UNAIDS best practice key material

Rural workers' contribution to the fight against HIV/AIDS: A framework for district and community action

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Colophon

The Best Practice Case Studies are a joint publication between the Tanzania-Netherlands project to support AIDS control in Mwanza Region (TANESA), the World Bank/Africa Region Development and Environment, the Royal Tropical Institute (KIT) and the Joint United Nations Programme on HIV/AIDS (UNAIDS)

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PREFACE

(i) In 1999, the World Bank's Africa Region launched an initiative to intensify actions in HIV/AIDS through the creation of a task force to support coordinated multisectoral approaches. This team, the AIDS Campaign Team for Africa (ACT-Africa), has been instrumental in mobilizing a wide-range of actors to help prevent and mitigate the adverse impact of HIV/AIDS. Its position based in the office of the Regional Vice President for Africa underscores the World Bank's commitment to HIV/AIDS, and helps to ensure maximum collaboration among the different sectors. In August 2000, ACT-Africa launched the Multi-Country HIV/AIDS Program (MAP) for the Africa region, a $500-million initiative addressing prevention, mitigation and impact of HIV/AIDS is sub-Saharan Africa.

(ii) The World Bank's rural sector contributes to this joint effort by mainstreaming HIV/AIDS in its activities; it also set up a regional initiative on Rural AIDS (RAIDS) in 1998. This program seeks to engage rural workers in the planning and implementing of HIV/AIDS prevention and mitigation activities. RAIDS has used Norwegian, Netherlands and Swiss Trust Funds, UNAIDS resources and World Bank resources to support local rural AIDS consultants in seven countries: Benin, Cameroon, Chad, Guinea, Malawi, Niger and Nigeria. The initiative also supported Bank staff in field offices to involve rural workers in HIV/AIDS prevention. The current focus of the rural development sector in the Africa region is on scaling up HIV/AIDS programs in order to achieve national coverage. This challenge was clearly outlined in an article in Science magazine by Hans Binswanger, the sector's director.

(iii) In late 1999, the RAIDS team commissioned a review of initiatives that involve rural workers in Africa. The objective of this work was to examine best practices in the field and to indicate opportunities for more extensive and effective involvement of the rural sector in the fight against HIV/AIDS. A joint team of health and agricultural specialists from the Royal Tropical Institute in Amsterdam (KIT) conducted the work, building upon a decade of combined experiences in HIV/AIDS prevention in rural areas in Africa. Most of this work is the result of KIT's longstanding collaboration with the Tanzania Netherlands Support for HIV/AIDS (TANESA) project in Mwanza.

(iv) The methodology for the work included a literature review of best practices in sub-Saharan Africa. The main lessons of this review are incorporated in the current report. The synthesis of this review (see appendix 1) was also discussed with actors in the field during a series of country visits. The consultant team visited a total of six countries in sub-Saharan Africa to: (i) review the practical experiences of the RAIDS initiative; and (ii) identify successful prevention and mitigation approaches within the context of the HIV/AIDS programs that are currently being implemented in these countries. Countries visited in French-speaking Africa included Burkina Faso, Guinea and Côte d'Ivoire, and Nigeria and Malawi in English-speaking Africa. The consultants met with the local RAIDS advisors and with World Bank staff involved in the regional program and visited NGOs, CBOs and rural communities involved in HIV/AIDS prevention and mitigation efforts. Tanzania's experience and especially the TANESA program experience are also reflected in this document.

(v) Following the field visits, in January 2000 the consultants spent a day at KIT/Amsterdam working together with experts from the health department to strategize on the outline and content of the framework for action. In February 2000, the consultants produced a first draft report which subsequently benefited from extensive comments by the World Bank team in Washington, DC. The work on the framework was interrupted for several months in early 2000 as a result of the untimely death of Dick Schapink, the leading KIT consultant. Following consultations with

KIT/Amsterdam, the RAIDS team decided to consolidate the draft report. The document was further strengthened on the basis of suggestions and ideas from a small working group that met several times during a recent Pan African workshop in Mwanza on community participation and HIV/AIDS. During the weeks following the workshop, KIT finalized the document together with a senior consultant of the RAIDS team and a senior advisor of the local response team of UNAIDS.

EXECUTIVE SUMMARY

I. INTRODUCTION

(i) The Rural HIV/AIDS Initiative (RAIDS) is a contribution of the rural sector to the World Bank's multi-sectoral effort designated as AIDS Campaign Team (ACT-Africa) launched in 1999. Since its inception in 1998, RAIDS seeks to involve rural communities in HIV/AIDS prevention and mitigation through rural frontline workers — especially extension workers — and/or local RAIDS consultants in several African countries, namely: Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Guinea, Malawi, Niger and Nigeria. The current focus of the rural development sector in the Africa region is on scaling up HIV/AIDS programs in order to achieve national coverage. This challenge was clearly outlined in an article in Science magazine by Hans Binswanger, the sector's director.

(ii) In late 1999, RAIDS commissioned a team of consultants from the Royal Tropical Institute (KIT)/Amsterdam and the Tanzania Netherlands Support for AIDS (TANESA) to review HIV/AIDS activities in sub-Saharan Africa and to develop a framework for action. This framework should indicate ways to better capitalize on the potential of rural workers and rural communities in HIV/AIDS prevention and mitigation efforts. This report is the outcome of their work, and is based on a comprehensive literature review, field visits to six African countries and KIT/TANESA's experience in district level approaches to HIV/AIDS prevention and mitigation in Africa. The report also reflects suggestions and ideas from participants at a recent Pan African workshop on community participation and HIV/AIDS, held in Mwanza, Tanzania in June 2000.

(iii) The report presents a framework for action at national, district and community level to support and sustain a social mobilization process. Its objective, as agreed to by workshop participants, is:

> *To strengthen and build upon existing organizational structures for a multisectoral response to HIV/AIDS prevention and mitigation through community mobilization, with support from all appropriate levels and sectors.*

(iv) The framework aims to help develop and operationalize mechanisms for community empowerment in gender analysis, priority setting and action development. Additionally, the framework seeks to mobilize multi-sectoral district bodies that can provide leadership in HIV/AIDS prevention and mitigation actions. The framework further puts forth the need for effective collaboration between national AIDS coordinating body, NGOs and the UNAIDS theme group in the respective countries, to create momentum for bottom-up participatory approaches and accountability. This includes mechanisms to channel funds effectively from national to community level.

(v) Following the introduction, a brief discussion is included on social mobilization in the context of HIV/AIDS and a review of the social context (chapters 1 and 2). The document then sets out to identify the basic principles for a shared vision (chapter 3) by showing how a social mobilization program fits into an overall strategic framework for HIV/AIDS intervention planning. In chapter 4 the paper proposes a framework for immediate action focusing on the actors and their roles at village, district and national level. Finally chapter 5 presents a possible scenario for efficient channeling of resources to the various key partners.

(vi) Selected country experiences offer lessons learned that are presented in text boxes throughout the main document.

II. CONTEXT

(vii) An overview of recent literature indicates that there is a wide array of projects in sub-Saharan Africa that work in HIV prevention and AIDS mitigation. To date, only a handful has begun the process of scaling up pilot activities, and as a result, overall coverage levels remain low. Nevertheless, successful models exist in every context and at all levels from the national down to the grassroots; these should be considered in the development of and support for social mobilization programs and improved district coordination.

(viii) Until recently, HIV/AIDS prevention and control activities in many African countries were centered around a predominantly bio-medical approach and the repeated use of Information, Education and Communication (IEC) messages. The underlying models predicted behavior change subsequent to increased awareness about the disease and related risks. Nevertheless, so far it is clear that minimal behavior change has occurred despite impressive awareness raising efforts in many countries.

(ix) Lack of action on social determinants is now believed to be one of the major reasons why the epidemic keeps growing in sub-Saharan Africa and other parts of the world. Addressing social dimensions of HIV/AIDS is very challenging since this touches upon cultural norms and values that are deeply engrained in society. Issues related to sexuality and sexual relationships remain taboo subjects in many African societies.

(x) Over the last decade, social research has indicated the urgent need to act on the social dimensions of HIV/AIDS. In this regard, the work of John C. Caldwell *et al*. (1999) provides important theoretical insights on different social factors that facilitate the progression of the epidemic. Two factors in particular stand out, namely: (a) attitude towards death; and (b) importance of sexual relations with multiple partners outside marriage.

(xi) Two types of responses that have both sought to include social perspectives in HIV/AIDS prevention and mitigation work are worth mentioning. In northern Thailand, a supportive social environment was created to make possible a drastic increase in condom use with sex workers. Among customers, peer education and mass media campaigns have strengthened peer support for condom use. Owners and managers of all brothels, through the 100% condom use programme, have agreed with government authorities to enforce condom use among customers. The second type of response can be illustrated by the case of Uganda where the epidemic reached a 'threshold of visibility' that triggered social mobilization and strong political will to combat HIV/AIDS. In Uganda, this reaction became highly noticeable when the infection rate rose over 25 % in some population groups.

(xii) In line with current international thinking, the World Bank is gradually incorporating social dimensions in its development strategies such as the Comprehensive Development Framework and the Community Action Program. National leaders have achieved remarkable progress in bringing about awareness about the epidemic and its devastating impact on development – with the support of the World Bank's ACT Africa team, UNAIDS and UNAIDS partners. These developments set the stage for initiating the social mobilization process for HIV/AIDS prevention and mitigation in Africa.

(xiii) Within this process, there is an urgent need to move from individual awareness raising and sensitization to the promotion of behavioral change. Such behavioral change can only take place in a supportive socio-cultural environment that offers well-functioning care and support structures. A successful social mobilization program needs the full participation of people in the communities, starting with an analysis of their risk and vulnerability to HIV-infection. Based on

this analysis they can plan actions that stimulate behavioral change and improve care and support for people living with AIDS, their caretakers and orphans. Ideally, such a social mobilization program builds on locally available resources —in addition to those channeled from higher levels— and improved health and development structures. For sustained behavioral change, interventions should be gender-sensitive and appropriate to the different ways in which the HIV/AIDS epidemic affects men, women and youth.

(xiv) The UNAIDS spearheaded local response initiative to HIV/AIDS emphasizes analysis, prevention, care and support for PLWHA and fund-raising with and by the communities. It also advocates local partnerships and people-driven social actions. UNAIDS defines local responses as effective and socially acceptable interventions that are based on local needs and seek to complement existing approaches. Through local responses people and communities are looking at their own problems and risks, as well as their opportunities with regard to the epidemic. Local response initiatives are being brought to scale in several countries including Thailand, Burkina Faso, Ghana and Tanzania.

(xv) The consultant team strongly believes that mobilizing communities for action works best when such efforts are coordinated from the district level. Ideally, this implies that all district actors work together to support and scale up social mobilization programs under the responsibility of the district authority. This is generally the best placed actor to oversee multi-sectoral collaboration, given ongoing health reforms and decentralization and devolution schemes. Such collaboration calls for the active involvement of all concerned sectors such as health, development, agriculture, education and social welfare, NGOs, community-based organizations, religious organizations, the private sector and voluntary groups. Ideally, each actor's contribution is reflected in the district development plan that represents a joint framework for action.

III. FRAMEWORK FOR ACTION AT THE DISTRICT AND COMMUNITY LEVEL

(xvi) The following proposed framework for action sets forth a schematic outline of the different actors and respective activities at the national, district and community levels.

Enabling environment at national level

(xvii) At the national level, the National AIDS Control Program (NACP) or Coordinating Committee should endorse and incorporate social mobilization programs in a national strategic framework. The NACP can facilitate the development and implementation of such social mobilization programs by identifying best practices that include multi-sectoral contributions. By taking responsibility for the mobilization of financial support, and by allowing the direct transfer of money to village level accounts, it can help advocate the scaling up of community level prevention and mitigation activities. Monitoring and evaluation is also the responsibility of the NACP. Experience shows that its position is strengthened when the NACP is placed directly under the office of the President or Prime Minister.

(xviii) In many countries, both the NACP and the Ministry of Health are represented at the district level: the NACP has AIDS coordinators and the Ministry of Health supports AIDS committees. These resources need revitalization to better guide social mobilization planning from the district level. Whenever possible, these committees should work across sectors and coordinate jointly.

(xix) Lastly, the UN Theme Group on HIV/AIDS, whose role it is to combine forces in HIV/AIDS, should discuss community programs and identify ways for donor support to local action plans. Its tasks should also include donor coordination at all levels.

Framework for action at district level

(xx). At the district level, in most instances the district council leads HIV/AIDS multi-sectoral teams in the form of a District AIDS Action Committee (DAAC). The DAAC is composed of all actors and stakeholders (health, education, rural development, administrative, legislative branch, executive branch, NGOs, civil society). District AIDS coordinators or committees appointed by the Ministry of Health and/or the NACP are an integral part of this multi-sectoral committee. In terms of organization and day-to-day operation, the DAAC should function under the national strategic framework that is in place to mobilize collective action.

(xxi) In essence, AIDS social mobilization plans form the backbone of the district development plan. One of the most important tasks of the DAAC is to facilitate the scaling up of best practices[1] identified through the social mobilization plans. Additional activities may include: multi-sectoral coordination; facilitating situation analyses; mainstreaming HIV/AIDS in sector-wide activities; identifying comparative advantages of different actors; implementing and supporting workplace programs; priority setting; surveillance; joint monitoring of social mobilization plans, etc.

(xxii) In this schematic framework, NGOs play two complementary roles. An NGO or an individual can play the role of the catalyst within the DAAC. The catalyst helps to guide the interaction between the different actors and to build capacity of the various stakeholders. Other NGOs and community-based organizations can help replicate best practices and speed up coverage to reach all communities.

Framework for action at community level

(xxiii) At the sub-district level and below, the Community AIDS Action Committee (CAAC) should spearhead the community mobilization process. Often, the CAAC is composed of different stakeholders and actors, including key community groups (youth, PLWHA, bar workers, mobile workers, etc.), frontline workers, local leaders, service providers, civil society groups, etc. All these groups should be involved in active response development, including planning, behavioral change promotion, food security, orphan support, etc. Whenever possible, local drama groups should be included as evidence suggests that such media are very effective in opening up discussions on sensitive issues such as stigma and sexual behavior.

(xxiv) CAAC's first task should be the development of a social mobilization plan. HIV/AIDS preventive activities need to be facilitated through participatory strategic planning, mapping, active group participation, etc. Mitigation efforts can be reinforced through an impact assessment to identify effective interventions, coordination for care and support, and improved coping mechanisms within existing community structures, for example.

(xxv) Frontline workers such as extension agents, health workers, teachers, community development agents and service providers, among others, should be trained in the use of participatory tools (community entry, facilitation, and monitoring) to better involve communities

[1] For the purpose of this document, the term 'best practice' refers to successful methodologies, models or approaches in HIV/AIDS response development. Its use does not imply the existence of a blue print for local response development.

in HIV/AIDS awareness and response development. Ideally, HIV/AIDS activities should be incorporated into their routine activities.

(xxvi) The framework for social mobilization outlines a series of steps for response development that can be summarized as follows:

(1) *Keep the proper balance between awareness raising and focus on behavior change and other components of an effective behavioral change package*: IEC campaigns continue with old messages focusing on abstinence, faithfulness and condom use. Given the high level of awareness about these preventive measures in sub-Saharan Africa, other components of behavioral change interventions must be added, such as life skills training, peer education, and provision of condoms.

(2) *Promote behavioral change action*: This process can be initiated by working with different groups (men, women and youth) in the community who each make a vulnerability assessment (risk mapping). They then decide on actions to reduce vulnerability to HIV/AIDS, and on ways to create a supportive environment for behavior change.

(3) *Linking AIDS to broader development*: Development actions are essential because they create a positive environment for behavioral change. Income generating opportunities for women, men and youth can be an initial step toward mitigating the negative development impact of HIV/AIDS. However, it is important to note that national broad-based community development programs can only be established over a longer period of time. Meanwhile, there is an urgent need to reach national coverage with targeted programs to support communities in their fight against HIV/AIDS, even when broader development programs are not active.

(4) *Analyzing the impact of the epidemic on the community*: Often, social barriers and the epidemiological profile of HIV/AIDS make it very difficult to link disease symptoms with the prevalence of the epidemic. Thus, social mobilization to address the impact of AIDS are lacking. Participatory diagnosis by the community helps raise awareness on the impact of AIDS. Frontline workers are well positioned to facilitate this process.

(5) *Addressing stigma:* Stigma attached to PLWA, their family, care takers and the community at large should be reduced through training, counseling, coping mechanisms and community discussion. Reasons for stigma, barriers and facilitating factors to including PLWA in local response development need to be addressed.

(6) *Reinforcing coping strategies*: Communities need assistance to analyze existing/traditional coping mechanisms and to develop means of strengthening them without depending on external resources. The coordination of coping mechanisms has to be improved at the village or ward level.

(7) *Improve essential services for care and support*: Improved basic diagnostic and treatment facilities in addition to counseling services in health centers are essential to facilitate care seeking for PLWA. Community initiatives are needed to improve quality of home care. Involving PLWA in planning and coordination helps build their confidence, reinforce their role in the community, bring in first hand experience on useful inputs, and prioritize needs.

IV. ASSISTANCE TO SUPPORT THE STRATEGY: OPERATIONAL IMPLICATIONS

Financial support and disbursement

(xxvii) At the national level, financial support should be available for supervision and monitoring visits. A separate fund may be made available under the NACP for monitoring and evaluation of the response development. In addition, there may be financial support for media support programs.

(xxviii) Funds should be controlled and disbursed from the district level to communities for prevention and mitigation. Innovative schemes to channel funds to communities should be explored, including the definition of spending targets (community versus district). At the district level the DAAC should identify areas for support and mitigation activities, such as prevention and treatment of opportunistic diseases and counseling. Funds will be channeled through the district or, if capacities are not sufficient, through independent institutions such as social funds. In addition, DAAC should mobilize its own resources and integrate these into the district development plan. Individual sectoral budgets could be used to help fund mainstreaming of HIV/AIDS into the different sectors.

(xxix) Based on initial experiences with community generated resources, CAAC could be eligible for direct external assistance. Frontline workers can verify the local financial need for preventive activities, and DAAC in turn can assess and approve the money. All parties should be clear on accountability requirements, and agree on transparent procedures. Loans or grants for actions in mitigation of HIV/AIDS could be considered contingent on the verification of community actions. Loans or grants for productive and income generating activities could be channeled through sectoral services given their link to broader development.

V. CONCLUSION

(xxx) The proposed framework for action is based on a process of social change. It puts the emphasis on the social dimension of HIV/AIDS, with community mobilization at its core. It further identifies relevant actors at community, district and national level and clarifies their respective roles. Best approaches for prevention include those that are gender-based, focus on behavioral change, and facilitate community responses. Mobilizing communities for action works best when such efforts are coordinated from the district level. At the national level, National AIDS Committees — together with the UN theme group and other stakeholders — help establish the enabling conditions that allow for adequate response development at the district and below. Together with international partners, they should also work to ensure the availability of good guidelines, training modules and tools for community entry, situation analysis, district coordination, and monitoring and evaluation of community responses.

(xxxi) HIV/AIDS is a development problem that can only be effectively countered through a multi-sectoral approach. Despite the many obstacles to more effective collaboration and integration of sectoral programs, rural frontline workers and the capacity of existing rural programs are important for the development of effective interventions at community level.

CHAPTER I: INTRODUCTION

1. The present document is mainly intended to guide project and program planners in the design of specific programs for prevention and mitigation of HIV/AIDS in rural areas. It does not pretend to address all aspects of HIV/AIDS prevention; these are well described in the ACT Africa document *Intensifying Action Against AIDS*. The current document was used as a draft background paper for discussion during a Pan African workshop on community participation and the fight against HIV/AIDS organized in June 2000 in Mwanza, Tanzania. At this workshop, participants from 18 African countries, World Bank staff including the rural AIDS consultants, staff from UNAIDS, National Research Institute/UK, KIT and TANESA looked at ways to support the efforts of the communities in their fight against HIV/AIDS.

2. At the workshop, participants agreed the objective of the framework for action:

To strengthen and build upon existing organizational structures for a multi-sectoral response to HIV/AIDS prevention and mitigation through community mobilization, with support from all appropriate levels and sectors.

3. Participants at the workshop including the regional team on rural AIDS and the KIT-TANESA team agreed that the social mobilization process is at the core of the framework for action, especially at the district and community levels. They also considered it a key strategy for nationwide multi-sectoral efforts. Yet, this process should be complemented and reinforced by other sectoral interventions. Significant and sustainable results are most likely achieved in an enabling environment that includes, for example, improved health and education services, improved rural infrastructure, etc. When integrated into broader sectoral efforts, this process can result in: (i) a reduction of individual, social and economic factors facilitating the spread of HIV/AIDS; and (ii) a mitigation of the impact of HIV/AIDS.

4. The present document proposes a framework for action based on a process of social change. Broadly speaking, the process involves (i) the sensitization of social actors based on social and cultural conditions facilitating the spread of HIV/AIDS, and (ii) support for their efforts to change these conditions. Supporting a community mobilization process often does not require major resources. To initiate and maintain such a process requires capacity building and support to local organizations. Once organized, communities need access to resources for activities directly related to social mobilization and mitigation of HIV/AIDS. In addition, they need access to resources for social and economic development. Without these resources, communities will not be able to develop sustainable solutions to diminish the impact of HIV/AIDS.

CHAPTER II: SOCIAL CONTEXT

From information and education campaigns to social change

5. Until recently, efforts in HIV/AIDS planning in many countries were conducted along two main lines: (i) bio-medical activities related, for example, to blood safety, STD/STI and TB control within the health sector; and (ii) IEC messages. IEC campaigns aimed at increasing awareness based on the assumption that this would lead to preventive actions. Messages focused on improving risk perception, highlighting perceived benefits of behavior change, and influencing norms toward safer sexual practices.

6. Health education for HIV/AIDS remained largely information-driven, with general awareness messages such as: 'stick to one partner', 'be faithful' and if that is not possible, 'use condoms'. In all countries that the team visited, these messages were constantly repeated and information campaigns led indeed to impressive awareness levels. However, when proper balance between awareness raising and other components of an effective behavioral change package is maintained, behavioral change does occur. It has been found that among young people, information campaigns, life skills training, peer education and provision of condoms led to their behavior change.

7. One reason for this is the lack of action on social determinants of behavior in people's environment (workplace, peer group, communities). In each society, there are specific social factors related to the progression of the epidemic and social responses can be triggered to reduce this progression. Poverty is a major factor but not the only one; the epidemic affects all classes of people. The rich and the poor share certain social behaviors and common values that facilitate the progression of the virus. Important in this regard is the shift from individual to social vulnerability.

Box 1: Factors of social vulnerability as identified by communities in Tanzania

- Poverty
- Unemployment of the youth
- Lack of income opportunities
- Crisis in leadership and social control
- Alcoholism
- Gender power relations, 'men beating women'
- Gender oppression
- Exploitation/violence/inheritance practice

Social factors facilitating the progression of HIV/AIDS in Africa

8. It is well recognized that the decision to 'take action' reflects individual feelings of responsibility that are embedded in social and cultural norms. The progression of the HIV/AIDS virus is directly influenced by social behaviors that are part of local cultures. The current framework puts the emphasis on the social dimension of HIV/AIDS, with community mobilization at its core. HIV/AIDS is perceived as a development problem that can only be effectively countered through a multi-sectoral approach.

9. In rural areas, social organizations are often referred to as 'communities'. This report uses the definition of 'communities' used in the Participation Sourcebook.[2] It promulgates the use of participatory processes and an approach of learning by doing. An enabling environment for behavioral change often starts with a situation analysis by the community. Following an analysis of factors that make community members vulnerable to HIV-infection, community groups draw up joint action plans. These plans address some of the problems identified, including supportive actions to reduce high-risk behavior or exposure to HIV/AIDS.

10. Communities may identify social factors that can vary greatly from one social group to the other. For example, two factors were identified as possible factors facilitating the spread of HIV/AIDS in some societies in Africa, namely: attitude towards death and the importance of sexual relations with multiple partners outside marriage. Social scientists have studied these factors in detail for more than a decade. Important work has been done by John Caldwell and national collaborators in Kenya, Ghana, Nigeria, Zambia and Zimbabwe. Caldwell's work offers important insights into socio-cultural factors that inhibit behavioral change to reduce HIV-infection. Caldwell's most recent publication, 'Rethinking the African AIDS Epidemic' (March 2000)[3], highlights the importance of the two social factors mentioned above.

11. According to Caldwell's research, attitude toward death in predominantly agrarian societies was based on 'a widespread belief that some role is played by predestination',' and that 'the underlying cause of a premature death is witchcraft'. In a study in Nigeria, the vast majority of respondents explained that 'AIDS was caused by malevolent forces or was a divine punishment'. The research further revealed that, 'families are silent about members suffering from HIV/AIDS because they fear isolation or ostracism from neighbors'; 'this silence in turn makes AIDS seem even more unusual'; 'it is made possible by the long latency period of the disease', which makes it very hard for infected people 'to relate the appearance of AIDS symptoms to sexual encounters that occurred almost a decade ago', as most infected people 'only know that they have been infected at the symptomatic AIDS stage'.

12. In Ghana, Awusabo-Asare (1999)[4] argues that, 'risk-taking especially sexual risk-taking almost defines adolescence; and Anarfi (1999)[5] found that 'sex among street children was necessary for mutual support, companionship and binding the group together'. Caldwell argues that 'across sub-Saharan Africa, there are almost irresistible peer-group pressures on both male and female adolescents to have sexual relations'.

[2] *Source Book on Community Driven Development in Africa Region – Community Action Programs.* The World Bank, March 2000.
[3] Caldwell, J., *Rethinking the AIDS Epidemic.* Population and Development Review 26(1):117-135, March 2000.
[4] Awusabo-Asare Kofi, J., Boerma, T., and Basia Zaba (eds) 'All die be die: Obstacles to change in the face of HIV infection in Ghana'. In: Caldwell *et al*, 1999, pp.125-132.
[5] Anarfi, John K., 'Initiating behavioral change among street involved youth: findings from a youth clinic in Accra'. In: Caldwell *et al*, 1999, pp. 81-90.

Box 2: The importance of sexual relations: Example from Mwanza

During the Mwanza workshop (June, 2000) a presentation was given on the struggle against AIDS among street children. The presentation reported that new children (boys or girls) arriving in Mwanza and joining a group of street children were expected to have sexual intercourse with many older members as a rite of integration into the group. The newcomers consider this a normal practice and they extend this practice to other newcomers later. This situation is common among street children in many countries around the world. However, it reflects a social paradigm where powerful people can force less powerful people and vulnerable groups into having sexual relations with them. This translates into domination of the young and the poor (clear in the case of prostitution, for example) and into other types of coercion and forced sexual relations including sexual violence.

Rethinking the fight against HIV/AIDS

13. Information and availability of condoms are important but that alone is not enough to bring about behavioral change. Additional actions are needed: (i) to change the social conditions facilitating the spread of HIV/AIDS, such as reducing seasonal migration to urban areas; and (ii) to create social stimuli to induce behavioral changes. Community members themselves are best placed to determine the type of stimuli following a process of information, analysis, and decisions to enforce new social norms. In some cases, an authority can use its influence to stimulate community members to change. There are many types of local organizations or powerful traditional authorities that hold important potential to support behavioral change.

14. Sustained behavioral change usually comes as a result of a shared social reaction; this may occur when the level of infection becomes highly visible along with a clear perception that deaths are attributable to HIV/AIDS. The emotional impact of the disease triggers a series of reactions in the community, where many people begin to realize the virus poses a real threat, and that they and their families are at serious risk. This process has been witnessed most evidently in Uganda.

15. In Uganda, public support and formal statements from the President calling for urgent interventions, and sustained and focused IEC programs contributed to high public visibility of HIV/AIDS. Reaching and mobilizing national leaders is a crucial part of the social mobilization process that begins at the national level and makes its way down to the district and community level.

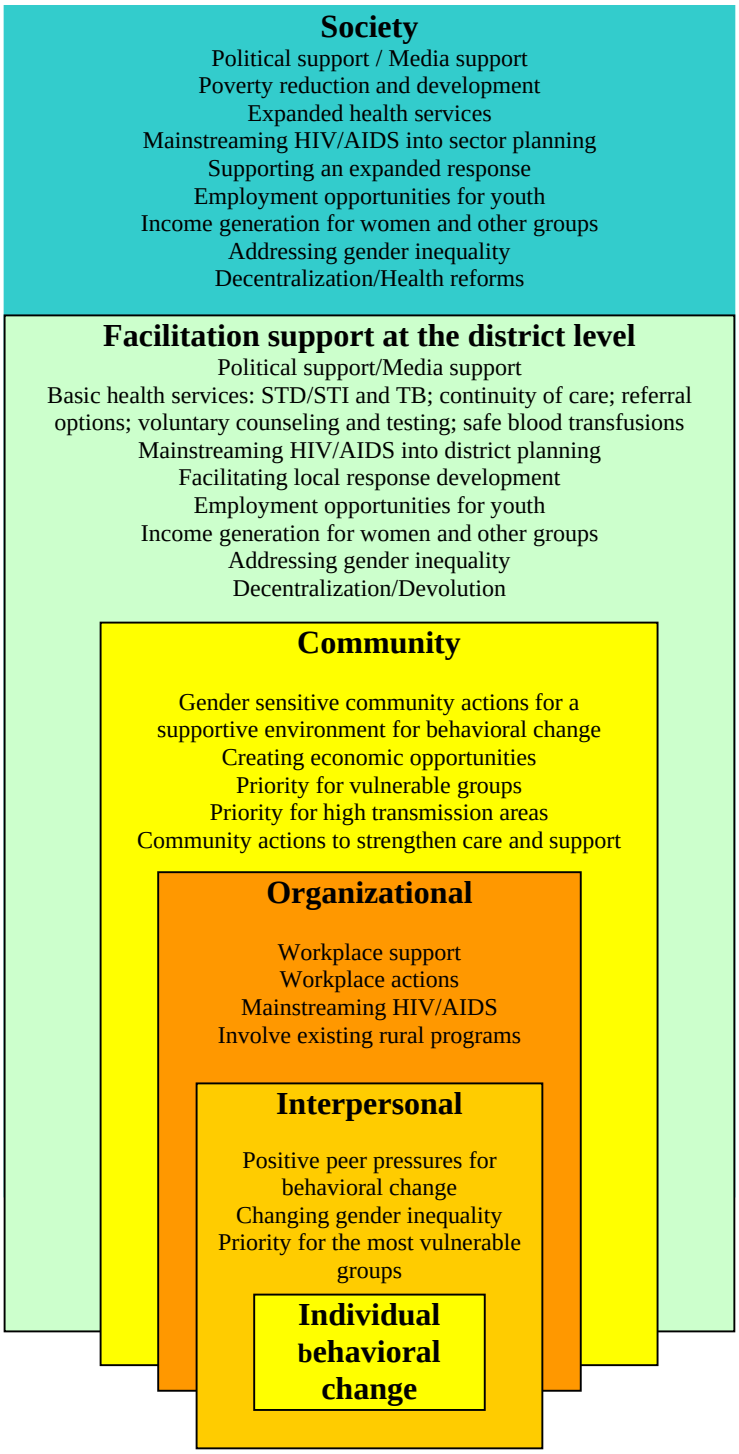
16. The team observed that in many countries interventions at the community level are largely left out. Additionally, resources are hardly available to support community initiatives. Some successful pilot activities exist, especially among NGOs, but these have a limited coverage; many organizations work in a few districts only and within these districts with a handful of communities. Coverage remains a big challenge; it has been said that the fight against HIV/AIDS is lost in scaling up. There is a need for massive support to community initiatives; without such a mobilization, the combination of increased poverty and higher mortality will make it far more difficult to support a dynamic social response to HIV/AIDS.

17. A well-supported mobilization process should result in a myriad of local initiatives. Along with the sensitization and social mobilization process, PLWA need social recognition allowing them to become key actors in the fight against AIDS. They are likely to call urgent attention to mitigation and mitigation needs.

18. Social mobilization requires a paradigm shift that to some extent is already taking place in many African countries. Figure 1 facilitates understanding of this emerging approach. Specific types of shifts are listed below:

1. A shift from individual to social vulnerability.
2. A shift from isolated interventions to the involvement of all stakeholders with an emphasis on vulnerable groups at the different levels.
3. A shift from working with the health sector only to involving all sectors (multi-sectoral approach), and
4. A shift from project strategies to 'people strategies', where partnerships are formed and ownership of the problem and its solutions lie with all stakeholders:
    a. at the national level by a national AIDS program spearheading and supporting the expanded response;
    b. at the district level by a joint network of actors under the overall guidance of the district council; and
    c. at the local level by the community.

Figure 1. Schematic presentation of the emerging approach to promote behavioral change to control the spread of HIV/AIDS



Multi-sectoral collaboration in the fight against HIV/AIDS

19. It was striking for the consultant team to note during the field visits that the potential role of rural AIDS consultants and rural workers in HIV/AIDS is received with considerable skepticism, especially by those already active in the response. They doubt whether rural workers have the expertise to enter in the fight against AIDS, as this quote illustrates: 'rural workers know just as much of HIV/AIDS as the general public, which does not automatically equip them to facilitate the response in communities'. Additionally, some people wondered whether the rural sector will understand that response development needs to go beyond message delivery. They were weary of rural workers starting to learn all over again and to promote awareness while the field is clearly aiming for sustained behavioral change. The team felt that this skepticism is not entirely justified, as the rural sector is moving to more participatory approaches; it uses village level participatory approaches, participatory technology development inducing farmers' behavioral change in production, etc. Nevertheless this skepticism appeared to exist quite strongly.

20. Existing rural projects and programs can be mobilized at the district level to play a role in reaching out to communities. Mainstreaming HIV/AIDS interventions into sector programs can only be successful if and when they are integrated in the district development plan. Mainstreaming for every sector separately from the ministry level down to the grassroots is likely to frustrate decentralization efforts and undermine district HIV/AIDS planning activities. Hence, tools for mainstreaming HIV/AIDS into sectoral programs have to carefully consider integration needs at the district level.

21. Rural extension workers can play different roles in the fight against HIV/AIDS:

(i) All staff in the different sectors should benefit from training and counseling to confront HIV/AIDS in their personal lives. This is a precondition for their credibility (as for all actors involved). They can serve as role models and demonstrate their commitment in their personal and professional lives.

(ii) Support is needed for HIV/AIDS related activities in rural development, including in rural infrastructure (year-round access for isolated villages, village health centers), in rural technologies (improved varieties requiring less inputs, less work for families with less labor available), new technologies like no-tillage cropping that require less equipment (as families sell their equipment to care for the sick). Rural workers should confront HIV/AIDS systematically, from sector studies (measuring the impact of HIV/AIDS on the sector) to identification of vulnerable groups and targeting of community members that are most affected. Once rural workers gain a better understanding of the situation and the needs of the affected population, they can develop adapted technologies and channel resources for these groups. A participant at the Mwanza workshop articulated his commitment as follows: 'Each of us in the rural sector, from researchers to extension officers, should prepare a work plan where we report each year on concrete actions against HIV/AIDS in our regular activities'.

(iii) Selected dedicated rural workers can take part on a voluntary basis in the social mobilization process at the district level. They can offer their experiences in community development, but should not be systematically designated to play a role in the district and community mobilization activities. Ultimately the district level has the responsibility to identify who is best placed to facilitate this process.

Box 3: What lessons can be learned from Guinea?

Prevention

- Involve representatives of the high-risk groups in qualitative research, the development of communication strategies and messages, and in the management of the program.
- Combine IEC activities with income generating activities for vulnerable groups, provided the process is carefully guided and conditions are set to assure that IEC activities remain innovative and form an essential part of the intervention package.

Decentralization

- Each country should identify what level of community intervention is recognized by the government *and* representative of the population (directly or indirectly).
- Sector field agents should justify the pertinence of their activities to the District Council.

Sector programs

- Sector programs should distinguish between the effect of HIV/AIDS on their human resources and the effect on their mandate. Mitigation activities should be incorporated in decentralized planning procedures.

Approaches in the rural zones

- Community approaches seem to be effective, despite the general lack of awareness of the dangers of the AIDS pandemic. Well-known methods like PRA and GRAAP play an important role in the diagnosis of problems and the planning of activities. The existence of a small community fund for AIDS-related activities stimulates awareness as it gives proof of the importance of the topic.
- The horizontal exchange between field agents deserves a higher priority than regular training programs. While it is useful to copy structures, systems, procedures and means, the facilitative attitude of the field agents is a precondition. The desired change in personal attitude can only take place in a peer learning situation.
- Interventions aimed at a refugee population should also address the local population. Additionally, one should rather speak of refugee zones as high transmission areas than of refugees as a group with a higher prevalence.

The gender dimension

22. In all countries the team observed that there is a growing realization that the HIV/AIDS epidemic is by and large a male driven epidemic that affects women differently than men. Gender issues are an essential element in planning interventions for HIV/AIDS transmission. A gender perspective is necessary to understand sexual behavior, underlying social and economic factors, and to develop specific interventions. Participatory Rural Appraisal (PRA) methods can help address the needs of women, men, young people (boys, girls) as distinct stakeholders with specific needs. Action plans produced by each community should be prepared and implemented by the various groups of stakeholders to make sure that they reflect their respective needs and priorities.

23. The relationship between men and women is at the center of social conditions that can facilitate the spread of HIV/AIDS. Important gender differences between men and women that impact on vulnerability to HIV/AIDS are:

a. Differences in *knowledge, risk perception and sexual behavior.*

b. *Care taking* and *child care*. The health of the children is often the responsibility of women, hence the impact of AIDS on young people affects women more than men. Women also carry the burden of caring for the sick and dying, and often become principal breadwinners in the absence of male household heads.
c. *Decision-making*. In many communities women have little say in official matters, and their representation on decision making fora is often poor. In Tanzania, for example, women are supposed to be represented in social services committees at the community level, but in fact the majority of women are no longer active in these committees due to time pressures, family commitments or family resistance.
d. *Negotiation of safe sex*. Messages directed at the general public that promote condom use or sex with just one partner are irrelevant to the situation of many women. Women may themselves stay with one sexual partner but they cannot control the behavior of their husband/partner. In many societies, women have no established right to discuss the risk behavior of their husbands/partner. This includes the right to negotiate condom use.
e. *Poverty*. General conditions of poverty, decreased productivity and related food security problems, and illiteracy bring many women in a situation where they have to sell sex for money; this kind of survival sex is often risky as men who pay for these service also decide on whether they will practice safe sex or not. Young adolescent girls are among the most vulnerable groups.
f. *Openness to change*. Men have more difficulty changing behavior and a greater tendency to underestimate the risk for HIV-infection, seeing it as a problem of others (foreigners, gay men, drug users, etc.).
g. *Responsibility*. In many communities, women and men blame each other for the spread of HIV/AIDS, which inhibits honest and open dialogue between the sexes.
h. *Unequal power relations*. In many societies women have very little or no control over matters related to sex and their sexual health. Men play a dominant and decision-making role in this area and because of this inequality and in many cases physical violence against women, women become more vulnerable to unprotected sex, coerced sex, and sexual abuse.
i. *Changes in power imbalances*. These exist at the level of relationships, in the community and the society at large.
j. *Equity in sharing economic and social benefits*. This includes livelihood opportunities, land ownership and access to credit to improve women's economic capacity and independence.

24. Sustained and responsible sexual behavior change is, therefore, not possible without:

a. *Gender awareness*, especially advocating (among men and community leaders) women's right to discuss sexual matters with their partners such as multiple partners and extra-marital relations and their right to protect themselves from infection.
b. *Changes in gender roles* in the community, especially to enhance women's socio-economic status in the community and their formal representation in decision-making.
c. *Changes in sharing responsibility* between men and women, especially with regard to caring for the sick and dying and for orphans.
d. *Changes in power imbalances* that exist in the community and the society at large.
e. *Mobilizing resources to improve women's access to quality sexual and reproductive health care* and to meet their needs for information and services.

25. Tools such as situation analysis and action development have to be gender-sensitive and assess how HIV/AIDS affects men, women and youth in a given context (see Box 4).

Box 4: Example of a gender-based situation analysis in Tanzania

Separate groups of men and women did a risk and vulnerability mapping exercise. This led to:

a. Different maps by women and men; men mapped bars and guesthouses, women mapped the water well, firewood collection sites, the milling machine, the market and many other places.
b. Men and women formulated different action plans.
c. Based on the analysis, discussions were held between men and women about the need for behavioral change and shared responsibilities for family matters and for care and support. Over the past 3 years, many villages produced 'village laws' that have contributed to improved gender relations.

CHAPTER III: FRAMEWORK FOR ACTION

26. The team strongly suggests that the process of scaling-up a social mobilization program cannot be owned by a single sector but necessitates a multi-sectoral structure that includes agriculture, health, social welfare, education, rural development, etc. At the national level it is recommended that this process be owned by the NAC, at the district level by the district council and at the village level by the village social services committee or alternatively, the AIDS action committee. Different actors operate at each of these levels and in order to develop an efficient and fast response, they need to know their respective roles and responsibilities. For this, clear guidelines and tools are needed to assist them in carrying out their tasks. The team identified a series of such tools but also realized that in many instances more effective partnerships need to be formed to facilitate sharing of resources and practices.

27. It is important to realize that behavioral change has to take place at the community level and that all other levels play a facilitating role to promote and support action in the community. In this regard, the team encountered an interesting operating principle. This principle was formulated by field staff at the district level who are working on integrated TB/HIV strategies, to prevent superiors from interfering with the decentralized structure:

A person is not allowed to analyze a situation, to propose solutions, to plan activities, to monitor or evaluate a plan if that activity could be delegated to a lower hierarchical level.

Enabling environment at the national level: coordination and delegation

The National AIDS Committee (NAC) – National AIDS Control Program

28. In many countries, planning for HIV/AIDS by the NAC has changed from making medium-term plans (MTPs) to the development and coordination of a national strategic framework for HIV/AIDS. The MTPs focused mainly on the bio-medical components of the epidemic, while the strategic plan mobilizes collective action to address the social, economic, cultural and political determinants of the epidemic. The challenge remains to translate such a strategic framework into action and to include the social mobilization program as one of its cornerstones.

29. The team suggests that the scaling-up process for a social mobilization program is best coordinated under the responsibility of the NAC. Monitoring, evaluation and progress reporting are also the responsibility of the NAC. Placing the NAC directly under the office of the President or the Prime Minister provides the opportunity for multi-sectoral approaches, and lends the NAC credibility and visibility.

Tasks and responsibilities of the NAC

1. Integrate the scaling-up process of a social mobilization program into the national strategic framework.
2. Monitor and evaluate the progress and processes of the social mobilization program in the pilot districts.
3. These pilot initiatives are are evaluated, documented and disseminated as best practices.
4. Provide technical support and help build capacity at district level (as appropriate).
5. Facilitate disbursement of funds to district and community levels and establish transparent procedures for the release of funds.

Box 5: How to identify best practices for a social mobilization program

1. Have all actors develop criteria for best practices for prevention and mitigation in view of the possibility to involve all communities in HIV/AIDS action.
2. Identify all relevant components that different actors have available for a social mobilization program.
3. Identify tools for community entry in HIV/AIDS that will work in the local context.
4. Develop the community entry protocol for a joint social mobilization program.

UN Theme Group on HIV/AIDS

30. This group combines the forces of all UNAIDS' co-sponsors for the HIV/AIDS response development and includes important NGOs. Most co-sponsors are engaged in activities that are relevant for a social mobilization program. The most important role of this group is to promote the further development of community HIV/AIDS action programs and to identify ways for all stakeholders to support such programs.

31. In many countries, coordination among UN Theme Group on HIV/AIDS members leaves much to be desired. An ambivalent commitment to donor coordination on the part of the host government is part of the problem. Moreover, individual donor organizations and executing agencies also lack motivation as coordination may diminish the visibility of their individual activities. The seriousness of the AIDS epidemic, however, necessitates urgent attention to this lack of coordination.

Tasks and responsibilities

1. Network/partnership to support social mobilization program planning.
2. Advocate with national governments and donor agencies for funds to cover community programs.
3. Share commitment for scaling-up of a social mobilization program.
4. Support the pilot districts working in HIV/AIDS at the community level.

32. Most organizations have small-scale program activities that are directed at the community level. However, they often need to be convinced of the importance of scaling-up a community HIV/AIDS action program. This discussion should be include all partners and focus on the role that each could play in scaling up. The best practices are most often combinations of experiences.

33. When carefully studying best practices in prevention, care or mitigation, a trend can be observed toward multisectoral community-based action. Many ongoing programs could benefit from such an approach. A quick overview matrix of activities in Malawi, for example, shows that a majority of organizations already supports community-based HIV/AIDS activities. Some support the national AIDS control program and the national programs on STD and TB control, other initiatives go in the direction of supporting sexual and reproductive health promotion. Although the example in the table below is from Malawi, it is illustrative of other countries' experiences as most organizations operate with similar strategies.

Table 1: Overview of international organizations' support for community-based actions in Malawi

Donor:	Main activity:
UNICEF	Strengthening community-based activities for young people, orphan care and IGAs. Support to family and community care projects, HIV/AIDS groups that care for orphans in the community. Development of youth centers and fora, family/community care, out-of-school youth clubs, production of IEC material.
UNFPA	HIV/AIDS control and STD/HIV, safe motherhood, gender and population development and refresher training for community health volunteers on HIV/AIDS.
USAID	VCT, home-based care, NGO grants and capacity building .
UNDP	Mainstreaming HIV into all aspects of development, capacity building of individuals and communities, strengthening national institutions.
WHO	Support to the NACP: STD treatment and prevention of HIV, safe blood transfusions.
World Bank	Procurement of reagents and STD drugs and other supplies/equipment, integration of HIV/AIDS into rural development programs, capacity building.
DFID	Sexual and reproductive health, provision of contraceptives and condoms, reproductive health services, safe motherhood and STD management.
Action Aid	Capacity building for communities with AIDS projects, linking health projects with NGOs, institutions and donors; promoting positive living for people with HIV/AIDS.
GTZ	Support to HIV reference laboratory at district level, home-based care projects.
EU	Peer education among college youth, traditional healers, the army, prisons, truck drivers and bar-girls, financial support to other NGOs doing peer education, ensuring blood safety.
Save the Children	Community mobilization to mitigate the impact of AIDS on children, HIV prevention through IEC, outreach strengthening and clinical training.
World Vision	IEC, training of community members in home based care.
NORAD	Support to the national TB program and institutional support to NAC.

Rural AIDS specialists

34. The World Bank has provided an international cadre of rural AIDS specialists who assist National AIDS Committees in involving the rural sector in HIV/AIDS. These rural AIDS specialists further function as catalysts, facilitators and trainers to support rural workers in the fight against HIV/AIDS.

Tasks and responsibilities

- Advocate for social mobilization programs at the national and the district level.
- Assist the NAC in the identification of areas where the scaling-up of a social mobilization program can be piloted.
- Represent the rural sector in the UN theme group. This may include:
  - assist in conducting an assessment of the impact of HIV/AIDS on the rural sector;

- assist in the process of identifying best practices in the country and in the districts with a social mobilization program;
- assist in the identification of appropriate tools for use by the different actors;
- assist in the planning, preparation, implementation and evaluation of impact of action plans involving rural actors;
- monitoring and documenting progress of the social mobilization programs in the country;
- support to pilot operations, mainly to scale up pilot initiatives and to train trainers.

Integrating community HIV/AIDS planning at the district level

35. The ongoing decentralization process in many sub-Saharan African countries provides opportunities for scaling-up social mobilization programs. Such programs are ideally integrated into the district[6] development plan. Decentralization in practice means that implementation responsibility and decisions over resource allocation of the different sectors are delegated to the district council. At the level of local government/district, a social mobilization program has to be 'owned' by the district council. Such an arrangement facilitates multi-sectoral collaboration and increases the chances of sustainability. In many instances, however, the team found that district councils are often less active than anticipated and their role taken over by NGOs. This has resulted in a patchwork of activities without systematic district-wide coverage.

36. Figure 2 (see next page) presents schematically the linkages between the national strategic framework for HIV/AIDS, the strategies of the different sectors, and the integration at the local government level. Ideally, the district council will lead a multi-sectoral HIV/AIDS program. The district council is well placed to guide multisectoral and NGO collaboration; it is at the district level where networking should take place between all actors involved in HIV/AIDS. Box 6 presents selected reasons for a response at the local government level.

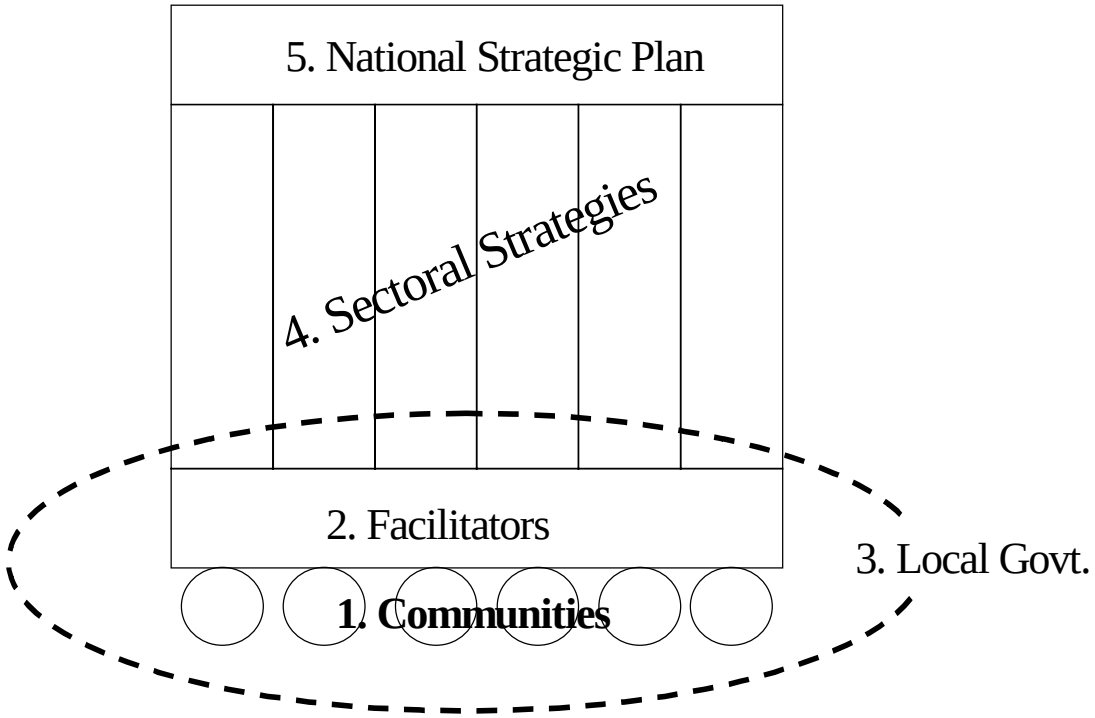
Box 6: Selected reasons for a response at the local government level

- It is the first level of sector coordination and management.
- It is the focus of most government sectors after decentralization.
- It is the platform for program coordination, collaboration and networking.
- It gives guidance and manages resources.
- It is where decentralization takes place and its effects are most visible.
- It is where feedback mechanisms are possible regarding demand for improved services.

37. In many countries district AIDS coordinators or committees have been appointed by the Ministry of Health (or the National AIDS Control Program) as part of the national strategic framework. In instances where this structure is not fully operational, support should be directed from the national level to establish and maintain the necessary preconditions that ensure effective functioning of these committees.

[6] For the purposes of this paper, the concept of a 'district' refers to the lowest administrative level that is on the one hand accepted by the state and on the other hand recognized or chosen by the population; it should have a minimum management capacity and be allowed to manage its own funds. In some countries this will be the district, in others the prefecture, the zone or the local development committee.

Figure 2: **Linkages between the strategic framework and local government**

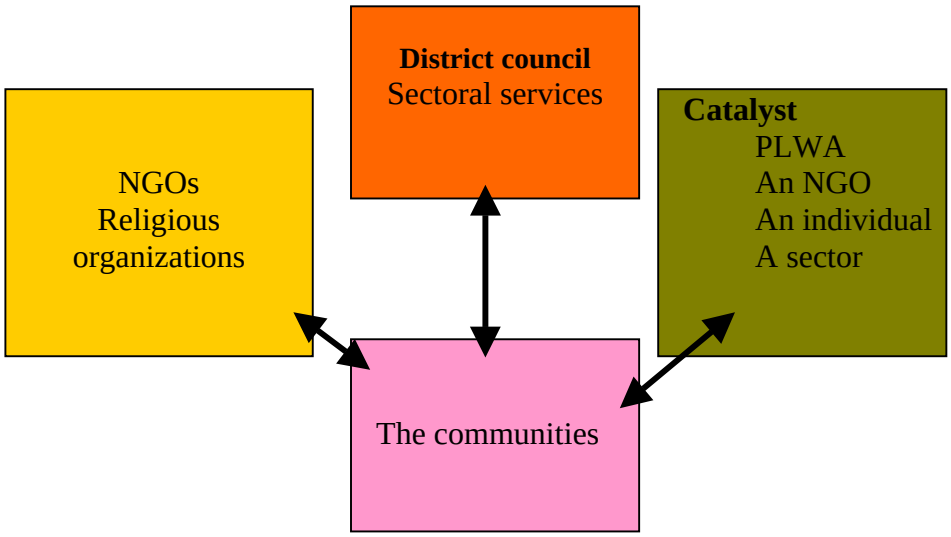


Box 7: Lessons from district-level interventions in Burkina Faso

- Effectiveness should be improved without rushing: AIDS is a development problem and ad hoc activities can create more problems than they resolve.
- The superior level in a hierarchical organization should facilitate the planning and monitoring of activities at the lower level yet refrain from imposing its perception of the problem or the solution (no uniformity, but flexibility regarding the community plans – respecting the learning process).
- Facilitators (preferably CBO volunteers) play a key role as interpreters and brokers between the population and the service providers of the sector line agencies.
- A minimum of resources is required to launch attractive IEC interventions.
- Donor agencies should be present at the strategic planning exercises in the districts.
- Support of the local and traditional authorities is a prerequisite for the success of a district level strategic plan.
- It is key to respect the ideas and contributions of all actors/participants in the strategic planning process.

Figure 3: Multi-sectoral coordination at the district level

Figure 3 outlines the different actors at the district level:



Possible **tasks and responsibilities** of the district council are:

1. Strengthen coordination/multisectoral commitment for HIV/AIDS planning .
2. Facilitate a situation analysis (magnitude of the epidemic, determinants of the epidemic in the district, high transmission areas, stigma at individual, family and community level, identification of most vulnerable groups).
3. Develop commitment of all partners in the district and below.
4. Mainstream HIV/AIDS in development planning and development activities, and facilitate sector analysis (human resources, capacity for implementation, etc.).
5. Identify comparative advantages of the different sectors to assist communities.
6. Stimulate workplace programs, determine the impact on the sector and facilitate action planning.
7. Plan to mobilize all communities for AIDS planning and action district-wide.
8. Priority setting for high transmission areas.
9. Monitor the epidemic.

38. Tools needed by the district council include those for a HIV/AIDS situation analysis, and for networking and mainstreaming HIV/AIDS. Additionally, it may be useful to provide basic training on participatory approaches, gender analysis and qualitative research methodologies to selected members of the district councils.

Box 8: Strategy for the development of a social mobilization program at the district level

1. Develop/improve multisectoral coordination for HIV/AIDS planning in the district under the responsibility of the district HIV/AIDS action committee.
2. Create an organizational set-up in line with the structure presented in the national strategic framework.
3. Identify best practices in the district and beyond.
4. Identify appropriate tools for community entry in the district and beyond.
5. Integrate a social mobilization program into district development planning.
6. Create a network of all relevant actors for a social mobilization program.
7. Assist the sectors to analyze the impact of HIV/AIDS and facilitate action planning.
8. Plan to mobilize all communities in the district.
9. Monitor response development.
10. Develop feedback mechanisms to respond to demand created by the communities for improved information and services.

Box 9: Lessons from a multi-sectoral pilot intervention in Chiradzulu District, Malawi

1. The Integrated Technology IEC (ITIEC) project in the district was selected as a best practice for a social mobilization program. This project promulgates three entry points (food security, population and HIV/AIDS) to address rural development challenges.
2. The ITIEC process involved a series of steps, namely: building partnerships through a District Executive Committee (DEC); training district and field staff on participatory processes; community appraisal and joint action plans; participatory monitoring and evaluation by social mobilization groups; sharing community experiences with neighboring communities for replication and expansion of the participatory rural development.
3. The DEC is made up of all relevant sectors and NGOs working in the district. The DEC accepts responsibility for HIV/AIDS program development and integration into the district development plan.
4. This initiative gives a good example of social mobilization for food security, against population pressure and against HIV/AIDS. With the multi-sectoral support of the Departments of Health, Agriculture, Forestry and Education the communities were assisted in their commitment and activities to:
    - Establish a seed bank in the community;
    - Improve agricultural practices;
    - Improve family planning services and promotion in the community;
    - Improve STI management and drug supplies;
    - Improve the infrastructure to make the village more accessible for services.

Non-governmental organizations (NGOs)

39. Once best practices are identified, a plan can be made to scale-up these initiatives inviting the participation of the best-placed actors in a given district. In many countries, government services have had insufficient capacity to organize and spearhead HIV/AIDS responses, and prevention and mitigation initiatives were developed by NGOs. These NGOs are often well experienced, but lack the capacity to ensure wide coverage under a true district focus. Reaching district-wide coverage through expanded NGO services is not financially viable, despite the ambitions of many NGOs to grow and increase their capacity for implementation.

40. A complementary role of the NGOs is envisioned that includes sharing of experiences and successful practices. This may be in the area of capacity building of sectors and communities in care and support for PLWA and orphans, in the area of training for peer education, for example, and in monitoring and evaluation of HIV/AIDS response development. Moreover, an experienced NGO is often well placed to play the role of catalyst.

The catalyst

41. Field experience shows that sector programs and NGOs need a catalyst in order to keep the momentum going for a social mobilization program. There are too many reasons why activities are stalling, why plans are not implemented, and why front-line workers lose motivation if the process is left without a catalyst. A catalyst facilitates the interaction between the different actors and helps build capacity. The role of the catalyst should be discussed at the district council level and its mandate should be formally agreed upon among all actors in the district. The catalyst could be an NGO with relevant expertise and the capacity to fulfil these tasks or it could be an individual. In most cases, an active and experienced NGO with complementary expertise is the best choice for this role. The choice of the catalyst should be left with the district council as this role needs a clear mandate and warrants its own budget.

Specific **tasks and responsibilities** of the catalyst include – depending on the capacity and prior experience of the catalyst – to:

1. Network and develop partnerships for HIV/AIDS planning.
2. Develop commitment of all partners (shared vision and clear goals).
3. Collect best practices in the district and outside of the district.
4. Analyze processes and results of the work when an expanded response is being implemented.
5. Assist people/communities in resource mobilization (technical, financial).
6. Facilitate the development of tools.
7. Document the response, monitor the epidemic and collective responses.
8. Articulate support needed from district and national levels.

42. For catalysts to be effective in their work it is important that they possess the skills and tools to collect (and support) best practices at the district level, help in monitoring and evaluation and engage in network development and advocacy.

Framework for action at the community level

43. For an individual to change behavior he/she needs support from his/her peers, friends, relatives or other members of his/her community. The community may be defined as a workplace, a peer group, an association, or the place where the person lives. In order to develop a supportive environment, the community itself has to analyze the factors that make people vulnerable to HIV-infection in that particular community, and to develop actions that will reduce vulnerability. Creating a supportive environment calls for a participatory process and an approach of learning by doing.

Community learning and social mobilization

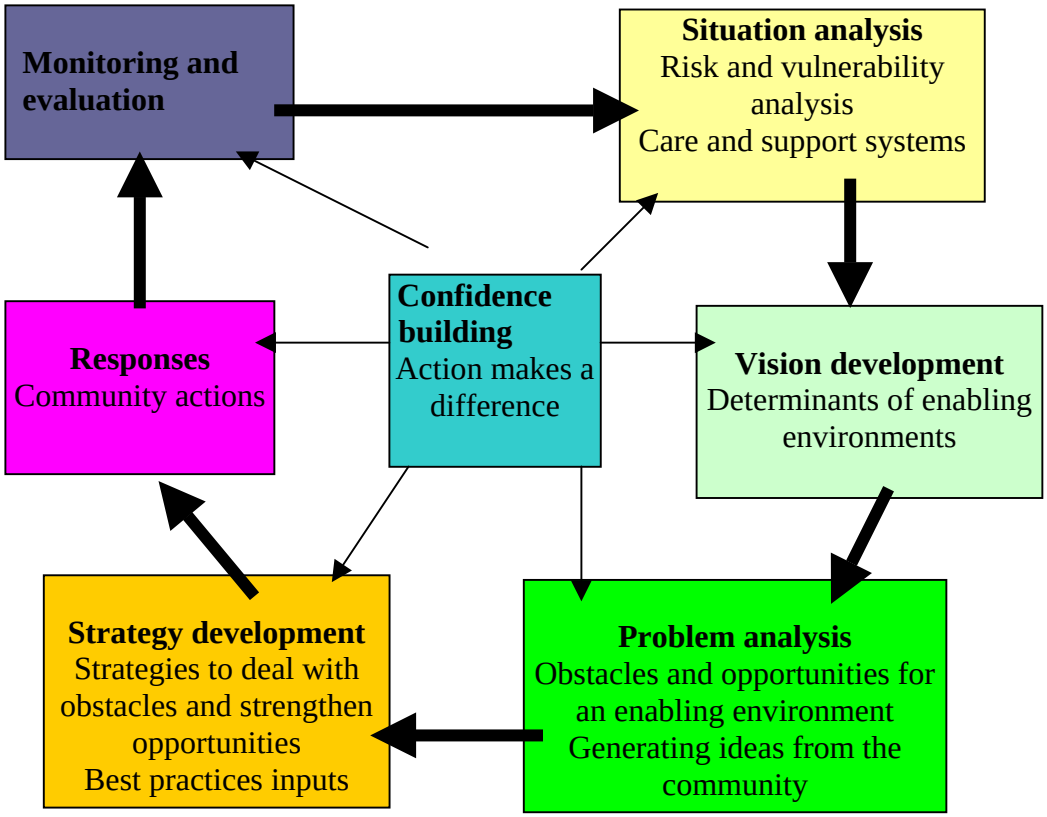
44. Figure 4 presents the planning and learning cycle of social mobilization. The cycle is based on the Methods for Active Participation and adapted by TANESA for an HIV/AIDS action program. The stages in the cycle are:

- Situation analysis: Community analysis of risk and vulnerability.
- Develop a vision on an enabling environment conducive to change.

- Identify obstacles and opportunities to create an enabling environment.
- Choose strategies to deal with the obstacles and strengthen opportunities.
- Analyze what can be done by the community and where external assistance is needed.
- First actions focus on success and confidence building.
- Self-monitoring and evaluation of the actions reinforces the process.

45. After the evaluation the communities enter into a new and hopefully improved situation, after which further actions can be developed following the same pathway for change.

Figure 4: The planning and learning cycle of social mobilization plans



The types of response development in a social mobilization program

46. Moving from a 'best practice' community analysis, the stages of response development can be determined. The team compared response development between the different countries that were visited and concluded that the higher the HIV prevalence, the further along the community will be in its response development, according to the seven stages next described.

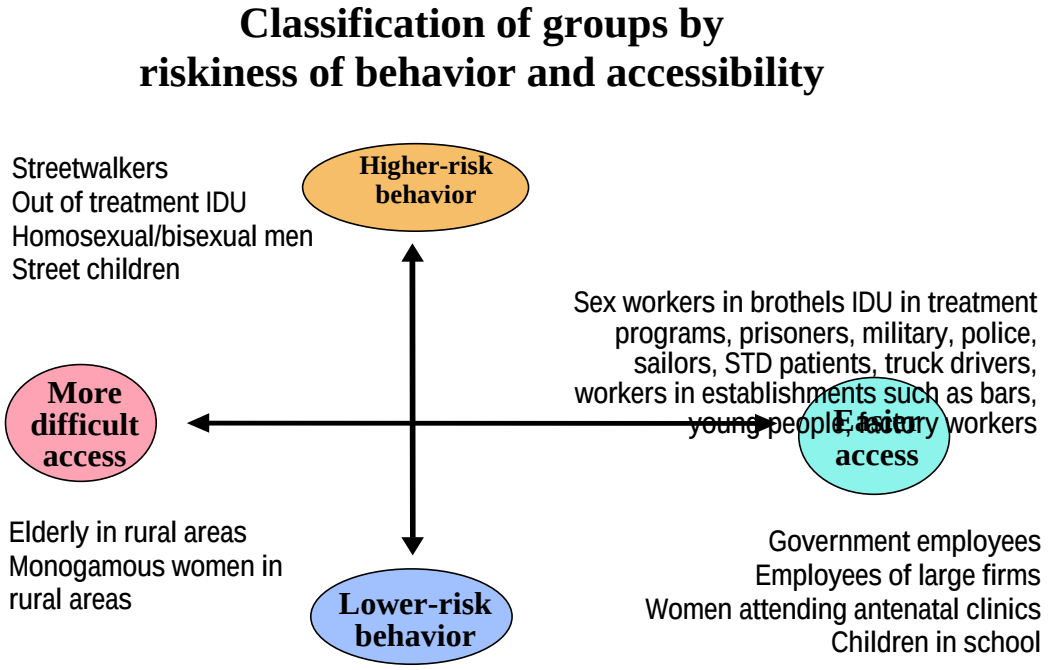
Stage 1: Awareness promotion about the epidemic

47. In all countries visited, the team noted that awareness campaigns were well on their way using a variety of media approaches. However, there existed a tendency to sensitize the population with the same old messages of abstinence, faithfulness and condom use. In many countries awareness levels may measure as high as 90%-95%. While awareness of the general population is known to be a prerequisite, it is not sufficient to lead to behavior change. Given the

high level of awareness about these preventive measures in sub-Saharan Africa, other components of behavioral change interventions must be added, such as life skills training, peer education, and provision of condoms.

Stage 2: Promotion of behavioral change actions

48. Community involvement in HIV/AIDS seeks to stimulate a community's own critical assessment of risk and vulnerability with respect to HIV/AIDS, and to enable processes in which they develop their own appropriate response. Most communities need some initial guidance to effectively reduce the incidence of new HIV/AIDS cases. Figure 5, for example, helps communities understand the epidemiology of AIDS and the risk/accessibility dimensions.



49. Mapping of risk places in the community is a good tool to visualize where risk behaviors and vulnerability take place in the community. For example, it indicates places where people socialize, where they look for new sex partners and shows that not all sexual acts are voluntary. Once people have identified the risk areas in the community they will analyze factors of vulnerability by asking themselves why it is so difficult to avoid risk behavior, despite knowing the basic facts about HIV/AIDS and having access to condoms. Based on the vulnerability analysis, the community makes decisions on actions to reduce vulnerability to HIV/STI risk behavior. To show differences in vulnerability for men and women, it is recommended that the mapping be done by groups of women and men separately. Other vulnerable groups like youth should also follow this process separately. It is key that the different groups present their maps and analysis to each other along with their proposed actions, to stimulate discussion between the different groups. Box 10 presents an example of actions taken by the Kisesa community in Magu District, Tanzania.

Box 10: Example of actions to create a more supportive environment for behavioral change

1. Change in closing hours of bars and local beer shops.
2. Imposing restrictions for youth to enter drinking establishments.
3. Official meetings in the community should always address HIV/AIDS issues.
4. Traditional dances close before darkness falls.
5. Women only collect water/firewood after dark when men accompany them.
6. Ensure condom availability at places where people meet new sex partners like bars, guesthouses, market places, etc.
7. Community drama groups present results of the mapping process and actions to the wider community, and stimulate discussion between men and women, boys and girls.
8. Community asked for improved STI services, especially drug availability.
9. Community asked for improved and more youth-friendly sexual and reproductive health (S and RH) services.

Stage 3: Linking HIV vulnerability to the underlying development factors

50. When communities are asked to identify reasons why it is difficult to avoid risk behaviors, they mention socio-economic reasons such as unemployment among youth, poverty leading to survival sex by women and girls, unequal gender relations, and even sexual abuse. Examples of socio-economic development programmes which can reduce vulnerability include scholarships for the continuation of school education, vocational training and creating rural industry, and the establishment of credit cooperatives for women. Especially in this phase of the social mobilization development, there is a need for multi-sectoral support from structures/departments/organizations that address such broader issues. Development actions will create a positive environment for behavioral change as they bring hope for the future and can contribute to income generating opportunities for women and youth. In addition, they will be first steps towards mitigating the development impact of AIDS in the rural/agricultural system.

Stage 4: Analyzing the impact of the epidemic on the community

51. The need to address the consequences of AIDS can be reflected, for example in the collapse of traditional coping mechanisms; an increase in the number of AIDS cases; and a rise in the number of orphans. Many communities underestimate the impact of the epidemic on their own community because AIDS was an invisible disease. When people are asked about AIDS in their community, their answer often masks uncertainty. In most places, very few people are actually tested and thus uncertainty prevails about the extent of HIV-infection. Because of the strong stigma, people with HIV/AIDS often hide from the public eye. Thus, the need for improved care and support remains hidden. Participatory diagnostics within the community are essential to provide insights into the magnitude of the problem locally.

52. Such diagnosis can be done by, e.g.: looking at the number of people that have died over the last few years who were in their prime age; looking at the number of orphans in the community; and making an inventory of voluntary care initiatives. Communities are also encouraged to look at how the early death of young and active people affects production and distribution of resources in the community, and to identify vulnerable families. This is important for well-functioning care and support structures.

53. From the above, it is clear that the existing agricultural outreach system can and should not only be used as a channel for AIDS-related diagnostics. Beyond this, AIDS has a direct impact on

their mandate and is known to result in: the reduction of acreage of land under cultivation; changes in cropping patterns; decline in yields; decline in variety of crops; and the loss of agricultural knowledge and skills. This in turn forces the agricultural sector to adapt the knowledge it generates and to spread this widely, as AIDS has a major impact on its target groups. After a shift from male farmers to female farmers (as most important beneficiaries), in highly affected countries the agricultural sector is increasingly forced to work with widow(er)s, female-headed households, households run by grandparents, and orphan-headed households.

Box 11: Lessons from the regional and community level in Côte d'Ivoire

- Indicators for the effectiveness of an intervention in a community must be defined by the community itself and not by outsiders since it is an essential part of their learning.
- Scaling-up should start at the bottom; the first priority is from one community to another, the second priority from one sub-district to another sub-district and then onwards from district to district.
- A regional team of (part-time) communication and AIDS trainers should be capable of identifying training needs of personnel at all levels.
- Each superior level should have a facilitating supportive role toward a lower level and this should be an official part of their job description so their performance can be monitored.
- Voluntary work in the fight against AIDS is possible and essential when it comes to IEC/prevention activities. It guarantees the commitment of the people involved. To stimulate voluntary work, a charismatic and committed leader who can set the right tone and example is essential.
- Knowledge of and insight into the local environment, respect for the prevailing social order and communication lines is at the basis of community interventions.
- The program activity plan must be coordinated at an administrative level that is on the one hand accepted by the state and on the other hand recognized or chosen by the population; it should have a minimum management capacity and be allowed to manage its own funds.

Stage 5: Dealing with stigma

54. One of the most neglected aspects of the HIV/AIDS epidemic is dealing with stigma. Communities should analyze what stigma exists in the community for individuals that have developed HIV/AIDS. This includes stigma attached to families/care takers and the community at-large. Stigma can be reduced by a variety of strategies, as Box 12 indicates.

Box 12: Reducing stigma in the community

- More individuals need training to deal with the negative psychological problems related to stigma.
- Care, support and continuous counseling will help infected individuals and their families.
- More families need to be exposed to ways of coping with the stigma often related to caring for an AIDS patient. This will also teach communities to deal with prejudice regarding PLWA.
- Discussions in the community about the prevailing faces of stigma will make it possible for communities to be more caring and to improve support for PLWA, their families and orphans.

Stage 6: Strengthen the existing coping mechanisms in the community

55. Communities need assistance to analyze existing/traditional coping mechanisms and to develop means of strengthening them without becoming fully dependent on outside resources. In many communities, different organizations, especially religious ones, have developed care and support initiatives. Box 13 summarizes a support mechanism in one region of Tanzania.

56.

Box 13: Traditional coping mechanism

In Mwanza Region, Tanzania, 'Ifoghongo' schemes are revived in urban and rural areas to assist families in the event of a crisis like a funeral. In case of a death in any family in the neighborhood, all neighbors contribute cash to support this family. Membership is informal but not voluntary: If a family decides not to contribute to crisis situations of others, this family will not be supported in any way by the neighborhood in case of a crisis and nobody will attend the deceased member's funeral. This coping mechanism could be expanded to include schemes to care for a chronically ill person and orphan support, for example.

56. Beyond analyzing coping structures, coordination at the village or ward level often needs improvement. For this a thorough inventory should be made of the actors involved in care and support in the community including all religious organizations, NGOs and CBOs, and sectoral services. Coordination at the ward level should honor existing community-based initiatives and aim to strengthening services, including assistance to vulnerable families with a sick person and orphans.

Stage 7: Improve essential services for care and support

57. Many PLWHA and their care takers do not present themselves as such to the health services as the quality of services is generally perceived as poor and they fear further stigmatization. Voluntary testing and counseling remains rare in most communities. Little experience exists to date with programs that teach people how to live positively with HIV/AIDS. Improved basic services would make it easier for people to ask for help and also reduce stigma as basic health needs are being met. In many communities home-care of PLWA is the norm and community initiatives are needed to improve the quality of such care. For home-care to be most effective, it needs the backing of basic health referral services.

Inputs needed at the home

58. For a minimum level of home-care a basic kit has to be available at the home to ensure essential nursing care. The contents of such a kit are listed in Box 14. Besides providing nursing care, home-care can provide important psychological support.

Box 14: Basic content of a home-care kit

- Pain killers (aspirin, panadol).
- Anti malaria drugs.
- Anti diarrheal drugs (either oral rehydration sachet or home-made solution).
- Skin care: soap, vaseline, cotton oil, and coconut oil, benzyl benzoate emulsion.
- Wound care: eusol, dettol, gentin violet; salt water, clean cloth, plastic bowl.
- Hygiene: disposable gloves, plastic bags.
- Plastic sheet.
- Mouth care: potassium permanganate, salt water, toothbrush.

Inputs needed at the community level

59. Voluntary groups can organize regular home visits to families who take care of an PLWA. The involvement of PLWA and their caregivers in planning and coordination is an important asset for a care and support program; not only to build their confidence and reinforce their role in the community, but also to benefit from their experience and to best prioritize mitigation needs.

Box 15: Involving PLWA in prevention and care programs

1. Involvement in planning for a community prevention and care and support program.
2. Support to home visiting schemes.
3. Support for counseling services to help encourage people to disclose their HIV status.
4. Involvement in the training of home visiting teams and care givers.
5. Participation in community events.
6. Involvement in monitoring and evaluation.
7. Assistance in the mobilization for resources.

Inputs at the health center level

60. An empowered community is more likely to request improved health services for the PLWA and their families or caretakers in the community. Improved services should focus on:

1. *Referral support*. Essential for proper care and support is the link between home-care and referral support at the dispensary, clinic or hospital. The need for assistance is more pronounced when the home kit does not supply the drugs. TB treatment should be readily available from the health services as in sub-Saharan Africa some 50-60% of people with TB are also infected with HIV. Drugs to treat opportunistic infections (TB, STIs) should be readily available and accessible at health services.

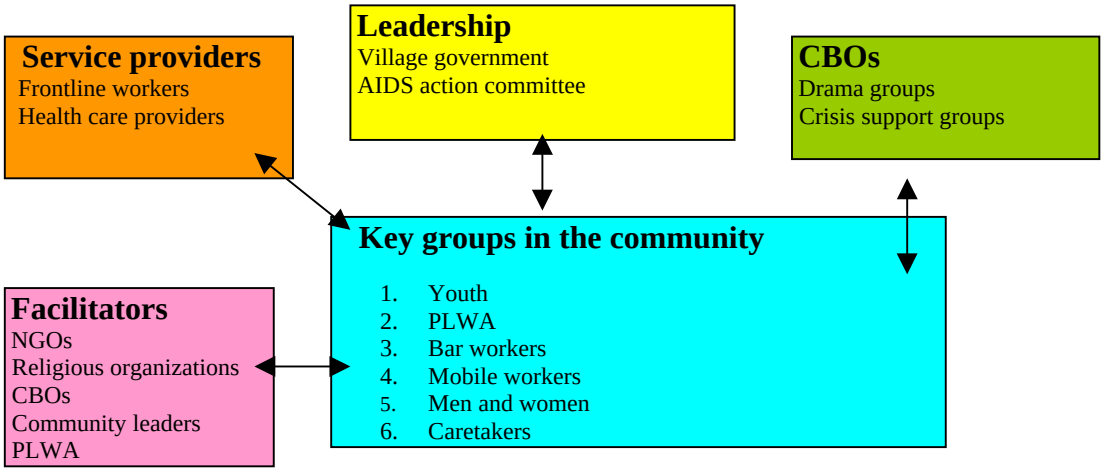
2. *Information*. Information on how to take care of an PLWA has to be available for PLWA and their caretakers at the health facility. Training and information should also be provided to the community caregivers and the home visiting teams.

3. *Counseling support*. Initiatives are needed for voluntary and confidential testing and counseling services at the district level and below. When stigma reduces in the community

and improved care and support become available, an increasing demand for counseling services can be expected.

Partnership at the community level

61. At the core of the approach to scale-up a social mobilization program is the belief that communities should own the problem of HIV, determine local factors for vulnerability of HIV-infection for different groups, and be given the opportunity to develop social mobilization to find solutions for the problem. Figure 6 presents a schematic overview of the different actors at the community level:



Frontline workers

62. Frontline workers facilitate response development in the community. They may come from existing sectoral services, religious organizations, NGOs and sometimes are activists from neighboring communities. Sectoral services – health, agriculture, education, community development – contribute the largest pools of frontline workers. Irrespective of their background and organizational affiliation, frontline workers should be mobilized to include HIV/AIDS into their day-to-day activities in order to reach as many communities as possible. Social mobilization must be nurtured and supported over time, and sectoral services need to be prepared to act on an increasing demand for services from the communities.

63. Frontline workers can help ensure that:

- the community is assisted to make its own risk and vulnerability analysis and to organize an AIDS Action Committee
- the momentum keeps going
- confidence is built among the local committee that action does make a difference
- social mobilization benefits from frequent monitoring and evaluation to assess progress and identify obstacles for behavioral change

64. Tools for frontline workers include those to conduct participatory approaches, community entry tools, facilitation tools and tools for monitoring the response development. It is also important that frontline workers are sensitized to gender differences in the way HIV/AIDS impacts on communities.

The Community AIDS Action Committee (CAAC)

65. In many countries, a structure was established in the 1990s that involved AIDS committees at the village level. In some countries this is a sub-committee of the village government, a village Primary Health Care committee or another existing committee. It may also be a new structure that was set up for health and development. The team learned during the field visits that many structures at the village level are inactive and that their members lack clarity on specific roles and responsibilities. The team concluded that concerted efforts are needed to revive and revitalize these village committees by incorporating new members. This includes supporting and promoting the participation of women, youth representatives and (possibly) PLWA and caretakers, and building capacity among these groups. For the committee to be effective operationally, a membership of 8-10 individuals is suggested. One of the priorities of such a committee should be to maintain good working relations with the village government.

Tasks of the CAAC

66. One key role is to facilitate the community planning and learning cycle as presented in the previous chapter. The first role for the committee is often to guide a situation analysis of the risks and vulnerability for HIV-infection. This task is greatly facilitated if tools are available to guide this process in the community. For each country best practices exist of working with communities.

67. Such tools include:

- Mapping of risk and vulnerability (developed by TANESA, Tanzania, and suitable for rapid scaling-up)
- Local strategic planning
- Methods for active participation/participatory planning
- Stepping stones (needs to be adapted for scaling-up purpose)

Box 16: The mapping program in Tanzania

This represents a success story in terms of coverage and motivation. Within one year all 900 communities or sub-villages of a district developed social mobilization plans for prevention of HIV infection using the mapping tool. Funding came from the district council, which was instrumental in developing the spirit of voluntarism needed for the program. Communities were very motivated for the program. Only in those communities where the leaders (counselors) were not committed did the program not succeed.

68. For mitigation efforts, CAAC's functions can include:

1. Analyze the impact of the epidemic on the community (number of PLWA, orphans, food security).
2. Strengthen coordination for care and support in collaboration with efforts at the ward level.
3. Strengthen existing coping mechanisms e.g. support of orphans and schemes to support families during illness and after death.

Local drama groups

69. Traditional and local artists can act as a mirror for community reflection. They speak the proper language, use the appropriate symbols and know how to deal with delicate subjects in an

acceptable way. They are not merely a channel for transferring messages but play an essential part in changing cultural norms and values and thus in changing behavior.

70. The use of drama is not new in HIV/AIDS campaigns; however, in many countries the use of drama was limited to professional groups, the use of which became very expensive as the groups moved around to reach remote communities. The use of local drama groups seems to hold great potential. In nearly all communities in sub-Saharan Africa, local drama groups are formed and constitute an important channel to diffuse information and stimulate community discussions. Other forms of successful culturally appropriate communication channels are puppets, songs, dances, drums, storytellers, village clowns, poets such as the *griots* in West Africa and the messengers in East Africa.

Function for prevention

71. Most artists will need some assistance/training in translating community mapping findings into their preferred creative form like songs, role-plays or poems. It is important that the performances develop into a two-way exchange with the audience, therefore they must be short and aim at starting a discussion. In Tanzania the most difficult change was to transform the tradition of staging long theater performances into short role-plays as discussion starters. Leaders of drama groups often need some practical training and guidance in this.

Function for care and support

72. Local drama groups are instrumental in opening up discussions on issues surrounding stigma in the community. Messages about care and support can also be diffused using this resource.

Box 17: Using local drama groups

It is important to keep in mind when using local drama groups that they should not turn into income generating activities for the groups. Compensation for the work done by the groups should be in line with what is customary in the community as the following example illustrates:

In Tanzania, ten local drama groups were mobilized in order to reach 15,000 people in an entire ward. The leaders were given a two-day training to learn how to translate key messages into songs, theater and poems. A prize was offered for the best performing drama groups. Within one month the groups had reached nearly everybody in the community in a very enthusiastic way. The prize money available was Tsh. 100,000 ($150). The groups decided to divide the prize money as a sign of collective solidarity. They gained an important experience that makes them a good community resource for future care and support activities. With some small funds to motivate initial interest and participation, drama initiatives can be sustainable.

Key groups in the community

73. In most communities, subgroups can be identified that are often the most vulnerable groups within a given society, such as unemployed youth, migrant workers and bar workers. It is important to engage key groups in participatory action planning; one way to do this is through peer education sessions. Peer educators are also a resource for activism in:

1. prevention and health education sessions among the most vulnerable groups;
2. preventive activities in the community;
3. HIV/AIDS response development in the community.

CHAPTER IV: ASSISTANCE TO SUPPORT THE STRATEGY

Specific services to support the strategy: operational implications

Financial resources

74. The kind of activities that require financial resources from the community itself and external sources to support a social mobilization program on HIV/AIDS can be listed as follows (based on experiences in Nigeria, Tanzania, Malawi and Cote d'Ivoire):

a. a community fund to support the activities at the community level;
b. facilitation activities at the district level like sensitization meetings, training, etc.;
c. the function of the catalyst;
d. the research agenda of a social mobilization program, e.g. research into existing traditional coping mechanisms;
e. horizontal exchanges between communities and districts to enhance learning;
f. the national level for monitoring and evaluation of the program;
g. the development of guidelines and tools;
h. documentation of progress and learning process;
i. development of guidelines and tools;
j. increase the number of local technical experts such as through training.

Activities at the different levels

75. Examples of activities to be costed at different levels are listed below.

Community level

a. improve mobility for volunteers;
b. provision of a bicycle ambulance;
c. training for peer educators;
d. project activities proposed by the community;
e. mitigation activities;
f. improved condom distribution;
g. diffusion of messages to the wider community;
h. coordination of care and support at the ward level;
i. strengthening existing care and support;
j. horizontal exchange.

District level

a. field allowances of frontline workers ;
b. training of trainers (TOTs);
c. transport (to be shared among the different actors);
d. meetings;
e. initial research on how to strengthen existing support structures for care and support of PLWA, their families and orphans;
f. funds to enable the services of a catalyst in the district.

National level

a. monitoring and evaluation of scaling-up of the social mobilization program;
b. supervision of the program;

c. coordination/advocacy for the program.

International support

76. It appears most appropriate to establish an international support and exchange structure that would provide:
a. exchange of lessons learned and technical expertise between countries;
b. advocacy for political commitment and external resources;
c. monitoring of the scaling-up of the social mobilization programs in different countries.

Disbursement procedures

77. In order to support the process at different levels it is advised that financial assistance be directed to the different levels directly.

Community level

78. Social mobilization for behavior change should start immediately and be independent of external support. Based on initial actions by the community, the action committee could request support for improved condom distribution, support for the diffusion process and for increased mitigation activities and improved services.

79. In most cases, communities are not eligible for financial assistance. Resources available for HIV/AIDS are mostly controlled and consumed by actors other than those at the community level. However, a social mobilization program needs to recognize the community as an actor eligible for direct external support. The team encourages that the possibilities are explored to have selected villages open an account so that external financial assistance may reach the community directly. Support channeled directly to the village has the advantage that momentum can be kept much easier as delays in disbursement from the district level are eliminated.

Box 20: Village accounts in Magu District, Tanzania

1. As part of the local government reforms, villages have opened their own village account with the National Bank of Commerce in the district capital. In a district of 400,000 people, this meant a total number of 125 accounts.
2. All revenues collected in the village are presented to the district and allocated immediately: 30% remains in the village account, 10% is allocated to the ward account and the rest remains with the district.
3. The village has agreed on the signatories of the village account and accountability is the responsibility of the village government.
4. Expenditures for development are made from the village account directly. The village is free to make purchases from the nearest and cheapest place.
5. The village accounts can also be used to channel HIV/AIDS support to the village.

- *Grants for prevention*

80. Requests for external assistance may be forwarded to the District AIDS Action Committee, after the community develops its initial actions and the responsible frontline workers verify such actions. The District AIDS Action Committee should then decide on the amount of money available for the community for preventive (and mitigation) activities geared toward community condom promotion and distribution, diffusion of messages, etc. HIV/AIDS responses can be

monitored through the social mobilization committee report and by frontline workers' visits. Indicators should be set to determine whether real actions have been implemented at the community level.

- *External assistance for mitigation*

81. After the community has introduced HIV/AIDS preventive activities and has developed its social mobilization plans, the community may then present requests for mitigation activities. Only those communities that have reported on their prevention activities are eligible for support to improve care and support in the community. External support may be directed at:

a. improved coordination at the ward level;
b. initiatives to strengthen care and support to PLWA at the village level;
c. initiatives to support families and orphans affected by HIV/AIDS.

District level

82. The district AIDS Action Committee should receive support to:

a. improve networking of HIV/AIDS organizations;
b. develop actions plans to reach out to communities;
c. provide per diems for frontline workers (following routine procedures);
d. provide transport;
e. facilitate the work of the catalyst in the district.

83. The amount of money available to the district level should be related to the number of communities reached. In this way performance is linked to scaling up and to the amount and type of support available. The number of communities involved in HIV/AIDS should be closely monitored through reports from the communities and frontline workers.

- *Grants for prevention and mitigation*

84. The funds available for the social mobilization should be controlled and disbursed from the district level, following previously agreed upon procedures.

- *Grants to improve essential health services for HIV/AIDS*

85. Funds for improving essential health services may be best channeled through sectoral budget lines. Improvements are needed in service delivery and management of opportunistic diseases, in particular STIs and TB. Additional investments are likely to be necessary for the health service structure to support community care. The District AIDS Action Committee is best placed to identify the need for such investments, and funds can be made available to support them in doing so.

- *Grants for revolving development fund*

86. As soon as the program reaches the stage where it is capable of supporting social mobilization, innovative schemes should be explored to determine how funds can best reach the community. This includes identification of appropriate channels. Regardless of what channel is ultimately used, funds have to be made available and integrated into the district developmental plans.

- *Support to the catalyst*

87. The team recommends that a separate contract be drawn up between the District AIDS Action Committee and the catalyst on the expected outcome and the compensation for this activity.

- *Support to sectors*

88. As the social mobilization program is set up and run under the responsibility of the district council, no immediate budget lines need to be created for different sectoral responsibilities. Initiatives to mainstream HIV/AIDS into the core business of these sectors can initially be paid for from sectoral budget lines.

National level

89. At the national level there is a need to support the catalyst and the transportation needs that enable supervision and monitoring visits to the districts involved in the program. A separate fund can be made available for monitoring and evaluating of the response under the responsibility of the NACP. As the NACP/UNAIDS and UNFPA initiative in Malawi has shown, support can also be provided to a media program that includes a radio for frontline workers and print media (newspaper, fliers, etc.) to strengthen social mobilization programs.

Box 21: Costs involved with scaling-up of the mapping program in Magu District, Tanzania (from 20 to 900 communities)

1.	The initial research and development cost for the mapping program	$2000
2.	Scaling up to the entire district	$4,000
	a. Training of the district resource team	
	b. Training of TOTs at the ward level	
	c. Materials for mapping in the communities	
	d. Support to social mobilization plans: by-laws	
	e. Monitoring and support by district resource personnel	
3.	Cost for radio program to support the initiative	$1,000
4.	Community condom promotion / distribution program	$5,000
5.	Diffusion program: $300 per ward	$5,700
6.	Cost of technical support by catalyst	$1,000
Total cost of the program:		**$ 18,700**

CHAPTER V: CONCLUSION

90. The present document outlines a strategic framework for local, district and national action in HIV/AIDS response development. The principles set out in this document are in line with the UNAIDS local response initiative, with social mobilization as an integral component.

91. The framework for action identifies relevant actors at community, district and national level and clarifies their respective roles. It is apparent that best approaches for prevention include those that are gender-based, focus on behavioral change, and facilitate community responses. Mobilizing communities for action works best when such efforts are coordinated from the district level. Ideally, this implies that all district actors work together to support and scale up social mobilization programs under the guidance of the district authority.

92. At the national level, the National AIDS Committee (NAC) needs to focus on revitalizing existing structures such as district or village social or AIDS committees, to help them mobilize effective local action to fight HIV/AIDS. There remains the need to identify best practices at the district and national level that will ensure that all communities in the district are reached through expanded response interventions. Currently efforts are fragmented and mostly carried out by NGOs with limited opportunities for district-wide coverage. National AIDS Committees further have an important role in advocacy and networking, in the provision of technical assistance to the district, and the creation of enabling conditions that allow for adequate response development at the district and below. Together with international and regional partners, they can also work to ensure the availability of good guidelines, training modules and tools for community entry, situation analysis, district coordination, and monitoring and evaluation of community responses.

93. Mainstreaming HIV/AIDS within the different sectors can best focus on human resources in the sector, and on reducing the impact of AIDS on the respective sector through horizontal district HIV/AIDS programs. Despite the many obstacles to more effective collaboration and integration of sectoral programs, rural frontline workers and the capacity of existing rural programs are important for a multi-sector approach at the district level and below. The team visited several countries where the agricultural sector has shown a strong capacity and motivation to become involved in multi-sector response to HIV/AIDS. Part of this commitment may result from the visible impact of AIDS on household and national food security.

94. And lastly, the framework proposes ways to channel external assistance to ensure that this is directed at the levels where it is needed without unnecessary delays. Communities should be given the opportunity to develop and control their own response. In practice, this implies that external financial assistance reaches actors at the different levels directly and financial control is enacted retrospectively through random audits. Assistance in phases and based upon existing response development seems a promising and perhaps appropriate and timely approach.

Annex - 1

LITERATURE REVIEW

Introduction

It is not possible to take stock of all experiences in sub-Saharan Africa on such a complex and comprehensive topic as HIV/AIDS prevention and mitigation in a short time frame. The team has therefore made a synthesis of a selection of 'best practices' already collected at the AIDS resource center in Amsterdam. In addition, they chose to make use of the extensive UNAIDS literature and reviews on best practices in sub-Saharan Africa.

The aim of the review was threefold, namely to:

- take stock of what is happening in terms of responses to the HIV-epidemic in SSA;
- evaluate what approaches for preventing HIV and for mitigation work best;
- give special attention to the 'how to' of scaling up effective experiences from village to district and national level.

Trends and lessons learned in prevention

The most important lessons on prevention are summarized in box 1.1.

Box 1.1: Lessons learned in preventive activities

- There is need for political will and government support.
- Multisectoral approaches are necessary.
- Communities need to be mobilized to own the problem and create supportive environments for individual behavior change of its people.
- Communities need to develop the capacity to analyze the causes for vulnerability to HIV-infection and propose effective actions.
- It is essential to integrate prevention activities at the community level.
- There is a need for alliances and networks to function as facilitators between community agencies, the government and the private sector (among others).
- Involvement of people living with HIV/AIDS (PLWA) strengthens the response.
- Input is needed from operational research in addition to continuous careful monitoring and evaluation of existing (pilot) interventions.

As a result, several shifts have occurred in intervention development. Most experts would agree that the most important shift is the one from awareness creation to behavioral change promotion.

This change has led to subsequent shifts, including:

- from influencing the individual to community mobilization for action;
- from looking at individual vulnerability to social vulnerability;
- from looking at high-risk groups to high-risk areas and vulnerability;
- from information-driven health education to mobilization for supportive environments.

These shifts in turn resulted in changes in the approaches used for health promotion, and as such:

- Health promotion has become holistic and typically seeks to involve all levels for intervention.

- The focus has been broadened to include sexual and reproductive issues.
- Structural approaches aim to address root causes such as poverty, unemployment of the youth, gender inequalities, power relations/oppression, and sexual exploitation.
- AIDS has become a development problem and has to be addressed in this context.

A summary of the type of programs that may work best in HIV/AIDS prevention include the following:

- Programs that shift from influencing the individual to community mobilization.
- Programs that support activities to empower communities to reduce vulnerability for HIV infection.
- Programs that allow communities to set their own priorities.
- Programs that build on what is already in place.
- Programs that manage to integrate HIV/AIDS into district development plans.
- Programs that introduce cost sharing at all levels and in that way strengthen local ownership.

Box 1.2: Examples of effective prevention activities (based on the literature review)

- Behavior change communication.
- Peer education for sustained behavior change.
- Information and support groups.
- Gender sensitive community appraisal and action.
- Involving PLWA in sessions.
- Counseling and voluntary testing.
- Workplace programs.
- Improved TB and STI treatment and referral.
- Promotion of human rights for PLWA.
- Social marketing of condoms combined with community distribution and promotion.
- Income generating activities for vulnerable groups.

Trends and lessons learned in the mitigation of the consequences of HIV/AIDS

Box 1.3 summarizes the most important lessons from mitigation strategies in sub-Saharan Africa:

Box 1.3: Lessons learned in HIV/AIDS mitigation

- Strengthen autonomous care and support responses in the community rather than investing directly in new services.
- Build the continuum of care based on the demand from the community.
- Improve basic care and referral options.
- Link mitigation with prevention activities.
- Recognize that most mitigation efforts take place without outside support.
- Include known effective elements for mitigation:
  - involve volunteers;
  - involve PLWHA and care takers;
  - integration with Tuberculosis control efforts;
  - support orphans in their own community;
  - encourage and invest in networking of community-based organizations.

From the literature review several important policy directions emerged that could help guide efforts to:

- Optimize and properly direct available resources at community and district level to the most needy families.
- Strengthen indigenous responses at households and community level.
- Improve access to resources like labor, capital, land, draught power, management skills (this is an area where agricultural extension services may be best mobilized for this task).
- Improve food security.
- Develop partnerships between communities, districts, government and private sector on mitigation initiatives.
- Encourage donors to make finances available to the grassroots level for small project support.
- Develop strategies to deal with the underlying developmental problems of poverty, education, health care.

Lastly, the team also identified priority areas for continued support to HIV/AIDS mitigation as presented in Box 1.4.

Box 1.4: Priority areas for mitigation support

- Community-based home care/child care.
- Support to orphan education (vocational).
- Social support groups for PLWHA.
- Self-help groups.
- Community-based support groups (credit /crisis support).
- Economic support to people with AIDS and their families.
- Reducing demands on women's labor.
- Improving access to essential drugs (TB drugs, other opportunistic infections, pain killers).
- Counseling and voluntary testing.
- Nutritional support to families of care takers.
- Support to community efforts to deal with the impact of AIDS on food security in terms of production and labor losses.

Cost effectiveness

Data on cost effectiveness of programs for HIV/AIDS prevention, care and support are very limited. During the literature review the team did not find studies that make comparisons between the cost effectiveness of different interventions. However, there is increasing recognition of the fact that many programs are donor driven and donor dependent, which in the long run threatens their impact and sustainability. This seems especially true of many care and support programs that are often developed with donor funds.

In the field, a shift from developing new services to strengthening existing community structures and support for home care is clearly visible. As a result, whereas programs may become cheaper, costs are being transferred to the families and communities. Many donor driven programs achieve low coverage levels, and have a pilot focus because of the cost involved. Scaling up of such programs is often not a realistic option. Therefore, the aim of intervention strategies should be rather to develop activities that are low cost and do not require long-term financial assistance from donors. This should ultimately lead to more intensified cost-sharing initiatives and pave the way for support to minimum care packages that are acceptable (in content, price and quality) to the communities involved.

Sustainability and hence effectiveness of interventions depend to a large extent on:

- ownership of the initiatives by the communities;
- exchanges to keep the momentum going;
- an effective supporting role from relevant sectors;
- integration into overall development plans.

Focus on scaling up

Scaling up of interventions can be looked at from different perspectives. In this paper the team relied on four key principles, namely:

- *Quantitative* : Reaching more people and increasing coverage.
- *Functional* : Integration into other programs such as sexual and reproductive health programs.
- *Political* : Addressing root causes of the epidemic; community mobilization; policy Issues (budget and health reforms).
- *Organizational*: Better use of available resources for scaling-up; cost recovery; cost sharing options; increasing partnership; capacity building; adhering to a scaling up focus from the beginning.

Several guiding principles for scaling up at the district level could be identified from the district HIV/AIDS experiences in Zambia and Tanzania:

- Ensure full community ownership of HIV/AIDS responses.
- Promote AIDS Action sub-committees and linkages from existing structures at community, sub-district and district level.
- Strengthen multi-sectoral commitment such as the AIDS Action Committee including the district council, sectors, NGOs and representatives of PLWA.
- Increase advocacy and sensitization for support from leaders.
- Clarify the roles of the sectors, including the private and NGO sectors.
- Encourage all sectors to budget for HIV/AIDS activities.
- Encourage all sectors to include HIV/AIDS activities in routine planning.
- Integrate HIV/AIDS activities in overall development planning.
- Strengthen capacity building in the districts to enable sectors to facilitate social mobilization through participatory approaches.
- Priority setting in the district for high transmission areas as an effective response.
- Ensure that the responsible authority lies with the District Council.
- Clarify and support the role of the district, namely to facilitate through:
  - community mobilization by extension services and volunteers;
  - exchanges of best practices;
  - training of resource people including Training of Trainers (TOTs);
  - financial support/mobilizing resources/opening and maintaining an HIV/AIDS account;
  - integration of HIV/AIDS into development plans;
  - continuous monitoring and evaluation.

The team also identified guiding principles for the national level, as follows:

- Guide HIV/AIDS response through the National Response Development Process that includes a situation analysis on the determinants of the epidemic, a response analysis in the country and a selection of priority areas for interventions.
- Prepare an inventory of best practices in the country as a resource for planning at the district level.
- Prepare an inventory of available guidelines/manuals/tools for use at the different levels.

- Enlist support from leadership based on grassroots response, needs and priorities.
- Integrate HIV/AIDS programs in ongoing health reform processes and decentralization.
- Collaborate with sectors as scaling up often necessitates sectoral approvals (for modifications in school curricula; improved STI management, and in-service training of (health) workers, for example).
- Develop technical support for the scaling up process that is tailored to the needs at the national regional and district levels.

From the review the team listed the following issues in regard to scaling-up efforts, as indicated in Box 1.5. Most of these are questions that call for dialogue and collaboration between all stakeholders in the field of HIV/AIDS prevention and mitigation, and take into consideration the many different facets and phases of an effective program.

Box 1.5: Issues for scaling-up

- How to reach agreement on the needed components of a district program/best practices.
- How to identify the best practices in a district and in a country (i.e., who 'owns' the best practices).
- How to support districts to reach district coverage.
- How to mobilize multisector collaboration and the integration of HIV/AIDS in overall planning at the district level.
- How to reach political commitment to address root causes for vulnerability to HIV infection.
- How to ensure that health reforms address HIV/AIDS appropriately.
- How to determine who is in the driver's seat and design effective coalitions of NGOs, District Councils or other mechanisms for collaboration.
- How to make best use of available resources.
- What is an appropriate time frame for capacity building to facilitate community mobilization.
- How much training is needed for frontline workers.
- How to promote personal commitment among sector personnel.
- How to encourage and maintain cost sharing at all levels.
- How to get external money to where it is most needed and most useful.
- How to ensure accountability for local and external resources.
- How to keep the momentum going (district and community).

Annex - 2

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