing and piloted during implementation. Data capturers were identified by AMREF (usually programme staff), and the data entry process became a capacity-building exercise in itself. The benefit of data capturers being "from the field" and familiar with the research topics as well as the programme that the research is based on cannot be underestimated. A few key steps in the quantitative data analysis were that:

- data cleaning started at data entry, with the identification of inconsistencies, invalid or missing fields checked and followed up, even to the field level (i.e. tracing respondents if possible); and
- descriptive statistics, using a well-known statistical package such as the Statistical Package for the Social Sciences (IBM SPSS Statistics Developer 20.0), were generated, validated and used extensively during the first analysis workshop, after which advanced analysis took place.

During the qualitative analysis workshops, participants were motivated to read through transcripts and started analyses according to emerging themes. Triangulation of qualitative and quantitative findings was considered an integral part of the analysis workshop.

3. 5 Common challenges during the two research processes

One of the main challenges for participants from both TASO and AMREF was transitioning from using mainly quantitative methods to appreciating mixed-methods research including in-depth descriptive qualitative approaches. The temptation to calculate a representative sample, quantify responses and generalize results for a whole population was initially strong. This was addressed by highlighting the advantages and disadvantages of quantitative and qualitative data collection methods, the need for triangulation and, essentially, the mixed-method approach.

Some teams experienced challenges in operationalizing concepts such as "gender-based violence", "lost to follow-up" and a "stable relationship". This issue was addressed during the subsequent workshops. In the case of TASO, staff turnover and frequent transfers disrupted the continuity of the research process and limited access to reference materials, since these are rarely left with the teams. Involvement of new participants led to variations in participants' capacity to catch up at an advanced stage. For both TASO and AMREF it really took time to develop research-oriented minds. This could be achieved, however, with time, since participants showed a keen interest in research; several already described themselves as "researchers" in the programme evaluation activities.

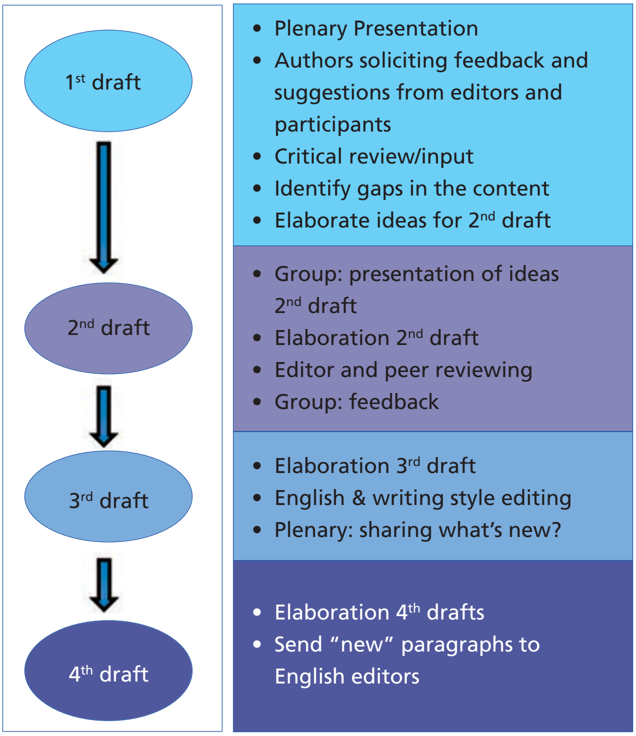
There were challenges in ensuring regular follow-up of the research process due to communication issues, especially for participants; up-country internet access was not reliable; among countries meetings were often linked to existing meetings, which meant an overload of additional work. In general, participants mentioned facing challenges coping with their regular heavy workloads alongside the research. This led to delays in implementing some of the activities.

3.6 The importance of writeshops

After the data analysis workshops, as mentioned above, the respective research teams wrote research reports in their regions or home countries. In both cases writeshops were organized: two for AMREF (September and December 2010) and one for TASO (November 2011).

Pioneered and inspired by the International Institute of Rural Reconstruction, a writeshop is an intense participatory process to support people in writing (Oro and Baltissen, 2009). It is extremely flexible, and the repeated presentations, comments and revision of drafts allow for documents to be reviewed and revised thoroughly (see Figure 9).

Figure 9: Typical process followed during a writeshop



Source: Own elaboration

A writeshop's objectives are to:

- develop capacities in writing for a specific audience;
- exchange experiences and lessons learned between researchers; and
- elaborate a written and edited output such as a book, scientific articles, case studies, working papers, policy papers.

Reviewing and editing by content and language editors and peer reviewing by other participants will strengthen the writing capacity of participants, improve the content and logic of write-ups, enable harmonization of content and writing styles and avoid content overlap. Plenary discussions generate input for joint introduction, conclusions and recommendations chapters. If necessary, desktop publishers and artists will provide support for layout and illustrations.

The number of participants and cases, the type of output requested, the writing skills and the time available for the writeshop all influence the amount of post-writeshop work. The objective is to achieve as much as possible regarding writing and editing during the writeshop (80 per cent ready), but subsequent additional editing is always needed. If the output is a book, the harmonization of content, additional introductory, overview and concluding chapters, the chapter sequence and the final layout need quite some time to accomplish.

A team of facilitators and editors, consisting of one facilitator, one English editor (from The Write Effect, working online), a copy-editor and three content editors guided and assisted participants in the writing process. Copy-editing took place after hours (i.e. overnight) to facilitate the flow of the process.

At the start of the writeshop, participants discussed the target audience and the writing style. Each participant presented the first draft of their paper, case study or article. Other participants provided critical feedback on the draft and suggested revisions. The facilitator allowed as much discussion as possible so that everyone could contribute their own knowledge on the topic. The aim was to constructively criticize the manuscript but to improve it, add to it and to remove unnecessary information so that it fitted the end product and was appropriate for the target audience.

In the case of AMREF, an internal call was launched to researchers and staff involved in the capacity development process, to work on case studies that originated from but were not limited to the research. During the first writeshop, organized at KIT in Amsterdam in September 2010, the book – *Understanding nomadic realities* – was written and later published in 2012 (Van der Kwaak et al. 2012). As a result of the first draft of presentations, participants decided to group case studies into three main chapters: Local beliefs and values, Pathways to childbirth, and Power to decide.

After finalizing their case studies, authors were asked to write a general introduction to their respective chapter. Plenary brainstorm sessions enabled enough input for the conclusions and recommendations chapter.

In the second writeshop, organized by AMREF in Nairobi in December 2010, articles for journals were composed. A scientific article is a peer-reviewed document, published in a journal or other source document readily available within the scientific community, describing original research results in a form whereby others can repeat the research and test the conclusions. On the first day of the writeshop, participants presented their research results and first ideas for an article. They were also asked to indicate their main messages. Other participants reflected on the presentations by asking questions and giving advice. In total three articles were written for the SAfAIDS/KIT magazine *Exchange* in 2011:

- Using safe spaces and social networks to convey reproductive health information to nomadic girls in Kenya (Gitimu et al. 2011);
- Promoting modern family planning among Tanzania's nomadic communities (Ernest et al. 2011); and
- Maternal health beliefs, attitudes and practices among Ethiopian Afar (Yousuf, Ayalew and Seid 2011).

During the writeshop held with TASO participants in November 2011, four articles were written for a special issue of the *Exchange* magazine that was published in March 2012:

- Tracing clients on anti-retroviral therapy in northern Uganda (Nyatia, Onega and James 2012);
- Stigma hinders couples with HIV and AIDS in rural Uganda from accessing services (Okoboi et al. 2012);
- HIV and gender-based violence among HIV-positive TASO clients (Kizito 2012); and
- Factors that influence infant feeding options among HIV-positive mothers in Western Uganda (Muhumuza et al. 2012).

The advantages of writeshops are that in a very short time – one week – a book or an article is written by providers or programme managers of health services who otherwise have no time to accomplish this. People who had never written an article before were guided to do so and even published it in a journal. The flexibility of the approach accommodates smaller budgets – meaning not having an editor involved during the workshop, as one content editor can be a viable option, and having the final copy-editing done all at once after the writeshop.

After the completion of the Nomadic Youth Reproductive Health programme in 2010, AMREF HQ wrote (and won!) two excellent proposals that had been submitted in response to tenders issued by the European Union and the Danish International Development Agency. These proposals focus on "Strengthening community capacity to improve maternal, new-born and child health in hard-to-reach areas of Tanzania, Kenya and Southern Sudan" and "Increasing access to gendered sexual and reproductive health, rights and services for youth, women and girls in marginalized communities in East Africa – a vital link in poverty reduction". Both proposals are currently being implemented over four years (2010–2013). A supplementary intervention covered by the Australian International Development Agency focuses on child health.

3.7 Discussion

The participatory, hands-on character of this capacity development process was the aspect most appreciated by participants. They appreciated the multidisciplinary backgrounds of fellow participants (medical, humanities and statistics), the opportunity for interaction between TASO staff from centres across the country or between the different AMREF country teams and the synergies involved. All participants were actively engaged in the learning process.

The facilitators made conscientious efforts to overcome challenges of hierarchies on the basis of seniority in position, age and sex which are usually prevalent in most organizations. An organization's values are important in influencing outcomes of capacity-building: 'the ship is built while sailing.' This allows for flexibility to integrate evidence-based decision-making, correct errors and, therefore, develop a responsive system (Sibbald et al. 2010).

Communication is and remains a challenge within and among country and regional teams, as well as between European and African partners, partly due to very full programme implementation schedules outside this capacity-building process. Proper planning to allow and cater for the capacity development process is essential and should be incorporated in overarching research proposals.

For sustainability, a supportive organizational environment, the use of research findings to effect positive change, recognition and (where feasible) rewarding of practitioners as researchers, and the objectivity of researchers (as insiders of the system) are essential. A potential challenge to this kind of intervention, therefore, is the failure to use research results, which can lead to apathy.

In addition to supportive organizational conditions, Brazil et al. (2005) and Langsan and Rodolfo (2004) stress the need for multidisciplinary research teams and the promotion of collaboration between researchers and decision-makers as essential for effective capacity-building in health services research. Our research teams combined social sciences, statistics and medicine. Langsan and Rodolfo (2004) also stress the need for involving native scientists in research capacity-building. All participants were African and working for TASO or AMREF. Since the identification of research priorities and the actual research was done by practitioners, with full support from decision-makers, the intervention is owned by everyone and, therefore, has the potential to be effective, meaning that not only are capacities developed but also the results of the studies inform the daily practice.

AMREF and TASO as organizations mentioned having benefitted greatly: the collective capability, defined as the capacity of a system to carry out a particular function or process, has also flourished. Inspired programme managers and research staff undertook the writing of country research proposals on top of their own hectic regular in-country schedules. As can be imagined, finding time to write proposals and conduct regional studies is a great achievement. Research and programme staff has more research capacity in-house and have built an evidence base that was used to write proposals and which, more importantly, informed their programmes to become more responsive to the needs of their target populations and clients. Thus the overall capacity and the overall ability of an organization or system to create public value were augmented. We observed four necessary conditions needed for this to materialize:

- Leadership is key. Without the interest and energy of senior members of staff, this process would never have taken off.
- Sufficient financial resources need to be in place – for the capacity development process as a whole and the studies in particular.
- The research needs to be embedded in the actual programmes for the programmes to really become evidence-informed.
- Creativity and inspiration are essential. This was realized through leadership and by giving staff the opportunity for individual growth.

The value of local knowledge and sharing it, especially during the writeshop, cannot be overemphasized. The selection of participants and their level of research capacity are vital to ensure that the sessions are pitched at the appropriate level. Hierarchy and gender also play a role; therefore, during the process it must be ensured that senior and junior staff, men and women all feel free to participate and express themselves. It was noticeable that many of the participants involved themselves proactively in other research studies as a result of their participation in this process. The capacity development in research created greener pastures not only in terms of new insights applied to new programmes but also in terms of broadening the horizons of the AMREF and TASO participants.

3.8 To conclude

This chapter described the process of building research capacity and implementing research within two alliances in Eastern Africa. Although there were some challenges, the process actually created benefits for all. The approach, using a series of participatory workshops, created many opportunities for individual and collective learning and growth.

We have learned that for sustained interest in and commitment to the programme and lasting results, the research agenda and process have to be owned by the participants; and the approach, content and areas of research have to be relevant and among the institution's priority concerns. The priorities, therefore, have to be identified by the participants from that institution. Research capacity development is essential for the health sector, particularly with regard to developing a system that is responsive to clients' needs. It should, therefore, be an integral part of organizational programming. Partnerships are essential to address capacity development gaps.

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Community members meet with health service providers and government health authorities as part of the accountability process; Banamba, Mali, 2008. (Photo: Jurrien Toonen, KIT)

4 Impact of HIV programmes on health systems strengthening in five African countries: Methodological challenges in studying complex systems

Lucie Blok, David Plummer, Georges Tiendrebeogo and Françoise Jenniskens

Abstract

Health is a complicated issue, and health service delivery depends on highly complex systems which are constantly evolving. Moreover, health systems everywhere have a reputation for having insatiable appetites for both money and human resources. The demands on the system are numerous and often only partially met. Because of the complexity of health systems and the budgetary implications of potential innovations, researching health systems is a key development priority. However, researching complex systems poses many challenges – for both developing and wealthy nations – and the multifaceted nature of these systems has important implications for the methods used to understand them. This chapter explores the experience of recent research designed to study the impact of HIV programmes on health systems in five African countries: Burkina Faso, Democratic Republic of Congo, Ghana, Madagascar and Malawi. This chapter is primarily concerned with documenting the methods used to conduct the research, the practical lessons we learned while collaborating with research institutes in the five countries on implementing this study, and the research innovations that we discovered in doing so.

4.1 Background

With the inception of the Millennium Development Goals (MDGs) towards the end of the 1990s and in light of deep-seated weaknesses of many national health systems, the international community structured much of its support for health systems in developing countries around several disease-specific control programmes, in part to focus and quarantine funds for priority areas. By channelling important amounts of donor support through funding mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank Multi-Country HIV/AIDS Program (MAP) and the Global Alliance for Vaccines and Immunisation (GAVI Alliance), substantial progress was made towards addressing the needs of people suffering from HIV infections.

However, it quickly became clear that the removal of financial constraints alone would not be sufficient – progress in controlling priority diseases also hinges on the ability of countries to expand the capacity of their health sector to meet demands (Ranson et al. 2003). In particular, the human resource crisis, so dramatically highlighted by the HIV epidemic in Africa, the attrition of health workers due to migration, and the impact of wider structural and economic reforms on intrinsically frail civil service systems constitute a fundamental barrier to universal and sustainable health care access. Other weaknesses in health systems such as poor governance, lack of infrastructure and sustainable supply systems and weak health information need to be addressed from short-, medium- and longer-term perspectives. Full and equitable access to the benefits of advances in disease control could only be reached and sustained by strengthening the health system at all levels (Travis et al. 2004). While policymakers within the priority disease programmes discussed ways to strengthen the health system, critics argued that the approach chosen to fight HIV and AIDS was damaging and fragmenting the wider health system and that other important health needs were neglected as a result (England 2009; WHO 2008a).

In 2008, health policymakers in the World Health Organization (WHO), GFATM and others started an initiative to bring together health systems and disease control expertise in the so-called “synergies project” (WHO 2008b). However, while the health policymakers from within health systems and disease control programmes tried to join forces in the quest to strengthen health systems, the issue as to whether priority programmes could help to strengthen health systems remained unanswered (Biesma et al. 2009; WHO 2009). Strong opinions in favour and against strengthening (largely anecdotal and underwritten by ownership and territorial agendas) characterized the on-going debate.

Against this background, in 2008 the Royal Tropical Institute (KIT) embarked on a multi-country study to investigate the influence of HIV programmes on wider health systems and to generate ideas on how priority disease programmes might affect the strength of health systems more broadly. National studies were undertaken in collaboration with local research institutes in five African countries with different levels of HIV prevalence and diverse levels of national investment in health.

Health systems are highly complex. A system consists of many subsystems, developed and administered by a wide variety of stakeholders from grassroots and private-sector services through to national and transnational policymakers. Numerous internal and external factors influence the functioning and effectiveness of a health system. In 2007, WHO published a Health Systems Framework to assist in developing and strengthening health systems based on ‘six building blocks’ (WHO 2007). Although different authors and research groups have commented on this framework’s shortcomings, no other commonly accepted framework had emerged, and the WHO framework remained the most commonly used model at the time that we developed our research (Marchal et al. 2009). Consequently, we decided to use the WHO Health Systems Framework as the starting point for our study, taking into account the identified shortcomings.

The study used a mixed-methods approach for each of our country sub-studies, combining epidemiological and financial data with key informant interviews and focus group discussions. We sought to document and compare observations and experiences of policymakers, service providers and beneficiaries. Respondents included key stakeholders at international, national, district and community levels.

In this chapter we describe the process of developing and guiding the case studies, explain how we strengthened the capacity of all partners to implement such complex research and present the lessons we learned and research innovations discovered.[1]

4.2 Development of the research protocol

During conception of the research, discussions were held with key stakeholders both at international and national policymaking levels. These revealed that there was consensus and considerable enthusiasm about compiling and analysing the evidence of the impact of HIV programmes on health systems. Answers were eagerly anticipated on the question of whether (and if so, how) priority programmes might contribute to the strengthening of health systems in general.

The African nations of Burkina Faso, DRC, Ghana, Madagascar and Malawi were identified as research sites. These five countries shared an interest in studying the effects of HIV programmes on their health systems but differed in levels of HIV prevalence, investment in health and HIV and included both Francophone and Anglophone countries. As part of our commitment to encouraging ownership of the study results, we partnered with key African research institutes to conduct the country studies. However, it became clear that the capacity within some partner countries to undertake mixed-methods systems research was uneven, and strengthening in-country research capacity was identified as an additional aim of the programme.

After general discussion of the overall objectives of the research and identifying counterparts in the research countries, a workshop was organized in Amsterdam to outline a research protocol. Three people from each country were invited to participate in this workshop: one senior policymaker on health systems, one senior policymaker on HIV and AIDS and the principle investigator appointed by the counterpart research institute. In the course of five days of intensive discussions the group reached agreement on the aims and focus of the research. Specific objectives for the studies were defined, generic research questions were developed and methodologies, key respondents and sampling frameworks discussed. The work of this group resulted in a draft research protocol that was then worked up in more detail by senior KIT staff.

As mentioned above, health systems are highly complex, involving multiple subsystems and stakeholders. Furthermore, a wide variety of factors internal and external to the health system influence its functioning, often in unpredictable ways. Due to the interdependence of the constituent subsystems, activities aimed at strengthening one part of the system potentially have indirect effects on other parts of the system that could either undermine or further strengthen the system overall. Contextual factors and simultaneous contributions by other actors make the attribution of improvements to any specific intervention a

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[1] The findings of this research have been reported elsewhere (Adjei et al. 2011; Bila-Ouédraogo et al. 2011; Kiyombo et al. 2011; Mwapasa et al. 2011; Ranjalahy et al. 2011; Jenniskens et al. 2012).

daunting prospect. More important, strengthening of the system is by no means a linear process that allows direct linking of inputs and outputs to outcomes. Strengthening systems involves cyclical processes, and historical investments often only come to fruition after other improvements have also been realized.

We chose a multi-case study design for our research using mixed methods, including a modified grounded theory approach that enabled us to construct explanatory frameworks for health systems impacts (Birks and Mills 2011; Layder 1993). Research instruments consisted of checklists for desk review and analysis of epidemiological and financial data as well as seven different guides for key informant interviews and focus group discussions. Interviews were planned with national-level policymakers, donors and other development partners, district-level policymakers, health providers, community-level decision-makers and opinion-leaders as well as lay community members. Interviews were designed to solicit information from stakeholders operating at different levels in the system on health priorities, responsiveness of the current health system to these needs, changes in health services and prevention and the effects of HIV programmes on the health system as a whole. Interviewees were also asked to express thoughts and ideas on how HIV programmes could contribute to health systems strengthening. The focus group discussions were meant to seek perceptions and opinions of community members on health priorities and the responsiveness of the health system.

4.3 Implementation of the country studies

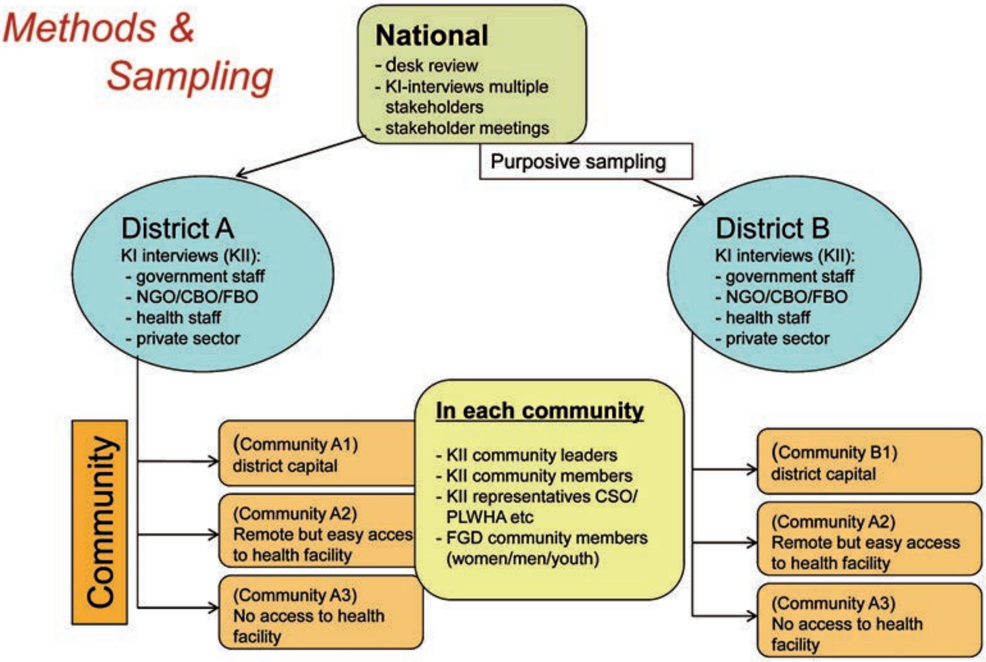
We recognized that many of the field researchers and data collectors had limited experience conducting semi-structured and in-depth interviews or focus group discussions. Most of the researchers had either done epidemiological surveys or had been involved in administering standardized questionnaires. Having designed a study with a very wide focus, covering all parts of a health system and all levels of stakeholders, we feared that important parts of the system would not be covered unless these were made explicit in the instruments. Therefore, extensive interview guides were developed for each type of respondent, covering all areas within the health system. To help researchers to ask open-ended questions that are adapted to the respective background of the respondents, sample questions were formulated for all the topics covered in the topic guide.

The next step in the process was to convene stakeholder meetings followed by induction workshops for the researchers in the five countries. During these meetings the purpose of the study was explained to policymakers, donors, development partners, service providers and representatives of civil society organizations, and input was sought regarding illustrations and significant examples of the HIV programme’s positive or negative effects on the wider health system. These examples also served to help to identify districts or regions to be included in the study, based on the assumption that these locations offered the best chance of documenting the identified positive and/or negative impacts of HIV initiatives. Last, we asked stakeholders to identify key informants and key documents to be included in the studies.

During the induction workshops KIT researchers worked with in-country research teams to create a full understanding of the purpose of the study, to pilot the research instruments and to adapt instruments and research methods to the country context. In some cases, in-country training on research interview techniques was arranged.

Interview topic guides that included fully formulated questions were developed by KIT staff. Clear guidance was given that these were sample questions and that the interviewers should use their own judgement and ask questions that were relevant, to maximize the chances of generating new information and original insights from respondents. The topic guides were prepared so that a wide range of elements of health systems and various potential examples of health systems strengthening were included. These guides were intended to function more as checklists than as prescriptive instruments, and by no means were all areas expected to be exhausted in each interview. The in-country researchers that conducted the interviews were asked to be strategic and to decide which topics to cover in each interview based on the respondent's background, knowledge and interest and observations and gaps that had emerged during previous interviews (Kvale and Brinkmann 2009). There were, nevertheless, some standard questions in the guide that were intended to be asked of each respondent. These were generic questions on health priorities, health system needs, and requests for concrete examples of positive or negative effects of the HIV programme on health systems and for any potential they saw for synergistic approaches to health systems strengthening.

Figure 10 Sampling framework within the countries



Source: own elaboration

The sampling approach was discussed and agreement reached among KIT researchers and the in-country teams. In each country, purposive sampling was used to select two districts with the aim of capturing concrete examples of the influence of HIV programmes on the wider health system. We wanted to capture effects and perceptions in both urban and rural areas. For each district we asked research teams to choose one community in the district capital, one community in a rural area but close to a health facility and one rural community that did not have health facilities nearby (see Figure 10).

Once the protocol had been piloted and adapted, the local research team implemented the desk study, interviews and focus group discussions over a period of between three and six months. Some of the teams completed data collection without additional assistance, but in some countries KIT researchers visited midway through the research and together with the in-country research team conducted an interim analysis. This analysis was a useful opportunity for troubleshooting, to refocus sampling and to bring more depth to the research. For instance, when discussing the first results and trying to reach consensus on the interpretation of the information obtained during the interviews, the interviewers discovered the need to probe further and explore interesting responses in much more depth before conclusions could be drawn. It also helped to identify questions that would usually yield useful information as well as topics that were less relevant to explore. During these sessions the in-country researchers were once again encouraged to use their own judgement during the interviews and to feel free to discuss with each respondent the topics most likely to provide valuable insights and that were expected to contribute to answering the research questions.

In one of the countries we learned during the mid-term visit that the in-country research team had decided to increase the number of districts and respondents to be included after receiving criticism that the chosen sample was not representative. Such misunderstandings showed once more the need to explain the theoretical basis of qualitative research and the conceptual differences in purposive sampling for exploratory studies as opposed to random sampling for quantitative research.

4.4 Expedited data analysis of complex datasets using the metaphor of investigative journalism

In total the research teams in five countries conducted 543 key informant interviews and a great number of focus group discussions. We had agreed with the research teams at the start of the studies that all interviews would be tape recorded, transcribed, translated into English or French and subsequently coded for analysis in ATLAS.ti, version 6.2 (see www.atlasti.com). A detailed code book had been prepared in English and French to be used across all case studies. Due to failing recording equipment in one of the countries, an important number of interviews were lost, while a lack of time forced country research teams to select the most informative interviews and focus group discussions for translation. In total 258 of the interviews and 45 focus group discussions were entered and coded in ATLAS.ti.

It quickly became apparent that the amount and complexity of data – collected from multiple countries and in several languages – posed formidable logistical problems if we were to complete in-depth analysis within a reasonable timeframe. This made it necessary to radically revise our approach to the analysis. Despite having the assistance of ATLAS.ti software, the standard approach to coding and analysis was going to be extremely time- and labour-intensive, and it became clear that rigid adherence to the coding manual risked losing access to important, original and unexpected findings. Ideally, what the interpretative process needed was access to the insights of people who had been immersed in the data and were intimately familiar with it. For this reason, we opted for an approach that was designed to leverage the insights gained by the field data collectors who conducted the original interviews. Provided they were oriented to the priorities of the project, these workers would be well placed to quickly identify the "newsworthy" themes that emerged. On the other hand, many of the field workers had had limited training in qualitative research methods; indeed, some even admitted a bias towards quantitative methods and a degree of scepticism when it came to qualitative research. So, to maximize their contribution and to address these methodological limitations, we decided to:

- convene in-country workshops designed to draw out the rich collective insights of the field data collectors and to make them available for the analysis;
- conduct an orientation session during those workshops to familiarize workers with the principles of qualitative data analysis and to address any barriers and misconceptions held by participants; and
- utilize a metaphor to explain the analysis process that was *intuitive and familiar* to the field workers, to facilitate their methodological understanding and to expedite the analysis. For this purpose, we chose "investigative journalism" as the metaphor (see Box 4).

The first step in our "journalistic" approach was to convene in-country workshops attended by KIT staff and local data collectors and research teams. Each workshop started with a brainstorm with the researchers who had conducted interviews and who had the most intimate understanding of the data. The aim was to identify the most poignant findings and emerging themes, which the researchers themselves considered to be "new" knowledge and worth exploring further. We then asked participants to work in small groups to flesh out these themes using a journalistic approach.

Box 4 Journalistic approach

Evening News Bulletin

Reporter:	Date:
Name Deleted	23 March 2010
Headline:	
Monitoring and Evaluation – a double-edged sword	
Storyline:	
Monitoring and Evaluation strengthens the research capacity of the general health system by improving data collection, management and reporting. However the detailed reporting requirement, the short delivery period and the pressure to meet deadlines increases the workload on the local staff involved in the data collection.	

Evidence:

'The ability to gather and process information was enhanced, because their [HIV programme] information requirement goes beyond what we used to aggregate at national level.' (NAME DELETED)

'The HIV programme helps gather information for the purpose of meeting the reporting system requirements. With these programmes specifically HIV/AIDS, you might get HIV Coordinators at the district level working with the district system. They are not isolated even though they are being paid or have been employed by the NACP [National AIDS Control Programme].' (NAME DELETED)

'We have developed appropriate M&E strategies, part of which is data management, developing a checklist of indicators that must be reported on a quarterly basis and collated. We have also developed simple software to enhance the management of the data. We always stress value for money so, if at the end of the first quarter you give an evaluation report, you have advanced resources for the next quarter.' (NAME DELETED)

'I think they are quite a few [changes in M&E]. If you look at the M&E systems for HIV, TB and malaria, the reporting system is swift and does not delay compared to other programmes. They can learn from this.' (NAME DELETED)

'The intensity and shorter time period that they require that information might not be the same, hence brings workload on the staff that works on this.' (NAME DELETED)

'The integration of the HIV/AIDS programme increased the workload for the clinical staffs, which can compromise the quality of care.' (NAME DELETED)

'We used to report 2 pages of health statistics each month. Now there are 20 pages.' (NAME DELETED)

In practical terms this involved the participants identifying findings that were new and newsworthy. They were then asked to produce an item for an evening news bulletin which told the story and gave the evidence to support it. The "bulletin" for each significant finding consisted of a single-page report with a headline (the emergent theme), a story line (the analytical narrative) and some newsworthy footage or "grabs" (typically quotes from the transcripts which gave clear evidence both for and against the story line). The teams were asked to search the transcripts for evidence and quotes that supported or contested the hypothesis captured by the headline and elaborated in the storyline. Transcripts were searched using codes and keyword search functions in ATLAS.ti (Saldana 2009). Using this approach, we managed to compile the main results of the case studies within a relatively short period of time, and there was also general consensus about the validity of the analysis (see Box 5).

Subsequently, in May 2010, all country research teams came together in Amsterdam to present and compare findings and to discuss themes emerging across the countries. This approach helped to deepen the analysis and to explore the similarities and differences between countries and to reach conclusions that are transferable to other settings.

For instance, we found that, while some countries reported negative effects of HIV programmes on staff availability within the general health services, others did not report such an effect. The teams were then asked to review their case study to confirm either similarity or difference and to try and explain apparent differences.

Another finding in some of the case studies was a strong divide between people working within the HIV programme and those within the general health system. While in at least one country this divide was voiced by respondents in terms of resentment, this had not immediately been recognized as a significant issue in other countries. However, on further investigation, it became clear that all country research teams could identify what they called ‘working in silos’ and saw greater or lesser degrees of protectionism on the part of people within the HIV programmes and resentment on the side of the people working in other parts of the health system.

Box 5 Summary findings of the study

We found a range of positive synergies between the HIV programmes and the health system overall, as well as negative effects. Findings, however, turned out to be remarkably similar between the countries given the differences in context. Among the positive effects are improved health infrastructure, systems for monitoring and evaluation (M&E) and systems of supply chain management, although the latter two had so far shown very limited contribution to the wider health system largely due to the establishment of parallel systems. Capacity development of health staff – especially in terms of introducing attention to provider–client interaction and patient-centred approaches – and increased engagement of communities through community services and community-based organizations were also mentioned as positive effects. The most important negative effects were the undermining of planning, management and priority-setting and the availability of health staff for general health services.

Less consistent were the outcomes with regards to access and quality of general health services, since some studies documented positive effects, and others did not reveal any effect. Accountability and transparency were found to have improved in terms of upward accountability, but downward transparency remains weak.

Importantly, we found that most effects on the health system, whether positive or negative, turned out to be spin-off effects of the HIV programme and not so much a planned action to strengthen the wider health system in a synergistic approach. The fact that these effects were unplanned made it difficult to unpack the factors that influenced the observed changes in the health system and to unravel who and what contributed to these changes, what were barriers and how these were overcome.

The most striking finding that cuts through all other findings is the strong and consistent divide and “parallelism”. This seems related to separate funding streams, management and planning, because people within the HIV programmes and health systems people have very different goals and use a different language. This all leads to a tendency to work in “silos” and may be the cause of a certain degree of protectionism within HIV programmes, while health systems people may envy the HIV programme for seemingly abundant resources, well-equipped offices, cars, computers, status, career opportunities and allowances. Power differences between a multi-sectoral body such as the National AIDS Commission under the mandate of the president’s office versus a health planning unit in the health ministry further contribute to this divide. Therefore, despite recent developments towards integration and trying to use disease-specific programmes to strengthen the overall health system, there is still an important need to better understand the mechanisms and effects of this divide and to pilot strategies to bridge it.

4.5 Discussion

Strengthening the capacity of research partners to conduct multi-method social science research poses a number of important challenges, especially when support is provided mostly from a distance. Because this project involved rather complex research that extended over prolonged periods of time, the need for support and technical guidance was not always identified in a timely manner. Moreover, approaches agreed on during the inception phases easily fade, or become misunderstood or superseded, which may only become apparent during the analysis phase. Despite an explicit agreement that all teams could seek advice at any time, country teams tended to try to solve problems and resolve uncertainties internally. In the process of this research we learned a number of specific lessons.

First, we found that research teams were initially reluctant to pilot interviews. However, after having been required to implement pilots, all teams reported that debriefing after the pilot was extremely useful for fully understanding the purpose of the study, for adapting questions to be asked and for improving interview technique. An interim analysis workshop in one of the countries turned out to be an eye-opener for the researchers, as they discovered that in several interviews significant issues had been raised that would have warranted more in-depth probing than had been exercised until then. Regular feedback and guidance during the implementation of the interviews would certainly have contributed to further strengthening interviewing skills.

Second, the elaborate interview guides with sample questions, covering all potential areas of interest for the study, turned out in most cases to be a constraint rather than a support. The likely explanation is that the majority of the interviewers had little experience conducting semi-structured and in-depth research interviews and were hesitant to depart from the guiding questions. Instead, the guide was used almost as a face-to-face questionnaire rather than a checklist of topics, despite repeated encouragement to be flexible and creative and to explore beyond the interview guide. This is an important finding for future research, because such restraints, by being so prescriptive, limit the chances of the research making new discoveries. An additional effect of adhering to guides that are too detailed and elaborate (in this case, with up to 47 sample questions) was a tendency of interviewers to rush through questions, with the consequent risk of severely limiting probing and follow-up of key points raised by the interviewees. In hindsight we feel that stronger results would most likely have been achieved by investing more in practising interviewing techniques and boosting interviewers' confidence in formulating their own questions and making on-the-spot decisions about the focus of individual interviews.

Third, sampling of two districts and three communities within each district turned out in practice to be more complex than anticipated. For researchers for whom quantitative methods were the norm, purposive sampling was often not grasped intuitively, and further training was required. Some researchers experienced difficulties when challenged to defend the choice of districts and communities by stakeholders who had concerns about how representative the sample was.

Finally, the most important challenge we faced was the difficulty of managing and analysing vast amounts of raw information generated by the research teams. As we sifted through the interview data for evidence to refute or substantiate emerging themes, it became clear how easily large amounts of detail could get in the way of original discovery. We concluded that an important alternate strategy was to identify cross-cutting themes as early as possible and use these to focus our attention on compiling the supporting or contradictory evidence. The brainstorm sessions with the research teams, "interviewing the interviewers" and the journalistic approach turned out to be excellent methodologies to assist research teams to quickly reach consensus on major findings.

The use of "investigative journalism" as a metaphor offers a number of benefits:

- it is intuitive and familiar, even to field workers with little or no training in qualitative methods, and this allows workers to quickly contribute to the analytical process;
- it is able to leverage the deep insights of those most immersed in the data and, therefore, greatly enhances the relevance and quality of the analysis;

- it can be used to overcome the limitations posed by large and complex datasets, where computerization has little to offer. This was especially useful in our case, where data was collected in several languages;
- the workshops based on this metaphor bring together the lead researchers at the international level with the grassroots researchers, in a similar way that reporters meet with editors in a news setting to decide what is newsworthy and what story leads to pursue;
- the approach greatly speeds up the analytical process by pooling expertise, concentrating the analytical process into a discrete timeframe and providing a forum for rapidly identifying the overarching themes and outcomes of the research.

4.6 Conclusion

Implementing qualitative research in development settings is challenging, particularly where field workers have limited or inconsistent training in qualitative methods or where their training is mainly quantitative. However, with the right approach and sufficient support, meaningful qualitative research is possible, and capacities can be strengthened. We learned that regular, flexible and on-site guidance of the researchers is to be preferred over extensive guidelines. We discovered that detailed research instruments, instead of being a support, may undermine researchers' confidence to explore interesting findings in greater depth. We recommend that the emphasis should be on on-the-job training in interviewing techniques and on collectively drawing lessons on the quality of the interviews through regular analysis of the transcripts of interviews and focus group discussions immediately after they are conducted.

Most importantly, we discovered that our methodology, which was derived from investigative journalism, made otherwise obscure qualitative approaches much more accessible to field workers, many of whom were not trained in qualitative methods. Their everyday familiarity with print and television news reporting enabled them to quickly understand data collection, thematic analysis and quality assurance in qualitative research. This approach also helped workers to overcome any misconceptions they might have carried over from quantitative methods. Far from undermining the quality of the work, the research was greatly enhanced by this manoeuvre because it gave researchers direct access to the detailed knowledge and rich insights from those most immersed in the data – namely, the interviewers themselves. A further benefit of this approach was the way in which the journalistic approach helped to expedite the analysis. Given that the project generated a large, complex dataset in several languages, even computer-assisted coding and analysis would have been unacceptably slow and laborious. In contrast, we were able to quickly identify emerging themes and gather unique insights by "workshopping" the findings with the field workers. Our journalistic approach proved to be an excellent method, especially when explorative studies threaten to produce information overload. Moreover, the approach can be applied in settings where qualitative skills are not well developed – both in low-income countries and beyond.

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The President of the ASACO in Dioila, Mali, is chairing a meeting with health providers to define health priorities, 2008. (Photo: Jurrien Toonen, KIT)

5 Proper preparation prevents poor performance: Getting started with results-based financing in Mali and Ghana

Bertram van der Wal and Jurrien Toonen

Abstract

Health systems and services in many countries have drifted away from their *raison d'être*: responding effectively to the needs and demands of the communities. In an attempt to change course, the concept of results-based financing (RBF) has been tested in various countries over the past decade, with varying results. Most positive experiences derive from countries in post-conflict situations such as Rwanda. The basic principle is that the money follows the patient. Health service providers and users are paid for predefined and verified results, often partly replacing input-based funding with output-based funding. The implementation of RBF requires a certain health reform in countries where the Ministry of Health is a purchaser, regulator and provider of health care at the same time. 'How to implement RBF' is the main question that we address in this chapter. From our experience in Mali and Ghana we deduced eight steps to implement the RBF concept sustainably. These steps fall broadly within four phases which require the development of specific capabilities: (i) to (re)think and innovate; (ii) to commit to a contracting approach; (iii) to sign performance contracts; and (iv) to apply, adapt and self-renew. Going through these same phases in both countries allowed us to arrive at two different models fitting the context of Mali and Ghana.

5.1 From resources to resourcefulness

There is no "one-size-fits-all" approach to improve the performance of a health system. Any health system has its specific social, political, economic and institutional characteristics. Therefore, the phrase *'no it's not a model, it is an approach'* became our mantra during the process of designing the appropriate institutional RBF framework for Mali and Ghana. In Mali we did not call it *recherche-action* (action-research), but *recherche d'actions* – French for "searching for actions". As such, we moved beyond the "blueprint approach" to an approach that results in a "best fit". This shift is fundamental to the sustainability of the change and responsiveness of the system to the needs of those who should actually benefit most from health services.

After we had introduced the RBF concept to a delegation of a regional health directorate in Ghana, one participant asked: 'so will you buy us a car?' Pointing to the car park outside we replied, 'look there are dozens of cars on your lot; why don't you use them?' 'No, these are for projects related to malaria, TB and other programmes'. For a moment we could not help being flabbergasted, but it is also very understandable knowing that this is a Pavlovian response that is the result of years and years of input-based funding. This "mind-set" will not change overnight, but there will always be that person in the room asking the right question, 'how does it work?' We put the focus on "mobilizing resourcefulness" instead of "resource mobilization".

5.2 Preparing the actors

We learned that it is essential to the success of RBF that medical and non-medical partners negotiate for health results (outputs) by entering into a contract. "Contracting" needs partners on each side of the negotiating table that are credible and at an equal level. To make services respond to the demand of users of these services, the voice of the patient needs to be well represented in focusing and managing health services. That is why we strengthened the capacities of non-medical actors to become credible partners, capable of determining which health results should be purchased, judging if these results were indeed achieved and holding providers to account. But also, capacities of medical partners need strengthening to adopt a learning attitude and to become resourceful to attract patients to their facilities.

5.3 RBF for dummies: A brief description

Although the RBF approach has recently attracted a lot of attention, many may have limited understanding of RBF and its underlying principles, so we will summarize it first.

It is important to understand how the thinking about performance in health care has developed over the past years to understand how the concept of RBF evolved. We use the definitions of the different types of Conditional Cash Payment systems as follows:

- In pay for performance (P4P), one sole institution is purchaser, verifier and payer of the services of the health service provider: it will determine the "results", set "prices" for these results and "verify" them.
- In the case of performance-based financing (PBF) and RBF, there is a clear split of function between purchaser, provider, regulator and verifier.
- The difference between PBF and RBF is that in PBF there are supply-side incentives only, and in RBF there are supply- *and* demand-side incentives.

At the beginning of this century, PBF started in Africa in Rwanda to speed up health results after the war. Two Dutch non-governmental organizations (NGOs), HealthNet International and Cordaid, replaced financing of inputs by ex post financing of outputs: the more services provided, the higher the financing. The project covered two rural districts and was successful (Toonen et al. 2009). Therefore, it was scaled up to national level, where again results were judged to be highly positive (Basinga et al. 2011).

The Norwegian and British installed a trust fund in the World Bank of US$ 550 million to support piloting of P/RBF in other countries. This trust fund aims to accelerate achieving Millennium Development Goals (MDGs) 4 and 5. Many high-ranking health officials from all African countries have since visited Rwanda, to witness the wonders of PBF. But, returning home, they all asked themselves how it would fit in the context of their country.

After an evaluation mandated by Cordaid that studied the experiences of PBF in Burundi, DRC, Rwanda, Tanzania and Zambia (Toonen 2009), KIT identified the *basic principles of RBF* that need to be adapted to other contexts. These elements should motivate health care providers to deliver services efficiently and be more entrepreneurial and creative to become more responsive to the clients' wants, needs and demands. The classical, deconcentrated way of organizing the sector does not promote an active attitude in providers to improve their services – it is often even used as an excuse for not being able to perform.

Table 5 Basic principles for results-based financing

A. Governance through contracting

RBF is first of all a contracting approach. This way RBF can bring order to complex health governance structures. RBF uses contracting as an instrument to capture agreements between local actors about their roles and responsibilities on the one hand – and on expected results, how to achieve these and how these will be compensated through incentives on the other hand. In a performance contract, negotiated priority health results and the incentives linked to them are defined between the purchaser and the provider of services. Performance will be defined in terms of number of outputs and in terms of quality of care – incentives may be financial (the "F" in RBF) but may be non-financial as well. To ensure that providers can be held to account on results, each individual health care facility should be contracted. The purchaser, who negotiates the contract, should be present at operational level, to ensure an optimal fit to local circumstances and local health priorities, and to guarantee effective monitoring by the purchaser.

B. Planning for results

In the case of classic input planning, providers plan inputs needed to implement activities they are asked to do. In the case of output planning, priority results are first defined by the purchaser at operational level. This will stimulate the provider to be creative and innovative to develop plans to attain as many of the indicated results as possible: the more results, the greater the funding, which again will allow them to achieve even more results. So the thinking for planning starts at the other end: at the results end, not at the activity end. This, we experienced, is for many providers a difficult first step in RBF. They tend to answer first in terms of classical inputs they need, without questioning if those inputs will be the best investment that will lead to increased results. Often, the actors start discussing RBF with 'oh, we need a 4-wheel-drive – oh, and a computer' without thinking if this will result in more assisted deliveries by skilled personnel.

C. Checks and balances

If contracts and payments are at stake, certainly if there are financial incentives to be earned, there need to be checks and balances. Providers may easily claim for outputs they did not realize. For that reason, a split of functions and responsibilities between the contracting parties is needed to ensure checks and balances: no stakes should influence decisions. The purchaser must be able to decide to pay for results based on impartial verification that they were indeed achieved. Standardized instruments are needed for verification. The bottom-up plans should match national norms and standards and with the wider strategic framework decided upon at (inter)national level. Probably local representatives of national Ministries of Health will play this regulatory role. This split of functions requires a carefully designed institutional framework. This way, contracting also strengthens governance in terms of transparency and accountability, as expected results and responsibilities of different actors are clearly defined.

D. Autonomy at the operational level

If the service providers and their contracting partners at operational level expect innovative and creative solutions appropriate to their context to be found, they need to be autonomous in using the (results-based) payments for the activities they identified at their level. They also need to be autonomous in proposing choices that will create an optimal ratio between outputs and inputs, within their specific context, to achieve as many of the priority results as possible. In input planning, providers have to comply with directives from higher levels to obtain earmarked input planning budgets – which prevents health care providers from being more entrepreneurial and creative to become more responsive to the clients' wants, needs and demands.

E. Introducing managed market principles

Of course, health is not to be compared with a commercial good. Even so, some market principles may be introduced to stimulate providers to become more efficient and more client-oriented. In this regard, RBF introduces – financial as well as non-financial – incentives based on services delivered rather than on inputs. But it also seeks to increase competition between different types of providers to avoid monopolies and unequal power relations. Finally, RBF links supply with demand by increasing the clients' involvement in decision-making and through demand-side incentives.

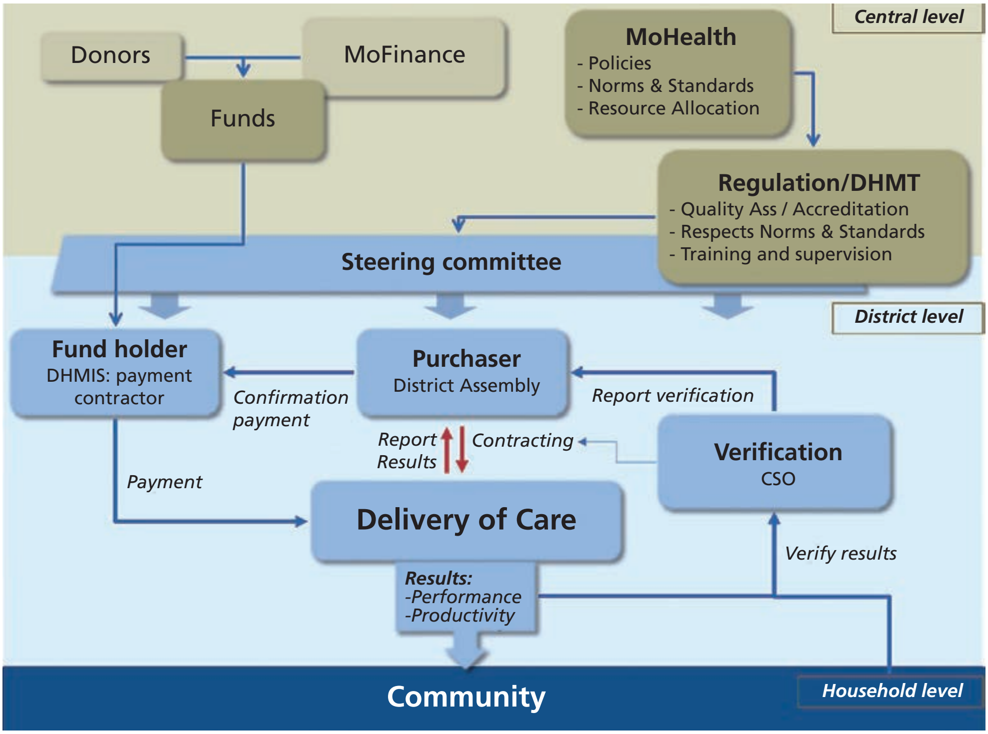
F. Providers responding to the demand side

Providers alone will not improve results in the sector – they will also depend on utilization of services by the patients. So, if providers want to improve the results, they will first have to look at their customers' interests when developing their strategies. Only if these are seduced to use the provider's services will their results improve. They will need to improve the quality of their services – that is, quality from the client's perspective. They will have to identify what obstacles the clients face to use their services, such as the risk the patient incurs, transport to the facility, financial barriers, or the organization of their own services that may not be client-friendly.

Source: own elaboration

These basic principles require a solid, sound institutional framework that defines the roles of different actors and ensures checks and balances, which are key in RBF (see Figure 11).

Figure 11 Institutional framework for results-based financing



Source: Toonen and Van 't Klooster 2011

The purchaser contracts the provider to deliver curative and preventive health services. A local fund-holder pays ex post incentives to the provider based on quantity and quality of results, after verification. The regulator ensures that services are delivered according to national policies, norms and standards. Purchaser, provider and regulator are represented at a higher level in a steering committee that provides boundaries for contracts and to arbitrate in case contracting partners disagree. The central level ensures the financial solvency of the fund-holder.

5.4 Capacity development to foster readiness of contracting partners

Capacity development roughly took place during four phases. These phases are in line with the five core capabilities as identified in the ECDPM study (Land 2009).

- *First phase* – we analyse the political context to identify the appropriate future contracting partners and potential entry points to embark on the process.

- *Second phase* – non-medical actors in particular are enabled to commit to the contracting approach, for which they need adequate and analysed information.
- *Third phase* – the partners are coached in negotiating performance contracts.
- *Fourth phase* – these contracts are tested, after which the idea of "performance incentives" is added, introducing the "F" of RBF.

Box 6 Confusing decentralization in Mali

At first the Ministry of Health (MOH) delegated tasks to the District Health Management Team (DHMT), establishing a decentralized system. Then health reform (*Politique Sectorielle*) in 1990 gave ownership of community health facilities to community health associations (*Associations de Santé Communautaires* – ASACOs). In 2002 certain mandates were devolved to Local Elected Authorities (*Communes*), which are now responsible for basic service delivery including health at local level.

5.5 Phase 1: Capability to (re)think and innovate

In *Mali* the entry point to start discussions about alternative performance arrangements was the institutional mismatch in the governance structure of the health sector at decentralized level (see Box 5). Development of the approach started in one district in the Koulikoro region. It should be noted that from the start onwards, the national level of the different ministries involved were engaged (Hilhorst et al. 2005; Toonen et al. 2007; Konaté et al. 2009).

In 2002 the country had gone through three different decentralization efforts, leaving three different structures (DHMT, ASACOs and *Communes*) to think that they were all primarily responsible for health services at decentralized level. This led to mistrust and power struggles, hindering performance of the health system. The shift of powers needed a rethink of how to adapt governance at operational level to national policies through a new and innovative *engagement strategy*. It formed the starting point to discuss a pragmatic distribution of mutual roles and responsibilities, and it was finally decided that this would be best approached by establishing contracts. It was also acknowledged that the *readiness* of all three key partners to develop such a contract was weak to non-existent. Therefore, they agreed to introduce a preparatory phase of learning by doing, to enable all to become credible contracting partners.

Box 7 Give me facts, not opinions

Ghana has enjoyed strong real gross domestic product (GDP) growth rates (above 6 per cent) for the past three years. Ghana's health sector had benefitted from this growth: the per capita expenditure on health has grown from a level of $6.7 in 1996 to $13.5 in 2005 and $27 in 2008. Only, it is estimated that around 95 per cent of the government contribution is spent on salaries – so health interventions need to be funded through internally generated funds (health insurance and out-of-pocket expenditure) and donor funding.

Even though health funding has increased significantly, results have not followed as expected, so the health-related MDGs may not be achieved. Although under-five mortality fell by 28 per cent and infant mortality by 22 per cent, maternal mortality remains high at 580/100,000 live births (Ghana Statistical Services et al. 2008). Although there is high coverage of ANC services (90 per cent), only 59 per cent of women have their delivery assisted by skilled personnel, only 7 per cent use postnatal control services one week after delivery, and 35 per cent have unmet family planning needs. These are aggregate data – for poor areas such as the Northern region, figures are even worse. Ghanaian health authorities state more and more often that 'health financing is not related to results.'

Using our experience from Mali, SNV and KIT started introducing RBF in *Ghana* at decentralized level in March 2010, by organizing two regional workshops, one in the Northern region and one in the Western region. We took the current gap between relatively high investment and low performance as our main entry point to start discussing alternative payment mechanisms. The facts (see Box 7) raised the question of how to get more and better results out of the available human and financial resources, presenting the main entry point to start considering alternative payment mechanisms.

We started with a workshop with about 50 participants representing community health workers, M&E officers, health insurance personnel, representatives of women's groups, members of local NGOs and of district and regional health directorates.

After presenting the facts, we asked *them* if *they* saw a need to improve the performance of their health sector. As they recognized the urgency of the situation, the tone was set by the regional health director of the Western region, who began to stress the need to start discussing potentially beneficial alternatives to improve the performance of the region's health services.

In addition to the relative underperformance, we also used the fact that the Government of Ghana itself had applied for a World Bank loan to start implementing RBF. This was granted at the beginning of 2009. However, implementation has still not started, as there is no agreement on the institutional architecture for RBF in Ghana. This, we realized later, also presented a risk, which we will elaborate on in phase 4.

At the end of the workshop the key decision-makers committed to an operational research approach to (re)search for the appropriate RBF model to fit their context. A similar workshop was organized in the Northern region, after which it was decided to start working with four districts to develop an appropriate understanding of RBF at district level, focusing on the challenge to get more and better "results" out of the existing "finance".

At this point in the process key partners shared a sense of urgency and agreed on the general idea and destination – a performance contract that would ultimately define the distribution of roles and responsibilities. The way to get there was not defined in the beginning and needed to be developed through *recherche d'actions*. This left the direction and speed of the process to the key stakeholders. At the end of this phase, there is an acceptance of the "minds", which needs to be backed up by empowering the partners to commit to a contracting approach.

5.6 Phase 2: Capability to commit to a contracting approach

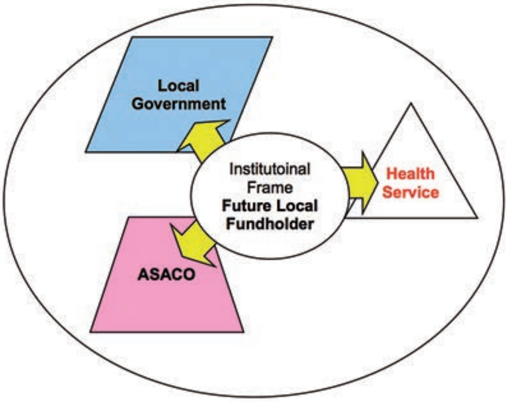
The second phase of the programme focuses on strengthening partners' knowledge and understanding of their roles and responsibilities, with a particular interest for the non-medical actors at decentralized level (local government and civil society organizations). These partners are too often passive participants, acting on the periphery of the health system, mostly because they think they are unable to analyse and value health information. This leads the medical actors to frame situations, challenges and solutions. This undermines accountability and creativity, as non-medical actors have an important role in representing – formally and informally – the voice of the patient. By building their capacities to analyse and monitor health information, they will become an informed contracting partner, able to commit to a contracting approach and representing the needs, wants and demands of the community. In Mali this was done in four steps, which were partly replicated in Ghana.

In *Mali*, SNV and KIT had already supported decentralized health services for many years at the operational level, particularly in the regions of Segou and Koulikoro.

The *first step* aimed at informing the three stakeholders (see Figure 12) on the policies and the official roles and responsibilities of the other two stakeholders. Their perceptions were based on a lack of knowledge about the actual roles of the other stakeholders. The official roles were:

- local government represented the community through democratic elections, and were responsible for all decentralized services;
- ASACOs represented the community and were legal "owners" of the health facilities; and
- health services represented the Ministry of Health (in a decentralized system).

Figure 12 RBF stakeholders



Source: Toonen and Van 't Klooster 2011

Box 8 Delivering rocket science?

In the village of Wakoro in Mali, during a meeting with ASACO, *Commune* and health staff, we showed them a graph for ANC, indicating the target and the development of coverage so far. The non-medical actors claimed that they did not understand the meaning of these statistics. Then, we asked the health staff to explain in layman's language. Representatives from the ASACO and the *Commune* immediately understood it – and looked like they understood rocket science. When we asked them to explain the next figure (assisted delivery), they could explain it very well. They could even pinpoint a main cause to explain the gap between the coverage of ANC and assisted deliveries: *their husbands!*

All three perceived that the others aimed at monopolizing power over health care. During meetings, each one explained their role to the other two. Also, the programme produced small booklets that aimed to inform each of them about the others. It appeared that in a number of governance issues the three were congruent to each other, so there was no conflict of interest. Even so, a number of issues were conflicting, and it was not clear from national policies who would be responsible on the ground. It was decided that this would be solved during the process.

In the *second step* we defined the kind of results the actors would want to aim for. In focus group discussions, the medical and non-medical actors discussed from their perspectives which health results needed improvement. Each group determined what "health" meant for them, what they saw as major risk factors and what would be their priorities – based on baseline data from their district. It appeared that the priorities did not differ much between them: all came up with issues such as mother and child health, malaria control and curative care. After the focus group discussions, they jointly selected some shared health care priorities that responded to their local needs.

This turned into agreed information needs for M&E, which represented the practical output of the meeting. Perhaps more importantly, the actors were capable of bringing coherence to their partnership working: they were chasing the same results.

However, when it came to defining the way forward, the non-medical actors fell back on their old response by saying: 'the doctor knows!' They felt unable to define the actions that needed to be undertaken to meet the objectives, nor to monitor whether results were actually being achieved. It was decided to develop tools that could support the non-medical actors to develop these skills.

The non-medical actors were formally already involved in the planning process – but only at the end of the planning cycle. When the medical actor had developed their plans, they passed these plans on to the *Commune* and ASACO for their approval. But these were plans based on national-level priorities and national priority plans – not necessarily reflecting local priorities. As a *third step*, the programme developed a tool, the "micro-plan", that started from the priorities as expressed by the three actors, who defined jointly the expected results and the strategies to achieve them. Both medical and non-medical actors proposed interventions that would lead to the results. So the non-medical actors were now involved from the beginning of the planning cycle, and there was a shift to results-based planning. They felt ownership for the plans, which they previously just signed blindly.

Box 9 Win–win in Wakoro

In the same village of Wakoro in Mali, the mayor went around on his motorbike to speak with members of his communities. During meetings he talks with the husbands, insisting that better care can be guaranteed when their wives go for ANC and deliver in the nearest health facility. When we asked why he does this, he replied that he had understood from the analysis of the data that he had a responsibility to act upon it. But also organizing men and demonstrating that he was working on improving health care increased his chances for re-election.

The ASACO and *Commune* normally received quarterly reports from the health services. These reports contain more than 1,000 indicators, making them hard to analyse and understand alongside equally voluminous reports from other services such as education, water and sanitation, etc. So they routinely signed for having received it, without any assessment of the performance of *their* health services. The *fourth step* was, therefore, to develop a *Système d'Information Essentielle pour la Commune* (SIEC) based on a "minimal package of information" related to their expressed health priorities (see step 2). The ASACO and *Commune* needed to fill in a scorecard – using traffic lights with standard scores to assess whether health results were good, mediocre or bad – which ensured that they *actively analysed* the performance of the health services. This helped to prepare them for the contracting approach. Steps 3 and 4 have resulted in non-medical actors becoming acquainted with health planning and holding providers to account on results. This is of utmost importance if all actors need to be credible informed partners, capable of negotiating a contract and holding providers to account on results – and even more: being accepted by the medical contracting partners, who usually under-estimate the capabilities of non-medical actors in health matters.

This first phase of the approach has already become a national policy in Mali, and the tools have been published in the form of a guideline (see Konaté et al. 2009).

Box 10 Capacity scan of NGOs in health

In May 2010 SNV finalized detailed profiles of 385 health NGOs, with information on the scale and scope of their programmes and other organizational characteristics. One interesting finding is that 74 per cent focus on HIV and AIDS, TB and malaria programmes and not on more generic health systems strengthening. Planning of these NGOs is mostly short-term, and their approach is predominantly "knowledge-brokering": sensitization and awareness-creation and (traditional) behaviour change.

Ghana has a well-established health governance architecture, with a health insurance scheme that already has purchasing power. Although civil society is perceived as vibrant, the main Coalition of NGOs in Health did not have detailed information on its members. SNV developed and applied a capacity scan, providing a basis for further discussion and engagement (see Box 10). A KIT study into the political economy of human resources policy-making in Ghana confirmed that the voice of the patients is hardly heard in holding health services to account on their performance (Toonen 2010). Social accountability, as an approach to enhance government accountability and transparency, by citizens holding the state to account on its commitments, could provide a solution here (McNeil and Malena 2010). Social accountability in the health sector would mean holding health services to account on results. Although this is a promising way of improving performance in the sector, this is actually hardly put into practice in Ghana. This is also due to the fact that civil society and local actors lack the skills, tools, instruments and resources to hold health services to account.

Capitalizing on the sense of urgency that was created in the regional workshops, we asked the participants to break into sub-groups and to identify results-based and innovative solutions to some of the main challenges. Most of the proposed interventions were, however, input-based, such as more training, and money to buy fuel. Second, most of the interventions were those that have been in use for a long time: information, education and communication materials, informing women about ANC, training and supervision, etc. When asked to identify the main obstacles that prevented them from achieving results, the answers were clear, but had nothing to do with the solutions proposed earlier: limited motivation of health staff, services being user-unfriendly, patients having numerous obstacles to access services, etc. Participants knew the real constraints very well. But health staff could not tackle these issues appropriately, as they felt they had to carry out the instructions given by higher levels, and all funding was attached to these – standard – activities. Particularly, providers felt there was very little room to move. Interestingly, it was the community health workers who then started some innovative practices. For example, one facility offered pieces of soap to the mother and the traditional birth attendants (TBAs) when they came to deliver in their facility. In another facility women were given a traditional soup after giving birth.

A very different dynamic developed in the two regions. The districts in the Northern region almost immediately shot into action, making it even difficult to get them back into the process and to agree on an appropriate institutional framework. The Western region took a more deliberate path, first setting up a *multi-stakeholder platform* in which the basic principles of RBF were discussed (again) and potential frameworks were developed. Anyway, it showed that there was trust in the process, unlike in Mali where it was necessary to have the partners first sitting together to define their respective roles before starting the contracting approach.

In all districts SNV assisted local NGOs to develop *situational analyses* to help identify local priorities based on accurate data. In the Northern region this led to the finding that apart from the usual suspects – ANC, skilled deliveries – malnutrition was identified as a major problem. This created the opportunity to include partners with a specific focus on malnutrition, including the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA), to engage, define specific outputs and integrate these into the contracting approach. In this way, partners with vertical programmes become part of horizontal systems strengthening. Also, it allows for bottom-up planning, based on local realities.

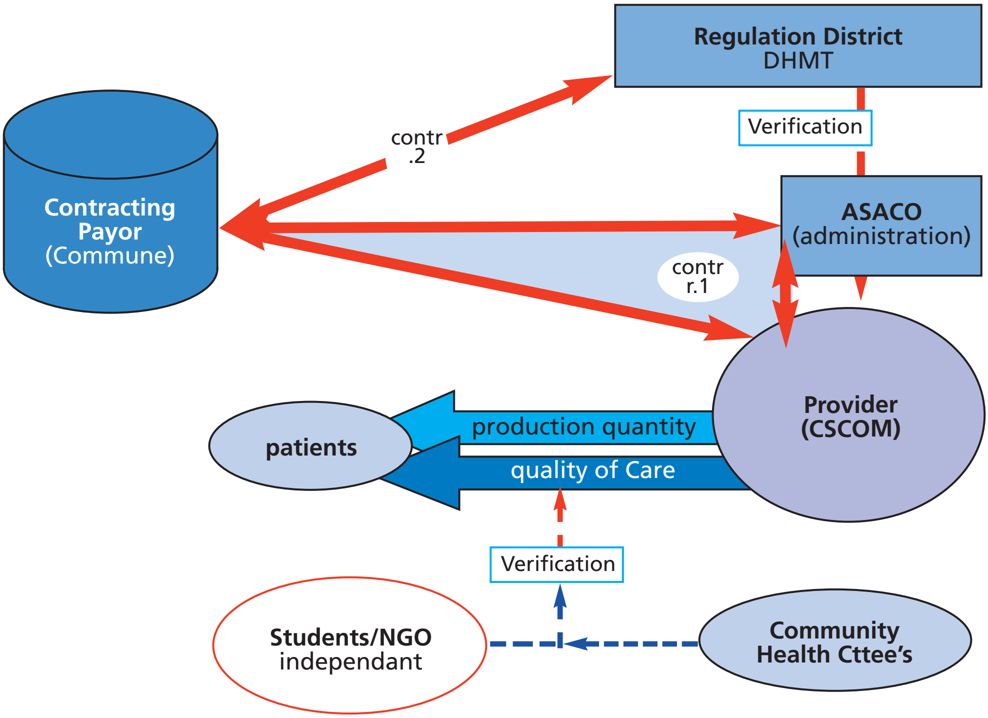
Finally, SNV and KIT organized workshops to strengthen capacities of health NGOs in health systems strengthening and health financing. In these workshops we also had them to develop results chains to improve their ability to discuss priorities and challenges with other (medical) actors.

5.7 Phase 3: Capability to sign performance contracts

The capacity-building activities in the second phase intended to bring all actors up to the same level, particularly by bringing the non-medical partners to a higher level of information and understanding of performance and their potential role in the health system. The third phase focused on the ability of all partners to agree on an appropriate framework, to match priorities of medical and non-medical actors, to develop results-based facility plans and to negotiate performance contracts.

Mali had a law which authorized the contractual approach, and a Memorandum of Understanding between *Communes* and ASACOs was launched: this Convention of Mutual Assistance (CAM) was signed in all *Communes* in the country. However, the partners in Koulikoro felt that this CAM needed to define more precisely (i) results; (ii) interventions to arrive at these results; and (iii) distribution of responsibilities and contributions of each partner.

Figure 13 RBF institutional framework Mali



Source: the authors

Therefore, the *institutional framework* first needed to be defined, explaining which partner would take on which role. After ample discussion it was decided that indeed the *Commune* would take on the role of purchaser, but that the contract would be tripartite: the actors were able to adapt to the given situation.

From the start it was clear that the DHMT would be the regulator, as it already had the task of checking whether facilities were respecting the policies, norms and standards established at the national level and of monitoring the providers. Also, the DHMT obtained a new role – one of coaching the facilities in identifying interventions that could improve their performance. Since its role would be crucial, a second contract was needed between purchaser (*Commune*) and the DHMT.

The next *main objective* is to come to negotiated *performance contracts* which define:

- the priority results – in terms of quantity and quality;
- the tendency of the priority results in the last quarter;
- strategies and subsequent activities to achieve these results; and
- funding needs (including source of funding) to achieve these results.

These contracts are developed in three steps. The *first step* is for the *Commune* and ASACO (the non-medical actors) to define – jointly – the priority results for the next quarter, based on analysing the SIEC. The *Second step* is for facilities to develop results-based plans in which they propose interventions to achieve the priority results identified by the ASACO and *Commune*. This results plan is then subject to negotiation, which is done by the *Comité Paritaire* consisting of representatives from the ASACO and the *Commune* (*third step*).

Facilities need support to develop results-based plans, as they are used to developing input-based plans in the classical decentralized system. They need to adopt an active and entrepreneurial attitude to improve their services, as they are no longer allowed to come up with an excuse not to perform. Facilities will be much more autonomous, although never completely so. They have autonomy in negotiating contracts with the local fund-holder, in managing and planning and – ideally – in managing all resources, including hiring and firing staff contracted by results-based funds. Regulators ensure that national policies, norms and standards are adhered to. External and national financing agencies do not interfere with how resources are used but will support service providers through capacity-building and with necessary instruments. Neither manuals nor classical training can be developed for learning to be creative to meet the needs brought up by the local context or expressed by their local partners.

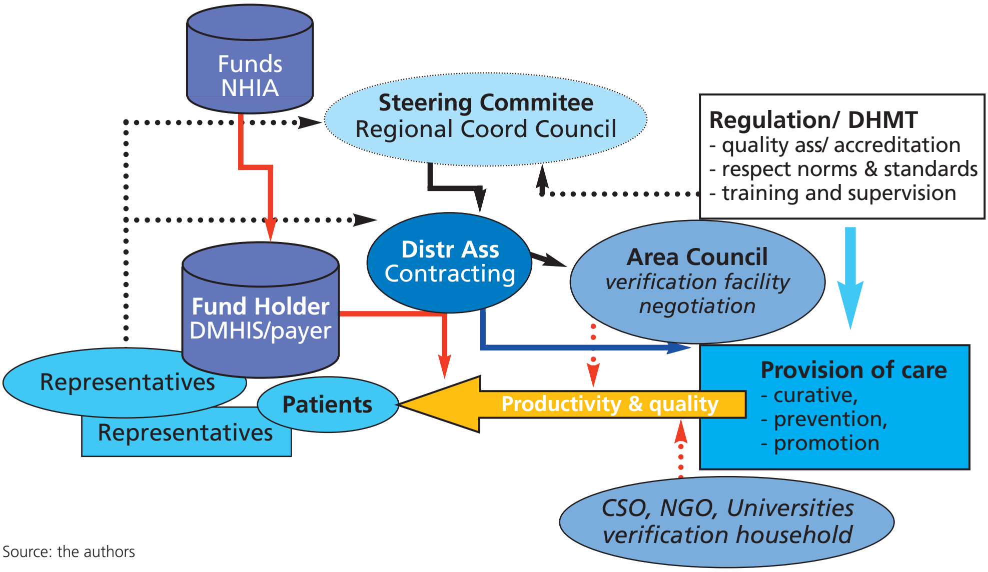
The three actors were already better prepared for their “new” tasks after following the first two phases. The programme staff supported the partners through coaching while they were developing and signing the contracts. The programme did this jointly with the DHMT: its capacities also needed to be strengthened, as it would take over this task later from the programme.

In *Ghana* we organized several sessions between the regional directorate and the two districts involved to identify how roles and responsibilities could be distributed between them, based on the principles of RBF. After explaining the need for a split of functions and the content of those functions, a similar institutional framework emerged in both regions (see Figure 14).

Interestingly enough, later on, when the MOH and World Bank team carried out a similar exercise in the Eastern region, the institutional framework that resulted was similar. The difference from Mali is that, on the one hand, the local government in Ghana (the District Assembly) was less advanced in the devolution process and, on the other hand, there was a district mutual health insurance scheme (DMHIS) that was already experienced in purchasing services from providers through a system of ex post payments for services.

In addition to the Malian process, we put the identified priorities in results chains, to identify the activities that could lead to those results.

Figure 14 RBF institutional framework Ghana



Source: the authors

This step of the process requires facilitators who can support the different type of actors in identifying an integrated selection of solutions to come to local solutions to achieve the priority results, instead of responding to the vast potential of vertical programme priorities. In identifying local needs, there is specific attention to:

- improving quality of care, as "coverage" of health programmes is less of an issue in West African countries;
- focus not only on supply-side but also on demand-side incentives;
- focus not only on financial but also on non-financial incentives; and
- avoiding "adverse effects", not focusing on a few specific indicators only.

5.8 Phase 4: Capability to apply, adapt and renew

With the performance contracts in place, it was increasingly realized in Mali that (not) complying with the contract needed incentives (or sanctions) to ensure that the contracting partners would comply. This was the moment the concept of RBF was introduced by the programme. In 2011 the MOH of Mali decided to pre-pilot RBF in the Koulikoro region, funded by a Dutch trust fund in the MOH to accelerate achieving MDG5. This pre-pilot will then inform the future World Bank RBF programme. In Ghana, this is yet to happen.

Box 11 Rwanda

In Rwanda, we asked a hospital director why he had not brought about all the changes for quality care before PBF? He answered that this was because (i) finally it was now clearly defined for what he would be held to account – before, the criteria always changed; and (ii) the results were published on the internet, and 'I will not let my hospital do worse than the others!!'

The cycle of three months was introduced to serve the learning exercise to identify unforeseen challenges or unintended effects but, above all, to render targets more realistic, to identify successes and to enable revaluation of priorities (if needed).

5.9 Thinking on your feet

The question did arise how the *money* should *flow*. In Mali it was decided that the purchaser (the *Commune*) would be the local fund-holder. This would empower the *Commune*, as allocating funding to the health services based on results would enable it to hold the providers to account on results. It is also less bureaucratic to channel funding through the devolved local government system than through the decentralized health structure. Furthermore, it would be a conflict of interest if the MOH judged whether MOH providers had the right to receive a results-based payment. In Ghana the local government will also have a purchasing role. We are carrying out studies into the readiness of local non-medical actors (District Assembly, civil society), a "legal" study and to improve our understanding of demand-side stimulation.

Box 12 Mali

During one of the first meetings in Mali, one mayor stood up and asked: 'so does this mean that I could say *"I will pay you 100,000 FCFA if you make sure that all children in my constituency will be vaccinated?"*' When this was affirmed, he said: 'OK, I will use my ANC money to make a deal with the health centre.'

During the implementation process many challenges will arise, which can be mitigated or limited when actors are aware of and understand ways to deal with them – for example, the very realistic risk of "verticalization": when RBF limits results to a few targets related to MDGs 4 and 5. In Ghana and Mali we try to solve the risks of verticalization and adverse effects by relating the *total* payments of "vertical" MDG5 results to a quality of care scoring list that is based on the "horizontal" minimal package of activities. Other risks are related to *sustainability* – financial, institutional, technical and social. For example, transaction costs may increase with the introduction of RBF due to the nature of ex post control, which requires counter-verification through household visits and/or exit interviews.[1] In Ghana we are exploring possibilities of using mobile technologies to reduce costs. Institutionally, we emphasize the roles and responsibilities of existing institutions, rather than creating new ones. Technically, we put a great deal of effort into developing the necessary tools and instruments to prepare the partners. A great contributor to success is, however, also leadership at national as well as local level, which can be encouraged by a coaching style of capacity-building. Socially, the SNV/KIT approach stresses the importance of spanning the boundaries of the health system, to include capable representation of communities by civil society organizations and local authorities. This may ensure that selected priorities continue to respond to the local needs and demands.

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[1] In Rwanda administrative costs associated with P4P are estimated at US$0.3 per head, which represents 0.8 per cent of total health expenditure per head and 1.2 per cent of public and donor expenditures combined (Basinga et al. 2011).

Equity is an important success factor in any health reform. Until now it is unclear whether pay-for-performance had a pro-poor effect, because the impact study in Rwanda does not indicate whether there was an increase in the number of facility-based births for women in the poorest quintile (Montagy and Yamey 2011). However, if we leave it to supply-side incentives only, providers will go where it is "easy" to obtain results, which will not benefit the poorer populations, often living in more remote, under-served areas. The consequence would be that health staff could migrate from under-served areas to areas where results are easier. A solution would be differentiation of payment for results: in under-served areas a result would meet a higher unit price than in populated areas.

These and other risks may be avoided or neutralized in the RBF design. However, many will occur during the process, so it is wise to keep reporting cycles short and invest in adequate verification. This allows timely adaptation and self-renewal. The partners need to think on their feet, for which they need proper preparation.

5.10 Verification of results

As RBF is about results-based payments, providers could become tempted to report more outputs then they attained in reality. Verification and counter-verification are, therefore, crucial for the credibility of the process. Whose responsibility would this be? Partners' first response was 'the doctor knows', so the DHMT. But would the doctor give an impartial judgement if the doctor and the provider were part of the same (MOH) system? This risk was recognized, but who else then but the doctor has the capabilities to judge? It was argued that standardization by instruments – similar to the SIEC – would solve the problem of non-medical actors feeling, or being perceived as, not capable. Verification will be done in three ways:

- First, the results reports will be verified with registers available in the health centre.
- Second, a quality of care scorecard has been developed with ex post criteria and not ex ante conditions to provide quality of care (hygiene etc.). Through workshops we ensured that the patient's perspective was taken into account, as this factor is an important indicator to increase utilization.
- Third, counter-verification will take place at household level, randomly selected, to verify if the patient found in the register had indeed received the service that was claimed. During the visit, the patient will be asked to answer a short client satisfaction questionnaire.

Verification tools have been developed by the programme. Verification and counter-verification will be carried out by so-called "Local Capacity-Builders" (LCBs): NGOs that are used systematically by SNV to build capacities at grassroots level. These LCBs will be contracted by the *Commune* as purchaser. As verification is critical to the credibility of RBF, building partners' capacities on this should not be underestimated.

5.11 Linking policy and practice

It is important that the idea behind RBF and its underlying principles are clear – so that an RBF policy can be developed at central level. The issue is about implementing the policy. This will need to be piloted and tested at operational level to show that the policy works or that it needs adapting, which is why the programmes started at operational level. From the beginning, there was close contact with the policymakers at central level. Meetings were organized in the capital, Bamako, with interested high-ranking MOH staff: the "Nord-Sud" meetings where "performance-based dinners" were served. Nord-Sud is a hotel where meetings were organized after office hours to ensure that MOH staff could be present. After the meeting, and if the participants performed well, they were offered dinner as a non-financial incentive. During these meetings developments at the operational level were presented and discussed to allow the policymakers to learn about implementation and to provide input to the process to ensure that the programme was acting within the boundaries of national policies. It also fostered ownership: when the World Bank appeared on the scene, the programme was presented as the Malian mode for RBF.

5.12 Discussion

Our experience is adding practical ideas to the existing body of knowledge, particularly on how to start an RBF approach in countries that have relatively well-developed health institutions. What makes the SNV/KIT approach different? Below we share some of these ideas in the form of statements, open for discussion.

No blueprint, but a one-size-fits-one approach
SNV/KIT developed an approach – not a model – that led to two different models in Mali and Ghana, as demonstrated. The process approach is based on operational research, which allows the RBF principles to be adapted, by learning and doing, to the local context, to existing local structures and to wants, needs and demand as expressed by the local stakeholders. This resulted in a different institutional framework in Ghana from the one in Mali. But it also came to a different scope of the content than in the Great Lakes Region: focus was more on quality of care than on quantity of outputs. Importantly, the approach provides the opportunity to adapt the pace of change to the time local actors need to develop their necessary capacities.

RBF should be decentralized as much as possible
The institutional set-up is different in Rwanda, Mali and Ghana. In the first PBF years in Rwanda the focus was on the district level. An NGO was assigned to be the purchaser agency (AAP). The AAP at the same time contracted local providers of health services based on payment per output, and the local fund-holder that paid for the results. Civil society organizations had an important stake in decision-making by the AAP. When PBF was scaled up to become a national programme, it became centralized: a central task force in the MOH established the priority results and the unit prices for results for all districts, and it was no longer necessary to develop a results-based "business plan". This could lead to

RBF becoming less responsive to local needs. Verification was given to the DHMT and the district hospital, with only a small representation of the community – risking PBF becoming re-medicalized. It may be right for Rwanda and DRC to centralize management of PBF, but, if possible, managing PBF should be decentralized as much as possible: results are not obtained through central policymaking; they are only produced at operational level, as here services can be adapted to local circumstances, needs, demand and wants.

Build upon existing institutions in stable states

In the KIT/SNV approach it was decided not to introduce yet another new institution such as an AAP in an already complex governance structure but to work within the existing structures. In fragile states such as Rwanda and DRC it may very well be possible – or even desirable – to set up a new governance structure, but in stable states such as Mali and Ghana with already complex health governance this is not a good choice.

In Mali, as explained above, contracting was between *Commune*, ASACO and health staff – so that existing health structures are strengthened, rather than weakened, by RBF. In Ghana a different institutional framework was developed. In Ghana, in each district there is a health insurance scheme (DMHIS) that already manages a provider payment mechanism: the health insurance that pays claims sent by providers. The DMHIS is already responsible for verification, which it, however, does in an unstructured and irregular way. Assigning verification for RBF and designing the verification tools for RBF strengthens its verification role for health insurance too. Also, health insurance is an existing funding channel that can be used for RBF: front-loading funding at central level can be channelled swiftly to operational level and can work out like a kind of banking function. In Ghana the purchaser is also the local government, but its function is limited to contracting and final sign-off for payment after results have been verified by the DMHIS and civil society organizations. In the end it is not the DHMIS that decides on payment for results: there is a nice split of functions this way that is not possible in Mali.

Involvement of communities is essential

Involvement of the community in decision-making on RBF is more important in Mali and Ghana. This was partly deriving from the devolution policies in these countries but also based on the conviction of all partners that results would improve if the services became more responsive to the demand of the population. The representative bodies of the community were also more likely to judge the provider's performance impartially, and they can better judge if services were indeed responsive to demand.

Focus on mobilizing resourcefulness and not on resource mobilization

Our approach is not only addressing the results-based payments – it does not put the "F" in RBF at the centre; it is more about the "R" – meaning that it is not like a bonus system in the banking world. Emphasis is more on building RBF arrangements necessary for negotiation between providers and (representatives of) the clients on what the results should be. By coming to agreement on the content of the contract, both parties become capable of engaging, committing and, as a consequence, acting, as both have become co-owner, jointly responsible for the results. And then, of course, there is a financial consequence of achieving what had been agreed, which will then be reinvested in health care to achieve even more results.

There are great examples of individuals making a positive difference by finding resourceful solutions to local problems which do not take big investments. Often these local solutions marry the traditional “guidelines” with the professional principles of good health care. For example, in Ghana some districts are testing involving traditional birth attendants (TBAs) to refer cases and assist pregnant women to deliver in a clinic. The TBA is offered a small incentive such as a piece of soap or cloth for her contribution. A delivery by a TBA is not registered as a skilled delivery. However, many women living in rural areas only want to deliver in the presence of a TBA. Good ideas could sometimes be copied, and external actors are often good catalysts to stimulate thinking outside the box. These actors do not always need a medical background to tap into the existing pool of resourcefulness of the sector.

Capacity development is at the heart of our approach

This chapter has focused on the need to invest in developing the capacities of the contracting partners, both non-medical and medical actors. Non-medical actors need to become credible partners to the medics, and medical actors need to be capable of shifting to results-based planning and to become entrepreneurial. We identify phases and steps, which is to organize our thinking and to give hands and feet to complexity – something that otherwise scares off most people. These steps do not always follow each other in chronological order. However, each step requires a significant building of capacities of all actors involved. Therefore, missing one step would undermine the effectiveness and sustainability of the RBF model at the end.

5.13 Conclusion

From experiences in other countries with P/RBF an important lesson learnt from an evaluation in the Great Lakes Region (Toonen et al. 2009) is to involve all local and national actors from the inception of RBF, to ensure that institutional embedding actually takes place. Another lesson was that a process approach is needed to adapt RBF to the country-specific context, making use of existing national structures instead of building new ones. Taking these (and other) lessons into consideration, KIT and SNV have intensively involved all stakeholders in Mali and Ghana in the design of a working hypothesis for piloting the contracting approach and RBF.

RBF is a tactical mechanism to help redesign the health system to implement the longer-term (inter)national strategic aims, laid down in multi-annual strategic plans. To make it operational, systems and tools need to be developed. Monitoring tools represent the backbone of the system. Importantly, all actors involved need to be accompanied to use these tools effectively and to make the mental shift that is also needed.

Table 6 Differentiating RBF from other mechanisms

Management level	Concepts & Mechanisms	Contracts	Planning cycle
Strategic – to aim at central level	MDG, SWAP, budget support, Multi-annual country plans	Design contract – framework, roles and responsibilities	Long
Tactical – to design at district level	RBF, PBF	Performance contract – agreement on priority results and conditions between purchaser and providers	↕
Operational – to act at facility level	Results-based action plans, results-based contracts, verification tool	Action contract – between facility and staff on exact targets and incentives	Short

Source: the authors

The basic assumption of this chapter is that there are no institutional templates that are valid for all countries and for all the stages of their development. The basis for successful implementation of RBF, therefore, is to adopt a learning or operational research approach: *(re)searching for the appropriate model*. For these reasons, we feel that a robust preparatory phase is needed to prepare the partners. A pre-pilot will allow actors to experiment and experience what the change means at their level. This simulation will stimulate actors to step out of their normal behaviour patterns and go through the full learning cycle (Van Deemter and Van der Wal 2002).

Introducing RBF needs capacity-building in each step, meaning more than training on how to implement the RBF model developed elsewhere. This requires a substantial investment, which will pay off in a sustainable model, fitting the context of a country. We consider RBF a major health systems strengthening operation, which will take a long time to evolve from a pre-pilot to a pilot and to a national programme. Therefore, it is crucial to create an undisputable sense of urgency as an entry point and constant reminders to stick to this process.

The steps and phases identified in this chapter are not a straightjacket. Capacity-building is about responding to the capacity needs as expressed by the actors during the process. Capacity-building in our approach includes training of medical actors and equally focuses on non-medical actors, as the client determines utilization and, therefore, the outputs. Non-medical actors are also included in the boundaries of the health system to jointly develop the appropriate model, to respond to their needs.

Medical actors in our approach are guided to mobilize their resourcefulness. Also, during the process, partners and facilitators should think on their feet to avoid and adapt to potential challenges. Many of these challenges can be limited already by developing a resilient institutional framework with strong checks and balances.

In our approach we combine direct "expert" support with the support to facilitate local problem-solving. To relate back to theory, this consulting style comes close to "process consultation" as described by Schein (1999). In adding this style, we act upon the belief that the existing institutions hold the key to development.

Acknowledgements

We would like to acknowledge all contracting partners in Mali and Ghana that made this all happen, in Mali: the Communes, ASACO and health service providers in the Dioila District and the Regional Health Direction of the Koulikoro Region; and in Ghana: the District Assembly, District Health Insurance Scheme, NGO/CSO, and District Health Management Team of Soboba District and the Regional Health Directorate of the Northern Region.

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Drama group at work in Gaborone, Botswana. Results of action research in Botswana have improved HIV interventions (Photo: Rob van Poelje, KIT)

6 Multi-stakeholder process and analysis: The case of the multi-country programme for social science research on HIV and AIDS in five African countries

Rob van Poelje

Abstract

This chapter uses a multi-stakeholder perspective to review a Multi-Country Programme for Social Science Research on HIV and AIDS (MCP). The MCP consisted of a preparatory multi-stakeholder process at international level and of a series of five parallel multi-stakeholder processes in five sub-Saharan countries. Both are described in hindsight, using the multi-stakeholder process model, and conclusions are drawn as to the usefulness of the model for analysis and planning.

The preparatory phase of the MCP led to an international agreement of the principles of participatory research management. The MCP in the five countries achieved a number of important results: identification of and bonding between HIV and AIDS social science stakeholders and joint formulation of criteria for the selection of research topics; the use of these criteria to jointly prioritize HIV-related research issues; consensus on the roles and responsibilities of each actor in the research management cycle; and local capacity development in formulating research proposals and participatory planning, monitoring and evaluation of action research projects. A total of 25 research projects were implemented across the five countries. However, the relevance of joint learning between, for example, Botswana and Ethiopia or Burkina Faso and Namibia was not sufficiently proven.

The multi-stakeholder process model offers important opportunities to look at the MCP systematically. Its use led to the insight that a proper balance between result and process orientation depends on stakeholders' awareness of each other's ways of dealing with uncertainty, on the aptitude to act as a collective, on the perception of time, and on their willingness to query power and gender issues. These aspects did not receive sufficient attention in the MCP process.

Using the model led to the insight that it was crucial to obtain explicit stakeholder commitment to the MCP principles before securing funding. Also, in countries with a high "power distance", a high level of institutional anchorage proved essential for the success of the MCP. Lastly, support to national capacity development in the field of social science research can indeed be better structured and balanced by the systematic use of capacity development models.

6.1 Introduction

Sixty years of development cooperation teach us that pro-poor development requires thoughtful organizational and institutional innovation. Such "inclusive" innovation relies to a large extent on the effectiveness with which a diversity of stakeholders can work together in the same direction.

Attention to multi-stakeholder processes and analysis finds it origin in management theory, aiming to help managers understand the turbulent and complex business environment (for example, Freeman and Gilbert 1987). The development cooperation sector adopted stakeholder analysis as one way to guide participatory project design and ensure integration of the interests and perspectives of disadvantaged and less powerful groups (Pretty et al. 1995, Chambers 1997). "Power", among others as a central attribute of knowledge, is described as central to stakeholder analysis (Chambers 1997, Mitchell et al. 1997). Stakeholder analysis is also a central theme in conflict management and dispute resolution and has important roots in the social actor perspective in the sociology of development (Long 1992). As Woodhill (2007:2) put it:

> *'Progress, particularly in relation to sustainable development, hinges on a social capacity for different sectors and interests to be able to constructively engage with each other. (...) [M]ost complex problems will never be solved by one group alone. (...) Multi-stakeholder processes enable different perspectives to be presented and debated, scenarios and options to be evaluated, decisions taken and action implemented.'*

Against this background, at the end of the last century a shift in thinking occurred, from a control-oriented development paradigm that saw "participation" predominantly as a strategic tool, to a learning and process-oriented development paradigm that considers participation as a prerequisite for sustainable, equitable development. The facilitation of inter-organizational multi-stakeholder processes thus gained importance in most development sectors (Jennings 2000).

The economic development and natural resource management sectors served to field-test development-oriented multi-stakeholder approaches (ODI 1999). Later, the increased attention to accountability, decentralization and other aspects of governance, as well as public–private partnerships for service delivery motivated traditionally more "closed" systems such as the health and education sectors to involve civil society organizations and private actors in decision-making (own analysis).

Box 13 Characteristics of multi-stakeholder processes

- Clearly bounded context and set of problems
- Involves set of stakeholders with common interests
- Different sectors and scales
- Agreed, dynamic process and timeframe
- Guided by negotiated and understood rules of interaction
- Deals consciously with power and conflict
- Engages stakeholders in learning processes
- Balance between bottom-up and top-down approaches
- Effective institutional change

Source: Woodhill 2007

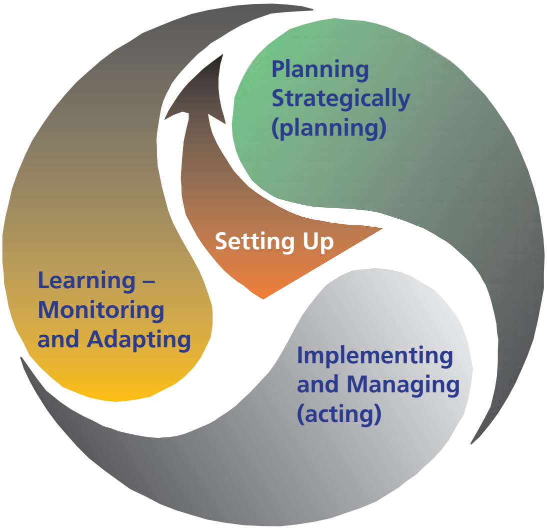
This chapter explains the stages and elements of a multi-stakeholder analysis framework as Woodhill has identified them. Then, it introduces the Multi-Country Programme for Social Science Research on HIV and AIDS which was operational from 2004 to 2009 in which multi-stakeholder processes were key. Finally, I share comments and lessons learnt in relation to these processes and the framework.

6.2 Multi-stakeholder framework: A process model

Multi-stakeholder processes aim to involve actors who are affected by certain situations to improve them. The processes thus encourage social interaction, enabling individuals, groups and organizations to gather and share experiences and engage in learning and decision-making. Actors may include community leaders, civil society representatives, policy-makers and other government officials, researchers and businesses (WUR-CDI, undated). Meanwhile, although there is a lot of diversity across multi-stakeholder processes, a number of key characteristics unite them (see Box 13).

Learning processes are often – justly – represented as cyclical, partly based on Freire's continuous alteration of action and reflection as a basic principle of community learning (Freire 1974). Along the same lines, the concept of development as a cyclical learning process (see Figure 15) that involves both action and reflection can be found in theories of social action learning (for example Serrat 2008), project management, strategy development and participatory policy formulation (OECD 2001). In this learning process model, monitoring and adaptation are critical aspects of the identification, planning and implementation cycle and not just an "add-on". They enable those responsible for the process to improve both process and results.

Figure 15 Multi-stakeholder process model



Source: Woodhill 2007

The multi-stakeholder process model used in this paper, as in Figure 15, has been adapted by Woodhill (2007) from similar models. It is based on the action learning cycle of planning, acting and evaluating, with an additional phase of setting up. The process model is a summary of the key aspects that need to be considered in planning, implementing, managing and evaluating a multi-stakeholder process.

The process model allows us to take a snapshot of the multi-stakeholder process at any given point in time. To this end, the model distinguishes a number of process key issues that need to be considered, as summarized in Table 7.

Table 7 Key issues in multi-stakeholder processes

Phase in MSP process	Key issues	Throughout MSP	Key issues
Setting up	• Clarify the reasons • Situational analysis (issue, stakeholders, institutions, power, politics) • Establish interim steering body • Build stakeholder support • Establish scope, mandate, expectations • Outline general process (timeframe, institutional requirements and resource needs)	Reflecting learning critically and adapting	• Create culture and environment • Define success criteria (performance questions and indicators) • Develop and implement monitoring mechanisms • Review, evaluate and discuss progress and capture lessons learned • Feed lessons learned back into strategies and implementation procedures
Strategic Planning	• Build stakeholders' understanding of each other's values, motivations, concerns and interests • Generate visions for the future • Identify problems, issues, opportunities • Institutional anchorage • Examine scenarios and feasible options • Make decisions and agree on key strategies • Linkage into official decision-making process • Set objectives and identify actions, timeframes and responsibilities • Document and communicate planning outcomes		
Implementation and Management	• Develop integrated initiatives and detailed action plans • Secure resources and technical support • Develop capacities of stakeholders • Establish required management structures and procedures • Manage implementation process • Maintain commitment of the stakeholders • Relate to not-participating stakeholders		

Source: Woodhill 2007

6.3 Multi-Country Programme for Social Science Research on HIV and AIDS

In 2001 an estimated 40 million people were infected with HIV globally, with over five million new infections each year (UNAIDS 2001). AIDS was the leading cause of death in sub-Saharan Africa, a region where more than 70 per cent of all HIV-infected individuals live. The United Nations declared HIV and AIDS to be a complex medical, social, cultural, economic, political and human rights issue, requiring multidisciplinary and multi-sectoral answers (United Nations 2001). The following year, the Netherlands Advisory Council on Development Research (RAWOO) reported an emphasis of recent and on-going research on biomedical and epidemiological aspects of the pandemic, while the social dimensions received much less attention. It decided to address the specific challenges facing social science HIV research:

- Which key areas for knowledge development and application deserve priority attention?
- How should these areas be addressed in terms of research methodologies?
- How can research competencies and related institutional capacity in Southern countries be enhanced?

Subsequently, RAWOO presented its report entitled *Making Social Science Matter in the Fight against HIV/AIDS* to the Dutch government (2002). RAWOO followed up its report with an expert consultation in 2004 which sought to identify the key elements of a multi-country programme in support of social science research in the field of HIV in five selected countries. In the course of 2004 a concept note for a Multi-Country Programme for Social Science Research on HIV and AIDS (MCP) was submitted for funding to the Netherlands' Ministry of Foreign Affairs and the Dutch Aids Fonds. Partners in Botswana, Burkina Faso, Ethiopia, Namibia and Rwanda and various Dutch universities committed themselves to the objectives and expected results of the MCP.

These five African countries were selected using the following criteria (KIT 2004):

- a high or medium HIV prevalence;
- the need for social science research or knowledge development in support of policies, programmes and interventions should be clearly expressed by some of the actors in a country;
- the potential for the MCP to address gaps and add value to the existing social science research landscape, which was operationalized by looking at the existing capacity in social science research and the support and capacity-building efforts already underway in the country;
- the potential for South–South learning: diversity in context, language, experience and capacity; and
- the active involvement of Dutch organizations in HIV-related programmes or related fields, as the MCP would facilitate the synergy of Dutch interventions.

MCP 2004 vision

The MCP's stakeholders viewed the HIV and AIDS pandemic in sub-Saharan Africa as a direct threat to the well-being and physical survival of many households. The MCP formulated its vision in terms of good-quality social science research for HIV:

- essential for informed decision-making at policy, strategy and operational level in the field of HIV and AIDS;
- targeting poverty reduction and sustainable development, in which a gender perspective is applied in an integrated way; and
- needs-directed: research priorities and contents are determined by the end-users of the research results.

MCP objectives

The MCP logical framework stated specifically that by the end of the programme in 2009 the following objectives had to be reached:

- a collaboration network among HIV and AIDS social scientists in five countries in sub-Saharan Africa;
- a partnership between the MCP research network and universities in the Netherlands;
- the capacity in the programme member countries to develop and implement operational social science research projects that are embedded in the on-going national and international HIV and AIDS programmes;
- a first round of operational research projects implemented; and
- learn lessons that can feed the development of a more comprehensive multi-country programme proposal in collaboration with national and international stakeholders.

MCP process

The MCP strategy meant to find a balance between sustainability and feasibility, between local ownership and externally driven institutional innovation, between learning and accountability, and between results-orientation and people/process-orientation. The international secretariat, run by the Amsterdam-based Royal Tropical Institute (KIT), facilitated the start-up of the MCP through national workshops in all five countries, contracting of the national secretariats elected by the country networks and encouraging information-sharing through a virtual knowledge community through which reports, technical documents and newsletters were provided.

For each country, funds were made available for (i) basic MCP-related operational activities, such as the initial meeting, the national secretariat and organization of the national steering committees; (ii) in-country capacity-building activities in line with identified needs, possibly in collaboration with Dutch academic partners; and (iii) seed money for a basket fund for HIV-related social science research. Transparent management of the basket fund was expected to attract additional donor contributions. This occurred in at least one country (Namibia), where a European Union-funded programme, implemented by the Ministry of Health and Social Services with KIT technical assistance, decided to contribute to the social science for HIV research basket fund.

The international secretariat monitored the progress of the national work plans and reported to the funding agencies. Annually, the International Steering Committee and Advisory Board met to monitor implementation and results and decide on any changes.

MCP results

The results of the MCP have been amply documented in the national and international evaluation reports. In all countries the stakeholders are convinced that the quality of the research proposals has improved. The review and appraisal process was also noted to be a major achievement of the MCP initiative. The transparency and accountability of the proposal review process has increased in at least four of the five countries.

In summary, the MCP inception phase results look as follows (see Figure 16): during the initial national workshops in the five countries, participants identified joint criteria for the selection of research topics and then used these criteria to prioritize HIV-related research issues. Furthermore, the roles and responsibilities of each actor in the research management cycle were identified. Bringing on board the key stakeholders and actors was a continuous process, as people, interest and organizations' agendas were subject to change.

Series of workshops were organized in each country, aimed at developing basic skills in formulating a research proposal and conducting research projects. Calls for research proposals were launched, and suitable proposals were selected and funded. A total of 25 research projects were implemented across the five countries.

In the last phase of the programme, the focus shifted to a more regional approach. The Great Lakes Applied Research Consortium was formed, which emphasized capacity-building, health systems strengthening and M&E, and the secretariat was moved to Rwanda (see Chapter 7 in this volume and Van der Kwaak et al. 2011).

6.4 Applying the multi-stakeholder process framework to the multi-country programme

The MCP multi-stakeholder process is specific in that it has an international dimension as well as a national dimension in multiple countries. Because of the two dimensions, the chronological order of the various steps from the framework differed from the multi-stakeholder process model outlined above: some aspects covered during the international preparations were not repeated during the national implementation.

In this section I will use the multi-stakeholder process model as a framework for analysis of the experiences of the MCP, reviewing the key issues of each of the four phases in turn.

6.4.1 Phase 1: Setting up

Rationale

At the international level, in reference to Box 13, the MCP clearly had many of the characteristics of a multi-stakeholder process: a clearly defined context and set of problems (the UN definition of HIV and AIDS as a development issue, the lack of attention to social science research); the involvement of stakeholders with common interests; involving different sectors and scales (international as well as national, linking policy to strategy to operational level); an agreed, dynamic process and timeframe; dealing consciously with power and conflict (the programme has been conceived to stimulate joint reflection and joint decision-making); engaging stakeholders in learning processes; and balancing bottom-up and top-down approaches (the funding agencies have been persuaded to allow for a great amount of freedom at the national level).

At the national level, no new structures were set up, and ownership of the MCP was in the hands of local coordinators with a local steering committee. The research fund was subject to national calls for proposals, with international arbitrage. As with the structure, as much as possible the existing national human resources and infrastructures were used, and no separate budget was reserved for recruitment or investment other than within the framework of research proposals. Lastly, learning focused on facilitating the development of the national social science research *system*, an iterative learning process that benefitted from international exchange among peers.

Situation analysis and stakeholder selection

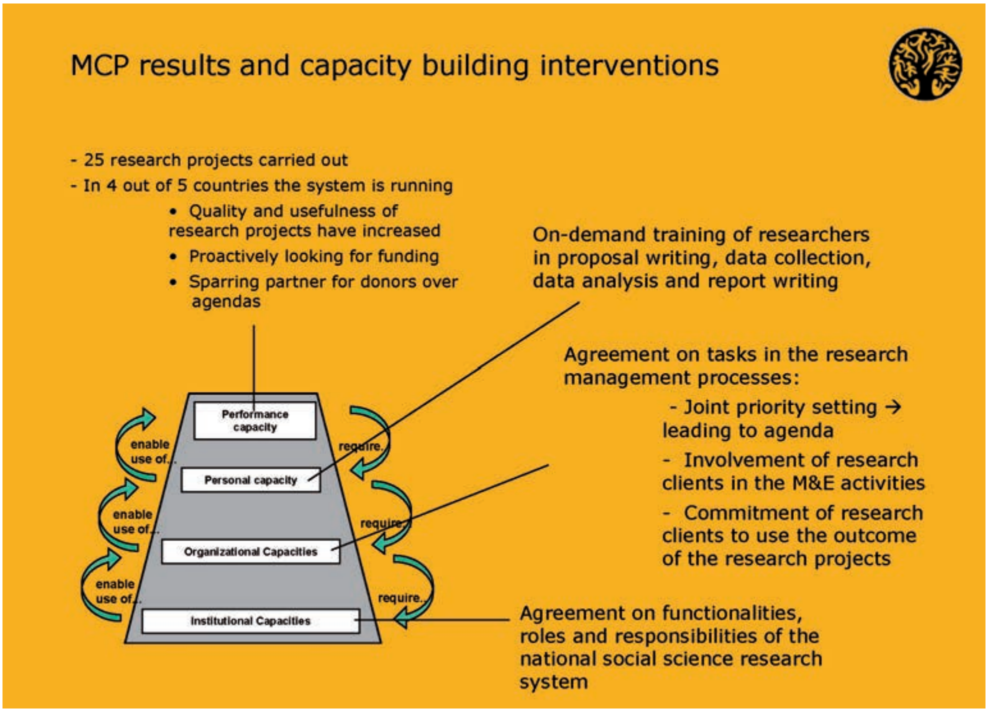
Over time, stakeholders at international and national levels researched and substantiated their views regarding the national social science research systems in various ways. Stakeholders themselves were selected to represent the research community, the health sector and affected communities. In addition, participants were invited from regional African social science research networks, the Dutch research community, WHO, UNAIDS, the Dutch government, private organizations and other private funding agencies.

Building stakeholder support

Internationally, the March 2004 expert consultation created important momentum through the commitment of governmental, non-governmental and research representatives from the five invited countries, of representatives from the Dutch research community and from KIT to actively search for ways to put the recommendations into practice. When at a later stage the opportunity arose to finance an inception phase for the MCP, the memorandums of understanding with the national representatives could be collected without delay.

At the national level, the very multi-actor formula of the international meeting was an encouragement for national stakeholder representatives to team up. The mixture of international commitment and national honour (‘Let’s show them what our country can do!’) provided the necessary appeal in at least three of the five countries. In all five countries the MCP started with a national workshop that united representatives from the government, the research community, the private sector, civil society and the community of people living with HIV.

Figure 16 MCP results and capacity-building interventions



MCP results and capacity building interventions

- 25 research projects carried out
- In 4 out of 5 countries the system is running
  - Quality and usefulness of research projects have increased
  - Proactively looking for funding
  - Sparring partner for donors over agendas

On-demand training of researchers in proposal writing, data collection, data analysis and report writing

Agreement on tasks in the research management processes:
- Joint priority setting → leading to agenda
- Involvement of research clients in the M&E activities
- Commitment of research clients to use the outcome of the research projects

Agreement on functionalities, roles and responsibilities of the national social science research system

Source: Own elaboration, using as starting point the pyramid model of interdependent components that together determine capacity, as developed by Potter and Brough (2004)

Scope, mandate and expectations

The roundtable participants confirmed that:

- financial resources for research are predominantly controlled by Western countries, which leads to…
- cultural dominance by Western scientists, which leads to…
- Western research paradigms being favoured over non-Western paradigms, which leads to…
- research themes being decided upon by foreigners.

6.4.2 Phase 2: Strategic planning

Building stakeholders' mutual understanding

After a first exploration during the international expert meeting, the stakeholders' real understanding of each other's values, motivations, concerns and interests regarding the programme grew over time.

The initial workshop was an important first attempt to confront stakeholders with each other's perceptions of the meaning of demand-oriented social science research.

Visions of the future

Already during the 2004 expert consultation, the presence of representatives of three stakeholder groups presented the opportunity to develop a joint understanding of each other's role and responsibilities:

- The meeting urged *governments* to take the lead in developing a (social science) research policy in a participatory manner.
- The *research community* was asked to adopt a more client-oriented attitude by allowing more active participation by civil society and end-users of the research findings.
- *NGOs* were asked to play a more active role in funnelling the demand for research and in disseminating the research findings.
- In turn, *international organizations* were asked to stimulate innovative approaches and research themes and to be the quality watchdog through a system of peer review.

During the initial national workshops, stakeholders were encouraged to share their visions and discuss the roles and responsibilities. This confronted the researchers with civil society's desire to get involved in research activities. Also, the double role of government, as a research client and as a research system facilitator, was often brought into the open.

At international level, situation analysis led to the identification of potential issues to be addressed through the MCP:

- facilitating access to social science research funding;
- increasing the involvement of stakeholders in agenda-setting;
- safeguarding scientific status, integrity and coordination;
- assuring the quality of research proposals;
- improving proposal selection procedures and funding mechanisms;
- documentation and information exchange;
- translating research findings into up-scalable strategies; and
- facilitating inter-country learning on specific themes.

During the national workshops and meetings, each country identified its own priorities within this bigger picture.

Institutional anchorage

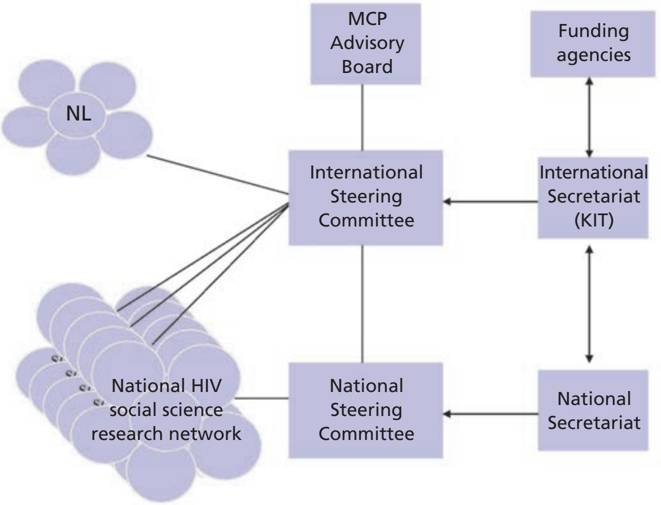
The initial national workshops also aimed at deciding on the institutional anchorage of the MCP in-country. The institutional set-up involving national and international levels is visualized in Figure 17.

Decisions and agreements on key strategies

An expert consultation in 2004 with representatives of all countries concerned formulated the following key principles:

- The balance between research capacity-building and research activities seems best guaranteed through separate budgets for the funding of research, for capacity-building

Figure 17 Multi-country programme structure



Source: Own elaboration

and for operational support. The research fund would be subject to national calls for proposals, with international arbitrage.

- As much as possible, existing national human resources and infrastructures will be used, and no separate budget will be reserved for recruitment or investment other than within the framework of research proposals.
- On the basis of the inventory of programme functions as given in the MCP document, an annual activity plan will be developed with process and output indicators.
- A multi-country study will not automatically be part of the programme, but on the basis of the approved proposals, issues for joint research can be identified and partnerships with Dutch universities forged. Some areas of common interest were identified and would be explored at the appropriate time.
- The development of the national social science research system is an iterative learning process that will benefit from international exchange among peers and that may call upon these peers and on an international support team for specific training, institutional analysis, process facilitation and the like.

Document and communicate planning outcomes

The participants at the 2004 expert consultation were made member of a virtual knowledge community to allow for information-sharing and long-distance discussions. Over time, this community has hosted hundreds of group messages and dozens of shared resources. At national level, the networks usually document and communicate decisions and work plans.

6.4.3 Phase 3: Implementation and management

Integrated initiatives and action plans

Detailed interrelated work plans were made for both the national programmes and the international network. Funds were available to react to requests for assistance. High adherence to the work plan did not necessarily define the quality of the multi-stakeholder processes in the countries; sometimes the focus on the participatory process was seen as more important than a focus on quick results.

Secure resources and technical support
Funding for the inception phase of the MCP was obtained through the Dutch Ministry for Development Cooperation and the Aids Fonds. Joint funding through other sources (National AIDS Programme and Global Fund) was only obtained in two of the five countries, Namibia and Rwanda. Several Dutch universities provided technical support through proposal-writing workshops, support to national evaluations and through peer reviewing of research proposals and reports.

Develop capacities of stakeholders
Each country had access to funds to develop stakeholder capacities. From the perspective of Potter and Brough's concept of capacity (2004, see Figure 16), the entire programme could be defined as an overall capacity development exercise; in addition to skills training, the programme was consciously building up structures and systems and defining roles.

Establish management structures, manage the process
Management structures and procedures were put in place both at national and international levels, as discussed above. This was paid for from the overall budget that had allocated a percentage for administration and management.

Maintain commitment of stakeholders
Continued commitment follows success. Due to the delays in the implementation of the work plans in some countries, motivation was reduced. Political unrest in one country worked against a favourable environment for intensified non-governmental–government collaboration. In others, local ownership of the MCP was strong and both process and result-oriented.

Relate to non-participant stakeholders
While most national work plans contained communication activities, the MCP process tended to be rather self-centred until research results became available which were shared with other actors.

6.4.4 Phase 4: Reflecting critically and adapting

Learning culture and environment
Apart from the accountability-oriented monitoring system, institutional and inter-agency learning became an explicit objective of each meeting; the annual meetings of the International Steering Committee were crucial. Joint learning took place at all levels during meetings and inter-country field trips.

The idea that the D-groups virtual environment would also stimulate cross-border reflection and learning, however, turned out too ambitious for several reasons: political or administrative agendas blocked open learning exercises; researchers resisted free sharing of their knowledge base; and NGOs were not eager to show their weaknesses.

Define success criteria and undertake monitoring

Success indicators were identified both at the international level (log frame) and at national levels, with important emphasis on bonding the stakeholders (process indicators). Implementers of the selected and funded research projects provided progress reports to the national secretariats.

Review, evaluate and discuss progress and capture lessons

The national steering committees were bent on guarding the quality of the research management process. As for the quality of research, international peer review was foreseen, but peer reviewers were hard to mobilize, and national researchers were not always interested in their proposals and reports being reviewed.

Feed lessons learnt back into strategies and implementation

This was done at both national and international levels, through participatory evaluation and planning workshops.

6.5 Comments and lessons learnt

The MSP model as presented above (Figure 15) offers important opportunities to look at its multi-stakeholder process systematically. Although efforts have been made to find a balance between result and process orientation, the definition of a multi-stakeholder process as presented in Box 13 lacks a certain cultural sensitivity. The way a multi-stakeholder process develops depends to a large extent on stakeholders' awareness of each other's ways of dealing with uncertainty, on the aptitude to act as a collective, on the perception of time, and on the capacity to query power and gender issues. These aspects did not receive sufficient attention throughout the MCP process.

Lessons learnt can be summarized as follows. The relevance of joint learning between, for example, Botswana and Ethiopia or Burkina Faso and Namibia was not sufficiently proven. Although exchanges between the countries were interesting, a more regional approach was likely to be more cost-effective. For other multi-country programmes it must be noted that collaboration between African countries does not come naturally. Diversity is a factor to be taken into account.

It proved of great importance to obtain explicit stakeholder commitment to the MCP principles and process before any funding was secured. Money should not be the main motivator.

In countries with a high “power distance” (between official and more informal spheres of interaction), an official mandate regarding the multi-stakeholder process and a high institutional anchorage proved essential for its success.

National capacity-building in the field of social science research can be better structured – for example, by using the capacity development models to develop a balanced intervention package.

Virtual (web-based) tools for discussion and learning can only become effective if embedded in a learning strategy and if combined with face-to-face communication.

Last but not least, it was perceived by all that a stronger M&E system is desirable. However, there should be enough attention to process; an accountability-oriented system may not lead to the innovation needed.

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Group of GLARC researchers visiting the Nonya hydro-electric power plant construction area near Kisumu, Kenya, as part of a team-building field trip, May 2009 (Photo: Hermen Ormel, KIT)

7 Multi-country programme on social science research redesigned: The case for a Great Lakes Applied Research Centre

Annemiek Richters, Hermen Ormel and Anke van der Kwaak

Abstract

During the last year of the Multi-Country Programme for Social Science Research on HIV and AIDS (MCP – see previous chapter), it was decided that it would be more strategic in terms of capacity-building in the field of applied qualitative research to work with a limited number of research institutes in a particular region in Africa, instead of a consortium of countries spread over the continent. Another major decision was that the ‘call for proposals’ approach as applied in the MCP should be replaced by an approach that would allow closer cooperation and exchange between the consortium members regarding research capacity development. For that purpose the choice was made to work from a common theoretical perspective and focus on a common research theme, while allowing enough space for each country to develop a specific research focus of particular relevance to the country concerned. This chapter describes the process towards setting up the Great Lakes Applied Research Centre (GLARC), its evolving approach to research capacity development, the selected theoretical perspective of “vulnerabilities and social capital”, the theme of “discordant couples” as the first common research theme and the country-specific foci for the proposed research as presented in draft proposals. The outcome of the GLARC process so far is that due to a lack of resources no progress has been made in the cross-country implementation of the various proposals. However, some GLARC members succeeded in carrying out exploratory research on the topic of discordant couples, and the networking between members resulted in various bilateral research activities. Leadership, partnership and the existence of a network in which research and mutual learning is the focus cannot exist without resources in terms of financial support, logistical means and innovative thinking. Unfortunately, the latter can only to be shared and implemented when the first two are in place to sustain the process.

7.1 Introduction

From 2005 to 2008, the MCP was operational in five African countries (Botswana, Burkina Faso, Ethiopia, Namibia and Rwanda), supported by various Dutch universities and funded by the Netherlands’ Ministry of Foreign Affairs and the Dutch Aids Fonds (Van Poelje 2012, in this volume). The MCP aimed to increase the national capacity for the management and implementation of social science research for HIV and AIDS in the participating countries and facilitate mutual learning and joint fundraising for social science research on HIV in sub-Saharan Africa. The added value of such multi-country research partnerships and, more specifically, the need to establish networks for social science research in the field of

HIV and AIDS have been repeatedly emphasized (Kippax and Holt 2009; GHIN and CREHS 2010).

During the MCP implementation process it became clear that the inception phase needed more time than envisioned, to come up with a solid proposal for a second phase of capacity-building in the field of HIV and AIDS social science research. In a one-year extension (2008–2009) the consortium membership changed and saw the inclusion of four new members (Burundi, Democratic Republic of Congo, Kenya and Uganda), while Botswana and Burkina Faso no longer participated. The rationale for this change was that capacity-building in the field of applied research would be more effective and strategic if applied to a limited number of research institutes in a particular region in Africa, instead of a consortium of countries spread over the continent. The newly chosen regional approach would allow for more frequent exchanges among the researchers, policymakers, end-users and other stakeholders from the various countries. In addition, it was expected that the participating countries would have similar research priorities, which would facilitate cooperation and exchange between countries in terms of research capacity-building.

Rwanda had played a key role in the coordination of the inter-country MCP process and had achieved much in terms of in-country capacity-building – substantial stakeholder participation, active involvement of the National AIDS Committee, identification of a common research agenda and implementation and validation of a number of studies. Given the partly new group of countries, it was decided that a focus on the Great Lakes Region, with Rwanda at the centre, would offer the best chance to achieve more common ground and cohesion: the national HIV epidemics in the region had a number of common characteristics, and across the countries there was a shared need for further capacity-building. Ethiopia could serve as a "resource country", since the quality of social science research conducted in this country was considered by far the best of the MCP group. Namibia would be linked to what was to become the Great Lakes AIDS Research Centre (GLARC), with the ultimate aim of starting an initiative similar to GLARC in Southern Africa.

In this chapter we will describe the capacity-building process as it developed in the fifth and last year of the MCP and in its aftermath. We will focus in particular on the main issues discussed by the MCP participants during the process, and its outcomes and challenges. We conclude with an overview of lessons learnt in terms of cooperation between the different consortium partners (South–South and South–North) and research capacity-building.

7.2 Capacity development: The process

The philosophy, objectives and capacity development approach of the MCP's extension phase (fifth year) were in line with those of the first four years. In addition to consolidating what had already been achieved, a major additional specific objective was the development of a proposal for a regional collaborative centre that would give substance to the follow-up phase of the MCP. To achieve the objectives for the extension phase, two workshops were held in Kigali (November 2008 and March 2009) and a third at the Royal

Tropical Institute (KIT) in Amsterdam (May 2009). Besides discussing the future of the collaborative network and its research agenda, capacity-building for social science research remained a priority of all workshops and separate strategy meetings. Sessions on health systems strengthening, research among young people, mental health and sociotherapy were given, but emphasis was also placed on putting a monitoring and evaluation (M&E) system in place and how to plan with milestones. The development of a log frame was part of this.

During the first workshop the vision of GLARC was extensively debated, against the background of the lessons learnt from the MCP's first four years. The vision as it evolved in the process leading up to a GLARC proposal (see below) reflects the vision which was steering the MCP process from the beginning as well as the work experiences of the workshop participants who had been involved in the MCP all along.

7.3 Capacity development: The content

Regarding research programming, two options for proceeding with research in the context of a multi-country study programme were examined: the call for proposals approach and the multi-country studies approach (see Annex 7.1). It was decided to build on the strength of both options and thus not continue with the call for proposals approach as applied in the previous MCP phase in each country separately. Workshop participants opted for a set-up that would allow for closer cooperation and exchange between the consortium members regarding research. For that purpose, the choice was made to work from a common theoretical perspective and focus on common research, while allowing enough space for each country to develop a specific research focus that would be of particular relevance to the country concerned.

A free listing exercise resulted in four possible research themes being proposed for GLARC with a list of sub-topics for each.

Table 8 Proposed GLARC research themes and sub-topics

Family planning and HIV and AIDS	Marriage and HIV and AIDS	HIV and AIDS and (post-) conflict situations	Sexuality and HIV and AIDS
Cultural aspects Role of grandparents Role of aunties Community participation Adolescent orientation Vulnerabilities	The role of faith Cultural aspects The role of community Poverty and socio-economic aspects Vulnerabilities	Migration Gender-based violence Rape Impact on health system Compliance with anti-retroviral therapy Religion Nutrition Family distortion Coping mechanisms Therapy and counselling	Teenagers Young adults Generational Sexual orientation Disclosure Risk and responsibility

Source: own elaboration

Post-workshop discussion with various stakeholders, particularly within Rwanda, resulted in a list of key theoretical concepts that could guide the future research programme (with one or more of the themes listed in Table 8 as its focus). The list included the concepts of vulnerabilities, accountability, value of life, risk perception and behaviour change. In addition, some desk review was done regarding these concepts and their relevance. The results were presented during the second workshop. There it was observed that the concepts of risk perception and behaviour change seemed over-used in the field of HIV and AIDS. They were, therefore, laid aside. The concept of value of life, originally chosen as a key concept for the proposed research, was considered to be an aspect of the much broader concept of vulnerability that came to the fore later (see below). It was, therefore, decided not to include the concept of value of life in the title of the research programme.

Eventually, the concepts of vulnerability and social capital were chosen as the most relevant for tackling the selected research themes. The theme of discordant couples was considered to be a neglected research topic in each participating country, while allowing enough flexibility for researchers to work on country-specific issues. It could also be considered as a theme cross-cutting the themes and sub-topics listed in Table 8. Each participant was asked to write a draft on the aspects of the theme of discordant couples they found relevant to research in their respective countries. The idea was that once GLARC were operational, a research theme to subsequently address in its second year and years to follow would be selected.

Throughout the various workshops the consortium developed the different sections of the GLARC proposal. Also, it addressed and defined capacity-building in terms of knowledge generation and shared information through separate sessions on: M&E for research and research communication, health systems and HIV programmes, ethical issues, the concept of resilience with regards to HIV and AIDS, the philosophy and practice of community-based sociotherapy in Rwanda, and the electronic monitoring system for the surveillance of AIDS patients as used in Rwanda. The objective of the finalizing KIT workshop (May 2009) was to present and discuss the outcome of the work achieved during the MCP extension phase in the company of donors, KIT personnel, representatives of non-governmental organizations (NGOs) and Dutch knowledge institutes and individuals interested in the topic. The draft GLARC proposal was finalized soon after (KIT 2009).

7.3 Capacity development outcomes: Vulnerabilities and social capital among HIV-discordant couples

The main outcome of the extension phase was the proposal for GLARC. It suggests that GLARC should be a regional membership-based and donor-supported research and capacity-building network whose mission is to promote dialogue and interaction between researchers, HIV practitioners, the private sector and policymakers in the Great Lakes Region and Ethiopia with a view to enhancing the impact of social science research in the field of HIV and AIDS on policymaking and development planning. Here we present only the part of the proposal that focuses on the content of the proposed research.

7.3.1 Theoretical framework of vulnerabilities and social capital

In the GLARC proposal the use of a theoretical framework of vulnerabilities and social capital is presented for the study of the complex factors that either prevent or facilitate behaviour change. An underlying idea of this framework is that an individual's reaction to HIV- and AIDS-related issues and adoption of a particular behaviour are not influenced by the quality of the available information alone, but also by biographical factors such as people's perception of the value of life and perception of death, by relational dynamics and by social contexts in which relationships occur and individual life trajectories develop. Another presupposition is that studies done from the perspective of a vulnerability framework point to the need for interventions aimed at enablement and empowerment. GLARC would engage with these kinds of interventions from the perspective of social capital development.

7.3.2 Vulnerability

The heuristic matrix of vulnerability that is suggested to guide the research proposed in the GLARC context contains three levels: the social trajectory level (biographical fragility or identity vulnerability), the level on which two or more trajectories intersect (relational vulnerability), and the social context (contextual vulnerability). Delor and Hubert (2000) argue convincingly that any in-depth, comprehensive study of vulnerability should include in its focus these three levels, the particular links among them and their respective impacts on HIV- and AIDS-related behaviour. To study complex situations of vulnerability, they use the framework as presented in Table 9, defining an objective and a subjective dimension of vulnerability. Within both dimensions, the three levels of vulnerability are distinguished.

Table 9 Framework with examples of a range of vulnerability factors

Level of reading of a situation of vulnerability	Objective dimensions	Subjective dimension
Trajectory level	Life cycle, age, gender, social mobility, social identity etc.	Subjective time, life project, perception of the future, *value given to life and death etc.
Interaction level	Partners' characteristics (ages, serological status etc.), setting of interaction etc.	Subjective representations of the partner, perceptions of condoms according to sero-status etc.
Context level	System of collective norms, institutions, gender relations, inequalities etc.	Subjective perceptions or norms, personal interpretation and expectation of punishment etc.

Source: Delor and Hubert 2000:1561 (* added to the original framework)

The various elements of vulnerability can be resituated in the process of identity construction, which can be described as a process aimed at maintaining, expanding or protecting the living space in which a person is socially recognized. Situations of vulnerability are the circumstances – in terms of specific moments and areas – during which this vital exercise is the most painful, difficult and perilous.

Since the first GLARC research proposed focusing on sero-discordant couples (see below for a justification of this choice), let us take such a couple as an example. The wife is living with HIV and the husband remains HIV-negative. She has been raped by soldiers and witnessed brutal war violence, which made her lose an interest in the future. Her husband forces sex upon her. Part of her family has been killed or went into exile; her remaining social network is small, and the social relations within this network are poor. It is mainly through in-depth qualitative research that we can learn to understand the behaviour of this particular woman, including her reasons for not wanting to disclose her HIV status to her husband and her still having a number of children with him even though she does not show much interest in children. While discussing this case and other specific vulnerabilities in post-conflict settings, the value people attribute to life and death was singled out as a factor that would need particular attention. It was then added to the framework of vulnerability factors.

GLARC studies, it was proposed, would focus on vulnerabilities of different population groups. Qualitative research approaches would be used to gain insight into the link between situations of vulnerability to various risks and situations of tension or upset balance in the complex system of relations with oneself, with others and with the world. We hypothesized that interventions to improve social relations would have a positive effect on changes at the other two levels and result in behaviour change that would contribute to the appropriate prevention, care and treatment in relation to HIV and AIDS. Based on this hypothesis we adopted the theoretical framework of social capital to approach the operational aspect of the research programme.

7.3.3 Social capital

The key element of the concept of social capital is that ‘relationships matter’ (Field 2003). In most social capital studies a distinction is made between *bonding* and *bridging* social capital. Within these two types of social capital a distinction between *structural* and *cognitive* social capital, both operating at micro (individual person or family) and macro (neighbourhood, community, formal or informal group) levels, is also made. The structural form of social capital comprises the extent and intensity of social links or activities, and the cognitive form covers the perceptions of support, reciprocity, sharing and trust. HIV prevalence has a negative effect on social capital, which in turn hinders the development process (David and Li 2008).

The hypothesis regarding the importance of access to social capital for behaviour change to occur is supported by experiences with sociotherapy as implemented in Rwanda (Richters et al. 2010). Participation in sociotherapy by people living with HIV reduced their isolation and hopelessness and contributed to their regaining self-respect and being recognized by others as a valuable human being. Sociotherapy stimulated its participants to go for testing, change their eating patterns and care for others. The increase in social capital also led to a reduction of sexual violence in intimate relations. The hypothesis that social capital is positively related to HIV control, in terms of reducing incidence, is also supported by a study undertaken in rural Zimbabwe, which explored the role of social capital and school education in avoidance of HIV among young women (Gregson et al. 2004). The conclusion was that participation in local community groups is often positively associated with successful avoidance of HIV, which in turn is positively associated with psychosocial determinants of safer sexual behaviour. A last example that supports the importance of social capital for behaviour change is the "community conversation" implemented by CARE in Ethiopia. This intervention functioned as a catalyst for stigma reduction and behaviour change (Getaneh et al. 2008).

In our discussion on the possible contribution of the strengthening of social capital to the reduction of vulnerabilities to HIV it was recognized that particular forms of social capital do not reduce that vulnerability but increase it instead. For instance, strong social bonds within extended families may foster gender norms and identities that obstruct the development of the psychosocial qualities and behaviours that are needed to successfully avoid HIV infection. This form of social bonding has been described by some authors as 'anti-social capital' (Gregson et al. 2004:2122). Another issue to consider is that sexual liaisons with multiple partners may serve to increase the size and diversity of an individual's sexual relationships and as such increases their social capital (Thornton 2009). This case could also be considered anti-social capital. We concluded that by using the concept of social capital as a key concept in our proposed programme for research, there would be a need to be attentive to positive and negative aspects of social capital in terms of HIV prevention and care for people living with HIV and AIDS.

7.3.4 Vulnerabilities and social capital among HIV-discordant married or cohabiting couples

The research topic for the first phase of GLARC was "vulnerabilities and social capital among HIV-discordant married or cohabiting couples". HIV infections in sub-Saharan Africa are mostly attributable to heterosexual transmission. On the basis of survey and clinical data collected in urban Zambia and Rwanda, it was estimated that 60–90 per cent of new heterosexually acquired infections occurred within marriage or cohabitation (Dunkle et al. 2008). However, even though HIV-discordant partnerships are a risky context for women and men, most HIV services in Africa currently deal primarily with clients as individuals.

The HIV-positive partner in a sero-discordant couple is often confronted with the challenge of, for instance, disclosing his/her HIV status to his/her spouse, relatives and/or friends and making a decision whether or not to become (for the first time or again) a biological parent. While voluntary counselling and testing and behaviour change interventions aimed at couples have shown to reduce HIV transmission among sero-discordant couples, the premise of GLARC is that given the contextual vulnerability of the partners in these couples, various kinds of community interventions enhancing the social capital of these partners may be even more effective towards HIV prevention (Kwagala et al. 2008). The same applies to contraceptive use among these couples. With the availability and increased access to anti-retroviral drugs (for anti-retroviral therapy (ART) and prevention of mother-to-child transmission) in certain sub-regions of the Great Lakes Region, sexual activity and the desire for biological children have increased, also among sero-discordant couples. With fertility rates already high, integration of HIV prevention and family planning efforts is advisable (Odhiambo 2007).

The spread of HIV in the countries involved in GLARC may be specifically affected by people's high mobility in the region and by (related) sexual violence outside and within marriage. Three country examples may illustrate this. Rwanda has a large prison population at high risk of HIV transmission through men having sex with men. This, in turn, results in the risk of ex-prisoners infecting their wives or new partners. In Kivu province in the east of the DRC, the civilian population is moving from place to place in search for peace, while military groups and rebels move frequently for various other reasons. A leading cause of HIV in this region is sexual violence by the military and rebels. Women who are HIV-positive as a result of rape may infect their partners. Many of these women, however, move within the region but also to neighbouring countries to avoid stigma and to search for survival opportunities, which include new marital and cohabitation relationships. In Kenya, post-election violence forced many families to move from one region to another, leading to separation of the families. This resulted in disruption of the use of ART. Cases of rape and new infections have been documented among the internally displaced persons who are living in camps. Further studies are needed to document sero-discordance, given that the recent Kenya AIDS Indicator Survey carried out in 2007 showed that in Kenya in relationships of people living with HIV who are married and know their partner's HIV status is 44 per cent (National AIDS and STI Control Programme 2008).

7.3.5 Towards a multi-country programme

As part of the preparation for a future multi-country programme on sero-discordant couples and HIV, a brainstorm took place about specific research questions and research designs. A selection of preliminary research subtopics included:

- the vulnerabilities that prevent disclosure of HIV status among sero-discordant couples (perceived responsibilities and guilt in cases of rape, extra-marital sex, polygamous marriages etc.);
- traditional practices in rural areas that can be adopted to reduce vulnerabilities (for example, the practice of elderly women who in the past counselled families when new situations arose and succeeded in prevention of stigmatization);
- decision-making processes within sero-discordant couples regarding conception and contraception;
- a comparison of use of and access to family planning methods between discordant and non-discordant couples;
- determinants of joining associations and networks of people living with HIV by sero-discordant couples compared to HIV-positive concordant couples;
- attitudes, whereabouts and reactions of children of sero-discordant couples after disclosure of their own HIV status and their parents' status;
- the impact of social capital strengthening on HIV prevention among sero-discordant couples;
- the possibilities of introducing a social capital approach to HIV prevention and care within health systems; and
- increasing health systems' accountability and responsiveness to vulnerable groups such as sero-discordant couples.

The results of the brainstorm process formed the basis for the development of country-specific research proposals, which were presented, discussed and rewritten during a workshop held in Kisumu, Kenya, in May 2010 (KIT 2010). A summary of the results of this exercise in the form of draft proposals is presented in Annex 7.2. The Kisumu workshop took place a year after the MCP extension phase had officially ended. Meanwhile the idea had developed that once the GLARC proposal was funded, a week-long capacity-building research workshop would be held, during which the proposed preliminary country research projects would be tuned into each other. So as not to lose momentum, participants and resource persons of the network that was supposed to merge into GLARC (all based at higher institutions of learning in the region) received the suggestion to encourage students to take up the proposed research or to develop proposals under the identified themes. This suggestion resulted in students working on the GLARC theme of sero-discordant couples as operationalized in the draft proposals under the guidance of senior researchers in Rwanda, Uganda, Kenya and Ethiopia.

In Ethiopia, a study carried out by Daniel Tadesse under the supervision of Prof. Getnet Tadele resulted in an MA thesis (Tadesse 2011). The study found widespread misconceptions about HIV-discordance among sero-discordant couples, health care providers and counsellors, such as: the belief that the other partner was already infected, but the test did not show it; biological immunity to HIV; and prevention of HIV through ART. As a result of these misconceptions, many couples were confused and unlikely to take the necessary preventive measures or they were not interested in being tested. Although service providers informed and educated them, nevertheless many of the sero-discordant couples continued to engage in risky sexual behaviours. However, it was also found that for some couples the presence of HIV did not bring about any change in their relationship. Still, they experienced a variety of psychosocial problems such as fear of infecting and being infected, blame, neglect, guilt and uncertainty. Their coping strategies were found to be safer sex, abstinence, communication, disclosure, silence, secrecy, cooperation and religion. Social capital was found to be a double-edged sword. While informants claimed they were receiving instrumental, informational, appraisal and emotional support from relatives, friends and acquaintances, these same groups of people were found to be a source of stress and anxiety.

7.4 Capacity development: Challenges

Apart from the above-mentioned activities, the GLARC process is more or less on hold. Due to budget cuts in development cooperation in the Netherlands, funds were no longer allocated by the Ministry of Foreign Affairs and Aids Fonds. Although the centre in development very much represented a network of partners working in South–South and South–North alliances, and a regional approach to social science research on sexual and reproductive health and rights (thus broader than the HIV focus before) still seems necessary and urgent, no funding was obtained through applications to global and regional calls for research proposals. The justification for working as a regional centre still holds to the present day. The region has a common geography and history, a history of effective collaboration for capacity development and common weaknesses regarding social science research and policy gaps. The topic of sero-discordant couples offers an opportunity to address cross-region issues regarding sexuality, decision-making, power and quality of life/positive living; the common objective then is to improve quality of life and care (by the community and by service providers). It should also be noted that both topics (regional approach, content topic) address issues in the context of shared socio-political structures and fragile states. Although partnerships were emphasized, and a group of institutions had already worked together with a strong focus on research and capacity-building and joint linking and learning, no funds have become available yet. Opportunities remain limited to exchange visits between some GLARC partners and occasional collaborative initiatives.

7.5 Conclusion

The outcome of the GLARC process so far is that due to a lack of resources no progress has been made in the cross-country implementation of the various research proposals. However, some GLARC members succeeded in carrying out exploratory research on the topic of sero-discordant couples, and the networking between members resulted in various bilateral research activities. On a more positive note, the experience taught participants that working together with a diverse but dedicated group of researchers from countries in the South and North definitely carries benefits in terms of capacity development: minds were sharpened, ideas challenged, skills built and concepts tested. The interaction between the African countries has been at least as important as the South–North exchange, and collaborative efforts between researchers and research institutes have continued. This book is definitely an outcome of this process. It has been inspired by it, and the creative and innovative thinking is there that can also be fed by virtual discussions and communications. The main lesson learnt is that, even if researchers and their institutions really become partners who share the urgency of studying important topics together, without funding the implementation of that urgency is not going to be feasible.

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Annex 7.1

Two options for proceeding with research in the context of a multi-country study programme

	The typical process	Strengths	Constraints
A. Call for proposals	1. Develop and circulate a call for proposals 2. Panel review of concept papers/preliminary proposals 3. Workshop(s) to strengthen proposals 4. Panel review of full proposals 5. Review by Scientific and Ethical Review Group 6. Approval by Coordinating Body and perhaps also funding agent 7. Technical support and analysis workshop 8. Workshops to develop papers and dissemination of findings	1. Respond better to local needs and interests and skills of local investigators 2. Feeling of complete "ownership" by local investigators 3. Flexibility in study design and timing	1. Difficult to monitor 2. Difficult to provide technical assistance 3. Difficult to compare results 4. Difficult to synthesize results 5. Prone to fragmented research 6. Subject to delays in completing projects
B. Multi-country studies	1. Identify the topic of priority and potential investigators and resource persons 2. Consultation to review the situation and agree on issues of high priority and study design and related issues 3. Commission preparation of the protocol and instruments 4. Investigators' meeting to review and revise the protocol, design and instruments 5. Review by the Specialist Panel and Coordinating Body 6. Regular monitoring, technical assistance 7. Workshops at critical stages of implementation 8. Meetings to disseminate results and implications of findings	1. Ensures good monitoring and quality output 2. Progress in time 3. Results are comparable 4. Greater potential for publication 5. Greater potential for impact	1. Requires more intensive staff/ consultant inputs 2. Country (context) variations not fully accounted for 3. Greater dependence of local researchers on Coordinating Body staff and consultants

Source: Department of Reproductive Health and Research of the World Health Organization (WHO). Presented at the RAWOO (NL), Aids Fonds (NL), WHO, UNAIDS, Global Forum for Health Research (GFHR) and Council on Health Research for Development (COHRED) meeting that took place on 7 March 2003 at WHO, Geneva.

Annex 7.2

Summaries of draft research proposals developed by representatives of proposed GLARC member institutions

Burundi: Psycho-affective and socio-economic aspects of the vulnerability situation of discordant couples (Sylvère Seguru)

In Burundi in the cities, in contrast to the countryside, the percentage of women affected by HIV and AIDS is at least twice as much as that of men. In the capital, Bujumbura, 13 per cent of women and 5.5 per cent of men are infected. In the countryside the percentages are 2.9 per cent and 2.1 per cent, respectively. An underlying reason for the high HIV and AIDS prevalence in the country is the poverty among the population. HIV and AIDS in turn contribute, partly through the consequent stigma-related reduction in social capital, substantially to that poverty. Against this background the research focuses on the specific vulnerability of sero-discordant couples as a causal factor of the HIV infection and as a consequence of it. Particular attention will be paid to vulnerability in terms of the increase in poverty within the household, the loss of social capital of the spouses, the psycho-affective state of all family members and the relations between these three aspects of vulnerability. To start with, an attempt will be made to ascertain the prevalence of sero-discordant couples who are already identified as such. Research methods include individual interviews, focus group discussions and identification of psycho-affective problems.

Democratic Republic of Congo: Men's practices in response to the vulnerability of women who are sexually violated and live with HIV in North Kivu province (Edmond Ntabe)

This study addresses one of the major negative consequences of armed conflict: sexual violence, often coupled with HIV infection. The situation in North Kivu is compounded by asymmetric gender relations, which are reflected in women's limited ability to negotiate safer sex, and their fear of testing for HIV or disclosing their status due to anticipated repercussions. Women's vulnerability increases in contexts where men's multiple partnering is culturally condoned. The cultural emphasis on male dominance often encourages or enhances negative practices that increase female (and sometimes household) vulnerability. Men's perceptions and related practices regarding the vulnerability of sexually violated and HIV-infected women is an unexplored area in the Kivu region. The study, therefore, aims to: describe the vulnerability of sexually violated women and women living with HIV; explore the gender-based perceptions and responses of men (as spouses and partners) to this situation; and the role of social capital in relation to women's vulnerable situations. Recommendations concerning strategies for addressing women's vulnerabilities and men's perceptions and practices will be made. Mixed-methods research, including a survey and focus group discussions, will be used for data collection.

Ethiopia: Situation analysis of sero-discordant couples (Getnet Tadele)

This proposal focuses on the situation analysis of sero-discordant couples and the exploration of people's understanding of and beliefs about discordance, experiences after disclosure of sero-status, coping strategies and challenges. The proposal exhaustively traces the background to understanding of and responding to HIV from a global perspective from the 1980s, when the first cases of HIV were diagnosed, to the present. The theme of sero-discordance is presented, including the fact that in Ethiopia 85 per cent of couples living with HIV are in discordant relationships. The need to include HIV-negative persons in sero-discordant relationships among groups of people who are most vulnerable to new infections is stressed. Challenges that HIV-positive and HIV-negative partners within sero-discordant relationships face - such as sexual violence, emotional abuse, verbal threats and unprotected sex - are highlighted. The study aims to explore lived experiences of sero-discordant couples, specifically addressing: understanding of sero-discordance; challenges of living in a sero-discordant relationship; effects of disclosure of status; and coping strategies for the couples, including the role of social capital in coping with sero-discordance. The proposed methodology is basically qualitative using in-depth interviews, case studies of sero-discordant couples of reproductive age that have stayed together for at least a year, and key informant interviews.

Kenya: The impact of vulnerabilities on discordant couples in Kenya (Rose Olayo)

With reference to the national HIV and AIDS strategic plan, the proposal highlights the fact that the number of new infections (incidence) in Kenya is unacceptably high and that there are major differences in susceptibility among different groups. Particularly vulnerable are young girls as well as males and females in HIV-discordant relationships. The acceptability and use of condoms among sero-discordant couples is low, and knowledge on how to deal with sero-discordance among couples is limited. The situation is compounded by the diversity of cultural beliefs and practices that negatively impact decision-making and the well-being of individuals in sero-discordant relationships. The study will focus in particular on young sero-discordant couples. It aims to identify socio-cultural factors that influence HIV infection among them; assess their level of disclosure of HIV status; explore the outcomes of disclosure for them; and investigate the role of social networks in supporting them. HIV prevention strategies attuned to the needs of young people will be proposed as one of the outcomes of the study. Qualitative methods, such as key informant interviews and in-depth interviews, will be used for data collection.

Rwanda: Discordant couples, vulnerability and social capital (Laetitia Nyirazinyoye)

The proposed study on sero-discordant couples, vulnerability and social capital is contextualized in terms of a post-conflict situation, characterized in Rwanda by significant social and cultural disruptions as a result of genocide, displacement, long-term return migration and high levels of family violence, including gender-based violence. Although the magnitude of sero-discordance in Rwanda is yet to be determined, it has been established that knowledge of sero-discordance can result in intra-couple conflicts, separation or divorce. On the other hand, lack of knowledge on sero-discordance increases the risk of HIV transmission. Research questions focus on: factors that facilitate and inhibit disclosure; outcomes of disclosure, including responses by the couple's children; use and access regarding family planning; determinants of joining associations and networks for people living with HIV and AIDS; mechanisms, services and resources available on a community level to promote healing relationships and family planning among couples; and behaviour, communication and change messages and strategies for sero-discordant couples and their relatives. Data will be collected through interviews with persons in sero-discordant relationships to be recruited at voluntary counselling and testing and prevention of mother-to-child transmission programmes at health facilities and at community level through community health workers.

Uganda: Social capital, discordance and reproductive choices (Betty Kwagala)

Uganda, like other countries in the region, has experienced the brunt of both conflict and HIV and AIDS. The relatively high levels of sero-discordance among couples increased interest in preventing infection of the non-infected partners mainly through condom use or abstinence. The availability of anti-retroviral therapy (ART) and prevention of mother-to-child transmission has increased interest in childbearing, often at the risk of increased exposure to HIV infection. Contraceptive use other than condoms remains low. The study intends to analyse how social capital influences sero-discordant couples' reproductive intentions and choices regarding conception and contraception. More specifically, the study will focus on the influence of socio-demographic factors on contraception and conception; the influence of the quality of bonding social capital (at partner and family level) on voluntary membership of associations; and the influence of the quality of bonding social capital at partner, family, health provider, peer and association levels regarding reproductive choices concerning conception and contraception among sero-discordant couples. Recommendations will be offered for enhancing the quality of life of persons in sero-discordant relationships regarding reproductive health choices. The study will be exploratory and descriptive, using key informant interviews, focus group discussions, in-depth interviews with clients in sero-discordant relationships, and secondary data.

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Josephine Birungi (MD) is a seasoned and experienced manager of HIV and AIDS programmes, providing leadership at the strategic level as well as spearheading the medical care capacity-building and research functions at TASO. In this role, she leads the development of strategic plans, standard operating procedures and guidelines for medical care and the design of research protocols for TASO's operations research. She identifies key strategic issues to improve HIV and AIDS programming and policy formulation at TASO. Josephine has co-authored many research papers and made presentations on HIV and AIDS at national and international conferences.

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Lucie Blok (MD, MPH) is a public health specialist with a focus on health systems strengthening and integrated approaches to priority programmes and disease control, through capacity-building on organizational development, human resources development, operations research and M&E. She has 23 years of experience in international health and humanitarian assistance, of which 10 years in management positions.

Lucie developed extensive experience with the formulation of medical policies and implementation strategies and with programme review and quality assurance. She supports organizations in monitoring programme performance and in building evidence-based policies and strategies.

She has performed consultancy missions in more than 25 countries in Africa, Asia and the New Independent States and teaches a number of modules at the Masters in International Health programme at KIT. In May 2011 she was elected Vice-Chair of the Technical Review Panel of the Global Fund to Fight HIV and AIDS, Tuberculosis and Malaria.

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Krissy Ferris (MSc) is a public health, gender and sexuality expert with a particular interest in facilitating lifestyle change by bringing together the diverse aspects of health and wellness. She worked at the Amsterdam Royal Tropical Institute (KIT) as a Junior Advisor and Share-Net Coordinator, after graduating with honours from the University of Amsterdam with a Master of Science degree in Gender, Sexuality and Society. During her year of study in the Netherlands, she was largely supported by a Fulbright Fellowship. Krissy is also Phi Beta Kappa graduate of Oberlin College (2007), where she majored in Religion and minored in Politics. Krissy is currently the Program Director at Revati Wellness, a small integrative medical practice in Cleveland, Ohio.

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Barend Gerretsen (MD, MSc) is a senior international health expert. Following training as a medical doctor, he worked in several sub-Saharan countries and was involved in institutional development and capacity-building, including formulating policy plans, budgeting and costing health services and providing continuous education for lower-cadre personnel.

Barend's main focus is on health systems, in particular on human resources for health (HRH), hospital management and postgraduate education. In Bangladesh, he has been working towards improving the use of the private sector to reach public health goals.

Barend is currently the coordinator of the Master of Public Health programme at KIT. In Tanzania, he is involved in capacity-building of a large research institute, assisting the development of its research agenda and Master of Research in Public Health programme. Recent publications are on human resources retention and integrated management of childhood illness (IMCI), using a realist synthesis approach.

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Françoise Jenniskens (MD, MSc) is a medical doctor specialized in HIV and AIDS and international public health. She has 27 years of experience and holds two Master's degrees. Until 2011 she headed the HIV and AIDS, Disease Control and Reproductive Health portfolios at KIT in Amsterdam, where she worked for 12 years. She has led several large evaluation teams and participated in many others and has experience in health systems research. She spearheaded the development of the HIV specialization of KIT's Master of Public Health programme. More recently she has been working on neglected tropical diseases.

Françoise worked in Tanzania, Kenya and Namibia for 12 years, starting as a medical officer in a rural hospital, then focusing on operational research programmes for STIs and HIV in Kenya. In Namibia she was the Senior Technical Advisor to the National Multi-sectoral HIV and AIDS Programme, assisting in shaping the country's HIV responses.

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Betty Kwagala (MA, PhD) is a sociologist with a Master's degree in Development Studies. She has been actively involved in research since 1993, first as a research fellow and for the past four years combining research and lecturing. Betty has researched and consulted on health and equity issues, including gender and reproductive health, ethics, issues of service delivery, community participation and inter-stakeholder engagement. Training activities include participatory research capacity development and M&E with development practitioners, including NGO staff. Among other courses, she teaches research methods at undergraduate and post-graduate levels.

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John has held several other positions since joining AMREF, including Country Director (Ethiopia), Deputy Country Director (Kenya) and Coordinator of the Sexual and Reproductive Health Programme. He has worked closely with the Ministries of Health in East Africa, and key organizations in policy development and elaboration of national implementation strategies in the areas of health sector reform and decentralization, reproductive health, national drug policy, child health, malaria and national HIV/AIDS strategies, among others. He has authored various publications on public health and sexual and reproductive health issues.

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Francis Obare holds a Ph.D. degree in Demography from the University of Pennsylvania. He has ten years' experience in research in the areas of health and mortality. His research focuses on inequalities in access to maternal and child health services, demand-side health care financing, adolescent health, sexual and reproductive health, and HIV and AIDS. He has conducted research in a number of countries in Eastern and Southern Africa including Kenya, Uganda and Malawi. He has authored or co-authored more than a dozen scientific articles and two book chapters. He has also taught research methods at the university level and presented papers at various national and international conferences. Francis is currently a Senior Analyst with the Population Council based in Nairobi, Kenya.

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Hermen Ormel (MA, MPH) is a social anthropologist and public health specialist with expertise in the field of sexual and reproductive health and rights, including HIV-related issues. His main areas of interest are capacity development, research and evaluation, mobile health, and gender and generational issues. His work has been in the areas of policy and programme development, research, training, technical assistance, regional support mechanisms and M&E in multilateral, bilateral and NGO settings. Hermen has extensive experience working in Africa, Asia and Latin America.

Hermen was recently team leader for an impact evaluation of a cervical cancer programme implemented by a women's health organization in Nicaragua. He is currently doing intervention research into the effects of mobile communication technologies for public health (mhealth) in Sierra Leone.

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Tobias Ouma works in an ICT organization that empowers youth from the informal settlements with ICT, entrepreneurship and life skills. Apart from his technical ICT qualities, he has facilitated many workshops within the community on matters relating to development and raising awareness. While working with MamaBits/Nairobits, Tobias was in charge of several projects, including the Building Bridges Peace Campaign, a country-wide campaign to promote peace and rewarding the peacemakers, and the Get H2O board game which addresses the issues of scarcity of resources in the community.

Tobias is fascinated with community work and engages with small and large organizations within the community to support capacity-building for sexual and reproductive health, self-esteem and peace-related subjects with the Sisi Ni Amani organization. As a developer and designer, he has created websites for over 20 clients as well as print media materials.

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David Plummer (MD, PhD) holds a PhD from the National Centre for Epidemiology and Population Health at the Australian National University. He is a medical doctor with a special interest in health sociology and applied research methods, including programme evaluation.

David has worked in the Caribbean, the Asia-Pacific region, Europe and Africa. He previously worked at KIT in Amsterdam, where he specialized in health and international development. Prior to that he held a UNESCO Professorship in Health Promotion at the University of the West Indies, where he worked in Trinidad, Barbados and Jamaica and several other Caribbean countries. He is also an Adjunct Professor in Public Health at the University of Texas, Houston. In 2003, David was appointed Member of the Order of Australia for services to public and community health.

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Annemiek Richters (MD, PhD) started her professional career as a physician and subsequently developed into a medical anthropologist. She retired in 2010 as Professor of Culture, Health and Illness at Leiden University Medical Centre but remained affiliated with the department. Since 2005 she has been a member of the Amsterdam Institute for Social Science Research of the University of Amsterdam, cluster Health, Care and the Body. Topics of her research included: gender and health, the quality of reproductive health care for migrant women in the Netherlands, the cultural comparison of medicine and women's body politics in the context of globalization, and sexual violence, trauma and healing. Over the past few years her research has focused in particular on psychosocial care in post-genocide Rwanda. She supports a variety of activities in the field of health and human rights.

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Georges Tiendrebeogo (MD, Tropical Medicine, Social Pediatrics, MPH, Medical Anthropology) has over 25 years of experience with strengthening community and health systems and HIV programmes in Africa. He has extensive experience in research and policy development, process facilitation and negotiation, strategic planning, M&E and development of evidence- and theory-based behaviour change communication and treatment adherence support strategies. Georges joined KIT in 2001 and has been coordinating operational research into the determinants of long-term adherence to HAART in Burkina Faso in collaboration with the University of Amsterdam (Amsterdam Institute for Social Science Research).

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Jurrien Toonen (MD, MSc) is working at KIT as the coordinator for universal health coverage, including performance-based financing (PBF), health insurance and public–private partnerships. For more than 20 years his work has focused on health systems strengthening and health financing at the cutting edge between policymaking and implementation. He has worked in 40 countries in Latin America, Asia and Africa, including long-term assignments in Bolivia, Mali and Ghana.

Jurrien's PBF experience stems from the development of a contracting approach in Mali, which has led to different PBF models for Mali and for Ghana, now being tested as mandated by the Malinese Ministry of Health. Jurrien led the 2008 formative evaluation of Cordaid's experiences in PBF in Rwanda, Burundi and DRC, and supported HealthNet International in developing a monitoring system for quality of care for its PBF programme in the Great Lakes Region.

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Anke van der Kwaak (MA, PhD cand.) is an anthropologist specialized in the field of sexual and reproductive health and rights, mixed-methods research and evaluation, and culture and health. She has worked as a researcher and trainer in the field of gender and health, especially in the Horn of Africa. Before joining KIT, she worked for 10 years as a university lecturer at the Medical Faculty of the Vrije Universiteit in Amsterdam. She has also conducted capacity-building workshops relating to health systems research in the field of sexuality, health systems, HIV and AIDS, tuberculosis, reproductive health and female genital mutilation.

Anke is currently training and teaching in social determinants of health, adolescent sexual health, and research proposal writing, analysis and reporting. She was recently team leader of an impact research on HIV prevention among young people in Uganda, Russia and the Netherlands. Anke is a member of the Scientific Advisory Board for Research on Islam to the Ministry of Foreign Affairs.

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Bertram van der Wal is a seasoned consultant with expertise in enhancing the governance of service delivery systems, particularly health and WASH systems. He holds a degree in Public Policy and Public Administration, specialising in performance management. His work covers a wide range of services to the public and not-for-profit sector, as a trainer, implementer and coordinator. This includes facilitation of multi-stakeholder processes, particularly strengthening the capacity of civil society organizations and local governments to participate in the management of local service delivery. For the past seven years Bertram has worked for the Netherlands Development Organization (SNV), based in Burkina Faso and in Ghana. In Ghana he coordinated a health care programme that covered five countries (Burkina Faso, Cameroon, Ghana, Mali and Niger). Prior to SNV he worked for four years at Berenschot BV, a private consultancy firm in the Netherlands, and one year for his own consultancy organization, Advision. Currently he works for Hiemstra & De Vries organization advisory services, aiming to increase the effectiveness of government.

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Trained as a social scientist, over the past 25 years Rob van Poelje (MA) has evolved from a communication trainer into an organizational development advisor into a facilitator of multi-stakeholder processes. His experiences in health, agricultural and local economic system development in Asia and Africa have led to many lessons learnt and fingers burnt. Rob worked at KIT as an institutional development advisor and team leader from 1999 to 2007. Convinced that the heart of development lies in action-learning processes that connect individual development to organizational and institutional change, he is presently working as head of the Learning for Change department at PSO. Together with colleagues at CDRA, PRIA and EASUN he experiments with more reciprocal relationships in international development and with various instruments that link lessons learnt to new organizational practice.

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Liezel Wolmarans (MSc) has a background in medical statistics. Over the last 20 years she has gained expertise in assisting researchers, programmers, project managers and students in the design and analysis of biomedical research, programme M&E and health management information systems.

Before joining KIT, Liezel managed the research and development department of the Social Marketing Association, building the in-house capacity to conduct qualitative and quantitative research. She also led all statistical analysis of large household surveys.

Liezel has extensive experience in sub-Saharan Africa and elsewhere. Since joining KIT at the end of 2009, Liezel has been involved in the development of the Epidemiology and Statistics module within KIT's Master of Public Health programme. She has also been project leader for a large 10-country study on HIV workplace programmes and has contributed to a range of health and HIV-related programme evaluations, action research studies and capacity development projects.