International HIV/AIDS Alliance

FRONTIERS PREVENTION PROJECT

www.aidsalliance.org

Supporting community action on AIDS in developing countries

ALL TOGETHER NOW!

Community mobilisation for HIV/AIDS

What is the International HIV/AIDS Alliance?

The International HIV/AIDS Alliance (the Alliance) is the European Union's largest HIV-focused development organisation. We were established in 1993 as an international non-governmental organisation to support community action on HIV/AIDS. Since then, we have worked with over 2,000 community-based organisations in over 40 countries, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to treatment.

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Acknowledgements

Organisations and individuals have been developing community mobilisation approaches over many years and in many countries. The tools found within this publication are the result of the creativity and enthusiasm of thousands of people. The original source of approaches is therefore rarely known. If you do know of the original source we'd be grateful if you could let us know so that they can be rightfully credited. We would like to thank the Participation Group at the Institute of Development Studies, our country offices and linking organisations for their support in helping us to catalogue these tools.

The following partner organisations helped us to field test them between 2003 and 2005:

Nigeria
Positive Association of Nigeria (PLAN), Oyo, Centre for Development and Health Promotion Activities (CEPHPA), Centre for Rural Family Advancement (CERFA), Multiview Advocacy Network (MANET), Community Health Alliance (COHAL), Youth for Christ (YFC), Life Vanguards (LIVA), Community Health Concerns Group (CHCOG), Women and Development Movement (WADEM), Concerned Group for Neighborhood and Education (CONGRONE), Egbeda Voluntary Health Workers Action Group (EVHWAG), Family Health and Development Initiative (FAHEDI), Ray of Hope (ROHPE), Bijoux Organization, Nigerian Centre for Rural Youth Development (NCRYD), The Repairers International (TRI), Life Support Initiatives (LSI), Environmental Development and Family Health Organization (EDFHO), Family Health and Population Action Committee (FAHPAC), Alliance Rights Nigeria (ARN), Project Concerned International (PCI), Life Care Organization, Healthy Africa Foundation (HAF), Femope Foundation, Itunnu Organisation, Family Counselling Center, People Against HIV/AIDS in the Barracks, Positive Support Network (PSN), Life Restoration (LIRO), Good Workers Movement International (GMI).

Mozambique
TRIMODER, MONASO, ASADEC, AMICUMO, KUKHALA, PACO, ASVIMO, ADR, Rudho ni Upenhi, AJULSID, AJAMO, MULEIDE, Luz na Comunidade, Aro Juvenil, AMAP/MTZ, Associação Chigwirizano, Associação Khalanamoyo, Comité de Caridade, RENSIDA, União e Amor, Associação Kulemequezana, DPMCAST (Acção Social) Ponto Focal, IPM, Centro Aberto da Kubatsirana Nherera, AJAF, AFDC, Kurangarirana, Grupo Cultural Kwaedza, AJUDE, Shinguirirai, OMM, MCDR, AFICRIMO WAFUNGUEI Associação TARIRO, FOCAMA, Rudo Kubatana.

Madagascar
Association STOP SIDA, Plate Forme pour l'Environnement et le Développement (PFED), Association MITSINJO, Association MITIA, Association Santé et Développement, Association des Jeunes Universitaires de Sainte Marie (AJUSM).

Ukraine
Eney Club, Step by Step, Donetsk Regional Society for the Assistance to HIV-positive People, Amikus Union, Life Line, Mariupol Youth Union, Virtus, Public Health, Victoria Club, The Way Home, Blagodiynist, UNITUS, Vykhid, Hope and Salvation, Youth Center for Women's Initiatives.

Cambodia
Akphiwath Strey, Community Development Action, Cambodian Vision in Development, Khmer Development of Freedom Organisation, Khmer Women's Cooperation for Development, Men's Health Cambodia.

India
Integrated Rural Development Society (IRDS), MERIBA, WINS, People's Action for Social Service (PASS), STEPS, Mahila Samatha Samithi, Pragathi Seva Samithi, SAMSKAR, SEWS, Action for Girijan Development.

Ecuador
Cemoplaf, Cruz Roja, FODIMUF, FUVES, Vida Libre, 1 de Agosto, Amazonas, Dios Vida y Esperanza, Rios de Agua Viva, Espoir, SOGA, Unidos Somos Mas, FAES, Alfil, APASHA, ASOPRODEMU, ORPHAIDS.

The Alliance is grateful for the valuable contributions made to this publication by Alex McLean and Sarah Middleton-Lee.

For further information on the use of this toolkit contact Josh Levene at:
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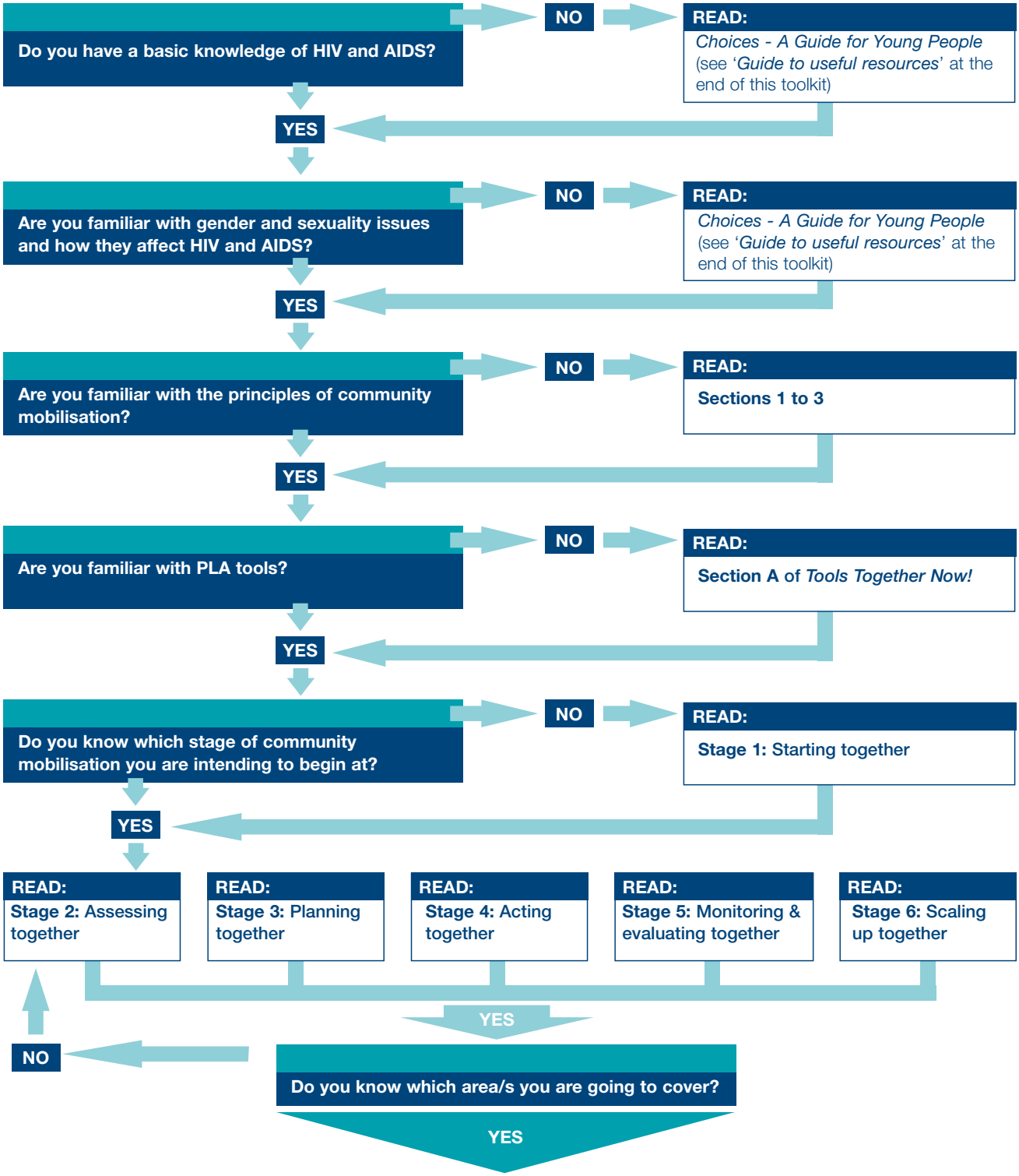
Quickstart – Don't panic!

This sourcebook looks larger than it actually is because most of the pages are made up of resource materials, so you probably won't need to read all of it.



Foreword

Participatory approaches and methods, well facilitated, have proved astonishingly powerful, especially in sensitive areas of social life. With HIV and AIDS their potential for enabling and improving prevention, care and support, treatment, and impact mitigation is enormous but still far from being realised. First, the behaviour and attitudes of facilitators have rarely been given the priority they deserve, yet they are fundamental. Second, just a few methods have often been adopted and made routine, neglecting so many others and the scope that all methods present for creative adaptation. Third, despite great HIV and AIDS pioneering work in participation, and the transformative effects of these approaches and methods, they lack the ease of measurement and costing and the simple appeal of top-down interventions. In consequence, they have not received from donor agencies the recognition and support they merit and that people in affected communities so manifestly deserve.

To realise more of this potential ***All Together Now!*** and ***Tools Together Now!*** are a wonderful resource. They are timely and state of the art. As an introduction and collection they are at once clear, comprehensive and accessible. The qualities and behaviours of a good facilitator are stressed. The 100 tools are an excellent and richly varied collection on which to draw for ideas. Designed and tailored for HIV and AIDS-related work, they have much wider application and are a treasury for all of us who are facilitators and practitioners in other fields.

May these two sourcebooks be widely read and used. May they encourage and inspire many facilitators and practitioners. May they help towards a balance in HIV and AIDS interventions, recognising people as people, as so much more than objects of interventions, and instead as creative and capable actors, able to do their own appraisal and analysis, enhance their own awareness, and take their own action. May, in consequence, innumerable among our fellow human beings in this world be better able to avoid or cope with HIV, may many others in communities be compassionate, considerate and caring towards those who live with it, and may the result be better lives for all.

Robert Chambers
Institute of Development Studies,
University of Sussex, UK

30 June 2003

Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	antiretroviral
CBO	community-based organisation
FBO	faith-based organisation
HIV	Human Immunodeficiency Virus
IDU	injecting drug user
MSM	men who have sex with men
NGO	non-governmental organisation
PAR	participatory assessment and response
PCA	participatory community assessment
PLA	participatory learning and action
PM&E	participatory monitoring and evaluation
PSA	participatory site assessment
SCM	site coordination mechanism
STI	sexually transmitted infection

Introduction

Background

Summary

An overview of what the toolkit is about, who it is for and how you can use it.

Today, more than 40 million people are living with HIV/AIDS and many millions more are affected indirectly through family members becoming ill or dying. However, the real story of HIV/AIDS is not happening at the global level but in the streets, settlements, families and communities that make up the world. It is here where action is needed most and counts most.

> "Communities are not only at the frontline of the response against HIV/AIDS, they are the frontline."
>
> **Peter Piot, UNAIDS**

The community mobilisation for HIV/AIDS set helps communities to become actively and influentially involved in addressing the causes and effects of HIV and AIDS. It consists of two resources published by the Alliance:

- ***All Together Now! Community mobilisation for HIV/AIDS*** guides you through the process of mobilising communities to address HIV prevention, care, support, impact mitigation and treatment for those affected by HIV and AIDS.
- ***Tools Together Now! 100 participatory tools to mobilise communities for HIV/AIDS*** is a set of participatory exercises designed to help put ***All Together Now!*** into practice.

Used together, these two resources will provide a powerful way for organisations and communities to work more effectively together to address HIV/AIDS.

What is the toolkit about?

This toolkit describes the process of community mobilisation. Community mobilisation is a capacity-building process through which individuals, groups or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others. The toolkit covers how to encourage community mobilisation for prevention, care, support and treatment activities. It uses tried and tested approaches to help you to facilitate communities to become actively involved in the assessment, design, implementation, monitoring, evaluation and scaling up of HIV/AIDS projects and programmes.

The philosophy of the two resources is that organisations and communities have to work closely together if they are to address HIV/AIDS successfully. Using the two resources, communities and organisations can:

- **start** to address HIV/AIDS together
- **assess** the HIV/AIDS situation together
- **plan** together
- **act** together to implement the plan
- **monitor and evaluate** activities together
- **scale up** action on HIV/AIDS together.

Who is the toolkit for?

This toolkit is intended to help organisations and community groups mobilise and work together to address HIV/AIDS issues. Whether these issues relate to HIV prevention, treatment, care and support for people living with HIV/AIDS, or mitigating the negative impact of HIV/AIDS on affected communities, this toolkit will be of use to you. It can also assist those wishing to support communities to assess the local HIV/AIDS situation: to plan, act, monitor, evaluate, reflect or scale up HIV/AIDS activities. The tools will be most helpful for people working directly with communities affected by HIV/AIDS. However, any organisation working broadly on HIV/AIDS should find the toolkit useful.

Introduction

Top tip

If you do not have a copy of ***Tools Together Now!*** or any other Alliance resource, it can be downloaded free of charge at: **www.aidsalliance.org** or ordered from the Alliance free of charge by sending an email to: **publications@aidsalliance.org**

How did we develop the toolkit?

The Alliance has over ten years' experience in supporting community action on HIV and AIDS in over 40 countries. A common theme of the Alliance's work has been encouraging community participation in the assessment, design, implementation, monitoring, evaluation and scaling up of HIV/AIDS-related activities. The experience of the Alliance is that involving communities at each stage of a project greatly enhances their capacity to mobilise and respond to HIV/AIDS more effectively.

A literature review of the experience of the Alliance and other organisations in mobilising communities for HIV/AIDS was carried out in 2004. All the tools and approaches described in this toolkit were then developed or adapted in the field by Alliance partner NGOs with communities.

How to use the toolkit

Before you start

The first two sections of this toolkit introduce you to what community mobilisation is and the skills required to mobilise communities. If you are new to community mobilisation or need to refresh your memory, read through these sections first. ***All Together Now!*** was specifically designed to be used alongside ***Tools Together Now! 100 participatory tools to mobilise communities for HIV/AIDS***. So it will help you to look through Section A of ***Tools Together Now!*** before starting to mobilise communities.

Stages of community mobilisation

The toolkit describes each stage of community mobilisation in a separate section.

Stage 1: Starting together
Stage 2: Assessing together
Stage 3: Planning together
Stage 4: Acting together
Stage 5: Monitoring and evaluating together
Stage 6: Scaling up together

If you are using this toolkit as a guide to lead you through a community mobilisation process from start to finish, we encourage you to work through the stages one at a time. If you are already carrying out a community mobilisation process, you can go directly to the stage of community mobilisation you want to complete next.

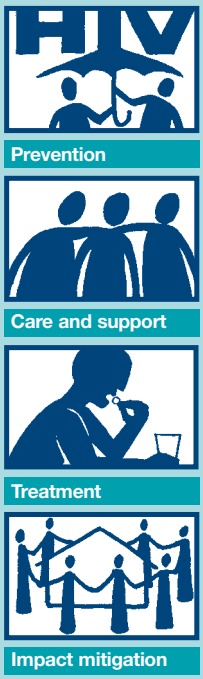
Mobilising in different areas of HIV/AIDS activities

We recommend that you mobilise communities in the following four areas in order to provide a continuum of care:

- prevention
- care and support
- treatment
- impact mitigation

At each stage of this toolkit, tables offer guidance on the specific issues that need to be addressed in these different areas. The areas are clearly identified in the tables with their own symbols (*see opposite*).

If you wish to concentrate on only one area, such as prevention, the prevention symbol will make it easy for you to identify where there are prevention issues to consider at each stage of the community mobilisation process.



Working in different contexts

For communities to address an area of HIV/AIDS effectively, they also need to look at the issues and actions required in four different contexts:

- individual (or group of similar individuals)
- community
- services and supplies
- laws and policies

At each stage of this toolkit, tables offer guidance on the specific issues that need to be addressed in these different contexts. The contexts are clearly identified in the tables with their own symbols *(see opposite).*

Although all of these contexts need to be considered to address HIV/AIDS effectively, if you want to look at just one context at a time the symbols will help you to identify that particular context in the tables at each stage. The symbols will also make it easy for you to refer to particular areas and contexts together; for example, to identify issues about prevention in an individual context.

Issues

Within each context, different issues will affect HIV/AIDS. For example, if you wanted to assess HIV/AIDS prevention in the individual context, it would be useful to understand issues such as which behaviours individuals think may lead to HIV infection and which they think are safe. A list of issues that you might find useful to consider is provided for each context, area and stage.

Tools, exercises and resources

In many context tables, a useful tool, exercise or resource is mentioned opposite the issues it relates to. This will help you to address specific issues with communities. The tools and exercises are named and numbered 1 to 100. The numbers correspond to the tool numbers in ***Tools Together Now!*** Resources are mentioned by title, and most can be downloaded from the address given in the 'Guide to useful resources' at the back of this toolkit.

Top tip

To address a particular issue, you do not have to use all the tools suggested! These are just options. Use the ones that you feel will be most effective for the community you are working with. Of course, you can also use your own tools, exercises and resources.

Community mobilisation for HIV/AIDS

Summary

An overview of what community mobilisation is and why it is used for HIV/AIDS.

Definition

What is community mobilisation?

Community mobilisation is a capacity-building process through which individuals, groups or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

What is community mobilisation?

Community mobilisation has certain characteristics that, together, make it different from other approaches.

Communities leading the response Community mobilisation tries to make sure that people most affected by HIV/AIDS (including people living with HIV/AIDS) can play an active and influential role in shaping an effective response to it. It means that community members take responsibility for addressing HIV/AIDS themselves, with the support of others where necessary. Although community mobilisation may involve external support or resources at some point, this is not always necessary. Communities make decisions together and take responsibility for the outcomes of their actions together.

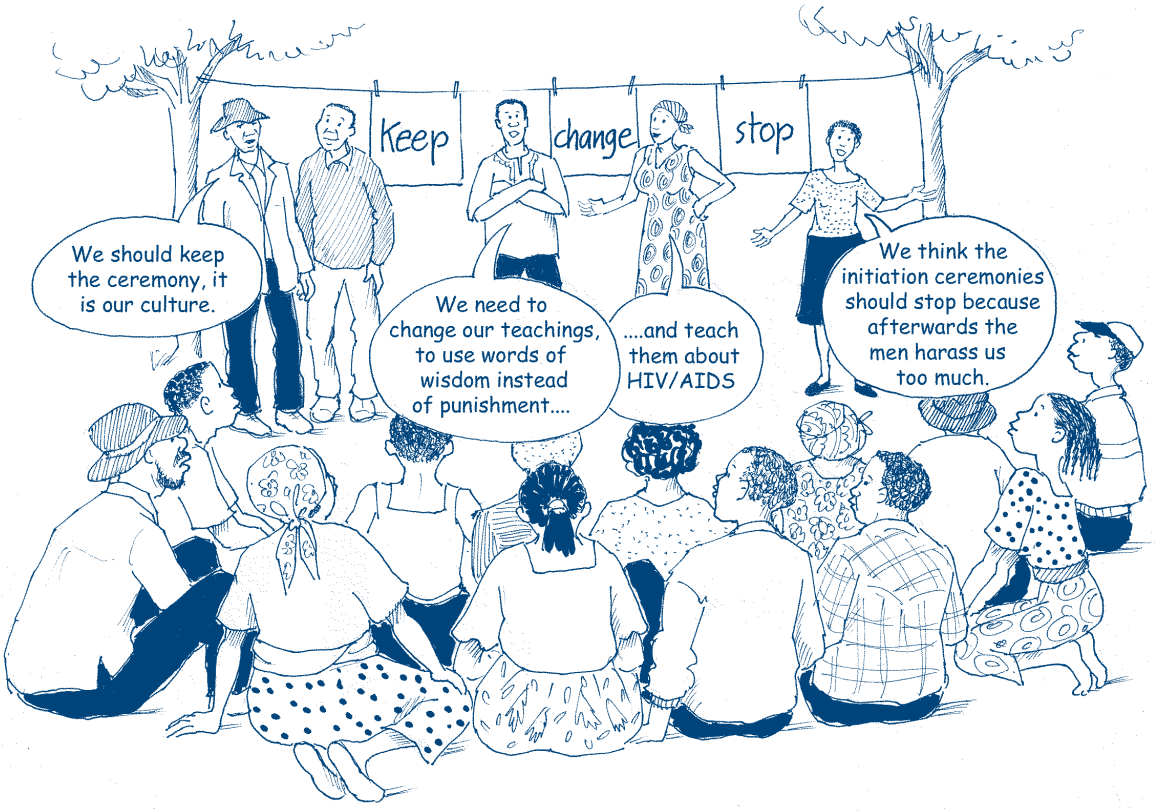
A process leading to action Ultimately, any community mobilisation process aims to empower communities to take effective action to address HIV/AIDS in ways that they had not managed to achieve before.

A flexible approach rather than a rigid model Communities have different characteristics and needs, and the way they mobilise has to suit these. That is why there is no single model for how to do community mobilisation. Rather, there is a set of tools and principles (*see page 13*) that can be adapted to suit the particular community. The process then unfolds according to the situation and priorities of community members.

An organisational process Often communities affected by HIV/AIDS are already trying to cope with it. However, their response is not always carried out in a coordinated and effective manner. Community mobilisation tries to help communities coordinate an effective response to HIV/AIDS.

A communication and education process For communities to coordinate an effective response to HIV/AIDS they need to have frequent and useful exchange of ideas and issues with each other. They also need to have regular contact with other individuals and organisations who may be able to offer them new knowledge and skills related to HIV/AIDS. So community mobilisation processes will try to ensure regular communication and education opportunities about HIV/AIDS within communities.

Community mobilisation is a process leading to change



An empowering process Rather than leaving communities to feel powerless in the face of HIV/AIDS, community mobilisation seeks to provide them with the necessary skills, knowledge, attitudes, behaviours, sense of unity and capability to address HIV/AIDS effectively.

A capacity-building process rather than a single event Community mobilisation is not a single event or project. It is a continual process that builds capacity. It is not a campaign, nor is it a series of campaigns. Neither is it the same as community participation or social mobilisation, although it may make use of these techniques.

Why use community mobilisation for HIV/AIDS?

> "The only relevant response to HIV and AIDS is that which has an impact at the community level."
>
> Baba Goumbala, ANCS

Community mobilisation can be seen as a **means** to achieving certain HIV/AIDS goals. It is also a valuable process in its own right; an **end** in itself. Potential outcomes of community mobilisation can be grouped into these two categories.

If a donor, government or community asks, "Why use community mobilisation?" you can offer some of the reasons below.

Community mobilisation is a **means** (or strategy) towards:

- **creating demand for HIV/AIDS activities**, because communities become more aware of their HIV/AIDS needs
- **increasing community access to HIV/AIDS services**, because communities can inform existing services of access problems, or they might expand or start new services to improve access for all
- **scaling up HIV/AIDS activities** – communities' participation in service delivery can help expand services (e.g. volunteer home-based care workers)
- **increasing the effectiveness and efficiency of HIV/AIDS services and activities**, because communities have been involved in the design of them so they are more closely matched to their specific needs
- **mobilising additional resources to the response**, because the community is working alongside other organisations, contributing their time and resources, and also learning how to access resources outside of the community
- **reaching the most vulnerable** – communities are often best placed to identify the most vulnerable and marginalised people in a geographical area (e.g. young people, sex workers, men who have sex with men, injecting drug users), and if they are members of these groups themselves, they may be better able than government services to work with them
- **addressing the underlying causes of HIV/AIDS**, such as gender, stigma and discrimination, which requires a deep understanding of a community's characteristics – something government services or outside agencies may not possess
- **increasing community ownership and sustainability** through taking part in the design and management of HIV/AIDS services and activities – it creates a greater sense that communities have a responsibility to keep them going in the long term with minimal outside support.

Case study

Evidence of the impact of community mobilisation: The Treatment Action Campaign

The Treatment Action Campaign successfully mobilised South African communities to demand and receive antiretroviral treatment from the government. This has saved many lives and helped reduce the stigma of AIDS and its association with an inevitable early death.

Community mobilisation for HIV/AIDS

Case study

Evidence of the impact of community mobilisation: The Sonagachi project

The Sonagachi prevention programme in India involved sex workers mobilising to address HIV prevention. By working together with local authorities on HIV prevention issues, consistent condom use increased and HIV/AIDS incidence rates among sex workers were successfully reduced.

Source: Jana, S. *et al.* (2004)

Definition

What is a community?

A community is a group of people who feel that they have something in common. For example, a community might be people who live in the same village or area; people who work together; or a group of people who share interests or circumstances. This means that formal and informal organisations may feel that they too are part of a community (rather than separate from it) if they share the same interests and circumstances. People can also belong to more than one community at the same time. For example, a health worker may identify herself as part of the local community where she lives and part of the wider "health community" in the region.

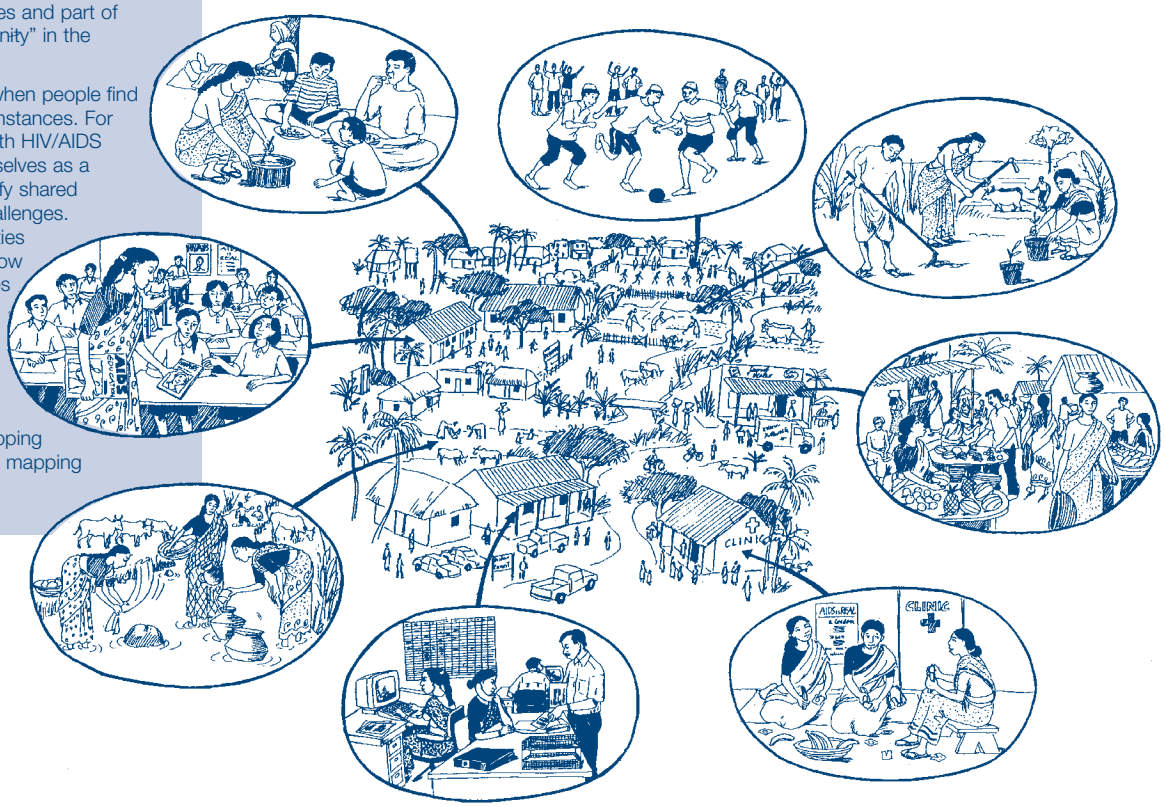
New communities form when people find themselves in new circumstances. For example, people living with HIV/AIDS might begin to see themselves as a community as they identify shared problems, needs and challenges. Understanding communities involves understanding how people identify themselves rather than relying on the views or definitions of others.

See also:
Tool 2 • Broad mapping
Tool 3 • Community mapping
Tool 11 • Social network mapping

Community mobilisation is an **end** in itself for:

- **rights fulfilment** – it is not just a "good thing to do"; it is people's human right to determine their own development and be healthy
- **applying political pressure** – communities can be encouraged to do this so that unhelpful local, national or international policies can be changed and new policies introduced
- **strengthening civil society/good governance** – mobilised communities in a country make up civil society, and a strong civil society has an important role to play in a country's development, alongside government and the private sector. When the three work cooperatively towards a development goal, this is called 'good governance'
- **empowerment and equity** – community mobilisation can lead to the fairer distribution of knowledge and resources across and within communities (e.g. by empowering women to control when, with whom and how they have sex)
- **increasing community developmental capacity** – community mobilisation should lead to new HIV/AIDS resources, skills, knowledge and leadership (e.g. how to plan and manage a project), with many of these skills being transferable and useful for addressing other community development concerns
- **increasing social capital** – this is the amount of trust community members have with each other; the more they have, the more they are able to work effectively with each other. Community mobilisation is a very effective way to increase social capital
- **reducing HIV/AIDS incidence** – communities with high levels of social capital have been shown to have reduced HIV/AIDS incidence rates and higher levels of consistent condom use (*see opposite*).

People may belong to many different communities at the same time, and HIV/AIDS responses need to address their specific needs. How many different communities can you see in this picture? What do you think their different HIV/AIDS needs are? How might they work together to address HIV/AIDS?



The principles of community mobilisation

Community mobilisation for HIV/AIDS is happening successfully throughout the world. Evidence of the impact of community mobilisation is leading to increasing understanding of the principles that can be used to support the process. Some principles to keep in mind when facilitating communities to mobilise are as follows:

Aim to achieve the dual outcomes of community mobilisation See community mobilisation as both a means to achieving HIV/AIDS outcomes and as a valuable end in itself (*see pages 11-12*). View community mobilisation as a capacity-building process that empowers communities with the skills to organise, assess, plan, act, monitor and evaluate together. This will make sure that communities not only achieve the immediate goals of a community mobilisation process (such as reducing HIV/AIDS incidence), but also have the capacity to mobilise to face new HIV/AIDS challenges, and sustain and scale up existing activities.

Encourage meaningful community participation This means that people affected by HIV/AIDS have an active and influential say in the decisions that impact on their lives. It is especially important that those most vulnerable to HIV/AIDS – people who are stigmatised (e.g. people living with HIV/AIDS), discriminated against (e.g. sex workers, men who have sex with men, injecting drug users) or marginalised (e.g. young people, women, the poorest of the poor) – participate meaningfully. There are different types of community participation and different types of community mobilisation. Not all are helpful. Evidence suggests that the more meaningful the participation, the greater the mobilisation and sustainability (see 'Types of community participation and mobilisation' overleaf).

Encourage meaningful community participation at every stage of the mobilisation process This means those most affected having an active and influential say in how they organise themselves, assess their situation, plan a response, act, monitor and evaluate (*see page 16*).

Work together Encourage all community members affected by HIV/AIDS to work together to cope with it. This means starting, assessing, planning, acting, monitoring, evaluating and scaling up together. If you are from an outside agency or NGO, you should try to form an equal partnership with community members, sharing roles and responsibilities fairly.

Build trust and social capital This means spending a lot of time on building mutual trust, respect and understanding both within communities and between communities, and any other organisations taking part in the process. Everyone participating needs to understand each other's strengths and weaknesses. This will encourage sharing of skills and knowledge within and between communities and organisations. Make sure plenty of time is set aside for doing this throughout the community mobilisation process.

Build community ownership of the process In the longer term, community action is sustained by community ownership not by external inputs. Ownership can be built by responding to the communities' priorities (rather than your own) and giving communities the primary responsibility for the community mobilisation process.

A relaxed process A community mobilises at its own pace. Don't try to rush. Community mobilisation is a process not an event. It requires significant amounts of time to build up communities' capacity to mobilise sustainably. But the investment is well worth it. A community that can mobilise for HIV/AIDS can apply much the same knowledge, skills, resources and organisational ability to mobilise for other development issues.

Maximise the use of resources Make sure that everyone in the community affected by HIV/AIDS is contributing whatever they can, and create links to outside services and resources where necessary.

Case study

Encouraging meaningful participation of communities that are discriminated against

The Frontiers Prevention Project in Ecuador worked with many groups that are marginalised and discriminated against. Among them, transgenders (people who are born as one gender but spend all or some of their time functioning as the other gender) were at higher risk of exposure to HIV. During the project, they designed their own process to mobilise their peers to address HIV/AIDS. They later went on to form Ecuador's first transgender NGO to demand access to health services and other fundamental human rights. Mobilising discriminated communities such as transgenders not only reduces HIV/AIDS incidence among this particular community but also prevents HIV infection spreading to the wider community.

Case study

Working together: The Dabur process

In Yei, South Sudan, members of different key populations affected by HIV/AIDS were mobilised by the Alliance to come together to address the HIV/AIDS situation in their county. They began by carrying out a participatory assessment with their peers. They then went on to form a County AIDS Council (CAC) and invited members of the government and private sector to join. They discussed the findings together and later went on to design a joint HIV/AIDS plan for the county, and a capacity-building plan to increase their collective knowledge, skills and resources to implement the plan. The government of South Sudan is now mobilising communities to set up CACs in the other 94 counties of the country.

Top tip

Trust is a verb, not a noun! It is something you do: you have to build trust, it is never given freely.
African proverb

Types of community participation and mobilisation

With increased community participation, there is increased community mobilisation

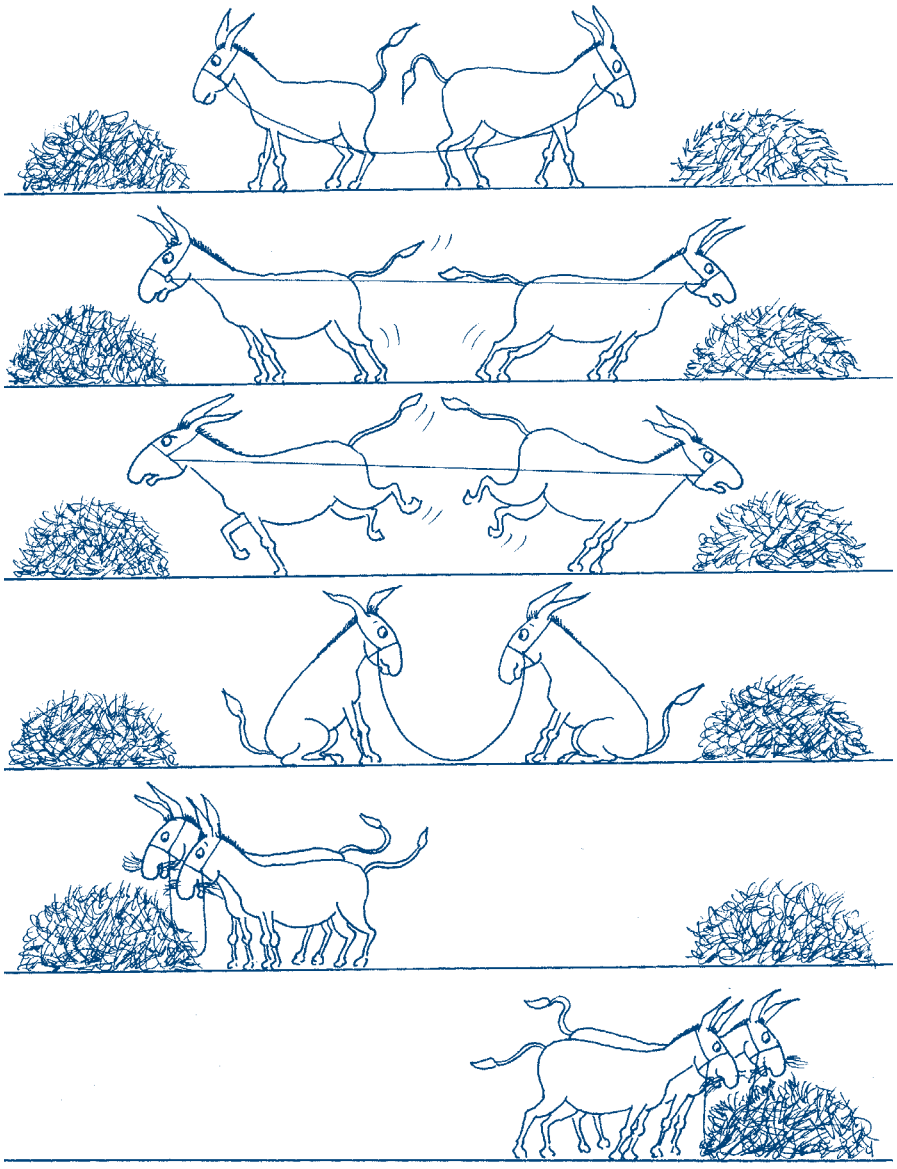
Level of community control	Type of community participation	Type of community mobilisation	Level of sustainability
High	Self-mobilisation: affected communities achieve an activity without help from an outside agency	Collective action: communities are leading the process of mobilisation and only requesting outside agency support if required	High
	Joint decision-making: affected communities and an outside agency make decisions together on an equal basis	Co-learning: communities and an outside agency are sharing skills, knowledge and resources during the mobilisation process	
	Functional participation: affected communities are invited to participate at a particular stage of action to fulfil a particular purpose	Collaborating: communities are working with an outside agency but are not necessarily building their own capacity in the process	
	Participation for material incentives: affected communities participate in an activity only because they need the material benefit of doing so (e.g. money)	Consulted: affected communities are asked about the process but their views may or may not have any influence over it	
Low	Consultation: affected communities are asked about an activity by an outside agency but their views may or may not have any influence over it	Cooperating: communities are mobilising but with little idea why	Low
	Information giving: people are simply informed that an activity is taking place and have no say on activity design or management	Co-opted: communities are forced to mobilise	

Source: How to Mobilize Communities for Health and Social Change, Health Communication Partnership, Howard-Grabman and Snetro, 2003, page 3

Use tools and techniques which maximise participation This set uses PLA tools. A hundred PLA tools and exercises, together with a full description of how to use them, and train others to use them, is provided in *Tools Together Now! 100 participatory tools to mobilise communities for HIV/AIDS*. Use the tools suggested at each stage to explore issues and accomplish the community mobilisation process. Other techniques that have proved successful include *Appreciative Inquiry* and the *Community AIDS Competence Approach*. The 'Guide to useful resources' at the back of this toolkit provides information on where you can obtain these.

Manage expectations Make sure that the short-term expectations of community members about the community mobilisation process are realistic. Community mobilisation takes time. It is a steady process but a sure one!

Conduct activities that maximise cooperation between people. Cooperation is better than conflict!



Definition

What is participatory learning and action?

Participatory learning and action (PLA) is a growing family of approaches, tools, attitudes and behaviours to enable and empower people to present, share, analyse and enhance their knowledge of life and conditions, and to plan, act, monitor, evaluate, reflect and scale up action on HIV/AIDS.

Top tip

And with the best leaders, when the work is done; the task accomplished. The people will say "we have done this ourselves".
Chinese proverb
Lao-Tzu

Summary

An overview of when, where and with whom to mobilise, and the skills needed to be a community mobiliser. The section also considers ethical issues, and concludes with answers to frequently asked questions about community mobilisation.

The community mobilisation process

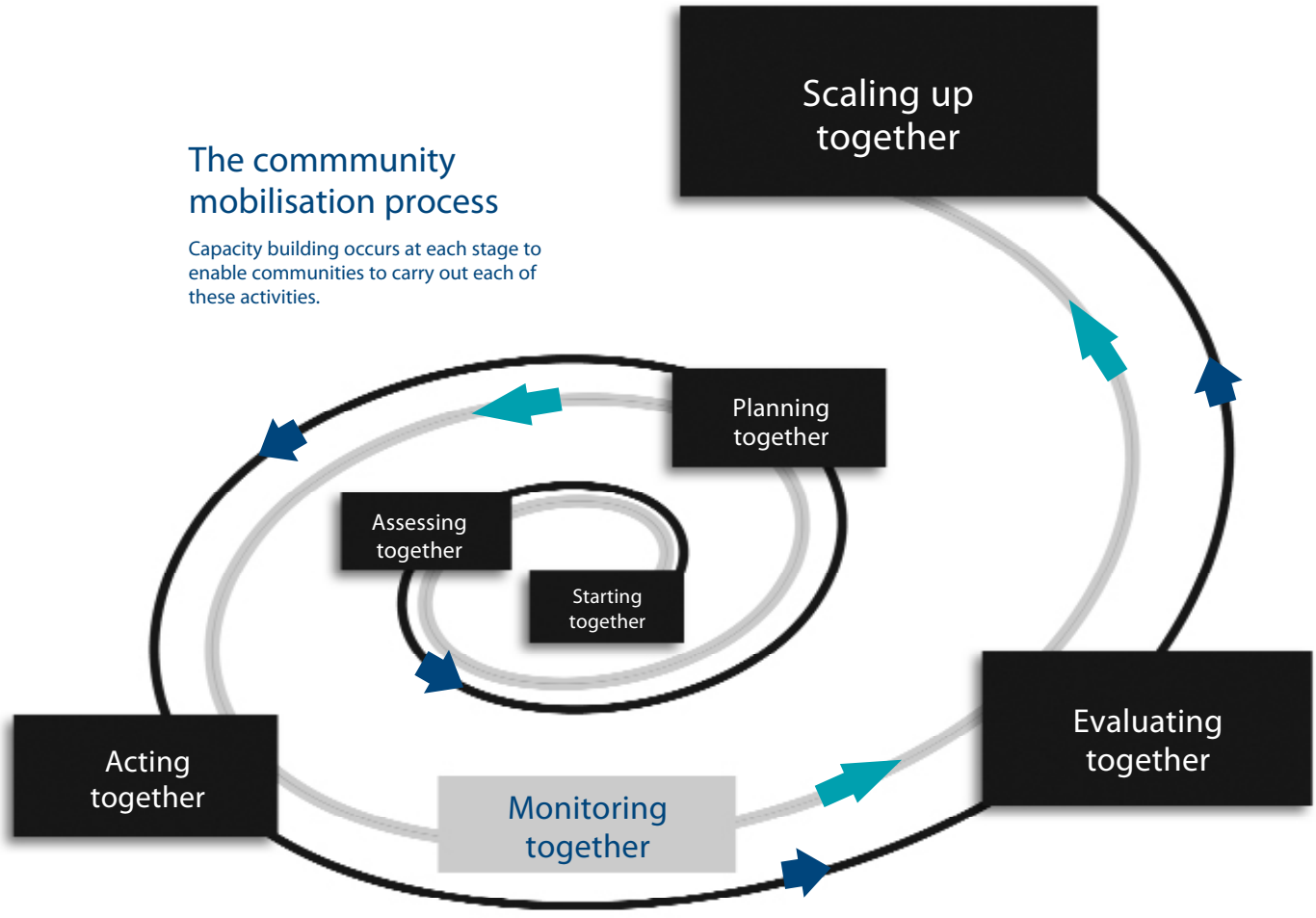
The process of community mobilisation is flexible, responding to the different circumstances and needs of various communities. There is no fixed model for community mobilisation and the timescale will vary from community to community. However, there are usually six stages in community mobilisation:

- Stage 1: Starting together – identifying and involving different stakeholders and getting organised
- Stage 2: Assessing together – learning more about the community and the problems different people face, and identifying possible solutions
- Stage 3: Planning together – prioritising problems and deciding how to solve them
- Stage 4: Acting together – taking action and implementing activities to address HIV/AIDS
- Stage 5: Monitoring and evaluating together – considering the results and impact of activities, and using monitoring information to adjust plans, including monitoring and evaluating the community mobilisation capacity-building process, as well as activities specifically to address HIV/AIDS
- Stage 6: Scaling up together – learning how to do more activities or expand existing ones.

Although each stage is dealt with separately in this toolkit, in practice they often overlap.

The commmunity mobilisation process

Capacity building occurs at each stage to enable communities to carry out each of these activities.



Source: Adapted from the community action cycle, Howard-Grabman and Snetro, 2003

Start where the community is at It is not essential to go through each stage of mobilisation. Communities may already have mobilised successfully without following these stages in a planned way. For example, they may have organised useful and important activities before any participatory assessment is carried out. The community mobilisation process is often planned in a more formal way when external people or organisations are involved. It is important for external organisations supporting community mobilisation to recognise past and current community action when they arrive in a community. This is so they can build on a community's strengths and achievements rather than undermine them.

Mobilise at the pace of the community At the beginning this may seem quite slow. But as the community mobilisation process progresses, the community's capacity will be built to organise activities faster and more efficiently.

Do the stages together *All Together Now!* means all those who are affected by HIV/AIDS in a community working together with all of the others who can help, using all the resources they can mobilise together. *All Together Now!* means including the most vulnerable, marginalised and discriminated against. It also means taking collective responsibility for addressing HIV/AIDS effectively and learning how to cope with it together. The rest of this section guides you through some of the principles and skills needed to mobilise communities to achieve this.

Case study

The AIDS Support Organisation

The AIDS Support Organisation (TASO) in Uganda started informally in 1987. People infected or affected by HIV began to meet in each other's homes to provide mutual support and practical help. As word spread, more people joined. Once the numbers and needs of members began to exceed the group's capacity, the group successfully approached an outside organisation for financial and technical help to develop a programme to meet the needs of members.

Source: UNAIDS (1997)

Working in different contexts

In order for communities to address HIV/AIDS effectively, they need to work in all of the different contexts HIV/AIDS can affect and be affected by. A community response will not be successful unless it fully considers the causes, effects and possible responses to HIV/AIDS in the following four contexts.

Individual (or group of similar individuals)

Communities are made up of individuals, and not all individuals within a community will be affected by HIV/AIDS in the same way *(see definition of a community on page 12)*. For example, a young man will have different vulnerabilities to HIV infection than a woman who is a sex worker. We need to understand how their knowledge, attitudes and behaviours affect HIV/AIDS and their ability to respond to it. To address HIV/AIDS effectively, it is therefore essential to look at how individuals or groups of specific individuals (such as young men or sex workers) are affected by HIV/AIDS differently. In this way, group mobilisation activities can be designed to suit the particular needs of specific groups within a community.

Community

Individuals and groups of individuals living in the same geographical area make up the wider community. The way these groups interact, the resources they share, their economic situations, values and traditions, and attitudes towards HIV/AIDS can all make a difference to how they are affected by HIV/AIDS and how they cope with it. By looking at this wider community context, we can consider common underlying issues such as stigma and discrimination. Community mobilisation activities for specific groups can then begin to address these wider community issues.

Services and supplies

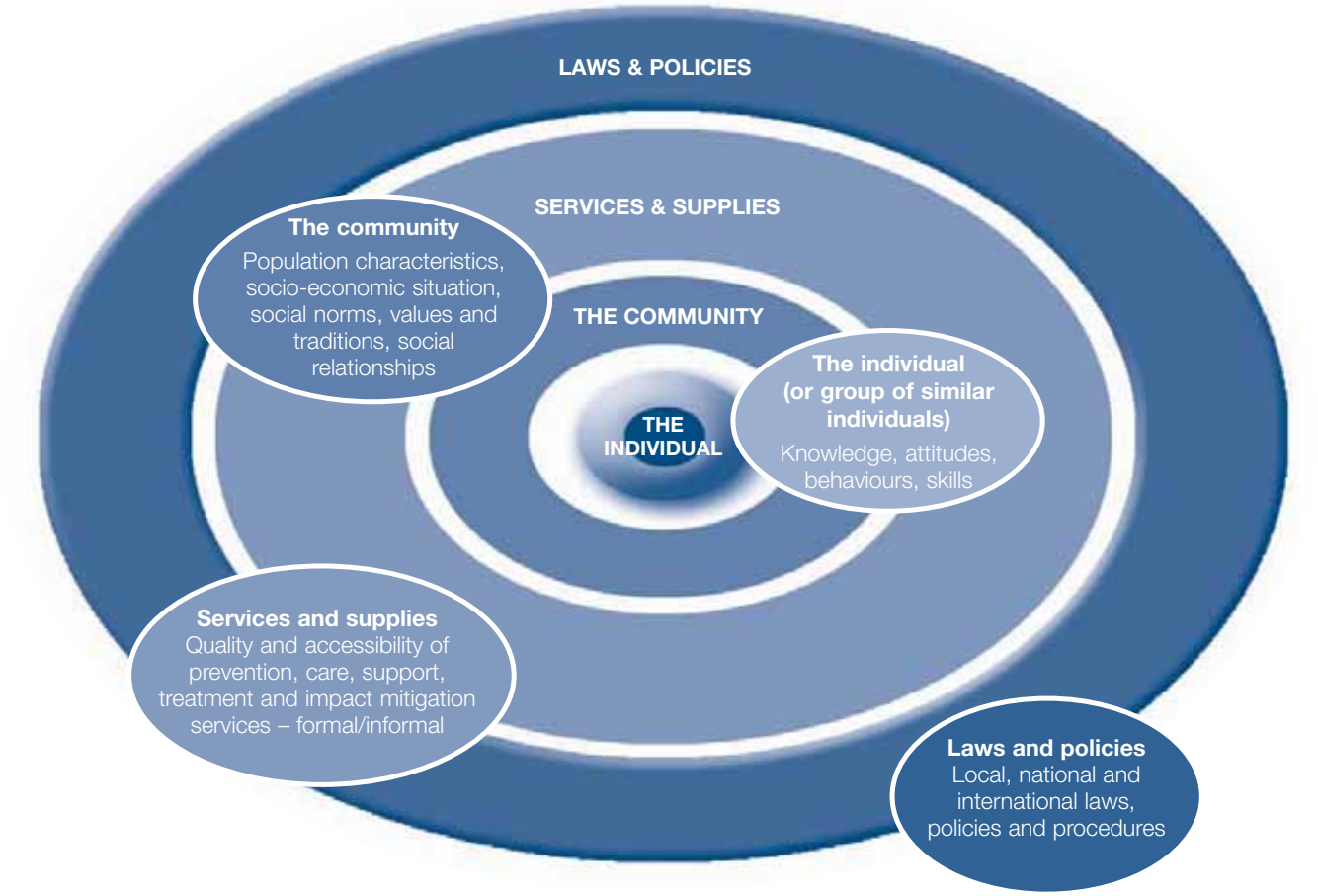
Within most communities there will already be some services and supplies, however basic, that will help to address HIV/AIDS. The quality and quantity of these services and supplies must match community needs. They must also be easy to access for all community members. By considering this context, communities can assess the quality, quantity and access to resources, and carry out actions aimed at improving services and supplies.

Laws and policies

The way in which communities and services are able to respond to HIV/AIDS is governed by a wider context of local, national and even international laws, policies and procedures. In order for communities to address HIV/AIDS effectively they need to consider questions such as, which national or local laws, policies and procedures help communities to develop effective HIV/AIDS responses? Which hinder communities? Which are being implemented and which are not? Communities then need to think about which policies, laws and procedures they can help to change. This may not be an easy process, but by working together they can sometimes bring about significant change.

In this toolkit you will find guidance on specific issues that need to be considered in these different contexts for each stage of community mobilisation and for prevention, care and support, treatment and impact mitigation.

Contexts that need to be considered for communities to address HIV/AIDS effectively



Mobilising for a continuum of care

In order for communities to cope adequately with HIV/AIDS, they should aim to mobilise to help provide a continuum of care for affected people. A continuum of care means supporting people affected by HIV/AIDS throughout their lifetime, involving prevention, care and support, treatment and impact mitigation activities.

Prevention

Prevention means making sure that people have the knowledge, attitudes, behaviours and resources to prevent themselves from becoming infected by HIV. It also means that people with HIV can prevent themselves becoming re-infected or infecting others. It includes preventing HIV-positive mothers from passing HIV on to their infant children (during pregnancy, delivery or breastfeeding).

Care and support

Care and support means making sure that affected people have adequate care and support to cope. This involves providing care and support to people living with HIV/AIDS, as well as households who have been affected (e.g. widows and widowers, orphans or children who have become vulnerable because one of their parents is ill). Care and support can take many forms: financial or physical (e.g. food or clothes), medical, social, spiritual and psychological.

Treatment

Treatment means making sure that people living with HIV/AIDS receive adequate medical care and treatment. Although there is currently no cure for HIV, there are medicines that can help with HIV-related diseases and delay the onset of AIDS in people who are HIV positive. Antiretroviral treatment (ARVs) can delay the onset of AIDS to such a degree that many people who are HIV positive can lead a normal life.

Impact mitigation

Impact mitigation means making sure that the negative impact of HIV/AIDS on communities is reduced to a minimum. HIV/AIDS not only affects people's physical health; it can affect the social and economic health of the whole community. For example, when there are many people ill with HIV/AIDS, there may be a shortage of those who are fit for work. This can impoverish a community. Mobilising communities to carry out activities that reduce the impact of HIV/AIDS on the social and economic well-being of the community can help them to cope better with HIV/AIDS.

In *All Together Now!* you will find guidance at each stage of the mobilisation process on how to address prevention, care and support, treatment and impact mitigation in order to provide a continuum of care for communities affected by HIV/AIDS.

Facilitating the community mobilisation process

The community mobilisation team The community mobilisation process is usually managed by a mobilisation team. The role of this team is to plan and coordinate mobilisation activities with communities. The team will be made up of members of the organisation or group that wishes to start up community mobilisation, and community mobilisers. It may also include key community leaders, gatekeepers or other stakeholders *(see page 31 for definitions of gatekeepers and stakeholders).*

The team's roles may include:

- deciding the aims and objectives of the community mobilisation process
- ensuring that each stage of the community mobilisation process is properly planned
- monitoring the progress of the mobilisation process
- ensuring adequate financial resources are available to mobilise communities, and managing these resources
- ensuring that the right human resources (people) are available to carry out the process and, if required, managing these resources
- training community mobilisers in the skills, knowledge, attitudes and behaviours required to mobilise communities
- coordinating community mobilisation activities
- reporting progress on the community mobilisation process to communities and other stakeholders (e.g. government and donors)
- ensuring that ethical standards are maintained (*see page 24*).

The role of the community mobiliser

The process of mobilising individuals, groups and communities is facilitated by community mobilisers. The roles they perform are central to this process. These include:

- **bringing people together** at each stage of the process; motivating them to get involved and develop a shared identity and awareness of needs and problems they have in common
- **building trust** and an atmosphere of mutual respect that will help community members work together effectively
- **encouraging participation** by actively addressing issues that prevent people from participating fully in the community mobilisation process; for example,

creating a safe space where people feel comfortable to meet together and talk freely, or helping negotiate with gatekeepers to enable participation

- **facilitating discussion and decision-making** using the appropriate PLA tools and techniques in order to support community members to discuss issues and make decisions. The community mobiliser has an important role in asking questions that help challenge assumptions and encourage discussion in a sensitive and non-threatening way
- **helping things to run smoothly** and supporting community members in solving problems as they come up; for example, helping to resolve conflict between community members.

Community mobilisers need to feel confident and comfortable with their role and be able to communicate it clearly. This will help them address the expectations of different stakeholders who may not have a clear understanding of the role at first. Community mobilisers need ongoing structured support from the community mobilisation team. This support should help them to find ways of addressing the problems and pressures they face and to receive encouragement for their work. Regular discussions with team members in the same role can provide very good support.

Case study

Treatment mobilisers in the ACER project

Treatment mobilisers were recruited to the ARV Community Engagement and Referral Project (ACER) in Lusaka, Zambia. Their role was to coordinate activities of partners in the communities served by the project and mobilise people to receive treatment. They conducted treatment education and a community referral system. They also acted as focal points for information on testing and treatment. Finally, they ensured that people who had been referred to the ARV treatment clinics were followed up when they returned to their communities so that they continued to get the services and support they needed.

Who can be a community mobiliser?

There is no "ideal" community mobiliser People from all kinds of backgrounds can be effective community mobilisers. Attitudes, behaviours and skills are more important than who the person is or what qualifications they may have (*see page 22*). Community mobilisers need to be able to motivate and establish strong and trusting relationships with different kinds of people. They need to be committed to the community mobilisation process and to be willing and able to participate in the community at times and in places that are convenient to community members. Different community mobilisers will face different opportunities and challenges. Building a team of community mobilisers provides an important opportunity to combine different skills and experiences.

Community members Community members are likely to feel more relaxed with mobilisers who share important characteristics with them, such as gender and age. Community members acting as mobilisers will have a strong understanding of their

Case study

The street boys of Brazil

An NGO working with street boys involved in sex work in Brazil found that it was necessary to spend a lot of time with the boys in order to gain their trust and build relationships with them. This was greatly helped by the fact that many of the NGO staff had been street boys themselves.

Source: UNAIDS (2004)

Case study

Mobilising ministers!

ActionAid recently completed a successful anti-stigma community mobilisation project in Africa. It involved recruiting Christian ministers with HIV/AIDS to drive across the continent giving church services along the way. In their sermons, they would tell their life stories and preach anti-stigma and discrimination messages. They completed their giant "safari" in October 2005 by turning up in their four-wheel drive vehicles at the opening ceremony of the ICASA conference in Abuja!

community and the relationships within it, which will facilitate acceptance by the community. Mobilisers who are from the locality will find their local knowledge useful and may already have good contacts with the community. So wherever possible mobilisers should be members of, or peers with, the community group they will be working with (e.g. young men working with other young men).

Positive role models If possible, it is very helpful if community mobilisers can be not only from the same group or community but also positive role models around living with HIV/AIDS; for example, injecting drug users who have stopped using drugs, or people with HIV on ARV treatment.

Mobilisers from outside the community may find it easier to ask questions about social or cultural issues that challenge assumptions and stimulate discussion. They may bring new ideas and experience from mobilising with different communities.

Language is an important issue in community mobilisation. Community mobilisers should speak the language normally used by community members. Expecting community members to communicate in a second language, or a language that is spoken by only certain community members, will seriously affect community participation and trust. There are no literacy or educational requirements for being a community mobiliser.

What skills do community mobilisers need?

Community mobilisers need to combine a range of knowledge, attitudes and skills in order to be effective.

Attitudes include:

- a willingness to examine and challenge their own assumptions, opinions and beliefs
- a genuine respect for all community members
- a non-judgemental and accepting approach
- an understanding that different people have different views and perspectives
- a belief in community capacity to take effective action.

Skills include:

- good communication skills, especially listening
- good facilitation skills to enable communities to conduct their own analysis of their lives and situations
- PLA and other techniques to help facilitation (***Tools Together Now!*** includes a section on page 35 on how to train people in PLA)
- awareness of political, gender and cultural issues and relationships
- an ability to challenge assumptions sensitively (e.g. about the role of women).

Knowledge includes:

- the community mobilisation process
- the principles of community mobilisation
- knowledge of HIV prevention – how it is transmitted and infection prevented
- knowledge of other HIV/AIDS issues (e.g. care and support, treatment and impact mitigation)
- understanding of the ethical issues related to community mobilisation.

Other skills and knowledge that may be needed at different stages in the community mobilisation process include:

- an ability to help communities form organisations
- an ability to identify capacity-building needs among communities (e.g. leadership skills, networking and partnership-building skills)
- an ability to help communities mobilise resources
- advocacy skills
- project planning and management skills.

Provide capacity building to community mobilisers Finding all these skills in one person is almost impossible! Community mobilisers will have different strengths and weaknesses. For example, a person may have very strong facilitation skills but limited knowledge of HIV/AIDS. Where possible, provide training or capacity building for community mobilisers to address important weaknesses, but remember that some skills take considerable time to develop. People often find it easier to learn new skills and knowledge than to change attitudes and beliefs. Providing intensive support from the start to inexperienced community mobilisers from within the community may benefit the community more than devoting resources to training external people.

Balancing a team of community mobilisers by including people with different strengths and weaknesses will help address those weaknesses and enable community mobilisers to learn from each other.

Learn from others People and organisations starting community mobilisation for the first time need to assess their capacity carefully. Identify key weaknesses before starting together with communities and plan how these will be addressed. Visiting communities that are already mobilising successfully, or organisations with experience in community mobilisation, can help identify skills and knowledge that need strengthening. Building partnerships with people or organisations that can provide ongoing capacity building is helpful.

Case study

Unintentionally stigmatising children orphaned by AIDS

Some well-meaning community mobilisation processes aiming to support children orphaned by AIDS have backfired. Sometimes, orphans were given so much support that other poor children in the community who were not receiving support became jealous of them. This worsened the discrimination against the children orphaned by AIDS. Being openly identified as children orphaned by AIDS also increased stigma against them. It is good practice to target all vulnerable children in a community, regardless of whether they have been orphaned by AIDS.

Case study

Confidential Cambodia

A workshop for organisations providing care and support in Cambodia revealed important differences in opinion about confidentiality. Some participants felt that confidentiality did not apply in all circumstances; for example, information might be shared with a husband or wife. Other participants disagreed. After discussion, it was agreed that confidentiality should always be respected.

Ethical issues and codes of conduct

What are ethics? Ethics are a set of shared principles that help us make decisions about how to behave in different situations. For example, one ethical principle that is important for HIV/AIDS work is respect for confidentiality. This principle helps us decide what information we share or do not share.

Ethics and community mobilisation In community mobilisation, there are broad issues around what you are doing and who will benefit from it ultimately. No activity is neutral, including community mobilisation. All activities will either empower or disempower people in some way. Furthermore, if not properly planned, some activities may make people even more vulnerable to HIV/AIDS or forms of physical and mental abuse.

People living with or affected by HIV/AIDS are often already highly stigmatised or discriminated against. People vulnerable to HIV may be discriminated against for many other reasons too: their sexuality, gender, level of poverty, age or the activities they are involved in (e.g. sex work or injecting drug use). If badly planned, well-intentioned activities may actually increase discrimination against and vulnerability of these groups *(see children case study on this page)*.

Do no harm While many organisations strive to improve the situation of marginalised or vulnerable populations, others go further and adopt a policy of "do no harm". A do-no-harm approach aims to minimise potential harm by considering in advance with vulnerable populations what risks might be involved in participating in an activity. The central philosophy of this approach is that even if activities do no good, they should at least do no harm.

See also: Tool 84 • Risk assessment

Discuss ethics People often have different views about the right and wrong ways to behave in different situations. It is essential that we agree ethical principles with vulnerable populations before we start community mobilisation activities. We may need to review our ethical principles as new stakeholders become involved in the community mobilisation process in order to maintain shared understanding and ownership. Allow plenty of time to discuss ethical principles and resolve any disagreements.

Active and influential participation In addition to ethical issues about doing no harm, there are also issues to consider about how empowering and participatory an activity may be. Community mobilisation should be an activity that allows people to participate actively and influentially in decisions that affect their lives. Careful consideration should be given to ensuring that people are genuinely able to do this and that their mobilisation is not tokenistic or mainly for the benefit of others. The 'Ethics checklist for community mobilisation and PLA for communities, organisations and decision-makers' on page 124 allows you to consider ethical issues when planning community mobilisation and PLA activities.

Codes of conduct We demonstrate our ethical principles with our behaviour: what we do and what we do not do. A code of conduct guides our behaviour, helping us to put our ethical principles into practice. For example, a code of conduct may state that we respect confidentiality relating to HIV/AIDS in all circumstances. Developing a code of conduct helps us to think about the importance of different forms of behaviour and to prepare ourselves for different situations. A code of conduct also encourages us to be accountable for our behaviour to community members and other stakeholders. Allow enough time to develop a code of conduct that provides clear, simple guidelines that all can support.

Example code of conduct: India

- We will be transparent and open about what we do and why we do it.
- We will be clear about what we can do and what we cannot do, and avoid raising expectations that we cannot meet.
- We will do what we say, and we will keep all the promises that we make.
- We will respect the knowledge and opinions of community members at all times.
- We will respect confidentiality relating to HIV/AIDS and sensitive information.
- We will enable the participation of all community members in the mobilisation process, including people who are often stigmatised or discriminated against.
- We will consider possible risks relating to our activities and make sure that people are aware of possible risks before they become involved.
- We demonstrate respect for everyone at all times.
- We demonstrate non-judgemental attitudes and openness to people's differences.
- We demonstrate equity with other people with all our actions; for example, by sitting at the same level, by staying with community members and eating local food.
- We will actively seek to involve children fully in the mobilisation process by creating space for them to participate and demonstrating respect for and interest in their views.
- We will be accountable to community members at all times.
- We will strive to challenge harmful attitudes, behaviours or ideas.

Frequently asked questions about community mobilisation

Is community mobilisation a quick and easy strategy?

Community mobilisation is a long-term process, not an event. It may take several years to achieve sustained results. It requires commitment from people and organisations supporting the process. It is important not to rush it. The process does not always fit easily into organisational planning processes and expectations of predictable results, and requires commitment from managers of organisations involved in community mobilisation. It is important to make sure that capacity, resources and commitment are in place before starting community mobilisation activities, and that capacity building continues throughout the process.

If it takes so long, why bother doing it?

There are many good reasons to do community mobilisation *(see pages 11-12).* It is particularly effective when:

- **national information, education and communication campaigns fail** to reach pockets of the country because access to mass media is limited or language is different
- **changes are needed at community level**, such as reducing stigma and discrimination
- **sustained community support is desired**, especially from communities vulnerable to HIV/AIDS
- **the issue is too politically sensitive** to be the thrust of a major national campaign (e.g. HIV prevention for sex workers, injecting drug users and other marginalised populations)
- **communities are very diverse** and local solutions are required

- **high HIV/AIDS incidence in a particular community group exists** and risks spreading HIV to the wider community.

Should communities do everything?

Community mobilisation does not replace the need for other HIV/AIDS services and activities, such as treatment provision, although it may increase the effectiveness of these by contributing to their design and delivery. The primary responsibility for providing health care still lies with governments.

What is the difference between community mobilisation and participation?

Community mobilisation is a capacity-building process rather than an approach like participation. It is a process in which members take responsibility for learning how to assess, plan, act, monitor and evaluate to address HIV/AIDS sustainably. Community mobilisation uses a range of participatory approaches, tools and techniques in order to do this. It is an empowering experience for many community members as they take the lead in building capacity, trust, networks and relationships. In contrast, participatory approaches use similar tools to involve community members in activities and strategies selected and managed by other people, such as NGOs or governments.

How can support for community mobilisation be developed among donors?

Build understanding of the benefits of community mobilisation Developing support for community mobilisation among donors involves addressing a range of issues. Community mobilisation approaches are gaining popularity as understanding of their impact grows. However, donors may not yet be familiar with the benefits and advantages of the approach *(see pages 11-12 and 'why bother doing it' on page 25).* It is useful to make donors fully aware of these advantages.

Provide evidence of its benefits Evidence of the impact of community mobilisation in other settings will help build the confidence of donors that the approach is effective. Carrying out evaluations, including impact assessments, can help build up evidence. Recording lessons learned about how to do community mobilisation (what works and what does not) will also help to improve community mobilisation processes. Documenting your community mobilisation process and its successes is very important for helping to fund future mobilisations *(see also **Documenting and communicating HIV/AIDS work: A toolkit to support NGOs/CBOs**, page 121).*

Build understanding of the process Community mobilisation processes rarely provide quick and dramatic results, and donors may question whether their resources are being used effectively. The best way to encourage support for community mobilisation among donors is to develop understanding of the capacity-building process. Make sure that donors have realistic expectations of the process from the start, including the likely timeframe. Regular updates on activities will help build understanding. Community mobilisation requires a flexible and responsive approach, and it is important to keep donors up to date with changes to plans. Additionally, donors need to understand that because community mobilisation is a capacity-building process, it can build communities' developmental capacity to address other development concerns.

What resources do we need for community mobilisation?

The resources needed for community mobilisation will vary and depend largely on the activities to be carried out (e.g. prevention activities require a slightly different set of resources than ARV treatment activities).

Many activities can be done with limited resources or by mobilising resources from within the community. This will reduce the dependency of the community on outside sources of support. Availability of resources is an important factor in decision-making by the community about the strategies to select to reach their objectives. Open discussion about the likely availability of resources will help avoid raising community expectations. It is important that inputs of external resources are introduced gradually, carefully and transparently, enabling full ownership by the community of decisions about the way they are used.

Who can do community mobilisation?

Communities mobilise themselves! However, they may need support from the outside. Supporting the process from the outside requires a range of skills, experience and understanding. Organisations that reflect the principles and values of community mobilisation will provide more effective support to community mobilisers. People and organisations considering involvement in community mobilisation need to make sure that they have sufficient capacity, commitment and resources to support a community to achieve sustained change.

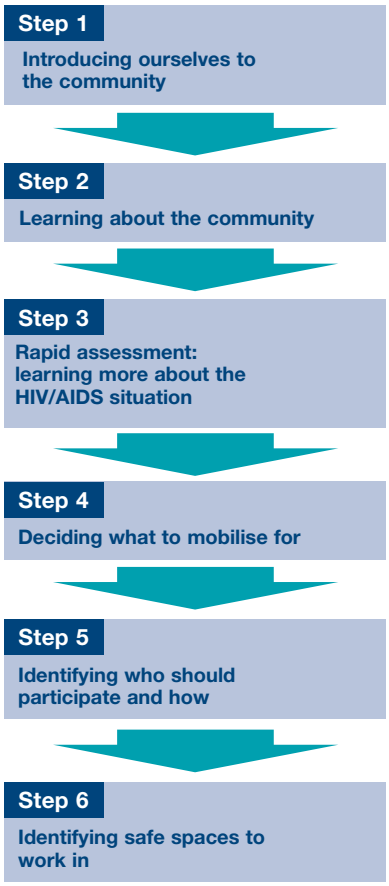
Stage 1: Starting together

Summary

Stage 1 describes how we begin to work in a community or area.
It covers:

- what we mean by starting together
- why we start together
- where we start mobilising
- who we start mobilising
- when we start mobilising
- how we start mobilising
- starting together on prevention, care and support, ARV
- treatment and impact mitigation
- checklist for starting together.

How do we start together?



What do we mean by starting together?

Starting together means deciding with the community where we should start mobilising, as well as with whom, when and how. It introduces the community to us and us to the community. It involves getting the commitment of the community to the process and beginning to learn about the HIV/AIDS situation in the community. We find out about how the community is responding to the epidemic. We start to see if, and how, the non-governmental or community-based organisation might help to mobilise the community. The overall aim of starting together is to build trust with the community. It is perhaps the most critical stage of the community mobilisation process, as how we start often sets the tone for how we will continue.

Starting together means:

- deciding where and with whom we start mobilising
- deciding the best time to start mobilising
- ensuring that all those who wish to participate are able to do so
- building up a picture of the HIV/AIDS situation in the community
- identifying what to mobilise for – prevention, care and support, treatment or impact mitigation (or a combination of these)
- agreeing roles and responsibilities
- building trusting partnerships with the community.

Why start together?

Starting together helps to:

- engage community members in responding to HIV/AIDS right from the start
- agree broad objectives of the mobilisation process with the community
- build trust between the community and your organisation
- develop a model of participation on which to build community mobilisation
- build self-esteem and confidence among community members
- provide an overview of the community, helping us to focus assessment activities in Stage 2
- identify or develop coordination mechanisms with community members and stakeholders
- avoid repetition of existing activities and identify unmet needs and gaps in services
- avoid conflict; for example, due to people feeling left out of the process
- encourage community ownership of future initiatives right from the start.

Where, when and with whom do we mobilise?

In order to mobilise communities successfully, we need to consider carefully where, when and with whom we mobilise. Our own priorities about which communities to mobilise with will influence our decision about how to mobilise. Governments and donors may also influence our decision. The community is key in deciding when, where and with whom to start mobilising.

There are a number of practical issues to consider.

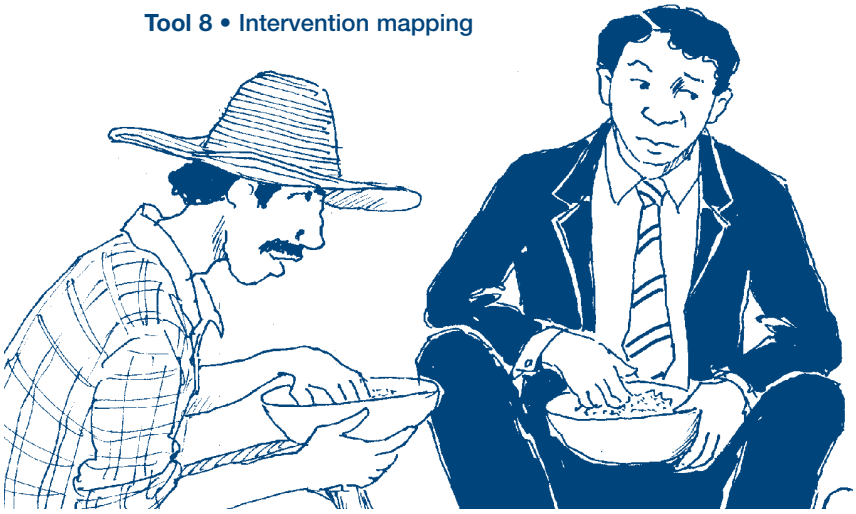
What information about needs already exists? Start by gathering as much information as possible about different areas. We can use sources such as research reports, government departments and people with knowledge of the area. Information about different areas and the communities living there is likely to be incomplete at this stage, and we need to use our judgement about gaps and people's opinions about

different areas. Exploratory visits to different areas and a rapid assessment *(see definition of rapid assessments on page 30)* may be helpful.

Different people's priorities Be aware that government and donor priorities about where and when we mobilise may be influenced by political or other concerns. Their ideas also may be based on incomplete information about communities and needs in different areas.

What activities are already taking place? We need to consider the activities other communities and organisations may be already carrying out in different areas and any activities they may have planned. Your mobilisation process might be able to complement or scale up existing processes. However, we also want to minimise overlap and duplication of effort. Two similar community mobilisation processes in the same community can lead to confusion and even conflict.

See also: **Tool 2 • Broad mapping**
Tool 8 • Intervention mapping



Consider the logistics of mobilising in different areas For example, are there particular concerns such as security? If so, how will this affect community mobilisation efforts? Are we able to access an area and coordinate our activities in an area easily? In a further example, community mobilisers should stay where community members are, or as close as possible. This helps mobilisers to develop a deeper understanding of life in the community and demonstrates their commitment to the community. It also makes it easier for mobilisers to be available at times and places convenient to the community, and reduces logistical and transport difficulties.

Where is the greatest need? We need to work with communities in greatest need. Key questions that will help us identify which communities have the greatest need are:

- Who is most affected by HIV/AIDS?
- Who is most important to the spread of HIV infection?
- Who is less well-served by HIV/AIDS services and activities?
- Who is more marginalised and discriminated against?

It is not always easy to know the answers to the questions *(see Tool 89)*. You may already have some knowledge; for example, if you have been working in the area. Talking to different people will provide you with more information, but you will need to distinguish between prejudice, opinion and fact. The best way to do this is to go to the community in question and see for yourself (*see Tool 12*). Once in the community, the tools suggested on pages 31-38 will help you to carry out a rapid assessment of the situation.

See also: **Tool 12 • Transect walks**
Tool 89 • Targeting

Some communities can be very hard to reach They may be invisible to outsiders and their existence not generally acknowledged. For example, in some places the existence of men who have sex with men is not recognised by the wider community.

Stage 1: Starting together

Definition

What are rapid assessments?

A rapid assessment is a quick participatory assessment that aims to provide a general picture of the HIV/AIDS situation. It uses PLA tools and secondary information to fill major gaps in our knowledge about a community. It is different from other participatory community assessments (PCAs) in that it does not aim to empower communities to conduct their own assessment of how HIV/AIDS affects their lives. Rather, it is led by outside organisations. The process of assessment will not in itself encourage communities to mobilise. A rapid assessment is usually done more quickly than a PCA.

But these hard-to-reach communities are often the most in need. Starting together, involving many stakeholders and using participatory tools such as mapping tools *(see Tools 1-14)* will help us learn more about the existence and identities of different communities.

The motivation of the community Where possible, we start community mobilisation when a community has also expressed interest in the process and in HIV/AIDS issues. Tool 74 can help you assess the community's level of motivation. Exploring the following issues with the community (e.g. in a community meeting) can help them to agree that action is required:

- critical incidents (e.g. someone dying of AIDS)
- common problems (e.g. how to look after children orphaned by AIDS)
- expressed needs (e.g. access to ARV treatment)
- traditional community events
- general development activities
- emergencies – in many communities, HIV/AIDS is an emergency!

See also: **Tool 74 • Feasibility matrix**

Exploring common community concerns can help to stimulate community action on HIV/AIDS

Are people able to participate freely? Where barriers to participation are very high (e.g. when community members cannot meet freely) we may need to establish relationships with gatekeepers or other stakeholders *(see opposite)* before we can decide when to mobilise. People whose basic needs are not met (e.g. for food and shelter) are likely to find meaningful participation in community mobilisation activities difficult. People involved in illegal activities such as drug use or migrant workers without permits may be unable to participate in meetings or discussions for fear of harassment or arrest. Communities with the greatest needs are often among the hardest to reach, and it is important not to dismiss the possibility of mobilising successfully because there are many obvious difficulties. Be aware that in some situations there may be significant risks to community members who start to mobilise *(see opposite)*. Tools 74 and 81 will help you to understand people's ability to participate.

See also: **Tool 74 • Feasibility matrix**
Tool 81 • Stakeholder participation matrix

When we have the capacity to start Before we mobilise, we need to assess our capacity. Do we have the skills and resources necessary to mobilise effectively? Do we need to address any weaknesses before we start? How can we do this? We start community mobilisation when we are confident that we have the commitment and resources to work with the community for long enough to achieve sustainable results.

See also: **Tool 74 • Feasibility matrix**
Tool 76 • Impact matrix
Tool 84 • Risk assessment
Tool 87 • Sustainability matrix
Tool 88 • SWOC analysis

How do we start together?

Step 1: Introducing ourselves

As we start working in a community or area, we need to introduce ourselves to the local people, leaders and authorities. It is important to let people know who we are and what we want to do. This is in order to:

- get permission to work in the community or area from the relevant authorities
- respect local leadership and customs
- begin to develop relationships
- begin to ensure realistic expectations of what your organisation may be able to contribute
- begin to establish honest communication and avoid causing suspicion and mistrust.

Be open with the community It is important to be prepared to listen and learn about the concerns and experiences of people and organisations in the community and area. People are likely to have questions and expectations about what the organisation is going to do. These should be discussed as openly and honestly as possible.

You should be prepared to talk about:

- who you are and where you come from
- the skills, interests and capacity of your organisation
- the general reasons you have come to the community or area
- the community mobilisation process
- how and when different stakeholders will participate
- what resources are available
- what the next steps are.

Definition

Gatekeepers and stakeholders?

Gatekeepers are people who control access to certain individuals, groups of people, places or information. For example, schoolteachers and parents are gatekeepers to children; brothel owners are gatekeepers to sex workers.

Stakeholders are people who have an interest (or stake) in the outcome of community mobilisation. A primary stakeholder is a person or organisation that a community mobilisation process aims primarily to benefit (e.g. a young person in a youth prevention process). A secondary stakeholder is someone who may not benefit directly but who will be affected or involved in some way (e.g. a teacher in a youth prevention process).

Case study

Building trust

Sex workers in Papua New Guinea believed that involvement in HIV prevention activities was contributing to the problems they were experiencing with police harassment. NGO workers took several months to re-establish relationships with the women, attempting to support the sex workers and demonstrate their commitment. Ensuring non-judgemental attitudes among NGO workers and avoiding media coverage of HIV/AIDS activities assisted with this.

Stage 1: Starting together

Top Tip

Encouraging realistic expectations

Community members and other stakeholders are likely to have many expectations of an organisation. These might be based on previous experience of organisations (non-governmental and community-based organisations) and/or on what people know or believe about the specific group that is starting work in the community.

Build realistic expectations It is important that stakeholders have realistic expectations of your organisation from the start. Unrealistic expectations will lead to disappointment when the group does not deliver and might cause the community to lose interest in the community mobilisation process.

The simplest way to manage expectations is to ensure clear and honest communication with stakeholders about the skills, intentions and resources of the organisation from the start. It is also important to be aware of situations that are likely to raise expectations. For example, stakeholders may hope that an organisation can help with all the problems they raise during a discussion. Clear communication about the objectives of such a discussion will help to avoid raising unrealistic expectations.

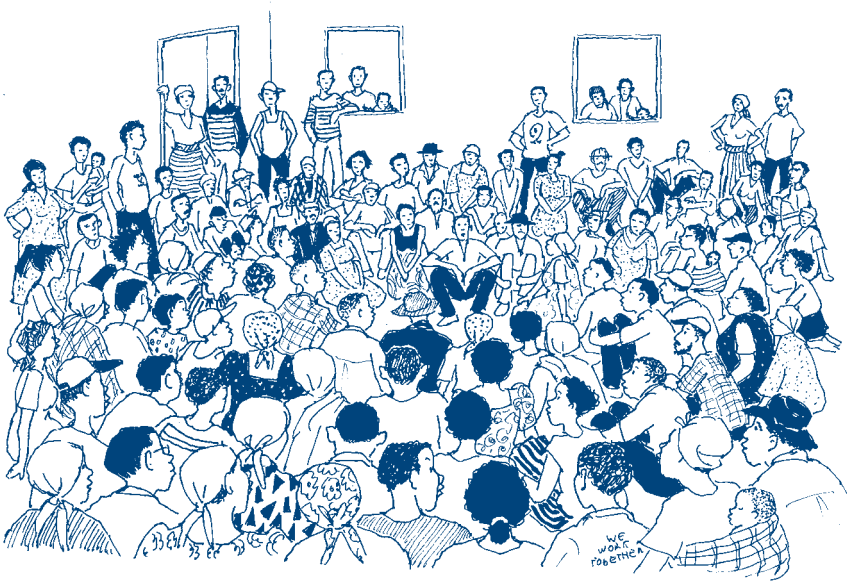
Where there is a history of organisations working in a certain way it may take time to overcome expectations. For example, if an organisation starts work in a community where people have previously received money for attending meetings, the organisation will need to provide a clear explanation of why they will not be providing payments and be prepared to keep repeating that explanation to different stakeholders.

Tensions and conflict An organisation may start with limited awareness and understanding of relationships and dynamics in a community. Discussions with different stakeholders may begin to reveal tensions and conflict as well as power relationships and interdependency. An organisation should be careful not to "take sides" in a conflict, especially if it only has a limited understanding of the situation. Be clear with stakeholders about the role and limitations of the organisation from the very beginning. This will help to avoid raising expectations that you cannot meet.

After meetings with key stakeholders, it may be useful to arrange a large meeting to explain these issues to the wider community and answer any questions.

Step 2: Learning about the community together

After introducing ourselves to the community, we now need the community to introduce itself to us. A useful way to do this is to involve the community in introductory activities such as mapping *(see Tools 1-14)*. This involves using participatory tools to map and explore key characteristics of the community. It helps to define the different groups within the community or area. It can also guide decisions about which people and organisations to work with during the participatory assessment *(see Stage 2)*.



Introducing yourselves to the community encourages understanding, trust and realistic expectations of the community mobilisation process

Involving different stakeholders in mapping the community helps to begin to build relationships. Where possible, it is useful to involve members of key populations as facilitators in the process. It also helps to enable the meaningful involvement of these groups in the next steps.

Mapping the community together	
Issues to explore	**Possible tools**
Community boundaries and landmarks Important places in the community. Views on the boundaries of the community. Different groups in the community.	**Tool 2:** Broad (or sketch) mapping **Tool 3:** Community mapping **Tool 12:** Transect walks
Services and resources Services, organisations, service-providers, non-governmental and community-based organisations, religious groups, etc. in the community. Important gaps in services in the community.	**Tool 3:** Community mapping **Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 12:** Transect walks **Tool 14:** Universe map
Relationships between service providers.	**Tool 23:** Circles diagram
HIV/AIDS context Key concerns, and levels of concern, about HIV/AIDS in the community.	**Tool 18:** Lifeline **Tool 63:** Matrix scoring
Past and present action on HIV/AIDS in the community.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline
Areas of action on HIV/AIDS to which the non-governmental or community-based organisation might contribute.	**Tool 8:** Interventions (services and activities) mapping **Tool 14:** Universe map **Tool 21:** Trend diagram **Tool 33:** Services (interventions) web

Step 3: Rapid assessment: learning more about the HIV/AIDS situation together

Mobilisers and community members need to understand the community and its HIV/AIDS situation in more detail. This will help agree the broad objectives of the community mobilisation and focus work on those most in need of mobilising. In order to do this, we need to encourage the community to ask itself the same questions we asked when deciding where to work:

- Who is most affected by HIV/AIDS in the community?
- Who are the key populations in the community?
- Who is less well-served by HIV/AIDS services and activities?
- Who is more marginalised and discriminated against?

To answer these questions, it is useful to carry out a rapid assessment with the community. Where possible, community members should be members of the rapid

Stage 1: Starting together

Definition

What are key populations?

Key populations are those groups or individuals who are most at risk of either contracting or passing on HIV. They will be at risk because their behaviour or circumstances make them vulnerable to engaging in risky behaviour (e.g. unprotected sex). By identifying and working with key populations, HIV incidence can be reduced not only within that group but also within the wider population.

assessment team. This will help the community to understand for itself what the HIV/AIDS situation is (guidance on how to train community members in rapid assessment tools can be found in Section A of *Tools Together Now!*).

When starting to mobilise together on HIV prevention, care and support, treatment and impact mitigation, some of the key issues and possible tools to explore them are included in the table below.

Starting together on prevention

Issues to explore	Possible tools
Possible key populations who live within the community. Size of populations.	**Secondary sources of information, such as reports, maps, newspapers, etc** **Tool 2:** Broad (or sketch) mapping
Living and working patterns of key populations.	**Tool 3:** Community mapping **Tool 5:** (Gendered) resource mapping **Tool 60:** What is …? diagram
The relationships between key populations and others.	**Tool 11:** Social network (relationship) mapping
Key services and gaps in services. Key gatekeepers. Current or planned prevention activities taking place in the community or area.	**Tool 3:** Community mapping **Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 14:** Universe map **Tool 33:** Services (interventions) web
Who are the most vulnerable?	**Tool 4:** Focused mapping **Tool 11:** Social network (relationship) mapping

Starting together on care and support

Issues to explore	Possible tools
Numbers of households/people affected by HIV/AIDS, including orphans and vulnerable children.	Secondary sources of information, such as reports, maps, newspapers, etc. **Tool 4:** Focused mapping **Tool 13:** Well-being mapping
Stigma and discrimination in the community.	**Tool 9:** Mapping stigma
Networks and support groups for people living with and/or affected by HIV/AIDS. Key gatekeepers, including those for orphans and vulnerable children.	**Tool 28:** Helping relationship web **Tool 33:** Services (interventions) web
Key services and gaps in services. Current or planned care and support activities taking place in the community or area.	**Tool 3:** Community mapping **Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 14:** Universe map **Tool 33:** Services (interventions) web

Starting together on antiretroviral treatment

Issues to explore	Possible tools
Numbers of households/people affected by HIV/AIDS.	Secondary sources of information, such as reports, maps, newspapers, etc. **Tool 4:** Focused mapping **Tool 13:** Well-being mapping
Stigma and discrimination in the community.	**Tool 9:** Mapping stigma
Networks and support groups for people living with and/or affected by HIV/AIDS.	**Tool 28:** Helping relationship web **Tool 33:** Services (interventions) web
Key services and gaps in services. Current or planned treatment activities taking place in the community or area.	**Tool 3:** Community mapping **Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 14:** Universe map **Tool 33:** Services (interventions) web

Stage 1: Starting together

Starting together on impact mitigation

Issues to explore	Possible tools
Levels of poverty in the community.	**Tool 5:** (Gendered) resource mapping **Tool 13:** Well-being mapping **Tool 24:** Division of labour chart
Numbers of households/people affected by HIV/AIDS. Numbers of child-headed households, homeless children and orphans.	Secondary sources of information, such as reports, maps, newspapers, etc. **Tool 4:** Focused mapping
Networks and support groups for poor people and people living with and/or affected by HIV/AIDS.	**Tool 28:** Helping relationship web **Tool 33:** Services (interventions) web
Key impact mitigation services and gaps in services. Current or planned impact mitigation activities taking place in the community or area.	**Tool 3:** Community mapping **Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 14:** Universe map **Tool 33:** Services (interventions) web
Impacts of HIV/AIDS on the socio-economic situation. Impacts of HIV/AIDS on children.	**Tool 30:** Problem tree

Step 4: Deciding what to mobilise for

When the rapid assessment is done, we need to use the information to focus our community mobilisation efforts. In order to do this, we work with the community to collect the rapid assessment information together and summarise it. The community is then given the opportunity to express their desired changes. Following this, the community is facilitated to make a basic activity plan that will bring about their desired changes. This plan includes:

- **Which groups or key populations in the community** will the community mobilisation process target?
- What will these groups or key populations mobilise for – that is, prevention, care and support, treatment, impact mitigation or a combination of these to provide a continuum of care?
- A rough timeline for mobilisation – when will each stage of the community mobilisation process take place?
- What resources will be required to mobilise these communities at each stage?
- What capacity building will be required to mobilise communities at each stage (e.g. training community members to conduct participatory assessments)?

At this stage the plan only needs to be basic. More detailed plans can be made for each group to be mobilised after the participatory assessments in Stage 3.

The time communities have available When planning, consider the time people have available. Seasonal work or holidays may mean that community members are busy or away at certain times of the year. The rainy season often disrupts transport and travel, which may be an issue if the community is scattered in different areas. Consultation with community members will tell us when we can start and will also help identify the days and times most convenient to community members for community mobilisation activities.

Deciding who to work with and on what issues	
Issues to explore	**Possible tools**
Collecting together all the rapid assessment information.	**Tool 71:** Assessment summary matrix
Identifying desired changes	**Tool 72:** Desired change diagram **Tool 91:** Vision diagramming
Timing activities appropriately.	**Tool 16:** Daily activity charts **Tool 19:** Seasonal calendar
Making a basic activity plan.	**Tool 69:** Action planning

Step 5: Identifying who should participate and how

Identifying all stakeholders After identifying the main focus of the community mobilisation process, it is now necessary to identify who needs to take part at what stage and what their roles and responsibilities will be. Tool 81 is a participatory tool that can help to make sure that everyone is able to participate as much as they wish to. It is vital that everyone who is affected by the priority HIV/AIDS issues is able to participate meaningfully in the community mobilisation process. For example, what level of decision-making responsibility will different stakeholders have? If we leave key stakeholders out, or if they feel that they have been ignored, full community mobilisation will not have occurred and we risk failing to meet our objectives. Therefore, spending a little time making sure that everyone who should take part is taking part – and is able to participate as much as they wish to – is time well spent.

At this point, it is also helpful to discuss the role of existing HIV/AIDS-related committees and networks. This can help to avoid bypassing existing mechanisms that are working well or revive those that are inactive. We can make sure that we have identified all stakeholders using our existing knowledge and contacts, using information from the rapid assessment (such as mapping) and by asking stakeholders that we meet to identify other stakeholders – a process known as "snowballing".

See also: Tool 81 • Stakeholder participation matrix

Definition

What is snowballing?

This is a simple way of identifying different stakeholders. Each time we meet a stakeholder we end the discussion by asking: "Who should we talk to next?" When no new names or groups are mentioned we know that we have identified most or all of the stakeholders.

Stage 1: Starting together

Involving community stakeholders	
Issues to explore	**Possible tools**
Who are all the primary community stakeholders? Who are all the secondary stakeholders?	Secondary sources of information, such as newspapers, maps and government or NGO reports **Tool 2:** Broad (or sketch) mapping **Tool 3:** Community mapping **Tool 6:** Health facility (service) mapping Snowballing
When to involve different stakeholders (e.g. in assessing, planning and/or implementing). What level of decision-making each stakeholder will have and who they need to communicate with.	**Tool 81:** Stakeholder participation matrix

Step 6: Identifying safe spaces to work in

Are there safe spaces for communities to meet? Before moving on to assessing together, we need to ensure that there are safe spaces for community groups to meet. Community mobilisation activities should take place at locations that are convenient and comfortable for community members. It is important to find a safe and private space where community members can build trusting relationships and participate in discussions freely (Tool 3 can help identify these). It may be necessary to negotiate with gatekeepers and other stakeholders *(see definitions of gatekeepers and stakeholders on page 31)* to find a place where community members can meet together without fear of harassment.

See also: Tool 3 • Community mapping

Checklist for Stage 1: Starting together	
Issue	**Tick** ☑
Are you clear why we start together?	
Have you identified the communities most in need?	
Have you considered the logistics of working in those communities?	
Is the community motivated to mobilise?	
Does your organisation have the capacity to mobilise?	
Have you introduced yourselves to the community?	
Does the community understand the community mobilisation process?	
Does the community have realistic expectations about it?	
Has the community been mapped?	
Have you carried out a rapid assessment of the HIV/AIDS situation in the community?	
Have you identified the key populations and the most vulnerable within the community?	
Have you agreed the focus of the community mobilisation with the community?	
Have you made a basic action plan for the next stages of community mobilisation?	
Have you identified who will participate, when and how?	
Have you identified safe spaces?	

If you have achieved all of these things it is time to move on to Stage 2: Assessing together

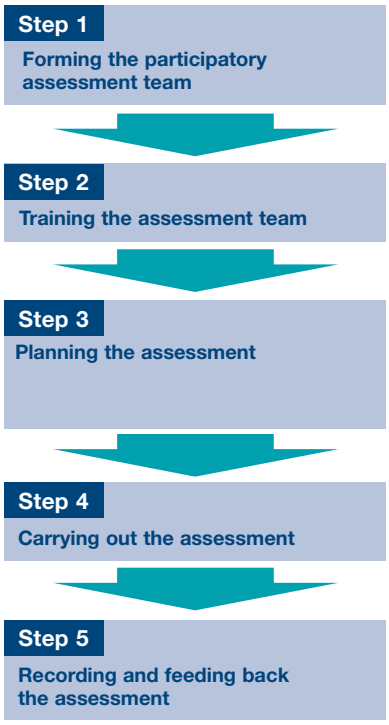
Stage 2: Assessing together

Summary

Stage 2 describes how the community can explore and analyse HIV/AIDS issues. It covers:

- what we mean by assessing together
- why assess together
- forming the participatory assessment team
- planning a participatory assessment
- how to assess prevention, care and support, ARV treatment and impact mitigation together
- feeding back and recording information
- checklist for assessing together.

How do we assess together?



What do we mean by assessing together?

Assessing together means building the capacity of the community to carry out a detailed exploration of the HIV/AIDS issues existing within it. The assessment focuses on broad areas of concern identified by the community during Stage 1. We use a series of participatory tools to enable community members to identify and analyse issues, share knowledge and ideas, enhance their knowledge of the situation and begin to identify the way forward. The knowledge, skills and understanding we develop by assessing together helps mobilise a community-led response to HIV/AIDS.

Assessing together means:

- providing the necessary training and support to enable community mobilisers to carry out a participatory assessment with the community's most affected groups
- finding out together what are the specific HIV/AIDS issues for the most affected groups within the community in order to plan better responses together
- beginning to mobilise the community for action on HIV/AIDS.

Why do we assess together?

Assessing together helps to:

- provide detailed information about HIV/AIDS issues in the community for planning together *(see Stage 3)*
- increase general community awareness, knowledge and understanding of HIV/AIDS-related issues
- enable specific community groups to share knowledge and ideas, so helping to develop appropriate and effective interventions
- build relationships with and between stakeholders
- build understanding of the perspectives of different community members
- build community ownership of the process, increasing effectiveness and sustainability of mobilisation
- build skills and capacity of community members in the assessment team
- build self-esteem and confidence among community members
- contribute to the impetus for community action
- build trust between all stakeholders.

How do we assess together?

Step 1: Forming the participatory assessment team

Forming the assessment team The assessment team is responsible for planning and facilitating the assessment, and for feeding back the assessment findings to the community. Forming an assessment team with the right mix of personalities, skills and credibility within the community is important for the success of a participatory assessment. It is important to include community members in the assessment team in order to build ownership of the assessment and to develop skills and capacity.

Include members from the same groups to be assessed People usually feel more comfortable talking to people who are like themselves. So it is important that the assessment team reflects the characteristics of community members; for example, by gender, age, language, ethnicity, social or economic status and sexual identity (if known). When working with communities who may be wary of contact with outsiders (e.g. communities who are involved in stigmatised or illegal activities) it is particularly

important to include peers from that group on the assessment team.

Including representatives of different stakeholders in the assessment team can also help build active partnerships and increase understanding of HIV/AIDS issues between different sectors of the community. For example, it might be helpful to include both formal and informal care providers in a care and support-focused assessment.

Future community mobilisers You should choose your assessment team bearing in mind that these people eventually will become the core group of community mobilisers throughout every stage of the process. It is quite acceptable for the assessment team also to be members of the community mobilisation team.

Step 2: Training the assessment team

Training these people in participatory assessment will be the first capacity building they will receive as community mobilisers. It is an essential skill for them to learn. Here they will discover many of the skills, knowledge, attitudes and behaviours that they can use in each stage of the community mobilisation process. Training must provide all team members with the opportunity to develop:

- knowledge relating to HIV/AIDS, gender and sexuality
- active listening skills
- effective questioning skills
- skills in facilitating group discussions
- appropriate attitudes and behaviours that encourage participation, learning and action
- knowledge of PLA tools and how to use them
- team-working skills
- knowledge of how to plan PLA sessions.

Training for the assessment team members should take account of differences in experience, capacity, social status and self-confidence among team members. Section A of ***Tools Together Now!*** provides guidance on how to train community mobilisers in these skills.

Definition

What is a participatory assessment?

Participatory assessment uses PLA tools, attitudes and behaviours to enable community members to share, enhance and analyse their lives and conditions so they can plan to improve them. There are many different types of participatory assessment used in mobilising communities for HIV/AIDS. They all make use of the same principles and tools but differ in what they are used for and who they are used with.

Some common types of participatory assessment used by the Alliance include:

- **participatory community assessment (PCA)**, used to assess the situation in a single community or group within a community
- **participatory site assessment (PSA),** used to assess the situation in several communities within the same geographical location (e.g. a city)
- **participatory assessment and response** (PAR), a specific type of assessment used to assess the situation with injecting drug users.

Stage 2: Assessing together

Top tip

The suggested issues and tools are for guidance only! It is not essential that you cover all the issues suggested. You may also find others that need exploring. In that case, include them in your assessment too. There is also no need to use all of the tools suggested. You may find that one tool alone covers many issues, or you may find other participatory tools more helpful.

Case study

Negotiating safe spaces

NGO staff in Thailand wanted to work with immigrant fishermen operating illegally in the area. Taking time to develop relationships with the fishing boat owners helped them to reach the fishermen and begin discussions about how they could work together. However, the fishermen were wary of meeting in groups as this made them visible to the immigration police. The NGO staff continued to develop relationships with individual fishermen and different gatekeepers. As trust developed, influential people among the local authorities agreed to facilitate the NGO and fishermen working together by providing safe venues. The fishermen became confident that they could meet together for discussions without fear of the immigration police.

Individual (or group of similar individuals) context – these issues concern those most affected by HIV/AIDS, as identified in the rapid assessment.

Community context – these issues concern the HIV/AIDS situation in the wider community.

Services and supplies context – these issues concern the quality of and access to HIV/AIDS services.

Laws and polices context – these issues concern the impact of laws, policies and procedures on HIV/AIDS.

Step 3: Planning the assessment

In order to allow people to analyse and learn about their situation fully, a participatory assessment will use several participatory tools at the same time. When several tools are used together in a sequence, in one sitting, this makes up a PLA session. PLA sessions should be planned so that participants can get the most out of them. In order to do this, it helps to answer as an assessment team the following questions in advance:

- **What are the objectives of the assessment?** Your rapid assessment in Stage 1 will guide you in deciding what are the main issues in the community. You now need to find out more detail about these issues with the groups specifically affected by them. This is so that detailed plans can be made for mobilising these groups.
- **What issues need to be explored in more detail?** The tables in Step 5 (*see 44-66*) offer guidance on the specific issues that need to be assessed for prevention, care and support, treatment and impact mitigation.
- **What PLA tools might we use?** These tables also offer guidance on the tools that can be used to explore specific issues.
- **Who to do the assessment with?** Your rapid assessment in Stage 1 will help you identify the people in the community most likely to be affected by HIV/AIDS.
- **Where to do the assessment?** Your rapid assessment in Stage 1 will also suggest where to find those most affected and how to identify safe spaces to carry out the assessment.
- **When to do the assessment?** Your rapid assessment in Stage 1 will help you determine when are the most suitable times to do the assessment.

Section A4 of ***Tools Together Now!*** will help you to answer these other important questions:

- What materials and resources will be required?
- What is the timetable and budget for the assessment?
- What are the roles and responsibilities of assessment team members?
- What should be done in difficult situations?
- What are the ethical issues to consider?

To help you plan, you may also like to use the PLA session planning form in ***Tools Together Now!*** (*see page 242*).

Step 4: Carrying out the assessment

You are now in a position to conduct your participatory assessment. The tables provide guidance on what issues and tools to consider using for assessing prevention, care and support, treatment and impact mitigation. They are further divided into the four different contexts *(see left)* that need to be considered in order to mobilise a community sustainably:

- individual (or group of similar individuals)
- community
- services and supplies
- laws and policies.

Step 5: Recording and feeding back the assessment

Recording the assessment It is necessary to have an accurate and detailed record of the assessment in order to use the findings for planning together. The original maps and diagrams drawn by the community should remain with them or be held in care by the assessment team if they request it. Since it was the community who carried out the assessment, the findings belong to them. This will encourage ownership of the assessment findings by the community.

You also need your own record of the assessment, both information about HIV/AIDS issues and lessons learned about how to do participatory assessments. ***Tools Together Now!*** provides a sample PLA note-taking form *(see page 246)* that can be used to help organise information for this purpose.

Feeding back and verifying the assessment findings When the assessment has been done, you need to make sure that the information accurately reflects the needs of the different groups within the community. You can do this by making a presentation to the community of your findings. In this presentation you can ask the community whether the assessment reflects their issues or not. Where it does not, they can correct you. This is called verification.

Top tip

You will notice that many of the issues that need to be explored for prevention, care and support and treatment are similar. If you are doing an assessment to provide a continuum of care, or part of a continuum (e.g. care and support and ARV treatment), you may be able to combine these into one assessment.

Feedback of assessment findings in Uganda highlighted how people living with HIV/AIDS identified stigma and discrimination to be one of their greatest problems, while other stakeholders did not realise that this was a significant difficulty

Stage 2: Assessing together

HIV prevention: Individual (or group of similar individuals) context

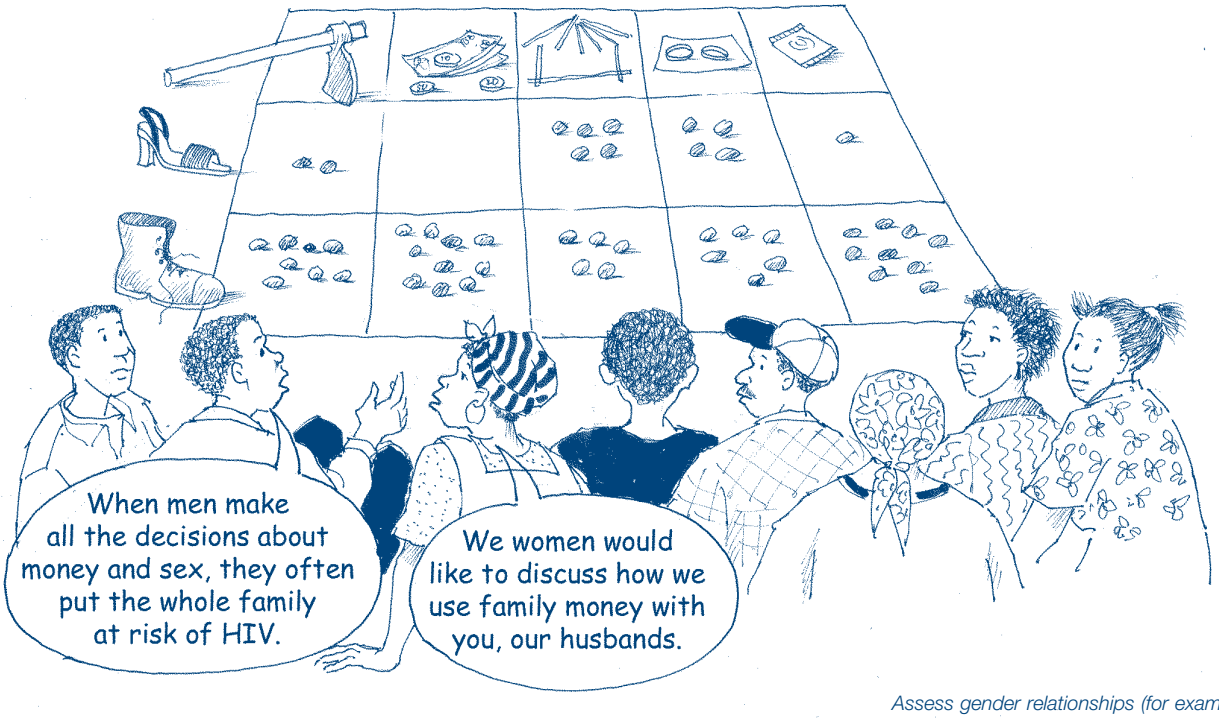
Issues to explore	Possible tools
Vulnerability and resilience Factors that make people vulnerable to HIV infection.	**Tool 22:** Cause and effect diagram **Tool 29:** Octopus diagram **Tool 70:** Measuring empowerment
Factors that help people avoid HIV infection.	**Tool 61:** Card sorting
Knowledge Knowledge and beliefs about AIDS and preventing HIV infection. Knowledge of HIV risk.	**Tool 1:** Body mapping **Tool 22:** Cause and effect diagram **Tool 29:** Octopus diagram **Tool 44:** Hot seating **Tool 55:** Risk game
Sources of information about HIV/AIDS.	**Tool 6:** Health facility (service) mapping
Attitudes About HIV/AIDS and STIs. About self-esteem. About risk. About sex, including roles. About people living with HIV/AIDS. About HIV-positive women having children. About sexual health.	**Tool 9:** Mapping stigma **Tool 36:** Agree/disagree game **Tool 44:** Hot seating **Tool 56:** Role play
Norms, values, traditions within the group Gender relations. Attitudes towards sex and sexuality. Age of marriage and families.	**Tool 25:** Gender boxes **Tool 26:** Gender roles chart **Tool 27:** Gender myths **Tool 45:** Ideal images
Age that males and females become sexually active.	**Tool 18:** Lifeline **Tool 40:** Community drama
Potentially risky cultural practices (e.g. male and female circumcision, scarification, etc).	**Tool 53:** Picture codes **Tool 54:** Picture story
Behaviours Relationships, in and outside of marriage – sexual and non-sexual. Sexual behaviours, including the selling of sex. Safer sex methods used/preferred. Age of sexual debut for boys and girls. Power dynamics. Alcohol and other drug use. Choices and risk. Role of elders and traditional leaders for sex initiation. Sexual abuse and rape.	**Tool 10:** Mobility mapping **Tool 16:** Daily activity charts **Tool 44:** Cause and effect diagram **Tool 54:** Picture stay **Tool 56:** Role play

continued

HIV prevention: Individual (or group of similar individuals) context

(continued)

Issues to explore	Possible tools
Skills Condom use. Negotiating sex and condoms. Assertiveness. Talking with sexual partners. Feeling in control. Self-defence from violent partners.	**Tool 49:** Negotiation card game **Tool 56:** Role play
Personal stories Life stories, both good and bad. Effect of life experiences on current vulnerability and resilience. Gender and sexual identity.	**Tool 18:** Lifeline **Tool 22:** Cause and effect diagram **Tool 47:** Life history **Tool 70:** Measuring empowerment
Hopes and dreams Ambitions, hopes and dreams for the future. Expectations and concerns about the future.	**Tool 15:** Before and now diagram **Tool 54:** Picture story **Tool 72:** Desired change diagram **Tool 91:** Vision diagramming



Assess gender relationships (for example, who makes decisions in the household?)

Stage 2: Assessing together

HIV prevention: Community context

Issues to explore	Possible tools
Population characteristics Number of people in the community. Age ranges. Ethnic groups in the community. Languages spoken. Religions of the community. Social status of different groups in the community.	**Tool 3:** Community mapping Focused group discussions. Secondary sources of information (reports, research papers, maps, etc).
Socio-economic situation Levels of poverty in the community. Levels of education and literacy. Livelihoods and sources of household income. Availability of transport, leisure activities, etc. Important places (markets, pharmacies, etc).	**Tool 3:** Community mapping **Tool 12:** Transect walks **Tool 13:** Well-being mapping Secondary sources of information (reports, research papers, maps, etc).
Gender division of labour and income.	**Tool 16:** Daily activity charts **Tool 24:** Division of labour chart
Mobility/migration patterns into and out of the community.	**Tool 10:** Mobility mapping
Seasonal changes, including income and spending.	**Tool 19:** Seasonal calendar
Social relationships Important relationships (family, with authorities, etc). Sexual relationships. Sources of information on HIV/AIDS (people, services, media, NGOs, CBOs, religious groups, traditional leaders, elders, etc). Role of religious groups or traditional structures.	**Tool 11:** Social network (relationship) mapping **Tool 23:** Circles diagram
Violence and conflict (personal, sexual, etc).	**Tool 47:** Life history
Norms, values, traditions Gender relations. Attitudes towards sex and sexuality. Age of marriage and families.	**Tool 25:** Gender boxes **Tool 26:** Gender roles chart **Tool 27:** Gender myths **Tool 45:** Ideal images
Age that males and females become sexually active. Role of traditional leaders in enforcing norms. Role of religious customs and practice.	**Tool 18:** Lifeline **Tool 40:** Community drama
Potentially risky cultural practices (e.g. male and female circumcision, scarification, etc).	**Tool 53:** Picture codes **Tool 54:** Picture story

continued

HIV prevention: Community context

(continued)

Issues to explore	Possible tools
General concerns Priority concerns about sexual and reproductive health (for men, women, young people, etc).	**Tool 22:** Cause and effect diagram **Tool 63:** Matrix scoring
Health General and priority health concerns. Sexual and reproductive health concerns.	**Tool 1:** Body mapping **Tool 63:** Matrix scoring (for frequency and severity of health concerns)
Frequency and severity of different health concerns. Seasonal changes in health.	**Tool 17:** Health journey **Tool 20:** Seasonal health and disease calendars
What people do and where they go when they are ill. How people pay for health care if it is not free. What people do to avoid priority health problems.	**Tool 17:** Health journey **Tool 21:** Trend diagram (for changes in sexual health) **Tool 54:** Picture story
HIV/AIDS prevalence. STI prevalence.	Records from health facilities.

Stage 2: Assessing together

HIV prevention: Services and supplies context

Issues to explore	Possible tools
Availability Services, supplies and support needed for HIV prevention (condoms, counselling, contraception, etc). Current availability, location, sources, quality, etc. of those services, supplies and support. Availability of services for specific groups (such as young people). Key gaps in services.	**Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 17:** Health journey **Tool 33:** Services (interventions) web
Costs of services.	**Tool 66:** Ranking line
Accessibility Who uses services and whether they find them easy or difficult to use. Who does not use the services and why. How the uptake of services is measured.	**Tool 17:** Health journey **Tool 31:** Road blocks **Tool 62:** Evaluation wheel
What services are used for what problems and when.	**Tool 63:** Matrix scoring
Quality What people like about services or supplies. What people do not like about the services or supplies and why. What improvements people would like to see.	**Tool 17:** Health journey **Tool 63:** Matrix scoring **Tool 67:** Weighted matrix ranking
Relationships between service providers Relationships between different service providers and suppliers. Formal and informal referral networks.	**Tool 17:** Health journey **Tool 23:** Circles diagram **Tool 28:** Helping relationship web

HIV prevention: Laws and policies context

Issues to explore	Possible tools
Political and administrative structures Local, district, national level structures.	**Tool 23:** Circles diagram
Relationships between government and civil society Communication and information sharing. Joint planning. Attitudes to one another.	**Tool 23:** Circles diagram
Advocacy opportunities to change policies Key supporters. Key moments in policy-making processes. Strategies to influence policies.	**Tool 75:** Force field analysis
Laws and policies affecting vulnerable groups National or state laws exist regarding HIV prevention? Which customary laws or policies exist regarding HIV prevention? Which existing policies support HIV/AIDS and which do not? Are existing laws and policies on HIV/AIDS being implemented? Impact. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change. Human rights.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line **Tool 77:** Laws and policies matrix Existing records and documentation.
Laws and policies relating to HIV/AIDS Barriers to implementation. Impact. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change. Human rights.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 31:** Road blocks **Tool 66:** Ranking line **Tool 75:** Force field analysis **Tool 77:** Laws and policies matrix
Priorities for government response to HIV prevention Local, district, national level. History of government response. What is currently being done. Priorities for further action.	**Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line

Stage 2: Assessing together


Care and support: individual (or group of similar individuals) context

Issues to explore	Possible tools
Knowledge About HIV/AIDS and preventing HIV infection. About positive living (taking care of your physical and emotional well-being if you are living with HIV/AIDS). About care and treatment of HIV-related illnesses. About the rights of people living with HIV/AIDS. About children's rights. About sources of information.	**Tool 1:** Body mapping **Tool 17:** Health journey **Tool 23:** Circles diagram **Tool 29:** Octopus diagram **Tool 36:** Agree/disagree game **Tool 44:** Hot seating
Attitudes About HIV/AIDS. About self-esteem. About people living with and/or affected by HIV/AIDS.	**Tool 7:** Household mapping **Tool 9:** Mapping stigma **Tool 36:** Agree/disagree game **Tool 44:** Hot seating **Tool 54:** Picture story **Tool 56:** Role play
About hopes, expectations and fears in relation to HIV/AIDS.	**Tool 91:** Vision diagramming
Care and carers Sorts of care or help that people living with and/or affected by HIV/AIDS need. Who provides care for men/women/children living with HIV/AIDS. What care providers do and do not provide and why. Who people living with HIV/AIDS prefer to receive care from. Support and training for carers. Links between carers at home, in the community and in health services.	**Tool 1:** Body mapping **Tool 7:** Household mapping **Tool 16:** Daily activity charts **Tool 18:** Lifeline **Tool 23:** Circles diagram **Tool 28:** Helping relationship web **Tool 56:** Role play **Tool 66:** Ranking line
Skills and knowledge of carers.	**Tool 46:** Knowledge, skills and attitudes
Physical and emotional health needs of carers.	**Tool 63:** Matrix scoring
Livelihoods and poverty How HIV infection affects livelihoods, income and spending of people living with HIV/AIDS, their families and carers. HIV/AIDS and employment. How people cope with changes in livelihoods, income and costs. Strategies to reduce the negative impacts of HIV/AIDS on livelihoods, income and spending.	**Tool 22:** Cause and effect diagram **Tool 32:** Spider diagram **Tool 54:** Picture story

continued


Care and support: individual (or group of similar individuals) context

(continued)

Issues to explore	Possible tools
Psychological and social issues Emotional and psychological needs of people living with and/or affected by HIV/AIDS. Who people living with and/or affected by HIV/AIDS do and do not talk to and why. Impact of HIV/AIDS on family relationships. Impact of HIV/AIDS on daily activities, social relationships, leisure activities, religious observance, etc. Strategies to reduce the negative psychological impacts of HIV/AIDS.	**Tool 7:** Household mapping **Tool 9:** Mapping stigma **Tool 11:** Social network (relationship) mapping **Tool 18:** Lifeline **Tool 22:** Cause and effect diagram **Tool 28:** Helping relationship web **Tool 32:** Spider diagram **Tool 54:** Picture story **Tool 56:** Role play
Planning for the future Inheritance laws and practices, and their impact on different people. Advantages and disadvantages of planning for the future. Key issues to think about in planning for the future. Who needs to be involved in planning for the future and why.	**Tool 22:** Cause and effect diagram **Tool 54:** Picture story **Tool 66:** Ranking line
Barriers to planning for the future. Factors that assist planning for the future.	**Tool 75:** Force field analysis
Priorities for change.	**Tool 91:** Vision diagramming
Children affected by HIV/AIDS Work at home and outside the home. Education. Caring responsibilities. How the situation is different for girls and boys.	**Tool 1:** Body mapping **Tool 5:** (Gendered) resource mapping **Tool 7:** Household mapping **Tool 9:** Mapping stigma **Tool 10:** Mobility mapping **Tool 13:** Well-being mapping **Tool 16:** Daily activity charts **Tool 18:** Lifeline **Tool 22:** Cause and effect diagram **Tool 24:** Division of labour chart
Basic needs (e.g. food, shelter, health care). Emotional needs.	**Tool 66:** Ranking line
Supporting adults. Friendships and play.	**Tool 11:** Social network (relationship) mapping **Tool 28:** Helping relationship web

continued

Stage 2: Assessing together


Care and support: individual (or group of similar individuals) context

(continued)

Issues to explore	Possible tools
Health problems General health problems. HIV/AIDS-related illnesses, frequency and severity. Health problems faced by HIV-positive children. Nutritional status and needs.	**Tool 17:** Health journey **Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line
Health-seeking behaviours Symptoms, events or other factors that lead people to seek health care. Where and from whom people seek care for different types of health problems. Positive and negative effects of seeking health care from different providers.	**Tool 17:** Health journey **Tool 32:** Spider diagram **Tool 88:** SWOC analysis
Hopes and fears Expectations, hopes and fears about the future.	**Tool 54:** Picture story **Tool 72:** Desired change diagram **Tool 91:** Vision diagramming


Care and support: Community context

Issues to explore	Possible tools
Population characteristics Age. Genders and sexual identities. Ethnicities. Languages. Religions. Social status, etc.	**Tool 3:** Community mapping
Socio-economic situation Levels of poverty. Education and literacy levels. Livelihoods. Gender division of labour (women's work and men's work). Mobility/migration patterns. Children's daily activities (girls' activities and boys' activities). Seasonal changes. Income and spending patterns. Leisure activities. Important places.	**Tool 3:** Community mapping **Tool 12:** Transect walks **Tool 16:** Daily activity charts **Tool 19:** Seasonal calendar **Tool 24:** Division of labour chart
Social relationships Important relationships (personal, communal, with authorities, etc). Family structures, patterns of childcare. Sources of information (people, services, media). Relationships between community members and health providers.	**Tool 11:** Social network (relationship) mapping **Tool 23:** Circles diagram **Tool 24:** Division of labour chart **Tool 28:** Helping relationship web **Tool 56:** Role play **Tool 65:** Pie charts (chapatti diagram)
Violence and conflict (personal, communal, sexual).	**Tool 42:** Focus group discussions
Children's roles and responsibilities.	**Tool 16:** Daily activity charts **Tool 24:** Division of labour chart
Norms, values, tradition Gender relations. Sex and sexuality. Marriage and families. Other relationships (such as paying for sex).	**Tool 25:** Gender boxes **Tool 26:** Gender roles chart **Tool 27:** Gender myths **Tool 45:** Ideal images **Tool 53:** Picture codes
Childhood and adolescence. Community definitions of health and well-being. Roles and responsibilities in caring for sick family and community members.	**Tool 18:** Lifeline **Tool 40:** Community drama **Tool 54:** Picture story

continued

Stage 2: Assessing together


Care and support: Community context

(continued)

Issues to explore	Possible tools
Health General and priority health concerns. Sexual health concerns. HIV/AIDS prevalence. STI prevalence. Tuberculosis (TB) incidence and prevalence. Frequency and severity of different health concerns. Seasonal changes in health. What people do and where they go when a family member is ill.	**Tool 1:** Body mapping **Tool 6:** Health facility (service) mapping **Tool 20:** Seasonal health and disease calendars **Tool 21:** Trend diagram (for changes in sexual health) **Tool 54:** Picture story **Tool 63:** Matrix scoring (for frequency and severity of health concerns) Existing records
HIV epidemic History of HIV/AIDS in the community. Past and current HIV interventions. Hopes for the future. Attitudes about HIV/AIDS and people living with HIV/AIDS.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 22:** Cause and effect diagram **Tool 72:** Desired change diagram **Tool 91:** Vision diagramming

Provision of food security for people living with HIV/AIDS is an important part of care and support

Care and support: Services and supplies context

Issues to explore	Possible tools
Availability General health services available (formal, informal, traditional). Services and supplies needed for care and support (including home-based care, etc). Available care and support services and supplies (e.g. counselling, condoms, TB diagnosis, home-based care services). Care and support service providers, locations, times. Gaps in services.	**Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 33:** Services (interventions) web **Tool 60:** What is …? diagram **Tool 62:** Evaluation wheel
Cost of services	**Tool 66:** Ranking line
Accessibility Location of services. Cost of services, including transport to reach them. Who uses different services and for what problems. Factors that help people access services. Who does not use different services and why.	**Tool 31:** Road blocks **Tool 32:** Spider diagram **Tool 54:** Picture story **Tool 63:** Matrix scoring
Quality What people like about care and support services. What people do not like about services and why. What improvements people would like to see in services. Who is involved in trying to improve the quality of services.	**Tool 62:** Evaluation wheel **Tool 63:** Matrix scoring **Tool 67:** Weighted matrix ranking
Referrals and coordination Relationships between different service providers. Formal and informal referral networks. Coordination mechanisms of care and support services. Strengths and weaknesses of referral and coordination systems.	**Tool 17:** Health journey **Tool 23:** Circles diagram

Stage 2: Assessing together


Care and support: Laws and policies context

Issues to explore	Possible tools
Political and administrative structures Local, district, national level structures.	**Tool 23:** Circles diagram
Decision-making processes in relation to HIV/AIDS Who is involved in decision-making, how and when. Involvement and role of people living with HIV/AIDS and other key populations.	**Tool 23:** Circles diagram **Tool 81:** Stakeholder participation matrix
Advocacy opportunities to change policies Strategies to influence policies (local, district, national and global).	**Tool 75:** Force field analysis
Laws and policies affecting people living with and affected by HIV/AIDS What national or state laws exist regarding care and support. What customary laws or policies exist regarding care and support. Which existing policies support HIV/AIDS and which do not. Are existing laws and policies on HIV/AIDS being implemented? Impact. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line **Tool 77:** Laws and policies matrix
Priorities for government action on care and support Local, district, national level. History of government action. What is currently being done. What are priorities for further action.	**Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line
Relationships between government and civil society organisations Communication and information sharing. Working together – joint planning and action. Attitudes and behaviours to one another.	**Tool 23:** Circles diagram

Antiretroviral treatment: Individual (or group of similar individuals) context

Issues to explore	Possible tools
Knowledge About HIV/AIDS. About the progression of HIV infection. About HIV/AIDS treatment. About treatment rights.	**Tool 1:** Body mapping **Tool 17:** Health journey **Tool 29:** Octopus diagram **Tool 44:** Hot seating
About sources of information about treatment.	**Tool 6:** Health facility (service) mapping
Attitudes About HIV/AIDS. About self-esteem. About hopes, expectations and concerns about treatment. About HIV/AIDS prevention for people living with HIV/AIDS.	**Tool 7:** Household mapping **Tool 9:** Mapping stigma **Tool 36:** Agree/disagree game **Tool 44:** Hot seating **Tool 54:** Picture story **Tool 56:** Role play
Treatment needs HIV/AIDS-related illnesses, frequency and severity. Treatment-related needs. Nutritional status and needs. Prevention needs of people taking treatment.	**Tool 17:** Health journey **Tool 63:** Matrix scoring **Tool 66:** Ranking line
Relationships and support Who do people talk to about treatment and why. What support people needing or taking treatment get and from where.	**Tool 28:** Helping relationship web
Treatment-seeking behaviours Symptoms, events or other factors that lead people to seek treatment. Where people seek treatment and why. What other medical/herbal/traditional treatments people seek as well as ARVs and why. What people do and do not discuss with treatment providers and why. What does and does not help people to adhere to ARV treatment protocols. How adherence problems can be overcome in the short and long term.	**Tool 17:** Health journey **Tool 32:** Spider diagram **Tool 54:** Picture stories **Tool 63:** Matrix scoring (direct matrix ranking) **Tool 66:** Ranking line **Tool 75:** Force field analysis

Stage 2: Assessing together


Antiretroviral treatment: Community context

Issues to explore	Possible tools
Population characteristics Age. Genders and sexual identities. Ethnicities. Languages. Religions. Social status, etc.	**Tool 3:** Community mapping
Socio-economic situation Levels of poverty. Education and literacy levels. Livelihoods. Leisure activities. Important places.	**Tool 3:** Community mapping **Tool 12:** Transect walks **Tool 13:** Well-being mapping **Tool 16:** Daily activity charts
Gender division of labour (women's work and men's work).	**Tool 24:** Division of labour chart
Mobility/migration patterns into and out of the community.	**Tool 10:** Mobility mapping
Seasonal changes. Income and spending patterns.	**Tool 19:** Seasonal calendar
Social relationships Important relationships (personal, communal, with authorities). Sources of information (people, media, health care providers, etc). Violence and conflict (personal, communal, sexual).	**Tool 11:** Social network (relationship) mapping **Tool 23:** Circles diagram
Norms, values, tradition Gender relations. Sex and sexuality. Marriage and families. Other relationships. Attitudes to health care and treatment.	**Tool 18:** Lifeline **Tool 25:** Gender boxes **Tool 26:** Gender roles chart **Tool 27:** Gender myths **Tool 40:** Community drama **Tool 45:** Ideal images **Tool 53:** Picture codes **Tool 54:** Picture story
General concerns Priority treatment concerns (for men, women, young people, etc).	**Tool 22:** Cause and effect diagram **Tool 63:** Matrix scoring

continued


Antiretroviral treatment: Community context

(continued)

Issues to explore	Possible tools
Health General and priority health concerns. Sexual health concerns. HIV/AIDS prevalence and incidence. STI prevalence and incidence. TB prevalence and incidence. Frequency and severity of different health concerns. Seasonal changes in health.	**Tool 1:** Body mapping **Tool 20:** Seasonal health and disease calendars **Tool 21:** Trend diagram (for changes in health) **Tool 63:** Matrix scoring (for frequency and severity of health concerns) Existing health records
What people do when they are ill.	**Tool 17:** Health journey
HIV/AIDS action and treatment History of HIV/AIDS in the community. Past and current HIV/AIDS interventions. History of treatment availability in the community. Hopes for the future. Impact of treatment (e.g. on prevention, stigma, people living with HIV/AIDS, demands for other services, etc).	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 22:** Cause and effect diagram **Tool 60:** What is …? diagram **Tool 72:** Desired change diagram


Antiretroviral treatment: Services and supplies context

Issues to explore	Possible tools
Availability General health services available (formal, informal, traditional). Treatment services available (ARVs, blood count monitoring, counselling, condoms, TB treatment, etc). Treatment service providers, locations, times. Costs. Conditions for receiving treatment (clinical, social, financial). Gaps in services.	**Tool 6:** Health facility (service) mapping **Tool 8:** Interventions (services and activities) mapping **Tool 14:** Universe map **Tool 33:** Services (interventions) web **Tool 62:** Evaluation wheel
Accessibility Who accesses treatment. Factors that help people access treatment. Who does not access treatment and why. How to overcome barriers to treatment.	**Tool 31:** Road blocks **Tool 32:** Spider diagram **Tool 33:** Services (interventions) web **Tool 53:** Picture codes **Tool 54:** Picture story **Tool 63:** Matrix scoring **Tool 75:** Force field analysis

continued

Stage 2: Assessing together


Antiretroviral treatment: Services and supplies context

(continued)

Issues to explore	Possible tools
Quality What people like about the treatment services. What people do not like about the treatment services and why. What improvements people would like to see in the services or supplies. Monitoring and overseeing of treatment providers. Procurement and stock management. Involvement of people taking treatment in improving the quality of services.	**Tool 23:** Circles diagram **Tool 42:** Focus group discussions **Tool 63:** Matrix scoring **Tool 67:** Weighted matrix ranking
Referrals and coordination Relationships between treatment service providers. Formal and informal referral networks between treatment service providers and other HIV/AIDS-related service providers (including community groups and traditional services).	**Tool 17:** Health journey **Tool 23:** Circles diagram


Antiretroviral treatment: Laws and policies context

Issues to explore	Possible tools
Policy-making processes in relation to HIV/AIDS and treatment Who is involved at local, district, national and global levels. How and when different people and groups are involved. Involvement and role of people living with HIV/AIDS and key populations.	**Tool 23:** Circles diagram **Tool 81:** Stakeholder participation matrix
Policies and laws relating to HIV/AIDS and treatment What national or state laws exist regarding ARV treatment. What customary laws or policies exist regarding ARV treatment. Which existing policies support ARV treatment and which do not. Are existing laws and policies on ARV treatment being implemented. Rights relating to access to treatment. Implementation of laws and policies. Impact of laws and policies. Background to laws and policies. Priorities for change.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line **Tool 77:** Laws and policies matrix
Advocacy opportunities to change policies Key supporters for changing policies. Key stages in policy-making processes. Strategies to influence policies.	**Tool 75:** Force field analysis

continued


Antiretroviral treatment: Laws and policies context

(continued)

Issues to explore	Possible tools
Priorities for government support for access to treatment Priorities at local, district and national levels. History of government response. Current government action. Priorities for further action. Role of civil society and people living with HIV/AIDS, including those taking treatment.	**Tool 18:** Lifeline. **Tool 63:** Matrix scoring. **Tool 66:** Ranking line.


Impact mitigation: Individual (or group of similar individuals) context

Issues to explore	Possible tools
Knowledge About HIV/AIDS. About positive living. About the rights of people living with HIV/AIDS. About children's rights. About women's rights. About sources of information.	**Tool 1:** Body mapping **Tool 17:** Health journey **Tool 23:** Circles diagram **Tool 29:** Octopus diagram **Tool 36:** Agree/disagree game **Tool 44:** Hot seating
Attitudes About HIV/AIDS. About self-esteem. About people living with and/or affected by HIV/AIDS. About hopes, expectations and fears about HIV/AIDS.	**Tool 7:** Household mapping **Tool 9:** Mapping stigma **Tool 36:** Agree/disagree game **Tool 44:** Hot seating **Tool 54:** Picture story **Tool 56:** Role play
Livelihoods and poverty Changes in livelihood strategies, income and spending. Who is affected by these changes (e.g. boys, girls, older people, widows, etc.) and how. Opportunities to reduce negative economic impacts and support livelihood development. Opportunities to reduce negative economic impacts and workload impacts on children.	**Tool 21:** Trend diagram **Tool 22:** Cause and effect diagram **Tool 88:** SWOC analysis

continued

Stage 2: Assessing together


Impact mitigation: Individual (or group of similar individuals) context

continued

Issues to explore	Possible tools
Property and inheritance Inheritance laws and practices. Impact of inheritance laws and practices on different people (children, older people, widows, etc). Changes in housing and ownership (e.g. leaving home, selling land, etc). Who is affected by these changes (e.g. boys, girls, older people, widows, etc) and how. Strategies for strengthening the property and inheritance rights of disadvantaged groups. Strategies to reduce housing and property loss.	**Tool 22:** Cause and effect diagram **Tool 54:** Picture story **Tool 63:** Matrix scoring **Tool 66:** Ranking line **Tool 88:** SWOC analysis
Families and care for children Who cares for orphans and vulnerable children. Where and with whom orphans and vulnerable children prefer to live. Children's experiences of living with relatives or foster carers. What happens to children without carers. The differences between girls' and boys' experiences. Support needs of relatives and carers and strategies to meet them. Strategies for supporting children looked after by relatives or carers. Psychosocial well-being of children (such as where they go if they need help).	**Tool 32:** Spider diagram **Tool 47:** Life history **Tool 54:** Picture story **Tool 63:** Matrix scoring **Tool 66:** Ranking line
Education Impact of HIV/AIDS on availability of education. Impact of HIV/AIDS on access to education by boys and girls. Barriers to children attending school. Factors that support children to attend school. Strategies to reduce impact of HIV/AIDS on education.	**Tool 22:** Cause and effect diagram **Tool 30:** Problem tree **Tool 63:** Matrix scoring **Tool 66:** Ranking line **Tool 75:** Force field analysis
Health and nutrition Impacts on health and nutrition of people affected by HIV/AIDS. Impact on nutritional status of people affected by HIV/AIDS, and reasons for this. Whose health and nutrition are most affected and why. Strategies to improve health and nutrition.	**Tool 22:** Cause and effect diagram **Tool 30:** Problem tree **Tool 54:** Picture story **Tool 63:** Matrix scoring
Psychosocial needs and support Psychological, emotional and spiritual needs of people affected by HIV/AIDS, including children. How those needs are met and by whom. What needs are not met and why. How existing support could be strengthened.	**Tool 10:** Mobility mapping **Tool 18:** Lifeline **Tool 28:** Helping relationship web **Tool 54:** Picture story **Tool 56:** Role play

continued


Impact mitigation: Individual (or group of similar individulas) context

continued

Issues to explore	Possible tools
Social inclusion and rights Impact on social and communal relationships (of children, women, men, older people, carers, etc). Impact on recognition and respect for rights. Strategies for reducing negative changes in relationships and respect for rights.	**Tool 22:** Cause and effect diagram **Tool 40:** Community drama **Tool 54:** Picture story
Hopes and fears Expectations, hopes and fears about the future.	**Tool 54:** Picture story **Tool 72:** Desired change diagram **Tool 91:** Vision diagramming


Impact mitigation: Community context

Issues to explore	Possible tools
Population characteristics Age. Genders. Ethnicities. Languages. Religions. Where people live and work. Social status.	**Tool 3:** Community mapping
Socio-economic situation Levels of poverty. Education and literacy levels, including who is and is not going to school. Livelihoods. Children's daily activities (girls' activities and boys' activities). Leisure activities. Important places.	**Tool 3:** Community mapping **Tool 12:** Transect walks **Tool 16:** Daily activity charts
Seasonal changes. Income and spending patterns.	**Tool 19:** Seasonal calendar
Mobility/migration patterns.	**Tool 10:** Mobility mapping

continued

Stage 2: Assessing together


Impact mitigation: Community context

(continued)

Issues to explore	Possible tools
Gender division of labour (women's work and men's work).	**Tool 24:** Division of labour chart
Social relationships Important relationships (personal, communal, with authorities, etc). Family structures, including patterns of childcare. Child-headed households. Children's roles and responsibilities. Children's psychosocial well-being (such as who they go to for help). Sources of information (people, services, media, etc).	**Tool 11:** Social network (relationship) mapping **Tool 16:** Daily activity charts **Tool 23:** Circles diagram **Tool 24:** Division of labour chart **Tool 56:** Role play **Tool 65:** Pie charts (chapatti diagram)
Violence and conflict (personal, communal, sexual, etc).	**Tool 47:** Life history
Norms, values, tradition Gender relations.	**Tool 25:** Gender boxes **Tool 26:** Gender roles chart **Tool 27:** Gender myths **Tool 45:** Ideal images
Sex and sexuality. Marriage and families. Childhood and adolescence. Community coping strategies.	**Tool 18:** Lifeline **Tool 40:** Community drama **Tool 53:** Picture codes **Tool 54:** Picture story
General concerns Priority concerns about the impact of HIV/AIDS on livelihoods (for men, women, young people, etc).	**Tool 22:** Cause and effect diagram **Tool 63:** Matrix scoring
Health General and priority health concerns. Sexual health concerns. Frequency and severity of different health concerns. Seasonal changes. What people do when they are ill.	**Tool 1:** Body mapping **Tool 6:** Health facility (service) mapping **Tool 20:** Seasonal health and disease calendars **Tool 21:** Trend diagrams for changes in sexual health **Tool 54:** Picture story **Tool 63:** Matrix scoring (for frequency and severity of health concerns)
HIV epidemic History of HIV/AIDS in the community. Past and current interventions. Hopes for the future. Attitudes about HIV/AIDS and people living with HIV/AIDS.	**Tool 8:** Interventions (services and activities) mapping **Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 22:** Cause and effect diagram **Tool 60:** What is …? diagram **Tool 72:** Desired change diagram

Impact mitigation together: Services and supplies context

Issues to explore	Possible tools
Availability Services and supplies needed for impact mitigation. Available services and supplies (e.g. HIV/AIDS information, counselling, poverty alleviation, training, microfinance, education, etc). Service providers, locations, times. Key gaps in services.	**Tool 8:** Interventions (services and activities) mapping **Tool 33:** Services (interventions) web **Tool 62:** Evaluation wheel
Accessibility Who uses the services and whether they find them easy to use. Who does not use the services and why. What different services are used in different situations and why.	**Tool 23:** Circles diagram **Tool 31:** Road blocks **Tool 32:** Spider diagram **Tool 63:** Matrix scoring
Quality What people like about the services. What people do not like about the services and why. What improvements people would like to see in the services. What other services people would like access to.	**Tool 62:** Evaluation wheel **Tool 63:** Matrix scoring **Tool 67:** Weighted matrix ranking
Relationships between service providers The relationships between different service providers. Formal and informal referral networks. The strengths and weaknesses of those referral networks.	**Tool 23:** Circles diagram

Stage 2: Assessing together


Impact mitigation together: Laws and policies context

Issues to explore	Possible tools
Political and administrative structures Local, district, national levels.	**Tool 23:** Circles diagram
Decision-making processes in relation to HIV/AIDS Who is involved in decision-making. How people are involved and when. How people living with HIV/AIDS and key populations are involved.	**Tool 23:** Circles diagram **Tool 81:** Stakeholder participation matrix
Relationships between government and civil society organisations Communication and information sharing. Joint planning. Attitudes and behaviours to one another.	**Tool 23:** Circles diagram
Advocacy opportunities to change policies Key supporters of change. Key moments in policy-making processes. Strategies to influence policies.	**Tool 75:** Force field analysis
Laws and policies relating to people affected by HIV/AIDS What national or state laws exist regarding poverty reduction and impact mitigation (e.g. in relation to economics, poverty alleviation, children's rights, inheritance rights, etc). What customary laws or policies exist regarding poverty reduction and impact mitigation. Which existing policies support poverty reduction and impact mitigation and which do not. Are existing laws and policies on poverty reduction and impact mitigation being implemented. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line **Tool 77:** Laws and policies matrix
Priorities for government action on impact mitigation Local, district, national level. History of government action. What is currently being done. Priorities for further action.	**Tool 18:** Lifeline **Tool 63:** Matrix scoring **Tool 66:** Ranking line

Checklist for Stage 2: Assessing together	
Issue	**Tick ✓**
Have you formed an assessment team that includes community members?	
Have you provided training for assessment team members to help develop appropriate skills, knowledge, attitudes and values for the assessment?	
Are all assessment team members confident about their role in the assessment?	
Have you identified the objectives of the assessment?	
Have you matched issues to explore with tools to explore them?	
Have you made a plan for your assessment: Who? When? Where? How?	
Does the assessment cover all four contexts: individual/group, community, services and supplies, laws and policies?	
Does the community have records of the assessment findings?	
Do you have your own records of the assessment findings?	
Have you given feedback and verified the assessment to the community?	

If you have achieved all of these things it is time to move on to Stage 3: Planning together

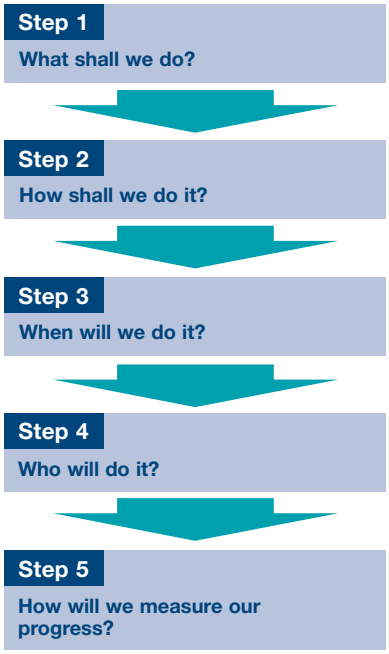
Stage 3: Planning together

Summary

Stage 3 describes how we plan responses to HIV/AIDS together. It covers:

- what we mean by planning together
- why we plan together
- how we plan together
- planning together – identifying strategies for prevention, care and support, treatment and impact mitigation
- checklist for planning together.

How do we plan together?



What do we mean by planning together?

Planning together means deciding how we and the community will respond together to address the different problems and issues identified during the assessment. Together, we review the current situation by analysing the assessment findings. We then prioritise the most urgent problems and needs. We choose strategies to address these issues depending on their feasibility, impact and sustainability. Planning together also involves deciding how these strategies will be put into action. We need to agree the practical details of who will do what and when. We also need to decide how we will monitor progress towards our shared vision of the future.

Planning together helps the community to answer the following key questions:

- What shall we do about the HIV/AIDS situation?
- How shall we do it – what strategies will help address HIV/AIDS in our community?
- Who will do it?
- When will we do it?
- How will we measure our progress towards achieving our objectives?

Why do we plan together?

Planning together helps to:

- develop a shared vision and sense of purpose in the community of how they can cope with HIV/AIDS
- use the experience and knowledge of many people to select the most appropriate strategies to respond to problems raised during the participatory assessment
- inform and interest community members and stakeholders in the intervention
- coordinate the involvement of all stakeholders
- make sure that the activity plans are appropriate for the community and the groups within it
- build community ownership and control of the plan
- clarify expectations within the community regarding the plan
- assist effective and efficient use of resources
- provide a community framework for action and monitoring progress.

How do we plan together?

Step 1: What shall we do?

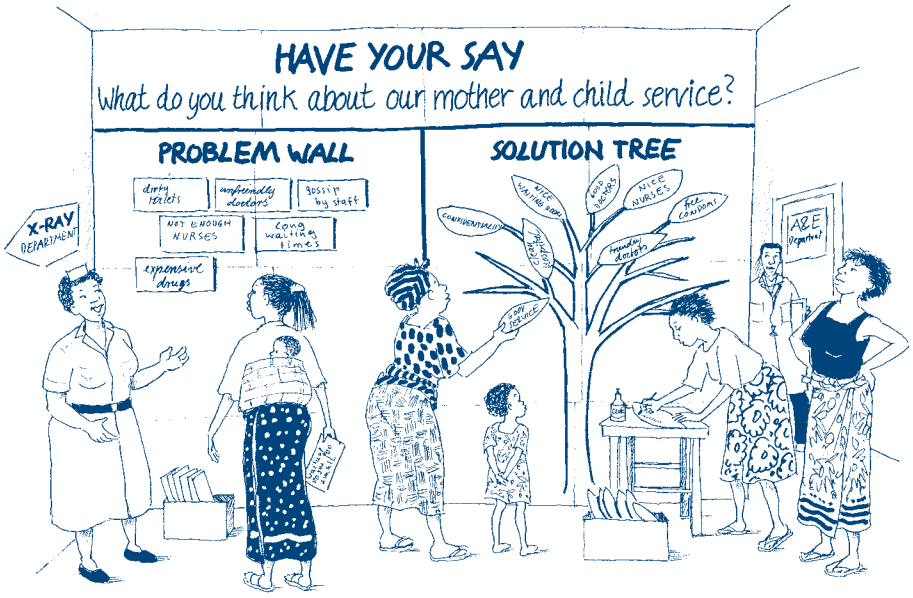
Collecting and sorting information together The participatory assessment is likely to have identified many HIV/AIDS issues. It is useful for the assessment and community mobilisation teams to collect all this information together and sort it into more manageable amounts. The best way to do this is to separate the information out by assessment objectives and by context. For example, sort the HIV/AIDS prevention information together, then separate this into information on the individual, community, services and supplies and laws and policies contexts. Tools 61 and 71 suggest useful ways to do this.

See also: **Tool 61 • Card sorting**
Tool 71 • Assessment summary matrix

Exploring root causes When information is sorted, we need to find out what the root causes of each HIV/AIDS situation are. By identifying root causes, we can think of activities that might improve the situation effectively. For example, a problem may be that children affected by HIV/AIDS are dropping out of school. The root causes of this may include a lack of school fees, books and uniforms as a result of deepening poverty at home. The problem-posing questions in the tables in Stage 3 will help you

to identify root causes. Tool 30 is also helpful with the problem-posing questions. Often this step is done during the participatory assessment with the community.

See also: **Tool 30 • Problem tree**



Identifying priorities for change Due to your capacity, it may not be possible to tackle all of the root causes at once. So it is helpful at this stage to decide with the community which root problems are most important for them to focus on. Questions to help prioritise problems include:

- **How serious is the problem?** For example, does the problem impact on many people in the community? Does it have a very severe impact on affected people? The potential seriousness of a problem may be important to consider; whether the problem is likely to grow if it is not addressed.
- **How worried is the community?** If the community is particularly worried about a problem they are more likely to mobilise towards addressing it. If the community is not so worried, a problem may be a low priority. In this case, it is important to explore why it is a low priority with community members. For example, is the problem perceived to affect only a few people or to affect only marginalised people? Perhaps the problem is perceived to be only potentially serious?
- **Are there gaps in current action to address the problem?** Are other organisations already addressing the problem? Are their activities effective or not?

Tool 73 is useful for prioritising problems and activities. The problem priority matrix (*see page 70*) can also be used for prioritising problems.

See also: **Tool 73 • Activity prioritisation grid**

Stage 3: Planning together

Definition

SMART objectives

Clear and precise objectives are often described as SMART objectives. These are:

Specific – an objective that describes exactly what will be achieved

Measurable – it is possible to measure whether the objective has been reached or not (e.g. it describes how many or how much will change)

Achievable – an objective that is realistic (do-able)

Relevant – an objective that will contribute to achieving the overall aim

Timed – an objective that states when it will be reached.

Examples of SMART objectives

- Within a year, 200 untrained home-based carers in the community will have received basic training and follow-up support related to the physical, emotional and psychological well-being of people who are sick.
- Within two years, the number of people accessing harm-reduction services in the community will have increased by 100 per cent.

Problem priority matrix

	How serious is the problem?	How worried is the community?	Are there gaps in current action to address the problem?	**Total (priority)**
High level of HIV infection in young men	5	3	5	13 (1)
Children orphaned by AIDS uncared for	3	3	4	10 (2)

SCORING:
5 = Very serious
1 = Not very serious

Agreeing aims and objectives The community mobilisation team now needs to agree mobilisation aims and objectives. We can begin by looking at the problems and needs that we have prioritised and think about how we would like the situation to be different in the future. Tool 91 can help with this. A vision diagram can also help to define our overall aim (e.g. all of the community to have free access to condoms). The aim summarises the broad change that we want to make in the longer term. Tool 68 can help you to define your aim clearly.

See also: **Tool 68 • Writing aims and objectives**
Tool 91 • Vision diagramming

Objectives We can look at how we can achieve this aim by returning to our Problem tree *(Tool 30)* and turning it into a Solution/objective tree *(Tool 86)*. The objectives are a realistic summary of what we want to achieve by addressing our priorities. They provide a framework for planning, acting and monitoring together. It is very important that our objectives are SMART *(see Definition box on this page)*. Answering the following questions as precisely as possible helps us to develop SMART objectives:

- What will change as a result of the mobilisation?
- Who are the key populations for the mobilisation?
- How much will the mobilisation change a problem or meet a need?
- Where will the mobilisation take place?
- When will the mobilisation or activity be completed?

Deciding on aims and objectives together provides an opportunity for stakeholders to develop a sense of shared purpose. It is important not to rush this step. Allow time for discussion.

See also: **Tool 30 • Problem tree**
Tool 86 • Solution/objective tree

What shall we do?	
Issues to explore	**Possible tools**
Collecting and sorting information.	**Tool 61:** Card sorting **Tool 71:** Assessment summary matrix
Exploring root causes.	**Tool 30:** Problem tree
Identifying priority problems to change.	**Tool 66:** Ranking line **Tool 73:** Activity prioritisation grid Problem priority matrix *(see page 70).*
Agreeing aims and objectives.	**Tool 68:** Writing aims and objectives **Tool 86:** Solution/objective tree **Tool 91:** Vision diagramming

Top tip

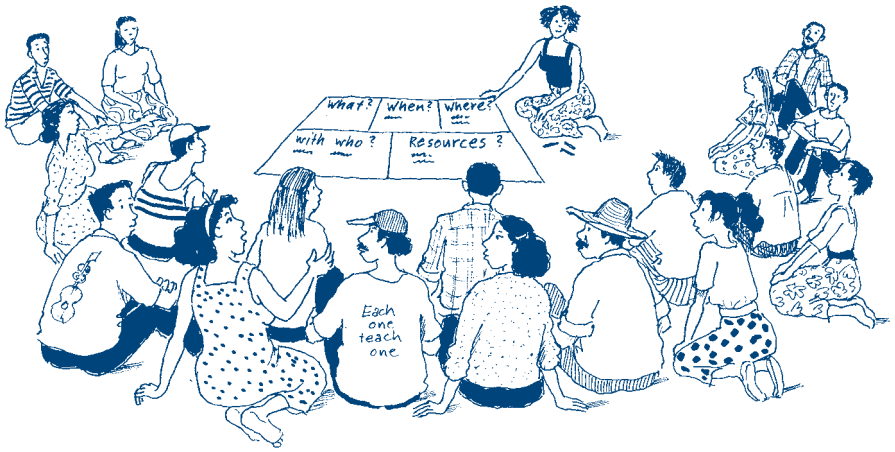
Encourage community members to think as widely as possible when suggesting strategies. Remember, people may find it difficult to imagine a service or intervention that they have never seen before

Step 2: How shall we do it?

Once we have set our objectives, we can decide what strategies we will use to reach them. There are two main steps in strategy selection: identifying strategies and selecting strategies.

Identifying strategies We identify strategies to address the root causes of the problems. Some strategies may have been identified already during the assessment. Others can be identified by looking at each of the root causes and thinking of ways to deal with it. For example, a strategy to support school attendance by vulnerable children may include working with school committees to waive fees or provide books and uniforms. It is a good idea to Thought shower *(Tool 57)* as many strategies as possible at this stage. The tables in this section also suggest strategies to address the various issues.

See also: **Tool 57 • Thought shower**



Stage 3: Planning together

Selecting strategies Now that we have listed all possible strategies, we need to select the most suitable strategies that will achieve our objectives. Important questions to consider when selecting strategies include:

- **How feasible is the strategy?** For example, does the organisation and the community have the capacity and experience to implement the strategy? Are the necessary resources available or likely to become available? How acceptable is the strategy to different stakeholders, including community members, gatekeepers and other stakeholders? How possible is it for community members to participate in the strategy?
- **What impact is the strategy likely to have?** For example, how many people will the strategy reach? How intensively will the strategy work with people? How well does the strategy target resources to the people most affected by a problem?
- **How sustainable is the strategy likely to be?** For example, will the community be able and willing to take responsibility for the strategy in the future? Will the impact of the strategy continue after the activities have finished?

How shall we do it?	
Issues to explore	**Possible tools**
Identifying strategies	**Tool 48:** Margolis wheel **Tool 54:** Picture story **Tool 57:** Thought shower Strategy tables *(see page 71 and 73)*
Selecting strategies	**Tool 74:** Feasibility matrix **Tool 76:** Impact matrix **Tool 77:** Law and policies matrix **Tool 78:** Low hanging fruit **Tool 87:** Sustainability matrix

Step 3: When will we do it?

We now need to prioritise and order each of the planned activities. When deciding when to do our activities we need to consider the following:

- Which tasks are the most important?
- Which tasks are the most urgent?
- What is the most logical sequence of activities?
- What resources (physical and financial) do we have available at different times?
- When are people available?

Placing the planned activities on a timeline can help reveal if plans are realistic or if we are trying to do too much. It can also help us identify if additional resources will be required.

When will we do it?	
Issues to explore	**Possible tools**
Which tasks are the most important? Which tasks are the most urgent?	**Tool 73:** Activity prioritisation grid **Tool 90:** VEN sorting
What is the most logical sequence of activities?	**Tool 83:** Project planning timeline
When will each activity take place? How realistic are our plans? When are people available? What additional resources are required?	**Tool 19:** Seasonal calendar **Tool 69:** Action planning **Tool 83:** Project planning timeline

Top tip

It may be helpful to combine this process with a review of participation in the community mobilisation process, ensuring that all stakeholders have an appropriate opportunity to be involved. For example, this is an opportunity to review or create a stakeholder participation matrix *(Tool 81)*.

See also: Tool 81 • Stakeholder participation matrix

Step 4: Who will do it?

Once we have selected strategies that can address the root causes of the HIV/AIDS situation and decided when we will carry them out, we now need to consider who will implement them.

It is first helpful to list all the activities related to each strategy: that is, planning, implementing, managing and evaluating the activity. Someone also needs to take overall responsibility for the strategy. This may not necessarily be the community mobilisation team. Some activities will be the responsibility of more than one individual or group.

Remember, if a stakeholder is not present when their roles and responsibilities are being discussed, they must be fully consulted before plans are finalised!

Who will do it?	
Issues to explore	**Possible tools**
Activities involved in carrying out each strategy. Who will do each activity.	**Tool 81:** Stakeholder participation matrix **Tool 85:** Roles and responsibilities

Stage 3: Planning together

Step 5: How will we measure our progress?

It has now been agreed who will do what and when they will do it. Next it is useful to identify how we will measure that we are:

- doing what we planned (e.g. things are happening on time)
- progressing towards our aims and objectives.

By regularly asking these questions we can adjust our plans and activities according to how activities are progressing. This is called monitoring. Planning monitoring activities together (and from the start) enables communities to take shared responsibility for it. It increases their willingness to use monitoring information (e.g. to improve activities) and it increases stakeholders' accountability to each other, as each will be aware of the others' responsibilities.

In order to monitor community mobilisation we need to identify signs (or indicators) that things are happening as planned. Activity indicators will tell us if we are doing what we planned. Change indicators will tell us if we are making progress towards our objectives.

Activity indicators What will tell us that things are going to plan?
How will we know that:

- the activity or task been completed?
- it has been done well?
- it happened on time?
- it happened within budget?
- everyone who wanted to participate has been able to?

Our action plans will help us to decide activity indicators to monitor the progress of activities. For example, are all activities being completed when the activity plan says they will be?

Change indicators What will tell us that we are making progress towards our objectives? How will we know that:

- activities are changing the HIV/AIDS situation for the better?
- the community capacity to mobilise is being built up?

Change indicators will vary according to what your objectives are.
But they might include:

- HIV prevention – HIV incidence and prevalence rates, the number of people who have access to prevention services, etc.
- care and support – the number of people who have access to regular care and support services
- treatment – the number of people on ARV treatment and the number of AIDS-related deaths
- impact mitigation – levels of poverty.

Adding regular review meetings to your action plans will help the community to discuss these indicators and answer these questions. Monitoring is discussed in more detail in Stage 5.

HIV prevention: Individual (or group of similar individuals) context

Issues	Problem-solving questions	Examples of possible strategies
Knowledge Knowledge and beliefs about HIV and preventing HIV infection. Knowledge of HIV risk. Sources of information about HIV/AIDS.	What are the main knowledge gaps? What are the most effective methods for addressing knowledge gaps?	Participatory learning methods. Peer education. Information, education and communication campaigns. Theatre for community change.
Attitudes About HIV/STIs. About self-esteem. About risk. About people living with HIV/AIDS. About sexual health concerns.	What positive attitudes support HIV/AIDS action? What changes in attitudes will help reduce vulnerability to infection? What methods will be most effective in changing negative attitudes?	Participatory discussion groups. Community organising for mutual support and solidarity (e.g. sex worker unions). Behaviour change activities.
Behaviours Relationships. Sexual behaviours, including commercial and transactional sex. Condom use. Alcohol and other drug use. Choices and risk. Role of traditional sex initiation. Leaders and elders.	What behaviours currently exist? What changes in behaviour are most important to reduce harm? What opportunities and barriers do people face for avoiding risky behaviours? What role do traditional and cultural norms play in relation to sexual behaviour?	Drug/alcohol harm-reduction initiatives. Counselling. Empowerment. Building social capital.
Skills Condom use. Negotiating sex and condoms. Assertiveness. Talking with sexual partners.	Who needs what skills? How do people best learn new skills? What do you do if people's skills are not enough?	Life skills development. Condom skills training. Assertiveness, negotiation skills training.
Vulnerability and resilience Factors that make people vulnerable to HIV infection. Factors that help people avoid HIV infection.	What factors most impact on vulnerability and resilience? How can those factors be reduced and resilience supported?	Empowerment. Building social capital.
Personal stories Life stories, experiences of trauma. Effect of life experiences on current vulnerability and resilience.		

Stage 3: Planning together

HIV prevention: Community context

Issues	Problem-solving questions	Examples of possible strategies
Socio-economic situation Levels of poverty. Education and literacy levels. Livelihoods. Sources of household income. Gender division of labour (women's work and men's work). Mobility/migration patterns into and out of the community. Seasonal changes. Income and spending patterns. Leisure activities. Important places. Costs of health care.	Which aspects of poverty and livelihood strategies most affect vulnerability to HIV infection? Does the way families increase their household income put members at risk of HIV? How can these aspects be changed? What prevention strategies are most appropriate to the context of people's lives? What makes men particularly vulnerable? What makes women particularly vulnerable? How can their different vulnerabilities be addressed? What resources and capacities do communities need to build to reduce vulnerability to HIV infection?	Economic empowerment (such as microfinance and income-generation programmes). Community organising for solidarity and empowerment. Gender equity initiatives.
Social relationships Important relationships (personal, family, communal, with authorities). Sources of information (family, services, media). Violence and conflict (personal, family, communal, sexual). Role of religious organisations and traditional structures.	How do important relationships influence vulnerability and resilience? What part do traditional structures have in this? How can the positive impact of relationships be maximised and the negative minimised? How can accuracy and usefulness of information be improved? Via existing sources? What new sources are needed? What collaborations are needed to reduce violence and conflict?	Education or advocacy with influential people regarding promoting resilience. Training/education for "information sources." Information, education and communication campaigns. Coalitions to reduce violence/conflict.
Norms, values, tradition Gender relations. Sex and sexuality. Marriage and families. Religious and cultural practices. Personal, family and community power dynamics.	Where do norms about gender and sexuality come from? Who has most influence over changing these norms? What are the priorities for change? What changes are already happening and how have they come about?	Advocacy with political leaders and policy-makers. Participatory analysis with influential people (e.g. traditional leaders, teachers and groups divided by sex and age).

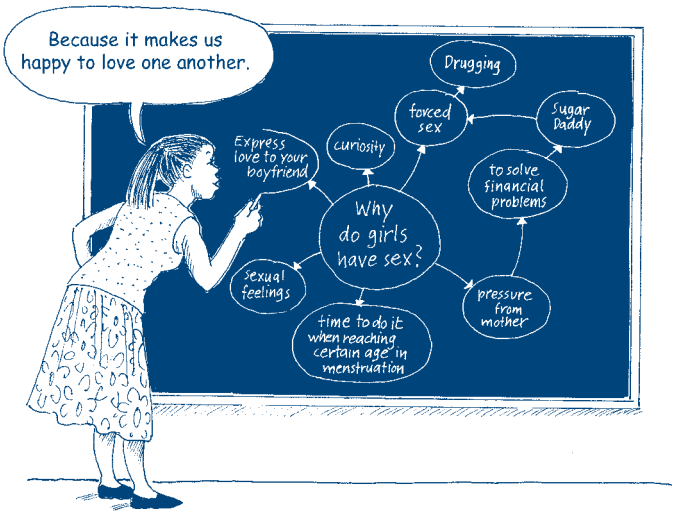
continued

HIV prevention together: community context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
General concerns Priority concerns (for men, women, young people, religious leaders, etc).	Which concerns can a prevention-focused intervention address? Which concerns are likely to influence the impact of a prevention-focused intervention?	Collaboration/coordination with other agencies. Empowerment of community members to address concerns.
Health General and priority health concerns. Sexual health concerns. HIV/AIDS prevalence. STI prevalence. Frequency and severity of different health concerns. Seasonal changes in health. What people do/do not do when they are ill. Where people go when they are ill.	What are the key health service needs? What needs to be done to make health services places where HIV prevention work takes place? What health concerns can a prevention-focused intervention address? What health concerns need to be addressed in order for a prevention-focused intervention to be successful?	Incorporation of key concerns into service provision. Referral networks. Community-based prevention activities.

Understanding all of the reasons for the behaviour of specific groups will help design specific HIV/AIDS strategies



How to use a condom and negotiate safe sex is an important skill for all to master

Stage 3: Planning together

HIV prevention: Services and supplies context

Issues	Problem-solving questions	Examples of possible strategies
Availability Services and supplies needed for HIV prevention. Available services and supplies (e.g. condom supplies, counselling, voluntary counselling and testing, STI diagnosis and treatment). Where and when services exist. Who provides services. Costs. Key gaps in services.	What kinds of services and supplies are needed? What are the barriers to expanding availability of services? What are the opportunities to create new services and expand existing services? What prevents people from accessing existing services?	Provision of basic services and supplies. Advocacy to expand service provision. Integration of services. Non-traditional ways to provide services, such as mobile and outreach projects.
Accessibility Who uses the services and whether they find them easy to use. Who does not use the services and why? What services are used for what problems, when and why?	Who needs better access to which services? How can services be changed to improve their accessibility?	Involvement of targeted clients, including those who are most vulnerable, in design, delivery and evaluation of services. Use ways to provide services that are appropriate to different groups (e.g. outreach, mobile services, youth-friendly services).
Quality What do people like about the services or supplies? What do people not like about the services or supplies? Why? What improvements are possible in the services or supplies?	What qualities of services do people value? How can quality be improved, maintained and monitored?	Involvement of targeted clients, including most vulnerable, in design, delivery and evaluation of services. Better selection, training and ongoing support for service providers. Clear service monitoring and evaluation processes.
Relationships between service providers What are the relationships between different service providers and suppliers? What formal and informal referral networks exist?	What coordination and collaborations are necessary to maximise access and quality of services?	Involvement of service providers and clients in developing services. Development of referral maps and mechanisms. Development of existing or new coordination mechanisms.

HIV prevention: Laws and policies context

Issues	Problem-solving questions	Examples of possible strategies
Political and administrative structures Local, district, national. **Decision-making processes in relation to HIV/AIDS** Who is involved. How people, including marginalised groups, are involved. When people are involved. **Advocacy opportunities to change policies** Key supporters. Key moments in policy-making processes. Strategies to influence policies. **Laws and policies affecting vulnerable groups/key populations** Implementation. Impact. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change. **Laws and policies relating to HIV/AIDS** Implementation. Impact. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change. **Priorities for government response to HIV prevention** Local, district, national. History of government response. What is currently being done. Priorities for further action.	What are the good points and weaknesses of existing customary and state policies and laws relating to HIV/AIDS and reproductive health? How can the good policies be promoted? How can the weak policies be changed? What structures and levels are key for what issues and outputs? What are the opportunities for influencing policy? Who are key supporters of change? How can current problems be described from a human rights perspective? What are the priorities for change? What changes are most achievable? What changes will be hardest to achieve?	**Representation on decision-making and policy-making bodies.** **Participatory advocacy strategies.** **Joint planning and coordination.** **Using a human rights perspective to consolidate advocacy and encourage change.** **Improved communication and information sharing.** **Participatory analysis of local policies, laws, rights documents.** **Participatory monitoring of the implementation of HIV/AIDS and reproductive health policies and rights.** **Participatory monitoring of HIV/AIDS budgets.**

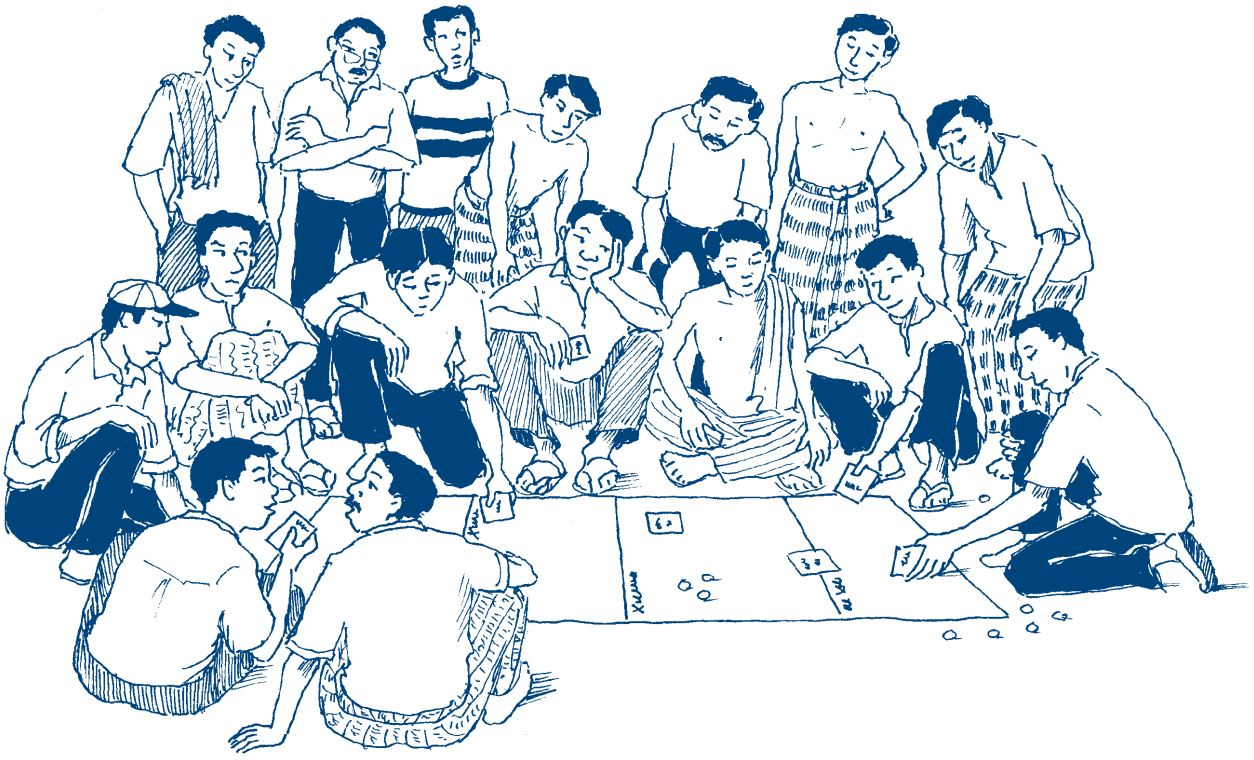
continued

Stage 3: Planning together

HIV prevention: Laws and policies context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
Relationships between government and civil society organisations Communication and information sharing. Joint planning. Attitudes and behaviours to one another.	What are the strengths and weaknesses of relationships between government and civil society? How can current problems be described from a human rights perspective? What are the priorities for change?	Joint planning and coordination. Improved coordination and information sharing. Using a human rights perspective to consolidate advocacy and encourage change.

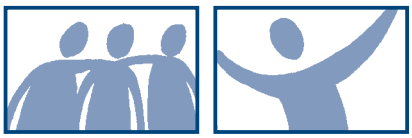


Care and support: Individual (or group of similar individuals) context

Issues	Problem-solving questions	Examples of possible strategies
Knowledge About HIV/AIDS and preventing HIV infection. About positive living. About care and treatment of HIV/AIDS-related illnesses. About the rights of people living with HIV/AIDS. About children's rights. About sources of information.	What are the main knowledge gaps? What are the most effective strategies for addressing knowledge gaps?	Participatory learning methods. Peer education. Information, education and communication campaigns. Integration of information provision in other activities (e.g. during home-care visits, accessing other services).
Attitudes About HIV/AIDS. About self-esteem. About people living with and/or affected by HIV/AIDS. About hopes, expectations and fears about HIV/AIDS.	What attitudes will support positive living? What methods will be most effective in changing negative attitudes?	Participatory discussion groups. Counselling. Community organising for mutual support and solidarity (e.g. support groups for people living with HIV/AIDS).
Care and carers Sorts of care or help needed by people living with and/or affected by HIV/AIDS. Who provides care for men/ women/children living with HIV/AIDS. What carers do and do not do and why. Who people living with HIV/AIDS prefer to receive care from. Skills and knowledge of carers. Support and training for carers. Referral links between carers at home and care services.	What are the strengths and weaknesses of current care provision? What are the key gaps? What strategies will best overcome the weaknesses and fill the gaps?	Home-care services. Training and skills development for carers. Practical support for carers. Referral networks. Collaboration/coordination between agencies.
Livelihoods and poverty How HIV infection affects livelihoods, income and spending of people living with HIV/AIDS, their families and carers. HIV/AIDS and employment. How people cope with changes in livelihoods, income and costs. Strategies to reduce the negative impacts of HIV infection on livelihoods, income and spending.	What are the key economic impacts of HIV/AIDS on individuals/ households? What strategies for reducing economic impact are most likely to be effective?	Advocacy/education with employers. Participatory analysis of spending patterns. Formal/informal savings opportunities. Advocacy with existing microfinance schemes to enable inclusion of people living with HIV/AIDS, families and carers. Vocational/skills training.

continued

Stage 3: Planning together



Care and support: Individual (or group of similar individuals) context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
Psychological and social issues Emotional and psychological needs of people living with and/or affected by HIV/AIDS. Who people living with and/or affected by HIV/AIDS talk to. Who people living with and/or affected by HIV/AIDS do not talk to and why. Impact of HIV/AIDS on family relationships. Impact of HIV/AIDS on daily activities, social relationships, leisure activities, religious observance, etc. Strategies to reduce negative impacts.	What are the key unmet needs for psychological and social support? What strategies for meeting these needs will be most effective? What are the key barriers to meeting these needs? How can these be overcome?	Counselling. Counselling training for selected community members. Community mobilisation for solidarity and empowerment (e.g. self-help groups for people living with HIV/AIDS). Initiatives to address causes of stigma and discrimination. Awareness campaigns. Participatory analysis and group discussions. Working with influential people to advocate for inclusion of people living with HIV/AIDS, families, children and carers in social and religious life of the community.
Planning for the future Inheritance laws and practices. Impact of inheritance laws and practices on different people. Advantages and disadvantages of planning for the future. Key issues to think about in planning for the future (e.g. who needs to be involved and how). Barriers to planning for the future. Factors that assist planning for the future. Priorities for change.	What are the priorities for change in current practices/laws? What are the barriers to change? What strategies will be most effective in bringing about these changes?	Making wills. Advocacy to change unfavourable laws and traditional practices. Information, education and communication campaigns regarding law and rights. Training in rights and law. Memory books. Counselling services. Advice services. Self-help/support groups and networks.
Children affected by HIV/AIDS Basic needs (e.g. food, shelter, health care). Work at home. Work outside the home. Education. Caring responsibilities. Supporting adults. Friendships and play. Emotional/psychological needs. Vulnerabilities. How things are different for girls and for boys.	What are the priority needs of children affected by HIV/AIDS? Which of these needs can be addressed by a care and support intervention? Who needs to be involved? What are the best strategies to meet each of the needs? How can these strategies take account of the different needs of girls and boys?	Welfare services. Support for carers. Advocacy with influential people. Information, education and communication campaigns regarding children's rights. Training on children's rights. Participatory analysis with influential people. Participatory analysis with children. Peer group support. Counselling services. Educational support services. Interventions to address stigma and discrimination.

continued

Care and support: Individual (or group of similar individuals) context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
Health problems HIV-related illnesses, frequency and severity. Health problems faced by HIV-positive children. Nutritional status and needs.	What are the priority health care needs? What are the priority health care needs of HIV-positive children? What are the priority nutritional needs? How are barriers to good nutrition best overcome?	Health service provision. Paediatric HIV/AIDS care services. Nutritional information and counselling. Nutritional support.
Health-seeking behaviours Symptoms, events or other factors that lead people to seek health care. Where people seek health care and for what problems. What people do/do not discuss with health care providers. The positive and negative effects of seeking health care from different providers.	What are the key factors affecting access to health services? How can barriers to accessing health services be overcome? How can negative health impacts be reduced?	Health information and advice. Participatory analysis. Peer support and education. Training for health care providers (including informal and traditional service providers as appropriate). Coordination and collaboration between health care providers (including informal and traditional service providers as appropriate).
Hopes and fears Expectations, hopes and fears about the future.	What hopes and expectations can be met or supported by a care and support intervention? What fears can be alleviated by a care and support intervention? What collaborations and coordination are relevant?	Address hopes and fears using strategies above and in subsequent tables.

Stage 3: Planning together

Care and support: Community context

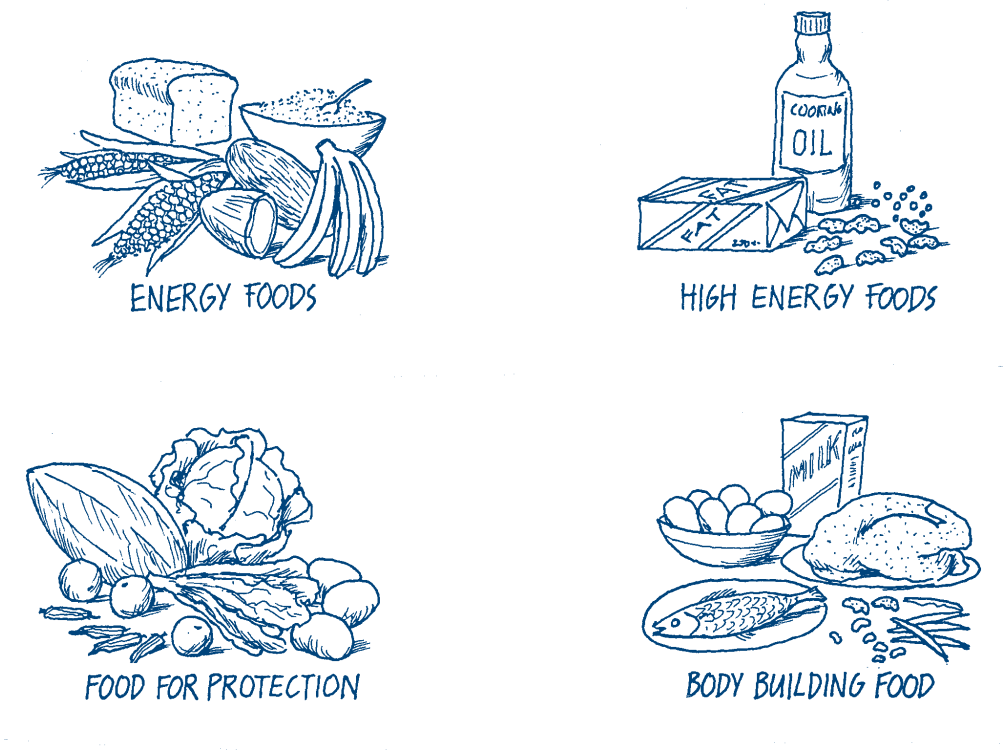
Issues	Problem-solving questions	Examples of possible strategies
Socio-economic situation Poverty. Education and literacy. Livelihoods. Gender division of labour (women's work and men's work). Mobility/migration patterns. Children's daily activities (girls' activities and boys' activities). Seasonal changes. Income and spending patterns. Leisure activities. Important places.	What aspects of poverty and livelihood strategies most affect care and support in the community? How can these aspects be changed? How do gender inequities affect care and support? What are the priorities for change?	Economic empowerment. Community organising for solidarity and empowerment.
Social relationships Important relationships (personal, communal, with authorities, etc). Sources of information (people, services, media, etc). Violence and conflict (personal, communal, sexual, etc).	How do important relationships influence care and support? What are the roles of influential people in strengthening care and support provision? How can these roles be supported?	Education or advocacy with influential people regarding needs and rights. Information, education and communication campaigns. Coalitions to reduce violence/conflict.
Norms, values, tradition Gender relations. Sex and sexuality. Marriage and families. Childhood and adolescence.	Where do these norms and values come from? Who has the most influence over changing these norms?	Advocacy with political leaders and policy-makers. Participatory analysis with influential people.
General concerns Priority concerns (for men, women, young people, etc).	What concerns can an intervention focusing on care and support address? What concerns are most likely to influence the impact of a care and support intervention?	Collaboration/coordination with other agencies. Community empowerment to address concerns.
Health General and priority health concerns. Sexual health concerns. HIV/AIDS prevalence. STI prevalence. Frequency and severity of different health concerns. Seasonal changes. What people do when they are ill.	What are the key health needs? What health concerns can be addressed by an intervention focused on care and support? What health concerns need to be addressed in order for a care and support intervention to be successful?	Incorporation of concerns into service provision. Referral networks.

continued


Care and support: Community context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
HIV epidemic History of HIV/AIDS in the community. Past and current interventions. Hopes for the future. Attitudes about HIV/AIDS. Attitudes about people living with HIV/AIDS, their families, children and carers.	What are the key concerns and priorities regarding HIV/AIDS? What are the causes and effects of stigma and discrimination? What are the community experiences of HIV/AIDS interventions? How should these experiences and lessons influence care and support interventions?	Collaboration with other agencies. Referral networks. Interventions addressing root causes of stigma and discrimination. Integration of lessons learned into intervention planning, implementation and monitoring and evaluation.



Ensuring a balanced diet is a vital part of care and support for people with HIV/AIDS

Stage 3: Planning together

Care and support: Services and supplies context

Issues	Problem-solving questions	Examples of possible strategies
Availability General health services available (formal, informal, traditional, etc). Services and supplies needed for care and support. Available care and support services and supplies (e.g. counselling, condoms, prevention of mother-to-child transmission, treatment of opportunistic infections, TB diagnosis and treatment, etc). Care and support service providers, locations, times. Costs. Gaps in services.	What services and supplies are needed? What are the barriers to expanding availability of services? What are the opportunities to create new services and expand existing services? What prevents people from accessing existing services?	Provision of basic services and supplies. Advocacy to expand service provision. Integration of services. Non-traditional ways of providing services, such as mobile and outreach projects.
Accessibility Who uses the services and whether they find them easy or difficult to use. Factors that help people access the services. Who does not use the services and why. What services are used for what problems, when and why.	Who needs better access to which services? How can services be changed to improve their accessibility?	Involvement of people living with HIV/AIDS, families, carers and children in design, delivery and evaluation of services. Use service provision mechanisms appropriate to different groups (e.g. outreach services, mobile services, youth-friendly services).
Quality What people like about the services. What people do not like about the services. What improvements people would like to see in the services.	What qualities of services do people value? How can quality be improved, maintained and monitored?	Involvement of people living with HIV/AIDS, families, carers and children in design, delivery and evaluation of services. Better selection, training and ongoing support for service providers. Clear service monitoring and evaluation processes.
Relationships between service providers Relationships between different service providers. Formal and informal referral networks. Coordination mechanisms of care and support services. Strengths and weaknesses of referral and coordination systems.	What collaborations and coordination are necessary to maximise access and quality of care? How can barriers to coordination and collaboration be overcome?	Involvement of service providers and service users. Development of referral maps and mechanisms. Development of existing or new ways of collaboration and coordination.

Care and support: Law and policies context

Issues	Problem-solving questions	Examples of possible strategies
Political and administrative structures Local, district, national.	What are the good points and weaknesses of existing customary and state policies and laws relating to HIV/AIDS and reproductive health? How can the good policies be promoted? How can the weak policies be changed? What structures and levels are key for what issues and outputs? What are the opportunities for influencing policy? Who are the key supporters of change? What are the priorities for change? What changes are most achievable? What changes will be hardest to achieve?	Representation on decision-making and policy-making bodies. Participatory advocacy strategies. Joint planning and coordination. Improved communication and information sharing. Participatory analysis of local policies, laws, rights documents. Participatory monitoring of the implementation of HIV/AIDS and reproductive health policies and rights. Participatory monitoring of HIV/AIDS budgets.
Decision-making processes in relation to HIV/AIDS Who is involved. How people, including marginalised community members, are involved. When people are involved.		
Advocacy opportunities to change policies Strategies to influence policies.		
Laws and policies affecting people living with HIV/AIDS, families, carers and children affected by HIV/AIDS Implementation. Impact. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change.		
Priorities for government action on care and support Local, district, national. History of government action. What is currently being done. Priorities for further action.		
Relationships between government and civil society organisations Communication and information sharing. Joint planning. Attitudes and behaviours to one another.	What are the strengths and weaknesses of relationships between government and civil society? What are the priorities for change?	Joint planning and coordination. Improved coordination and information sharing.

Stage 3: Planning together

Antiretroviral treatment: Individual (or group of similar individuals) context

Issues	Problem-solving questions	Examples of possible strategies
Knowledge About HIV/AIDS. About progression of HIV infection. About treatment. About treatment rights. About sources of information about treatment.	What are the main knowledge gaps? What are the most effective methods for addressing knowledge gaps?	Participatory learning methods. Peer education. Information, education and communication campaigns.
Attitudes About HIV/AIDS. About self-esteem. About treatment. About hopes, expectations and concerns about treatment.	What positive attitudes support HIV/AIDS action and access to treatment? What changes in attitudes will help increase access to treatment? What methods will be most effective in changing negative attitudes?	Participatory discussion groups. Community organising for mutual support and solidarity (e.g. support groups for people living with HIV/AIDS).
Treatment needs HIV-related illnesses, frequency and severity. Treatment-related needs. Nutritional status and needs.	What are the priority treatment needs? What are the priority nutritional needs?	Treatment service provision. Nutritional information and counselling. Nutritional support.
Relationships and support Who people talk to about treatment and why. Who people do not talk to about treatment and why.	What relationships and support enable access to treatment? How can these relationships be developed and supported?	Treatment buddies. Information for important people (e.g. family members).
Treatment-seeking behaviours Symptoms, events or other factors that lead people to seek treatment. Where and from whom people seek treatment. What other medical/ herbal/traditional treatments people seek as well as ARVs. What people do/do not discuss with treatment providers and why. What helps people adhere to ARV treatment protocols. What problems people have with adherence. How these problems can be overcome.	What are the key factors affecting treatment-seeking? How can barriers to treatment-seeking be overcome? What are the key factors affecting adherence? How can barriers to adherence be overcome?	Treatment mobilisers. Treatment support workers. Targeted information, education and communication about treatment access. Treatment buddies. Counselling to support adherence. Regular treatment monitoring and support. Involvement of people living with HIV/AIDS in design, delivery and evaluation of services.

Antiretroviral treatment: Community context

Issues	Problem-solving questions	Examples of possible strategies
Socio-economic situation Poverty. Education and literacy. Livelihoods. Gender division of labour (women's work and men's work). Mobility/migration patterns into and out of the community. Seasonal changes. Income and spending patterns. Leisure activities. Important places.	Which aspects of poverty and livelihood strategies most affect access to treatment? How can these aspects be changed or treatment provision adjusted? What are the gender inequities in treatment access? How can these be overcome?	Economic empowerment (e.g. income generation, microfinance schemes).
Social relationships Important relationships (personal, communal, with authorities, etc). Sources of information (people, services, media, etc). Violence and conflict (personal, communal, sexual, etc).	How do important relationships influence access to treatment? How can the positive impact of relationships be maximised and the negative ones minimised? How can accuracy and usefulness of information be improved? Via existing sources? What new sources are needed? What collaborations are needed to reduce violence and conflict?	Advocacy with influential people regarding treatment rights. Training/education for "information sources". Information, education and communication campaigns. Coalitions to reduce violence/conflict.
Norms, values, tradition Gender relations. Sex and sexuality. Marriage and families.	Where do norms about gender and sexuality come from? Who has most influence over changing these norms?	Advocacy with political leaders and policy-makers. Participatory analysis with influential people (e.g. religious leaders, teachers).
General concerns Priority concerns (for men, women, young people, etc).	Which concerns can a treatment intervention address? Which concerns are likely to influence the impact of a treatment intervention?	Collaboration/coordination with other agencies. Empowerment of community members to address concerns.

continued

Stage 3: Planning together


Antiretroviral treatment: Community context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
Health General and priority health concerns. Sexual health concerns. HIV/AIDS prevalence. STI prevalence. Frequency and severity of different health concerns. Seasonal changes. What people do when they are ill.	What are the key health service needs? What general health concerns can a treatment intervention address? What health concerns need to be addressed in order for a treatment intervention to be successful?	Incorporation of key concerns into service provision. Referral networks.
HIV/AIDS action and treatment History of HIV/AIDS in the community. Past and current interventions. History of treatment availability in the community. Hopes for the future. Impact of treatment (on prevention, stigma and discrimination, people living with HIV/AIDS, demands for other services, etc).	What collaborations will benefit access to treatment? What lessons from past HIV/AIDS action can be applied?	Networking and alliance building.

Antiretroviral treatment: Services and supplies context

Issues	Problem-solving questions	Examples of possible strategies
Availability General health services available (formal, informal, traditional, etc). Treatment services available (ARVs, blood count monitoring, counselling, condoms, TB treatment, etc). Treatment service providers, locations, times. Costs. Conditions for receiving treatment (clinical, social, financial, etc). Gaps in services.	What kinds of services and supplies are needed? What are the barriers to expanding availability of services? What are the opportunities to create new services and expand existing services? What prevents people from accessing existing services?	Provision of basic services and supplies. Advocacy to expand service provision. Integration of services. Non-traditional ways of providing services, such as mobile and outreach projects.
Accessibility Who accesses treatment. Factors that help people access treatment. Who does not access treatment. Barriers to accessing treatment. Overcoming barriers to treatment.	Who needs better access to which services? How can services be changed to improve their accessibility?	Involvement of people living with HIV/AIDS, including most vulnerable, in design, delivery and evaluation of services. Treatment mobilisers. Use treatment provision mechanisms appropriate to different groups (e.g. outreach, mobile services, youth-friendly services).
Quality What people like about the treatment services. What people do not like about the treatment services and why. What improvements people would like to see in the services or supplies. Monitoring and overseeing of treatment providers. Procurement and stock management.	What qualities of services do people value? How can quality be improved, maintained and monitored?	Involvement of people living with HIV/AIDS, including most vulnerable, in design, delivery and evaluation of services. Better selection, training and ongoing support for service providers. Clear service monitoring and evaluation processes.
Referrals and coordination Relationships between treatment service providers. Formal and informal referral networks between treatment service providers and other HIV/AIDS-related service providers (including CBOs and traditional services).	What coordination and collaborations are necessary to maximise access and quality of care?	Involvement of service providers and clients in development of referral maps and mechanisms. Development of referral maps and mechanisms. Development of existing or new coordination mechanisms. Treatment mobilisers and treatment supporters.

Stage 3: Planning together

Antiretroviral treatment: Laws and policies context

Issues	Problem-solving questions	Examples of possible strategies
Policy-making processes in relation to HIV/AIDS and treatment Who is involved. How people, including those who are marginalised, are involved. When people are involved.	What are the good points and weaknesses of existing customary and state policies and laws relating to HIV/AIDS and reproductive health? How can the good policies be promoted? How can the weak policies be changed? What structures and levels are key for what issues and outputs? What are the opportunities for influencing policy? Who are the key supporters of change? What are the priorities for change? What changes are most achievable? What changes will be hardest to achieve?	Representation on decision-making and policy-making bodies. Participatory advocacy strategies. Participatory analysis of local policies, laws, rights documents. Participatory monitoring of the implementation of HIV/AIDS and reproductive health policies and rights. Participatory monitoring of HIV/AIDS budgets.
Policies and laws relating to HIV/AIDS and treatment Rights relating to treatment access. Implementation of laws and policies. Impact of laws and policies. Background to laws and policies. Priorities for change.		
Advocacy opportunities to change policies Key supporters. Key stages in policy-making processes. Strategies to influence policies.		
Priorities for government support for access to treatment Local, district, national. History of government response. Current government action. Priorities for further action.		
Relationships between government and civil society organisations Communication and information sharing. Joint planning. Attitudes and behaviours to one another.	What are the strengths and weaknesses of relationships between government and civil society? What are the priorities for change?	Joint planning and coordination. Improved coordination and information sharing.

Impact mitigation: Individual (or group of similar individuals) context

Issues	Problem-solving questions	Examples of possible strategies
Knowledge About HIV/AIDS. About positive living. About the rights of people living with HIV/AIDS. About children's rights. About women's rights. About sources of information.	What are the main knowledge gaps? What are the most effective strategies for addressing knowledge gaps?	Participatory learning methods. Peer education. Information, education and communication campaigns. Integration of information provision into related interventions.
Attitudes About HIV/AIDS. About self-esteem. About hopes, expectations and fears about HIV/AIDS.	What attitudes will support positive living? What methods will be most effective in changing negative attitudes?	Participatory discussion groups. Counselling. Community organising for mutual support and solidarity (e.g. support groups for people living with HIV/AIDS).
Economic impacts Changes in livelihood strategies, income and spending. Who is affected by these changes (e.g. boys, girls, older people, widows, etc.) and in what way. Opportunities to reduce negative economic impacts and support livelihood development. Opportunities to reduce negative economic impacts on children (e.g. in terms of workload).	What changes in livelihoods, income and expenditure make the impact of HIV/AIDS worse? Which of these changes can be avoided and how? What alternative livelihood strategies will mitigate the impact of the HIV epidemic? What strategies for reducing economic impact are most likely to be effective? For whom?	Advocacy/education with employers. Participatory analysis of spending patterns. Formal/informal savings opportunities. Advocacy with existing microfinance schemes to enable inclusion of people living with HIV/AIDS, families and carers. Vocational/skills training. Livelihood support for orphans and vulnerable children (assistance with farming, skills training, etc).
Property and inheritance Inheritance laws and practices. Impact of inheritance laws and practices on different people (children, older people, widows, etc). Changes in housing and ownership (e.g. leaving home, selling land, etc). Who is affected by these changes (e.g. boys, girls, older people, widows, etc.) and how. Strategies for strengthening property and inheritance rights of disadvantaged groups.	What are the priorities for addressing loss of property, housing, land, etc? Who is involved in these losses? Who benefits from these losses? What strategies are most likely to be effective in reducing the impact of HIV/AIDS on property rights and ownership?	Microfinance schemes (including savings and insurance products) accessible to vulnerable groups. Collaboration with financial institutions. Advocacy regarding property and inheritance rights. Information, education and communication campaigns (on rights). Peer education (regarding rights). Participatory analysis with influential people. Community mobilisation for solidarity and realising rights.

continued

Stage 3: Planning together


Impact mitigation: Individual (or group of similar individuals) context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
Families and care for children Who cares for orphans and vulnerable children. Where orphans and vulnerable children prefer to live, with whom and why. Children's experiences of living with relatives/foster carers. What happens to children without carers. Differences between girls' and boys' experiences. Support needs of relatives/carers. Strategies for supporting children looked after by relatives/carers. Strategies for supporting relatives/carers. Support for child-headed households.	What are the most urgent care needs of orphans and vulnerable children? How can these needs be met most effectively? Are children's emotional and developmental needs being met? How can gender-based inequities be addressed? What strategies for supporting orphans and vulnerable children best reflect the preferences and experiences of children? What strategies are most likely to be effective?	Practical and social support for orphans, vulnerable children and their carers. Collaboration with community institutions (schools, religious organisations, etc). Peer support and self-help groups. Practical and social support for child-headed households. Participatory analysis with carers and influential people (e.g. regarding children's needs and rights). Information, education and communication (e.g. regarding children's rights and discrimination against foster/orphaned children).
Education Impact of HIV epidemic on availability of education. Impact of HIV epidemic on access to education by boys and girls. Barriers to children attending school. Factors that support children to attend school. Strategies to reduce impact of HIV/AIDS on education.	What policies and resource allocations will support education access and availability? Who has influence over policy and resources? Who has influence over barriers to school access? What support do children and carers need to overcome barriers to school access?	Advocacy strategies. Collaboration/coordination with school management and staff. Income-generating programmes. School feeding programmes. Scholarship programmes. Advocacy for waiving of school fees, uniform requirements, etc. Advocacy regarding girls' education. Participatory analysis with influential people. Community mobilisation to address discrimination and social exclusion.
Health and nutrition Impact on health of people affected by HIV/AIDS. Impact on nutritional status of people affected by HIV/AIDS. Whose health and nutrition are most affected and why. Strategies to improve health and nutrition.	What are priority health and nutritional needs? What are the underlying causes of poor health and nutrition? Which of these causes can be addressed by an intervention focusing on impact mitigation? What strategies will best address gender inequities in health and nutrition?	Health and nutrition counselling and information. Health service provision. Nutritional support. Collaboration/coordination with health service providers. Collaboration and coordination with other agencies. Economic empowerment. Agricultural programmes and support.

continued


Impact mitigation: Individual (or group of similar individuals) context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
Social inclusion and rights Impact on social and communal relationships. Impact on recognition and respect for rights (of children, women, men, older people, carers, etc). Strategies for reducing negative changes in relationships and respect for rights.	Who influences social and communal relationships? Who influences respect for rights? What strategies for strengthening relationships and respect for rights are most likely to be effective?	Advocacy. Information, education and communication campaigns. Participatory analysis. Community solidarity. Support/self-help groups. Action on stigma and discrimination.
Hopes and fears Expectations, hopes and fears about the future	What hopes can an intervention focused on impact mitigation support people to realise? What fears can an intervention focused on impact mitigation alleviate?	

Stage 3: Planning together

Impact mitigation: Community context

Issues	Problem-solving questions	Examples of possible strategies
Socio-economic situation Poverty. Education and literacy. Livelihoods. Gender division of labour (women's work and men's work). Mobility/migration patterns. Children's daily activities (girls' activities and boys' activities). Seasonal changes. Income and spending patterns. Leisure activities. Important places.	What needs to change in the socio-economic situation to help action on the HIV epidemic? How can these aspects be changed? How do gender inequities affect the impact of the HIV epidemic? What are the most important things to strengthen or change?	Economic empowerment. Community organising for solidarity and empowerment.
Social relationships Important relationships (personal, communal, with authorities, etc). Family structures and patterns of childcare. Sources of information (people, services, media, etc). Violence and conflict (personal, communal, sexual, etc).	How do important relationships and influential people help action on HIV/AIDS or make it worse? How can positive aspects be supported and negative aspects decreased?	Education or advocacy with influential people regarding needs and rights. Information, education and communication campaigns. Coalitions to reduce violence/conflict.
Norms, values, tradition Gender relations. Sex and sexuality. Marriage and families. Childhood and old age.	Where do these norms and values come from? Who has the most influence over changing these norms?	Advocacy with political leaders and policy-makers. Participatory analysis with influential people.
General concerns Priority concerns (for men, for women, for young people, etc).	What concerns can be addressed by work on impact mitigation? What concerns are most likely to influence the success of an intervention focused on impact mitigation?	Collaboration/coordination with other agencies. Community empowerment to address concerns.

continued


Impact mitigation: Community context

(continued)

Issues	Problem-solving questions	Examples of possible strategies
Health and nutrition General and priority health concerns. Sexual health concerns. HIV/AIDS prevalence. Reproductive health. Newborn and child health. Mental health. Frequency and severity of different health concerns. Seasonal changes. What people do when they are ill.	What are the key health needs? What health concerns can be addressed by work on impact mitigation? What health concerns need to be addressed in order for work on impact mitigation to be successful?	Incorporation of concerns into service provision. Referral networks.
HIV epidemic History of HIV/AIDS in the community. Past and current interventions. Hopes for the future. Attitudes about HIV/AIDS and people living with HIV/AIDS.	What are the key concerns and priorities regarding HIV/AIDS? What are the causes and effects of stigma and discrimination? What are community experiences, hopes and expectations about HIV/AIDS interventions? How should these expectations, experiences and lessons influence work on impact mitigation?	Coordination/collaboration with other agencies. Referral networks. Interventions addressing root causes of stigma and discrimination. Integration of lessons learned into intervention planning, implementation and monitoring and evaluation.

Stage 3: Planning together

Impact mitigation: Services and supplies context

Issues	Problem-solving questions	Examples of possible strategies
Availability Services and supplies needed for impact mitigation. Available services and supplies (e.g. HIV/AIDS information, counselling, health services, poverty alleviation and livelihood support services, skills and training services, microfinance services, educational support services, etc). Service providers, locations, times. Costs. Key gaps in services.	What services and supplies are needed? What are the barriers to expanding availability of services? What are the opportunities to create new services and expand existing services? What prevents people from accessing existing services?	Provision of basic services and supplies. Advocacy to expand service provision. Integration of services. Non-traditional ways of providing services, such as through mobile projects. Non-traditional service providers, such as religious organisations or schools.
Accessibility Who uses the services and whether they find them easy or difficult to use. Who does not use the services and why. What services are used in what situations and why.	Who needs better access to which services? How can services be changed to improve their accessibility?	Involvement of client groups in design, delivery and evaluation of services. Use of service provision mechanisms appropriate to different groups.
Quality What people like about the services. What people do not like about the services and why. What improvements people would like to see in the services. What other services would people like access to?	What qualities of services do people value? How can quality be improved, maintained and monitored?	Involvement of intended client groups in design, delivery and evaluation of services. Better selection, training and ongoing support for service providers. Clear service monitoring and evaluation processes.
Relationships between service providers What are the relationships between different service providers? What formal and informal referral networks exist? What are the strengths and weaknesses of the referral systems?	What collaborations and coordination are necessary to maximise access and quality service provision? How can barriers to coordination and collaboration be overcome?	Involvement of service providers and service users in development of referral maps and mechanisms. Development of referral maps and mechanisms. Development of existing or new collaboration and coordination mechanisms.


Impact mitigation: Laws and policies

Issues	Problem-solving questions	Examples of possible strategies
Political and administrative structures Local, district, national. **Decision-making processes in relation to HIV/AIDS** Who, including marginalised people, is involved. How people are involved. When people are involved. **Advocacy opportunities to change policies** Key supporters. Key moments in policy-making processes. Strategies to influence policies. **Laws and policies affecting people living with HIV/AIDS, families, carers and children affected by HIV/AIDS** Implementation. Impact. Background to laws and policies. Reasons for keeping or changing policies. Priorities for change. **Priorities for government action on impact mitigation** Local, district, national. History of government action. What is currently being done. Priorities for further action.	What are the good points and weaknesses of existing customary and state policies and laws relating to HIV/AIDS and reproductive health? How can the good policies be promoted? How can the weak policies be changed? What structures and levels are key for what issues and outputs? What are the opportunities for influencing policy? Who are the key supporters of change? What are the priorities for change? What changes are most achievable? What changes will be hardest to achieve?	Representation on decision-making and policy-making bodies. Participatory advocacy strategies. Participatory analysis of local policies, laws, rights documents. Participatory monitoring of the implementation of HIV/AIDS and poverty reduction policies and rights. Participatory monitoring of poverty reduction budgets.
Relationships between government and civil society organisations Communication and information sharing. Joint planning. Attitudes and behaviours to one another.	What are the strengths and weaknesses of relationships between government and civil society? What are the priorities for change?	**Joint planning and coordination.** **Improved coordination and information sharing.**

Stage 3: Planning together

Checklist for Stage 3: Planning together	
Issue	**Tick ✓**
Have you collected and sorted all of your assessment information?	
Have you identified root causes to problems?	
Have you identified priorities for change?	
Have you agreed aims and objectives for the mobilisation?	
Are your objectives SMART?	
Have you selected strategies that are feasible, sustainable and are going to have an impact on HIV/AIDS?	
Have you identified all of those who will participate in each task or activity?	
Have you identified who will take responsibility for the completion of each task/activity?	
Have you identified when each activity will take place?	
Have you written an action plan for all the activities?	
Have you identified activity indicators for each activity?	
Have you identified change indicators for each activity?	
Have you included regular monitoring review meetings in your overall action plan?	

If you have achieved all of these things, it is time to move on to Stage 4: Acting together

Stage 4: Acting together

Summary

Stage 4 describes how we work together to carry out our plans:

- what we mean by acting together
- why we act together
- doing what we planned
- problem-solving as we mobilise
- coordinating our activities with other stakeholders
- staying motivated and managing our expectations
- monitoring and developing our plans
- checklist for acting together.

How we act together

What do we mean by acting together?

Acting together means:

- doing what the community planned with their active participation
- solving difficulties in carrying out activities
- coordinating our activities with other stakeholders
- staying motivated and managing our expectations
- monitoring, developing and adapting our plans.

Why do we act together?

Acting together helps to:

- coordinate the efforts of different stakeholders in order to improve the effectiveness and efficiency of the mobilisation
- solve day-to-day problems
- build the skills and capacity of community members to mobilise
- develop community ownership of the mobilisation
- build relationships between different stakeholders
- use learning to improve the quality and effectiveness of strategies and activities.

How do we act together?

Step 1: Doing what we planned

Our activity plans are the guiding framework for our community mobilisation process. They help us to stay focused on the purpose of each activity. Carefully made plans will tell us who will do what, where they will do it and when they will do it. It is beyond the scope of this toolkit to describe how to carry out prevention, care, support, treatment and impact mitigation activities. The 'Guide to useful resources' will help you with information on these. Each activity that we do must be prepared and it must be done with meaningful community participation. Most activities will also require follow-up.

Preparation means getting ready to do an activity. We need to make sure that all of the resources and trained people are in place to carry out the activity. For example, our plans may involve providing basic training for home-based carers. Preparation for this activity will include identifying trainers and participants, preparing training content, inviting participants, planning a budget and arranging logistics (venue, materials, refreshments, etc.).

Meaningful community participation What is most important is that those most affected by HIV/AIDS continue to play a leading role in the implementation of activities. If the most affected members of the community are not yet able to lead, they must at least participate meaningfully. It is only through their active and influential participation that the community will be able to develop the capacity to sustain positive changes.

Follow-up means building on the results of each activity. For example, follow-up on training for home-based carers is likely to include providing ongoing support to newly trained carers and possibly additional training in the future. It is unusual for a one-off activity (an activity with no follow-up) to be very effective.

Step 2: Solving problems in carrying out activities

Challenges and problems Remember, plans are only a guiding framework and may need to be adapted when the work is carried out. Acting together will bring challenges and problems that we need to solve together. The activities may be harder to carry out than we expected. There may be obstacles that we did not foresee when we were planning. Conditions may change or the activity may not produce the results that we expected. Identifying and responding to problems quickly will help us find solutions and prevent small problems growing into big ones.

Sharing experiences can often help solve problems. Community members and other stakeholders carrying out activities are likely to benefit from regular opportunities to discuss issues with people who face similar challenges. Using participatory tools (such as Tool 48) with peer groups can help find solutions to day-to-day challenges.

See also: Tool 48 • Margolis wheel

Analysing problems together Some problems may be harder to understand or it may be difficult to see why an activity is not producing the expected results. For example, the activity may not be appropriate for its purpose, or there may be unforeseen barriers to carrying it out. It is important to take the time to identify the root causes of the problem so that we can find effective solutions. Using participatory tools as a group helps to analyse problems and identify solutions.

Problem stakeholders Community mobilisation often involves shifts in the balances of power between stakeholders. This can be unpopular with some stakeholders as they may feel they are losing authority or status. Measuring what empowers and disempowers people can help avoid this. Others may feel that they have been unfairly excluded from the benefits of the activities. They may even try to sabotage the community mobilisation process. The involvement of stakeholders in the community mobilisation process from the beginning may help reduce sabotage by providing constructive channels for stakeholders to participate. Similarly, a participatory approach will promote transparency, which will help avoid misunderstandings about potential benefits of the activities.

Possible tools for meeting challenges and problem-solving

Tool 31: Road blocks
Tool 37: Buzz groups
Tool 48: Margolis wheel
Tool 56: Role play
Tool 70: Measuring empowerment
Tool 75: Force field analysis
Tool 81: Stakeholder participation matrix
Tool 82: Problem wall and solution tree

Step 3: Coordinating our activities with other stakeholders

Coordination Building a response to HIV/AIDS brings together many stakeholders. Good coordination by the community mobilisation team improves the effectiveness of our activities and helps to use resources efficiently. Coordination between stakeholders also encourages networking, collaboration and the sharing of skills and experiences.

We can encourage coordination between stakeholders by:

- **establishing good communication channels** between stakeholders (these can include regular meetings, one-to-one communication, posters, written reports, etc.) – stakeholders need to know who they should communicate with, about what and why
- **planning activities together** and combining resources to implement together where appropriate
- **discussing** progress, challenges and achievements together in order to learn from our experiences and adapt plans as necessary
- **establishing effective mechanisms** for a particular activity to enable coordination. These often involve committees formed by representatives of different stakeholders. It is preferable to work with existing committees wherever possible rather than setting up parallel groups. If a committee has

Case study

Follow-up support

A CBO in East Africa provided training to women's groups in developing small businesses that would help support family members and children affected by HIV/AIDS. The CBO knew that they would need to visit the women's groups regularly after the training to see how they were getting on. This would provide ongoing advice and encouragement. They kept this in mind when they decided how many women's groups they had the capacity to work with. At the end of the training, each group made an action plan. These included agreeing when the CBO would visit again. After the trainings, the CBO realised that it was important to be flexible about follow-up as the various groups had different needs for future support.

Case study

Participatory problem-solving

An NGO in Peru needed to hold some "mixed" community meetings, bringing together a wide range of different people. Powerful people attending, such as educated men, often expected that the meetings would be held in English. This meant that some community members could not understand or participate in the meetings. NGO workers used role play to explore different ways of responding to this situation in order to enable all community members to understand and take part in discussions.

Stage 4: Acting together

been inactive, efforts to revive it should address the reasons why it has not functioned well in the past. Committees are more effective if their role is clearly understood, and it is important to make sure that committee members communicate well with the people they represent. Existing committees may not represent all sectors of the community and it may be necessary to negotiate the inclusion of some new stakeholders.

Case study

Establishing committees in the Frontiers Prevention Project

During this five-country programme, each site set up several committees. Firstly there was a site coordination committee. Their role was to coordinate all community HIV/AIDS activities within the site. Within the site committee, sub-committees were set up to deal with specific issues and activities. For example, a committee was set up specifically to deal with human rights issues; another to help with supporting new CBOs that were formed; yet another would focus on prevention issues. All of these sub-committees had members of key populations on them, and all reported to the site coordination committee.

Case study

Staying motivated in Uganda

Women living with HIV/AIDS in rural Uganda began to organise for mutual support and advocate for improved access to health care and HIV/AIDS-related treatment. Membership of the organisation grew rapidly at first as women found support and hope from coming together. However, initial enthusiasm declined in the face of continued disinterest among decision-makers in local government. The women made a presentation at a national conference about their objectives and their achievements to date. National decision-makers recognised their achievements publicly and this encouraged the women to persevere.

Step 4: Staying motivated and managing our expectations

After assessing and planning together, we are likely to make an enthusiastic start with high expectations. It may take some time before we begin to see results. Community members involved in action on HIV/AIDS are often volunteers and usually have many urgent demands on their time. Genuine ownership of the mobilisation process is essential for the motivation of community members. As community action starts to show results, this will help motivate people to continue their efforts. However, it can be hard to maintain enthusiasm in the early days when our efforts are not rewarded quickly.

Regular opportunities to discuss any frustrations and look for solutions to problems will help maintain interest in the activities and address any unrealistic expectations. They also provide an opportunity to adjust plans if necessary. Regular communication and coordination between different stakeholders also enables people to talk about their activities and receive recognition for their efforts.

Keeping the momentum going Similarly, community members may find it hard to maintain momentum over time. Encouraging them to set realistic objectives will help avoid burn out. Participatory monitoring and evaluation approaches will enable community members to assess their progress and see the results of their individual and collective efforts. It is also important to recognise publicly the community's achievements and to celebrate them. Opportunities to learn new skills and increase the effectiveness of activities may also help motivate sustained action. Building links with organisations outside of the community, such as regional and national networks, provides a wider opportunity to share experiences, receive recognition for community-led action and participate in larger-scale change.

Encouraging good community leadership Acting effectively together can be greatly helped by good leadership. There are many different types of leadership, but experience has shown that the communities most able to mobilise have leaders with certain characteristics *(see Definition box on next page)*. Identifying and supporting leaders who have these characteristics will improve the community mobilisation process. Where they do not exist, include a leadership programme into your process to build this capacity in new or existing leaders. Encourage those who feel their power is threatened to develop these leadership characteristics. This will help them realise that they do not have to give up their leadership role. Rather, they may need to develop a new leadership style.

Step 5: Monitoring, developing and adapting our plans

It is important that regular review meetings are held to discuss progress *(see Stage 3)*. These meetings need to discuss both activity and change indicators. Stage 5 provides information on how to monitor and evaluate together.

Celebrating community achievements helps to recognise people's contributions, strengthen the sense of community and keep communities motivated and mobilised

Definition

Leadership for community mobilisation

Communities most able to mobilise effectively have leadership characterised by the ability to:

- include both formal and informal leaders
- provide direction and structure for participants
- encourage participation from a diverse network of community participants
- implement procedures for ensuring participation from all during group meetings and events
- facilitate the sharing of information and resources by participants and organisations
- shape and cultivate the development of new leaders
- cultivate a responsive and accessible style
- focus on both task and process details
- be receptive to innovation and risk-taking
- be connected to other leaders.

Source: Adapted from Goodman et al. (1998)

Checklist for Stage 4: Acting together	
Issue	**Tick** ✓
Have you prepared adequately to carry out each activity and task?	
Are the most affected community members participating meaningfully in the process?	
Have you planned follow-up and support for community members mobilising?	
Have you planned opportunities for community members to share experiences and address common problems?	
Have you addressed issues regarding any changes in the balance of power in the community?	
Have you developed effective mechanisms for community communication and coordination?	
Are you holding regular review meetings to monitor progress?	
Have you planned activities to keep up community motivation and momentum?	
Are you building the capacity of community leadership?	

If you have achieved all of these things it is time to move on to Stage 5: Monitoring and evaluating together

Stage 5: Monitoring and evaluating together

Summary

Stage 5 describes how we assess the progress we are making towards our aims and objectives. It covers:

- what we mean by monitoring and evaluating together
- how we monitor and evaluate together
- collecting monitoring and evaluation information
- assessing what we have done
- assessing progress towards our objectives
- assessing a community's capacity to mobilise
- adjusting our plans and activities
- sharing information and results
- checklist for monitoring and evaluating together.

How we monitor and evaluate together

What do we mean by monitoring and evaluating together?

Monitoring and evaluating together helps us to assess the progress we are making towards our aims and objectives. It enables us to answer important questions, such as:

- How well are we doing?
- How far are we from meeting the aims and objectives we have set ourselves?
- Are we doing the right things?
- What difference are we making?
- What do we need to change about what we are doing or how we are doing it?

Monitoring and evaluating often overlap: they answer the same questions, they are talked about together and we can use the same tools for monitoring and for evaluating. However, it is also useful to think about how monitoring and evaluating are different from each other.

Monitoring is a routine process. We use it to adjust and improve our plans and activities on a frequent basis.

Evaluation is a more in-depth assessment of what we have done, what we have achieved and what impact there has been on HIV/AIDS. We evaluate after a longer period of time, such as one or two years, or at the end of the community mobilisation process. Evaluation helps us to see if bigger changes are needed in our plans and activities, or whether we need to scale up *(see Stage 6).*

Monitoring and evaluating means:

Collecting information about our activities We collect information about what we have done and about the results we have achieved.

Using information to assess what activities we have done and to adjust plans and activities For example, have we done everything we planned to do? If not, why not? Have we done things we did not plan? Why? We also review if we are doing the right thing. For example, we might have expected our activities to help reduce discrimination against people living with HIV/AIDS, but our monitoring tells us that there has been no change. We need to consider whether we should change our strategies for reducing stigma and discrimination.

Using information to assess progress towards objectives For example, one objective might be to reduce stigma and discrimination in the community. We look at the information to see whether stigma and discrimination has decreased since we started our activities, and we explore the reasons why progress has or has not been achieved.

Sharing the evaluation with different stakeholders We agree how and when we will share information from monitoring and evaluation with our stakeholders. This helps to check information from monitoring and evaluation activities and build effective and accountable relationships with different stakeholders. It also helps us to share lessons we have learned about how to do community mobilisation.

Why do we monitor and evaluate together?

Monitoring and evaluating together helps to:

- prove whether or not we have achieved the community's aims and objectives
- improve our effectiveness by helping to identify strengths and weaknesses in our activities
- revise and adjust strategies to make them more effective
- improve our understanding of how to do community mobilisation by identifying what does or does not work and why
- keep all community members and other stakeholders informed about our activities
- motivate community mobilisers and other stakeholders to continue their efforts
- ensure accountability to different stakeholders
- attract more resources by showing that our activities are effective.

How do we monitor and evaluate together?

Step 1: Collecting information about our activities

Collecting information Monitoring and evaluating relies on collecting useful information. Decisions about what information to collect and how to collect it are critical to the effectiveness of monitoring and evaluation. It is important to start collecting information as soon as possible.

Choosing indicators Deciding what information to collect usually involves choosing indicators. It is helpful to consider the following questions when deciding what indicators to collect information about:

- **How easy is it to collect information about the indicator?** It is important to choose indicators that are not too difficult to collect information about, and to only select the most useful indicators. Collecting information takes time. If we select too many indicators we will spend too much time collecting information.
- **Will this indicator tell us something useful?** Does it tell us something new? Is it relevant to the objectives of the process?
- **Is the indicator clear to everyone?** For example, if one of the indicators is the number of home-care clients, should we collect information about the number of people served or the number of households served?

How will we collect the information? Once we have decided what information to collect, we need to agree who will collect it and when and how they will collect it. Information for monitoring is usually collected on a regular and routine basis; for example, we might collect monitoring information about home-care visits every time we do a visit. There are lots of ways of collecting monitoring information; for example, by observation, by talking to people, from service records and by using participatory tools.

Choose methods that do not take too much time if they are going to be repeated often. Service records, such as health service records, can be a useful source of information. However, it is essential to consider issues of confidentiality when collecting or using this information. Meetings of the community mobilisation team can also be used to gather information on activities.

Recording information It is important to agree a simple and clear way of recording routine monitoring information and collecting it together. For example, people doing

Definition

Choosing indicators

Choosing indicators helps us decide what information we need to collect in order to monitor and evaluate our progress. Some indicators tell us about our activities. Some tell us about change.

We can choose **activity indicators** by asking: What will tell us if we are doing what we planned? For example, if our activities include providing training on the rights of people living with HIV/AIDS, we can use "number of people trained" as an indicator of what we have done. This indicator tells us if we have trained more or less people than we planned. It does not tell us if the trainings were useful to the participants or helped increase respect for the rights of people living with HIV/AIDS. For this, we need a change indicator.

We can choose **change indicators** by asking: What will tell us if we are making progress towards our objectives? For example, if we want to know whether the trainings were useful to the participants, we might use the indicator “number of people who reported training was useful”. If we wanted to know whether the trainings helped increase respect for the rights of people living with HIV/AIDS, we might use the indicator “number of human rights abuses against people living with HIV/AIDS reported”.

Case study

Monitoring activities in a home-based care mobilisation team

A community mobilisation team in India planned to train 20 home-based carers in one month. However, monitoring told them that they had only trained 10 people. They identified that the reason for this was that the timing of the trainings made it difficult for people to attend. They therefore decided to move the trainings to a more convenient time.

Stage 5: Monitoring and evaluating together

Checklist

Encouraging participatory monitoring and evaluation

Community members are usually busy. Collecting information for monitoring and evaluation may not seem like a priority compared to doing the planned activities. The following ideas can help motivate community members to monitor and evaluate:

- Enable community members to identify the benefits of monitoring and evaluation.
- Enable community members to identify their own indicators for monitoring and evaluation. Find out what indicates success to them; what matters to them.
- Make sure that community members are fully involved in all aspects of monitoring and evaluation, not just in collecting information.
- Keep monitoring and evaluation simple and easy.
- Use all the information that is collected. Do not collect information that will not be used.
- Share the results of monitoring and evaluation regularly and often so people can see the progress they are making.

Ethical issues It is also important to consider ethical issues about monitoring and evaluation. For example, some community members may expect to be paid for the time involved in collecting information, while others may worry about how the information about their community will be used.

home visits may use symbols on a wall chart to record how many visits they make.

An evaluation uses the information collected during routine monitoring and additional information collected specifically for the evaluation. Setting objectives for each evaluation will help identify what additional information we need. Evaluation involves many stakeholders and involves a more in-depth look at what progress we have made. Participatory tools are very useful for evaluation as they enable an in-depth look at progress. They are a good way of involving lots of different stakeholders and exploring different perspectives about the progress we have made.

Step 2: Using information to monitor what activities we have done

We need to monitor what we do and compare this to what we planned to do. We can ask the following questions:

- **Have we done each activity that we planned to do?** Have we done more or less than we planned? What are the reasons for this?
- **Have we done activities that we did not plan?** What are the reasons for this?
- **Are there activities that we should add to our plans?** What are the reasons for this?
- **What lessons have we learnt about how to do community mobilisation?** What works? What doesn't? Why?

Regular activity monitoring It is helpful to plan regular times to look at monitoring information that we have collected and assess our progress. For example, we might decide to do this weekly or monthly. Reviewing tools we used in planning, such as Tool 69 and Tool 83, is a useful way of answering the questions above and evaluating our progress. Identifying the reasons for differences between what we did and what we planned to do will help us decide what to do next.

See also: **Tool 69 • Action planning**
Tool 83 • Project planning timeline

Step 3: Evaluating progress towards objectives

Evaluating progress As well as monitoring what we do, we need to evaluate how much progress we are making towards our objectives. It is helpful to do this at regular planned intervals; for example, every year and at the end of the community mobilisation process. Each evaluation requires clear objectives. This helps different stakeholders agree on the purpose of the evaluation and guides us in deciding what issues and information to focus on.

Indicators for change We evaluate progress by comparing change in each of our indicators since we started our activities or since our last evaluation. We can use information from different sources to do this. We have some information from our day-to-day monitoring activities. We can also use participatory tools to discuss the current situation and compare this to information from our assessment before we started

Assessing what we have done	
Issues to explore	**Possible tools**
Whether we have done what we planned, and if not, why. Whether we have done things we did not plan, and why.	Review tools used to plan, such as: **Tool 69:** Action planning **Tool 83:** Project planning timeline
What people think about what we have done. What we should do differently. What else we should explore.	**Tool 75:** Force field analysis **Tool 80:** Output/outcome matrix
What lessons have we learned about how to do community mobilisation? What works? What doesn't? Why?	**Tool 88:** SWOC analysis

activities. It is often helpful to repeat a tool we have used before in order to see what change there is. For example, when we did the assessment, Tool 7: Household mapping, might have shown that people living with HIV/AIDS experienced a lot of stigma and discrimination in the home. Repeating this tool during an evaluation will help indicate if there has been any change in levels of stigma and discrimination.

The community's perception of change As well as comparing change in our indicators, it is important to explore what changes the most affected people think are important and why they believe this. Also, there may be important changes in the community that we did not expect. We need to ask open-ended questions about change so that we find out what is important to people. Remember, different people will have different views about what has changed, what is significant and which changes are positive and negative. All are valid.

Identify the reasons for change We also need to identify the reasons why something has changed. There may be a number of different reasons, some unrelated to our activities. Identifying these, including those that we did not influence, can help us develop more effective strategies and single out opportunities for collaboration.

If evaluation shows that there has been little change, we need to identify the reasons for this. There may be barriers and problems that we did not expect or our strategy may not be effective. An evaluation that shows little progress towards objectives can be demotivating for people who have been working hard to bring about change. Encourage people to view the evaluation as a positive opportunity for learning and take enough time to reflect on the reasons for lack of progress.

Case study

Evaluating services in Cambodia

An NGO in Cambodia used an evaluation wheel (Tool 62) with community members during a participatory assessment to identify barriers to reducing vulnerability to HIV infection. The NGO returned to the evaluation wheel at regular intervals to help community members evaluate their progress in overcoming these barriers. They also used it at the end of the project to illustrate the impact of the process.

Case study

Most significant change for people living with HIV/AIDS

A group of HIV-positive women began activities with the objectives of increasing knowledge about HIV/AIDS, reducing stigma in the community and providing care and support to women who were becoming sick. Using Tool 79: Most significant change, they identified how the membership of the group provided very important peer support to the women's children. This increased the group's interest in developing other strategies to support children. This was an unintended benefit of the process.

Stage 5: Monitoring and evaluating together

Assessing a community's capacity to mobilise

You may wish to monitor and evaluate whether or not a community's capacity to mobilise has been increased by your actions. Community mobilisation is, after all, a capacity-building process. You may have as one of your objectives "Increase the community's capacity to mobilise". Various people have come up with different change indicators that you might want to use to evaluate community capacity. Questions to help form these change indicators are suggested below.

Does the community have:

- increased access to resources?
- increased collective bargaining power?
- improved status, self-esteem and cultural identity?
- increased ability to reflect critically and solve problems?
- increased ability to make choices?
- recognition and response of people's demands by officials?
- self-discipline and the ability to work with others?

Source: Adapted from Kindervatter (1979)

Alternatively, others might be:

- degree of participatory leadership
- new leaders established
- ability of community to start, assess, plan, act, monitor and evaluate together
- ability to attract new resources
- increased trust and communication within the community
- increased trust and communication between the community and outsiders
- higher level of concern for community issues around HIV/AIDS
- a greater sense of community.

Source: Adapted from Goodman et al. (1998)

Assessing progress towards objectives

Issues to explore	Possible tools
Changes in each indicator. Reasons for those changes. Further action needed.	**Tool 42:** Focus group discussions **Tool 62:** Evaluation wheel Repeat tools used in participatory assessments and compare the information for change
Most significant changes in the situation that have taken place: • why those changes are important. • who has been most affected by those changes. • reasons for the changes. • further action needed.	**Tool 15:** Before and now diagram **Tool 18:** Lifeline **Tool 70:** Measuring empowerment **Tool 79:** Most significant change tool **Tool 80:** Output/outcome matrix

Step 4: Sharing evaluations with different stakeholders

Participatory monitoring and evaluation offers an important opportunity to review what we are doing with our various stakeholders. Sharing the evaluation with all stakeholders helps to:

- check that the evaluation is correct
- motivate community members and other stakeholders by demonstrating the progress we are making and how individuals contribute to this
- encourage continued support from donors by letting them see what difference their resources are making
- develop active support for community mobilisation and other strategies used among key stakeholders by demonstrating their effectiveness
- encourage stakeholders to help address problems and concerns identified by monitoring and evaluation
- enable accountability to different stakeholders.

Sharing information Monitoring information should be shared on an ongoing basis. For example, pictures and charts on walls can help community members see what progress they are making. Community dramas *(Tool 40)* can include updates on progress. Evaluations should also be shared. It is useful to plan a community meeting (or series of meetings) for the end of an evaluation to feed back and verify the results of the evaluation. Written reports and updates from monitoring activities and evaluations can be shared with partner organisations, government, donors and other stakeholders. The Alliance toolkit ***Documenting and communicating HIV/AIDS work: A toolkit to support NGOs/CBOs*** will help you to record and share your evaluation.

See also: Tool 40 • Community dramas

Checklist for Stage 5: Monitoring and evaluating together	
Issue	**Tick** ✓
Have you explained to the community why their participation in monitoring and evaluation is useful?	
Have you chosen activity indicators for monitoring your activities?	
Has the community identified change indicators for monitoring and evaluation?	
Are all the indicators easy to collect and useful?	
Does the community regularly collect information to monitor and evaluate progress?	
Do you hold regular review meetings with stakeholders to monitor activities and change?	
Have you conducted a final evaluation of the impact of the mobilisation process?	
Have you identified the reasons for change?	
Have you shared the evaluation with the community and got their feedback?	
Have you identified and shared lessons learned: what does and does not work and why?	
Have you checked out the toolkits about monitoring and evaluation at the back of this toolkit?	

If you have achieved all of these things it is time to move on to Stage 6: Scaling up together

Stage 6: Scaling up together

Summary

Stage 6 describes how we increase the number, breadth or scale of activities in order to strengthen our impact. It looks at the various aspects of scaling up community mobilisation and explores some of the issues involved, including:

- what we mean by scaling up together
- why we scale up together
- building on the community mobilisation process
- participatory site assessments
- selecting strategies to scale up our mobilisation
- partnerships, networks and coalitions, and working with CBOs
- advocating for policy change
- building capacity
- mobilising resources
- checklist for scaling up together.

What do we mean by scaling up together?

Scaling up together means doing more activities in order to increase our impact on HIV/AIDS. We can scale up together in several ways. We may work with more vulnerable groups or communities; for example, starting together in new locations or with new communities. We may add new activities to address needs within a community that complement those we carried out in our original mobilisation process. We may also add in new types of activities, such as advocacy, networking or resource mobilisation.

It is important to plan scale-up carefully and to be realistic about what we can achieve. Scaling up often involves learning new skills and working with other people and organisations. It means that we evaluate our experience, capacity and resources, and decide how to expand our activities, while maintaining the quality and effectiveness of what we do.

Why do we scale up together?

Scaling up together helps to:

- increase the impact of our activities by reaching and involving more people affected by HIV/AIDS
- increase our range of activities, meeting different needs in the community
- provide a continuum of care for people affected by HIV/AIDS
- enable learning and skills-sharing across communities
- increase our influence on HIV/AIDS policy and decision-makers by combining many voices
- strengthen sustainability of activities by building links to external resources.

How do we scale up together?

Scaling up together means:

Building on existing community mobilisation processes We need to evaluate the progress we have made so far and reflect on the lessons we have learned. This will help us to build on our strengths and address weaknesses. Demonstrating what we have achieved will also encourage other people and organisations to join us in scaling up. We can then identify priorities for action and make decisions about what, where and when to scale up.

Selecting strategies to scale up our mobilisation Possible strategies include:

- building partnerships, networks or coalitions
- initiating or building up CBOs
- carrying out activities with several communities at the same time.

Advocating for policy change How will laws and policies at national and regional level affect scaling up? What changes in laws and policies will help our work? At local level we can often develop relationships with stakeholders that allow us to sidestep unhelpful policies. This may no longer be possible as we scale up together. Scaling up also provides an opportunity to influence policy by bringing together the voices of many stakeholders.

Building capacity We may need to build skills in new areas of HIV/AIDS work as well as organisational capacity. We may also need to help CBOs build their capacity to carry out activities.

Mobilising resources for our new activities We may need to identify new sources of funds. To do this, it may be necessary to build skills in fundraising and resource mobilisation among our partners in order to enable sustainability.

Building on the community mobilisation process

Reviewing what we have done so far Scaling up builds on existing community mobilisation processes by increasing the number and type of activities that we carry out. So before we scale up we need to review what we have done so far. We use monitoring and evaluation information to assess how effective we have been. What works and why? What doesn't work and why? What still needs to be done? This will help us to build on strengths and identify and address weaknesses. It is important to scale up what works! We need to agree what we would do differently next time and what it is important to keep the same.

Deciding what to do next Reviewing our achievements and our strengths and weaknesses will help us to make choices about what to scale up. There are likely to be a range of possibilities and opportunities for scale-up. In addition to problems we have identified ourselves, we may be approached by other stakeholders to address particular issues or to work with particular communities. Thinking about where we can use our experience and skills to create most impact will help us to decide what new activities to start and where to work. Participatory site assessments can be a useful tool to help decide what needs doing next. This involves carrying out several participatory assessments over a wide area *(see Stage 2)*. Alternatively, we can look at the information from our original participatory assessments.

Don't take short cuts! Scaling up community mobilisation is a process. We need to remember each stage of community mobilisation when we scale: starting, assessing, planning, acting, monitoring and evaluating together. We can adapt these stages to our situation. However, it is important not to take short cuts in the process. For example, scaling up together involves setting realistic objectives about what we can achieve. We will face many new challenges, such as building capacity and mobilising additional resources. So we need to make clear plans about how we will address these challenges in order to scale up successfully. It is best not to try to do too much at once as this is likely to affect the quality of our work. We can scale up again in the future!

Definition

What are participatory site assessments?

A participatory site assessment involves assessing together with several communities in the same geographical area at the same time. The information from each community is shared within the site, and plans for activities are coordinated across the site. Participatory site assessments can provide useful estimates about the size of different communities. Regional, or even national, assessments can be achieved by doing several participatory site assessments.

Selecting strategies to scale up

Working together with new people and organisations is a useful strategy to scale up our activities. This enables us to achieve more than would be possible on our own. We can work together in various ways depending on what we want to achieve together. Partnerships, networks and coalitions are all types of relationships that can help us scale up our impact.

Partnerships

What is a partnership? A partnership is an agreement with a person or organisation to work together to achieve specific and practical goals. When we form a partnership we set clear objectives for what we want to achieve together. We agree the roles and responsibilities of the different partners. Forming partnerships enables us to combine resources with other people or organisations effectively.

What do partnerships offer? Different people and organisations have different resources to offer. For example:

- practical help to carry out activities
- access to people and places
- knowledge, skills and experience
- influence or political support
- money or material resources.

With whom do we partner? We may form partnerships with a range of different

Stage 6: Scaling up together

Case study

Ugandan Network of AIDS Service Organisations

The Ugandan Network of AIDS Service Organisations (UNASO) is a nationwide network of over 800 non-governmental, community- and faith-based organisations. It promotes coordination through networking, information sharing, capacity building and advocacy. UNASO supports the formation of district-level networks of AIDS service organisations and is linked to regional and international networks.

organisations, such as:

- CBOs
- NGOs
- faith-based organisations
- donors
- businesses
- media organisations
- government agencies or departments.

Planning partnerships Partnerships are most effective when they are carefully planned and managed, with realistic objectives. The first step is to review our priorities for scale-up. Then we can consider the wider context of our activities. What opportunities and challenges do we face? Who are our existing and potential partners? There are likely to be many opportunities and challenges. We need to prioritise the most important issues and use these to set clear and realistic objectives for forming partnerships.

Approaching potential partners We need to approach them by explaining clearly what we want to achieve, what we bring to the partnership and why we are approaching them. It is important to make sure that partners share our expectations about the partnership and that there is good communication between the different partners.

Managing partnerships We need to manage and monitor partnerships actively to make sure that they are helping us to reach our shared objectives. We can include monitoring of partnerships and the progress we make together in our usual monitoring. It is important to involve our partners in this. It may be helpful to include specific issues in our monitoring; for example, the amount of time and energy we are investing in a partnership compared to the progress we are making towards our objectives. A useful Alliance toolkit for organisations planning partnerships is ***Pathways to partnerships*** *(see page 121).*

Networks and coalitions

What are networks? Networks are groups of people and organisations that share interests or objectives; for example, a network of HIV/AIDS organisations who wish to work together for a common purpose. They usually have an organisational and governance structure, often including a management committee and a governing board elected by the membership. Networks are most effective when they have clear objectives and members can see the value of the network. This encourages active participation by members. They sometimes, but not always, require resources to sustain their activities.

Good communication within a network helps to make sure that the views and interests of the different members are genuinely represented by the network. Networks are linked to one another, helping to share skills, ideas and resources. Community-based efforts at addressing a problem can be linked to international efforts in this way. There may be opportunities for joint planning of activities by networks.

Coalitions are looser groups of people and organisations that form around a particular issue; for example, increasing access to treatment. They often have advocacy objectives and may carry out one-off activities or make longer-term plans.

Joining a network Networks and coalitions can be helpful for scaling up by enabling coordination and collaboration with a large number of people and organisations. They are often very effective for advocacy campaigns because they bring together large numbers of people, organisations and resources. However, membership requires time and resources. Considering the following points can help us decide whether or not to join a network or coalition:

- How relevant are the objectives of the network or coalition to our own objectives?
- How effective are its activities likely to be?
- How much time will we spend on the network or coalition?

Forming networks If no suitable network or coalition already exists, we may

consider forming a new network or coalition to help us scale up. Building linkages from the beginning to other networks – for example, at international or national level – will help us to do this. It is important to involve stakeholders in planning for the network or coalition right from the start. This helps the network to build ownership and shared expectations. The network or coalition will develop objectives and plans, and monitor its progress. This process can take up a lot of our time. It is important that we monitor the effectiveness of our involvement in helping us to reach our own objectives for scale-up. For more information on networks, see the ***Network capacity analysis toolkit*** *(see page 121).*

Community-based organisations

Scaling up may include supporting the formation of CBOs. Community members often form organisations when they want to start new activities or take over activities that previously were done jointly with other people or organisations. CBOs often form, or begin to form, during the community mobilisation process.

The advantages of forming CBOs include:

- providing a structure to manage activities on a larger scale
- attracting funds or resources more easily than an informal group
- helping accountability to the community and stakeholders by providing a clear focus for activities
- helping community members develop autonomy and self-sufficiency
- providing a focus to build organisational and management capacity among community members
- enabling networking and alliance building with other organisations.

CBOs are often membership organisations and usually have an organisational structure. There can be regulations governing their activities and registration. Community members need to agree the purpose and objectives of the organisation and be as open as possible in their discussions.

Community-based organisations' capacity building CBOs are likely to benefit from support in capacity building *(see page 116)*. Areas that often need strengthening include management capacity, leadership skills and HIV/AIDS-related skills and knowledge. It is essential that management and decision-making in CBOs is transparent and that good communication is maintained with the membership and the wider community, particularly if external resources are introduced. The toolkit ***CBO/FBO capacity analysis*** *(see page 121)* can help you assess the capacity of CBOs and identify their capacity-building needs.

Advocating for policy change and implementation

Laws and policies at regional and national level affect many aspects of HIV/AIDS action. For example, laws often criminalise activities such as sex between men. Policies about the enforcement of such laws may result in the harassment of men who have sex with men, preventing effective HIV/AIDS mobilisation. When we work at community level on a small scale, we can sometimes negotiate around harmful or unhelpful policies by working with key stakeholders. For example, building the support of local police for community mobilisation activities may reduce harassment.

However, as we scale up together and activities become higher profile, this may no longer be possible. We will need to address harmful laws and policies directly, or advocate for the introduction of laws that help community mobilisation for HIV/AIDS.

Scaling up together provides opportunities for advocacy As more people, groups and organisations work together, the growing number of voices adds weight to advocacy activities. Our existing community mobilisation activities and achievements provide an important starting point for this. They show that the advocacy is based on a good understanding of the situation and is likely to have identified a real need for change.

We can advocate for ourselves or for other people Some of the most powerful advocacy campaigns involve or are led by the people affected by the issue. It is very important to have the permission of the people affected if they are not directly

Case study

Durbar Committee for Coordination of Women

The Durbar Committee for Coordination of Women was formed by sex workers in India three years after community mobilisation activities began. The organisation supports its members to deal with their problems and acts to improve their working conditions. It advocates for sex workers' rights and against abuses and exploitation. It also organises conferences and meetings for sex workers from across India.

Source: Bandyopadhyay et al. (1999)

Stage 6: Scaling up together

Definition

What is advocacy?

Advocacy is the process of persuading influential or powerful people to make changes in policies, laws and practices. Advocacy can be used to change existing policies and laws and to make new ones. It can also be used to make sure policies really are put into practice.

involved in the advocacy work. Of course, this is only possible if we already have a close relationship with them.

Advocacy should be based on participatory assessments and consultation with the communities most affected by the issue. This is in order to:

- make sure that advocates understand the issues and opinions of those affected and represent them accurately to others
- make sure that advocates are, and are seen to be, advocating for what the community want and not just for their own interests
- build support among the community for the advocacy campaign
- involve or mobilise the community in the advocacy work itself.

Participatory assessments and consultation are essential even when advocates are members of the community themselves.

Advocacy can take many forms For example, it can be written, spoken, sung or acted. Activities can include using the legal system, joining committees and councils, holding meetings and using the media. Informal activities, such as conversations and networking, can also be influential. The support of well-known people such as celebrities can also help advocacy work. Some advocacy campaigns use high-profile methods such as demonstrations and boycotts (refusing commercial or social relations with an organisation).

Consider consequences Demonstrations and boycotts can be very effective in drawing attention to an issue. However, it is important to consider possible consequences before using them. Remember the principle "Do no harm!" A strong campaign may provoke an equally strong defence. Different methods work for different types of institutions and for different issues. Successful advocacy requires skills in a variety of methods and strategic knowledge of when each method will work best.

Advocacy varies in the time it takes It can take from one hour to several years. Advocating for change can be frustrating and may require persistence. We may combine many specific, short-term advocacy activities to reach a long-term vision of change. Setting short-term, realistic objectives for advocacy will help motivate people to keep going.

It is important to plan advocacy in the same way as we plan our other activities. This provides an opportunity for partners to agree on priorities for change and to allocate roles and responsibilities. Planning advocacy involves setting specific objectives, identifying who we need to advocate to, who can help us to do this and making an action plan. See also *Advocacy in action:* ***A toolkit to support NGOs and CBOs responding to HIV/AIDS*** *(see page 121).*

Capacity building

Capacity building Scaling up community mobilisation processes will require capacity building. Different stakeholders will have different capacity-building needs according to their role in scaling up community mobilisation. Capacity-building needs of groups and organisations are likely to fall into the following categories:

- **Organisational or management capacity;** for example, as we scale up, we may need to develop systems to manage people, fund activities and develop the skills to use these systems effectively.
- **HIV/AIDS-related knowledge and skills;** for example, we may need to strengthen our knowledge and skills about particular HIV/AIDS issues, such as treatment.
- **Community mobilisation approaches, tools and techniques;** for example, we may need to build skills in coordinating community mobilisation with different communities or in training others in community mobilisation approaches and techniques.
- **External relationships;** for example, ways of working effectively with other

stakeholders, building partnerships and coordinating activities.

- **Advocacy skills;** for example, ways of networking and lobbying with influential people to change policies or practices.

Identifying capacity-building needs The first step in the capacity-building process is to identify capacity-building needs. We involve stakeholders such as members of the organisation in assessing current capacity and in identifying skills and expertise needed in order to scale up effectively. It is important to establish a supportive atmosphere for this discussion so that people feel able to be open about the skills and expertise they need to strengthen.

Planning capacity building Once we have agreed capacity-building needs, we need to plan how to meet them. A capacity-building plan has clear objectives stating which capacity-building needs will be met, the methods to be used, who will do what and when they will do it. It is also important to identify resources that will be needed and who will provide them.

Capacity building is a process involving learning new skills, practising them and reflecting on what has been learned. Combining a range of different methods is usually an effective approach. Common methods include:

- training workshops
- visits to similar activities or projects that are working well
- peer support – discussions with colleagues or peers who are involved in similar activities to help share solutions and good ideas
- "on-the-job" support – regular discussions with people who have skills and experience in the activities or issues and who are able to offer advice.

Consider the resources (money, time, people and materials) needed for different capacity-building activities. It is also essential to monitor the impact of capacity-building activities in order to make sure that needs are being met and resources are being used effectively.

Resources that will help you assess and build capacity are ***CBO capacity analysis***; ***NGO capacity analysis***; *and* ***NGO support toolkit*** *(see page 121).*

Mobilising resources for our new activities

What is resource mobilisation? Resource mobilisation is the process of getting hold of resources that are needed to carry out activities. Scaling up activities is likely to require new resources. We may be able to mobilise some additional resources from within the community, but it is likely that we will also need to look elsewhere too. We have to identify what we need, where it is available and how we can get it. It is important to think broadly about the resources that we need, not just to think about money. This will help us identify a wide range of possible resource providers and opportunities for obtaining resources.

Mobilising resources There are many different ways of getting hold of resources; for example, holding fundraising events, writing proposals, asking for contributions, being offered contributions or running a small business.

Planning resource mobilisation Resource mobilisation can be a time-consuming process. It can be demotivating if it is not successful or if it takes attention away from important activities in the community. Making a plan for mobilising resources helps us to save time and effort by prioritising our needs and identifying different ways of meeting them. When we make our plans, it is important to be realistic about the amount of resources that we need. Tool 90 can help us to do this. A resource mobilisation plan also encourages us to stay focused on our priorities and to avoid being led by the priorities of donors or other organisations who offer to support us.

Once we are clear what we need, we can identify people or organisations that may be interested in supporting us. We may already have some ideas, and we can do some research to find others; for example, asking other NGOs or networks working in HIV/AIDS to suggest organisations.

See also: **Tool 90 • VEN sorting**

Case study

Treatment Action Campaign

The Treatment Action Campaign (TAC) is a South African pressure group led by HIV-positive people. It campaigns for greater access to HIV treatment and has achieved some important successes. For example, TAC successfully sued the South African Government for failing to make sure that mother-to-child-transmission prevention was available to pregnant women. The courts ordered the government to provide programmes in public clinics on the prevention of mother-to-child transmission.

Definition

What are resources?

Resources are the different kinds of things that are needed to carry out planned activities. They can be:

- money
- help to build technical skills, such as training, support from experts, study visits, publications
- goods and supplies, such as needles, condoms, vehicles, office equipment
- free services, such as office space, medical services, transportation
- people – those who are willing to help carry out activities, and those with particular skills that are needed, such as health care or financial management skills.

People and organisations who can provide resources include: communities, donors, international NGOs, governments, businesses, religious groups and individuals.

Stage 6: Scaling up together

Requesting resources We then need to identify how to approach different people or organisations according to their particular interests and motivations. Organisations who regularly provide resources, such as donors, are likely to have established procedures for requests for support, and we can contact them to ask about these. If we do not know much about a possible resource provider it is often helpful to meet with them to find out more about their interests and priorities before we make a formal approach.

It is useful to think about the motivations of different resource providers to give resources. For example, a local business may be motivated by getting publicity for its services through making a donation, as well as by assisting the local community. This helps us explain the benefits to different resource providers. It also helps us identify the consequences of accepting resources from different providers and any ethical issues involved. For example, accepting resources from government may affect our ability to advocate for changes in government policy.

Prioritising resources If we identify a number of opportunities for resource mobilisation, we will need to prioritise them. Factors to consider include:

- how essential the resource is
- how soon the resource is needed
- the skills needed to approach the resource provider
- the time and effort needed to request the resource
- how likely we think success is!

Creating a resource mobilisation plan Once we have identified and prioritised opportunities for resource mobilisation, we can make a resource mobilisation plan that shows what we will do, when we will do it and who will do it. As we make this plan, we may identify needs for skills building. For example, we may want to write proposals to donors but have little experience in doing so. It is useful to consider whether it is worth developing new skills and how we can do this.

Sustaining resources If we expect to require external resources for some time, we may want to consider the advantages and disadvantages of mobilising resources from a number of different sources. This reduces our dependency on individual resource providers, but is likely to increase the amount of time we spend securing and accounting for resources.

Resource mobilisation is an ongoing activity not a one-off event. We will need to maintain relationships with our resource providers and demonstrate that we are using the resources they have provided effectively and efficiently. When we receive resources from a resource provider, it is essential to agree clearly how the resource provider expects us to report and account for the resources. We also need to make sure that we have the skills and capacity in place to do so. It is helpful to be identifying potential new resource providers on an ongoing basis. This is in order to replace existing support that may come to an end or to enable us to scale up further in the future. Reviewing and updating our resource mobilisation plan on a regular basis will help us to do this.

For further information on resource mobilisation, see ***Raising funds and mobilising resources for HIV/AIDS work: A toolkit to support NGOs/CBOs*** *(see page 122).*

Checklist for Stage 6: Scaling up together	
Issue	**Tick ✓**
Have you reviewed your community mobilisation process and assessed the potential for scaling up?	
Have you assessed the potential for the community to form new partnerships?	
Have you assessed the potential for the community to form or join networks or coalitions?	
Have you assessed the potential for groups in the community to form CBOs?	
Have you assessed the capacity-building needs of existing CBOs?	
Have you assessed the potential for the community to carry out advocacy activities?	
Have you assessed your own capacity-building needs in order to scale up?	
Have you written a resource mobilisation plan?	

If you have achieved all of these things it is time to congratulate yourself!

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How to mobilize communities for health and social change, Health Communication Partnership, Howard-Grabman and Snetro, 2003.

STEPS - A Community Mobilization Handbook for HIV/AIDS Prevention, Care and Mitigation, Save the Children USA - Malawi Experience, 2005.

Guide to useful resources

Unless otherwise stated, all publications can be downloaded or ordered from www.aidsalliance.org/publications

Community mobilisation

100 ways to energise groups: Games to use in workshops, and meetings with the community. A collection of fun activities to help mobilise communities.

A facilitators guide to participatory workshops with NGOs/CBOs responding to HIV/AIDS. Shows you how to plan and manage workshops with the community.

Tools Together Now! 100 participatory tools to mobilise communities for HIV/AIDS. This publication accompanies All Together Now! and provides a selection of 100 participatory learning and action (PLA) tools which you can use for HIV/AIDS programmes.

How to mobilize communities for health and social change, Health Communication Partnership, Howard-Grabman and Snetro, 2003.

STEPS - A Community Mobilization Handbook for HIV/AIDS Prevention, Care and Mitigation, Save the Children USA - Malawi Experience, 2005.

Scaling up

Advocacy in action: A toolkit to support NGOs and CBOs responding to HIV/AIDS. International HIV/AIDS Alliance, 2002. This toolkit shows NGOs and CBOs how they can use advocacy to influence people in power in order to create an environment that protects the rights, health and welfare of everyone, whether HIV positive or negative.

CBO/FBO capacity analysis: A tool for assessing and building capacities for high quality responses to HIV/AIDS. CORE Initiative, 2005. This tool enables CBOs and FBOs to analyse levels of capacity in different organisational and technical areas.

Documenting and communicating HIV/AIDS work: A toolkit to support NGOs/CBOs. International HIV/AIDS Alliance, 2001. This toolkit aims to help NGOs and CBOs make the most of their lessons and results, both in promoting their organisations and in improving the quality of their own work and that of others (available in English, French, Spanish and Portuguese).

Network capacity analysis toolkit. International HIV/AIDS Alliance, forthcoming. A tool to help networks identify their capacity-building needs, plan technical support interventions, and monitor and evaluate the impact of capacity building.

NGO capacity analysis: A tool for assessing and building capacities for high quality responses to HIV/AIDS. International HIV/AIDS Alliance, 2004. This tool is designed to help organisations identify their capacity-building needs, plan technical support interventions, and monitor and evaluate the impact of capacity building.

NGO support toolkit (website and CD-ROM). International HIV/AIDS Alliance, 2006. www.ngosupport.net Full of practical information, tools and guidance, this toolkit covers a range of subject areas about supporting NGOs and CBOs working in HIV/AIDS.

Pathways to partnerships – A toolkit to help NGOs and CBOs responding to HIV/AIDS. International HIV/AIDS Alliance, 2001. This toolkit aims to help NGOs and CBOs to build effective and lasting partnerships with others.

Raising funds and mobilising resources for HIV/AIDS work: A toolkit to support NGOs/CBOs. International HIV/AIDS Alliance, 2002. This toolkit aims to help NGOs and CBOs plan and carry out resource mobilisation strategically and systematically. It helps them to obtain maximum returns for the least effort, while remaining true to their mission (available in English, French, Spanish and Portuguese).

Care, support and antiretroviral treatment

AIDS Infonet. US website with a wide range of factsheets and resources relating to HIV and ARV treatment in plain language, downloadable and regularly updated in English and Spanish at: www.aidsinfonet.org/factsheets.php

ARV treatment factsheets. International HIV/AIDS Alliance, 2005. These are a set of factsheets and participatory tools to support community engagement for antiretroviral (ARV) treatment.

Essential HIV treatment and care in primary care settings. International HIV/AIDS Alliance, 2006. This manual, aimed at primary health care workers, provides a comprehensive description of the common clinical manifestations of HIV and gives practical guidelines for the management of HIV in primary care and community settings.

Trainers' manual – Community engagement for ARV treatment: Participatory tools and activities for civil society organisations working with people living with HIV. International HIV/AIDS Alliance, August 2006 (available in English and French).

Orphans and other vulnerable children

Building blocks: Africa-wide briefing notes. Resources for communities working with orphans and vulnerable children. International HIV/AIDS Alliance, 2003. A set of briefing notes providing issues and principles for guiding strategy to strengthen support for orphans and vulnerable children (available in English, French, Portuguese, Shona and Ndebele).

Building blocks in practice – Participatory tools to improve the development of care and support for orphans and vulnerable children. International HIV/AIDS Alliance, 2004. This resource was designed to help communities assess the situations and needs of their children and the available resources, and to identify what action they can take using the participatory learning in action process (available in English, French and Portuguese).

Orphans and other vulnerable children support toolkit (website and CD-ROM). International HIV/AIDS Alliance, 2004. This toolkit is an electronic library of over 600 resources on supporting orphans and vulnerable children. www.ovcsupport.net

A Parrot on your shoulder – A guide for people starting to work with orphans and vulnerable children. International HIV/AIDS Alliance, 2005. This fully illustrated activity guide is aimed at facilitators and trainers who are starting to work with children affected

by HIV/AIDS. The guide provides 30 activities for engaging children in group work, and includes ice-breakers, energisers, role play, drama and more.

Prevention

Between men – HIV/STI prevention for men who have sex with men. International HIV/AIDS Alliance, 2003. This publication, one of the Key Population series, gives an overview of the issues for men who have sex with men in the context of HIV and other sexually transmitted infections (available in English, French and Spanish).

Choices – A Guide for Young People. Gill Gordon, MacMillan, 1999. This is an activity guide on HIV/AIDS prevention for young people. It also provides useful essential knowledge on HIV/AIDS that can be adapted to an adult setting. www.talcuk.org/

Developing HIV/AIDS work with drug users – A guide to participatory assessment and response. International HIV/AIDS Alliance, 2003. This publication describes the steps to designing and carrying out a participatory assessment of the drug-related HIV/AIDS epidemic and other drug-related harms.

Understanding and challenging HIV stigma: Toolkit for action. Change and International Center for Research on Women, 2003. This toolkit contains over 100 participatory exercises that can be adapted to fit different target groups and contexts. There are different sets of picture codes that help to identify stigma and discuss the rights of people living with HIV/AIDS. They help to stimulate discussions around gender, sexuality and morality issues that link to stigma.

Monitoring and evaluation

The monitoring and evaluation section of the NGO support toolkit www.ngosupport.net provides many useful resources on this subject.

Participatory monitoring and evaluation of community and faith-based programs. A step-by-step guide for people who want to make HIV and AIDS services more effective in their community. Still at field-testing stage, produced by the CORE Initiative, and available at: www.coreinitiative.org/Resources/Publications/PME_manual/

- **Criteria for community/site selection** Which groups have been involved in defining the communities/sites to work with and the criteria for selecting them? Do these represent a representative sample of the community/site? Do members of the defined community participating in the activity have a concern or experience with the issue?

- **Identification of aims and objectives** Are the aims of the activity clear, relevant and owned by all? Who should know and be involved? When and how should they be involved *(see Tool 81: Stakeholder participation matrix)*? Is the community interest clearly described or defined? Did the original drive for the activity come from the defined community?

- **Communication about the process** Is there a wide understanding of who you are, what the activity is about, what it aims to achieve and how all the various groups will benefit from the process?

- **Record keeping** How is the information being recorded and documented? Is there agreement on who owns the information? Is there a system for ensuring confidentiality and anonymity if necessary?

- **Comprehensive participation** Have you identified all of the people who want to, or should be, involved in the activity? Are there people in the community who are not involved? Is there a particular group that is dominating? Are community members participating regardless of age, sex, gender, sexuality, HIV status, ethnicity, religion or economic status? Have gatekeepers been identified? Are there opportunities for collaboration and participation between all these stakeholders as well as with them?

- **Influential participation** Have all potential social and economic barriers against people's participation been sought, defined and addressed? Have opportunities for increased participation been sought, defined and planned into the whole process? How will you recompense people for their time?

- **Tension and conflict** How are issues of conflict and tension being dealt with? Are they just ignored, glossed over, avoided?

- **Physical and emotional security** Are you sure that everyone is able to travel to and from activities, and take part in them safely? Is care and support available for people when mental or emotional issues arise? Do you know who to refer people to for specialist HIV/AIDS care?

- **Confidentiality** Have you made sure that no information is exchanged that could put people's future situations at risk?

- **Safe space** Has every effort been made to ensure that activities are conducted in a place where participants feel comfortable expressing themselves freely? Have participants been made aware that no space is totally "safe" and therefore that they should only share what they feel comfortable sharing?

- **Focus on positive action** Is this just an exercise in gathering problems (vulnerabilities and risks) and "wish lists"? Does the activity also explore the assets and strengths of stakeholders? Does the process move towards an action plan? Will the activity benefit the community?

- **Capacity building** Does the activity allow the community to reflect and learn collaboratively about issues and develop new knowledge, skills and capacity to address them?

- **Methods** Does the activity methodology allow for literate and non-literate people to participate equally? Does it allow communities to learn methods of assessment, analysis, planning, monitoring and evaluation for their own use? Does it allow for participants to develop their own conclusions?

- **Empowerment** Does the activity allow for the community to increase its knowledge, resource, positional and personal power to address the issue? Have any potentially negative implications of empowerment been sought, defined and addressed? For example, people may have a false belief that they are empowered to address an issue, when they may not be fully able to yet.

- **Don't dump issues** Have other actors been brought in to deal with issues outside the mandate of this community mobilisation process?

- **Verification** Is there a feedback mechanism to the community? Is there agreement on acknowledging different interpretations of issues between groups of people?

- **Maintaining momentum** What is the timeline for the process? Is everyone aware of this? Will the community have the opportunity to participate in every stage of mobilisation, including evaluation?

- **Maintaining community momentum and capacity** Does the community have access to information about how to enhance their capacity for self-mobilisation (in the areas of improved leadership, skills, resources, social and inter-organisational networks and a greater sense of community)?

- **Outcome and decisions** What plans are there to take actions forward or to monitor and evaluate the action plan?

- **Reporting, publication and presentation** Do any written reports reflect multiple voices/perspectives of the community? Have they, and other outputs, been widely circulated? Have all participants given their permission for their opinions and/or photographs to be presented? Have community members been given the opportunity to present the report? Have participants agreed who the report should be disseminated to?

- **Learning from the process** Is there a mechanism for stakeholders systematically to record and remember lessons learned about the process they are participating in?

Source: Adapted from Nikki van der Gaag (ed.) (2003) ***Have you been PA'd? Using participatory appraisal to shape local services***, Oxfam, June; ICW (2003) ***Draft guidelines on ethical participatory research with HIV positive women***, July; and sources from the International HIV/AIDS Alliance.

Glossary

Adherence – the process of taking doses of drugs and sticking to the treatment plan exactly as prescribed. This is particularly important with ARV treatment *(see below)*. ARV treatment requires people to take the correct drugs at the correct time and in the correct way, and to look after drugs to make sure that they are effective and safe to use.

Advocacy – the process of persuading influential or powerful people to make changes in policies, laws and practices. Advocacy can be used to change existing policies and laws and to make new ones. It can also be used to make sure policies really are put into practice.

Aim – the broad, long-term goal set for a piece of work or project.

Assessment – the process of identifying and understanding issues or problems.

ARV treatment – antiretroviral (ARV) treatment is treatment for HIV infections. It involves using drugs that interfere with the way the HIV virus reproduces in the body. ARVs reduce the amount of virus in a person's body, and lower the ability of HIV to damage the immune system. ARVs must be taken for life.

Capacity building – the process of enabling people, groups or organisations to build their knowledge, skills and resources in order to undertake activities more effectively.

Civil society – voluntarily formed groups and associations that share interests and values, and are separate from government and private business (e.g. non-governmental and faith-based organisations, trade unions, etc.).

Community – a group of people who feel that they have something in common. This can include formal and informal organisations and groups. People can belong to more than one community at the same time.

Community mobilisation – is a capacity-building process through which individuals, groups or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

Community mobiliser – a person whose role it is to facilitate a community to mobilise. They are usually a member of the community or a peer of a particular community group.

Community mobilisation team – a team of individuals responsible for facilitating the community mobilisation process. They are usually made up of a mix of community mobilisers, community leaders and any external organisations (e.g. a non-governmental organisation) that might also be providing technical support or resources to help the community mobilise.

Empowerment – is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. In order to be empowered to address HIV/AIDS, people need to develop four types of power: personal, positional, knowledge and resource power ***(see page 12 of Tools Together Now!).***

Evaluation – an assessment of what a project or organisation has achieved over a period of time, which helps those involved to see if changes are needed in plans and activities.

Facilitator – a person who will coordinate, rather than lead, an activity, encouraging the participation of others.

Gatekeeper – a person who controls access to certain individuals, groups of people, places or information.

Impact mitigation – reducing the negative impact HIV and AIDS can have on the wider social, economic and environmental well-being of a community.

Indicators – objective ways of measuring (indicating) that progress is being achieved. Activity indicators will tell us that we are doing the activities that we planned. Change indicators will tell us that we are making progress towards our objectives and having an impact on HIV/AIDS issues.

Key populations – groups that are particularly vulnerable to being infected or affected by HIV/AIDS. Key populations vary according to the local context. 'Populations' can apply to men who have sex with men, sex workers, injecting drug users, people living with HIV/AIDS and women.

Livelihood strategy – a livelihood strategy describes the way in which people use their capacities and resources to ensure a living (e.g. gaining food, income and other resources).

Microfinance schemes – the provision of financial services, particularly small loans, to people, groups or organisations. The aim is to allow them to set up a project or initiative to help generate an income.

Monitoring – the systematic and continuous collecting and analysing of information about the progress of a piece of work or project over time.

Objectives – statements about the specific, measurable, time-bound goals a project hopes to achieve by the end of its life. A project achieves its aim by meeting its objectives.

Participation – there are many different types of participation. In this series, participation refers to a process in which people are able to take an active and influential part in shaping the decisions which affect their lives.

Participatory assessment – a process that involves community members identifying and understanding for themselves issues or problems that affect them. Participatory assessment usually makes use of participatory tools such as those used in participatory learning and action (*see below*).

Participatory learning and action – a growing family of approaches, tools, attitudes and behaviours to enable and empower people to present, share, analyse and enhance their knowledge of life and conditions, and to plan, act, monitor, evaluate, reflect and scale up action. It is one method to help facilitate community mobilisation for HIV/AIDS.

Participatory site assessment – this involves an assessment being undertaken with several communities at the same time. The information from each community is shared within the site to aid scaling up and coordinating activities across a site.

Partnership building – this is about working with others to achieve what cannot be achieved on our own. Partners work together for a common purpose and for mutual benefit.

Peer education – a process by which community members are trained to promote learning and facilitate discussion with their peers on particular issues.

Procurement – the acquisition of goods or services. This term is often applied to the system of sourcing and purchasing antiretroviral drugs from pharmaceutical companies.

Resource mobilisation – this is the process of ensuring the availability of resources required to do the work that is planned. This includes a range of resources; primarily money, but also technical assistance, human resources, material goods and free services.

Social capital – the glue that holds social groups of people together. Social capital refers to the processes between people that establish networks, norms and social trust, and facilitate coordination and cooperation for mutual benefit.

Stakeholder – a person, group or organisation with an interest (a stake) in a project or initiative. A **primary stakeholder** is a person or an organisation who the community mobilisation process primarily aims to benefit (e.g. a young person in a youth prevention process). A **secondary stakeholder** is a person who may not benefit directly but will be affected or involved in some way (e.g. a teacher in a youth prevention process).

Strategy – a long-term plan of action designed to achieve a particular goal.

Sustainability – refers to the ability to maintain a process or effect; for example, the ability to keep an HIV prevention project going while also ensuring that it continues to prevent HIV infection. There are two aspects to sustainability: implementation and impact. Implementation sustainability refers to the sustainability of project activities. This will be influenced by the possibility of: continued financial support; maintaining political and community support; maintaining the participation of the target group; maintaining the quality of project work; and retaining project staff. Impact sustainability refers to the sustainability of changes that a project has achieved beyond the end of the project activities. This sustainability will be influenced by: the nature of problems addressed by the project; the circumstances of the target groups and communities that the project works with and the capacity of communities to take over the implementation of activities themselves.

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