Community Engagement Training Manual

– AN OPPORTUNITY TO IMPROVE COMMUNITY ENGAGEMENT PRACTICES TO INCREASE UPTAKE OF HIV/AIDS SERVICES IN NIGERIA

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Table of Contents

Acronyms:

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ANC	Ante Natal Care
CACA	Community Action Committee on AIDS
CAS	Community Analysis Sessions
CBHI	Community Based Health Insurance
CDC	Community Development committees
CSO	Civil Society Organizations
CHBC	Community Home Based Care
CHEW	Community Health Extension Workers
DDC	District Development Committee
DFID	Department for International Development
DOTs	Directly Observed Treatment Short course
ENR	Enhancing Nigeria Response to HIV/AIDS
FBO	Faith Based Organization
FGDs,	Focused Group Discussions
FGN	Federal Government of Nigeria
FHI	Family Health International
HCT	HIV Counseling and Testing
HCW	Healthcare workers
HIV	Human Immunodeficiency Virus
HEAP	HIV/AIDS Emergency Action Plan
IMNCH	Integrated Maternal Neonatal and Child Health
KACA	Kingdom Action Committee on AIDS
KII	Key Informant Interviews
LACA	Local (Government) Action Committee on HIV/AIDS
LGA	Local Government Area
MARPs	Most at risk populations
MDGs	Millennium Development Goals
MDHFA	Minimum District Health for All Package
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NACA	National Agency for the Control of AIDS
NASCP	National AIDS and STI Control Programme
NGO	Non-Governmental Organization
NARHS	Nigeria Demographic and Health Survey
NEACA	National Expert Advisory Committee on AIDS
NNRIMS	Nigeria National Response Information Management System
NSF	National Strategic Framework

NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PMTCT	Prevention of mother-to-child transmission of HIV
PLHIV	People Living with HIV/AIDS
PPE	Personal Protective Equipment
SACA	State Agency for Control of AIDS
SASCP	State AIDS and STI Control Programme
SMoE	State Ministry of Education
SPT	State Project Team
TBA	Traditional Birth Attendants
TOR	Terms of Reference
TWG	Technical Working Group
UNAIDS	Joint UN Program on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USP	Universal Safety Precautions
VDC	Village Development Committees
VHW	Village Health worker
WDC	Ward Development Committees
WHS	Ward Health Service
WMHCP	Ward Minimum Health Care Package

Acknowledgement:

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We also recognize the immense inputs of the various stakeholders, community leaders, and the SACAs in the 6 selected states from each geographical zone that were visited by the consultants to gather firsthand information for the desk review and practical community engagement practices. We particularly express our gratitude to community leaders in the various states who made out time of their busy schedule to give us their perspective to community mobilization efforts in their different domain.
Most of all, we give thanks to God for granting us safe journey in all the trips that we undertook especially into some remote communities where we needed to interact with their leaders, youth groups, market women and peer support groups. We hope that this work will translate to an improved community engagement process and practices and invariably leading to improved HIV/AIDS response initiatives in Nigeria.
We appreciate the consultant, Mr. Joshua Ida Samson who led the development of the Community engagement strategy as well as provided technical guidance to develop this Training Manual.

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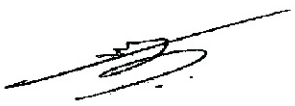

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Preface:

National Agency for the Control of AIDS (NACA) is the apex institution in Nigeria's multi-sectoral HIV/AIDS response architecture and it is mandated to provide overall coordination of the national response while State Agencies for the Control of AIDS (SACA) and LGA Action Committees on AIDS (LACAs) ensure coordination at state and local government levels respectively.

In spite of the concerted efforts in halting and reversing the spread of HIV and AIDS epidemic in Nigeria, major challenges still exist on how to engage the community for maximum uptake of health services not minding the myriads of service points and providers that government continues to provide across the country. It is in this respect that the community engagement strategy was developed and now being transformed into this training manual. The Community Engagement Strategy document is designed to involve all relevant stakeholders in the decisions and plans to prevent new HIV infections among community members and to develop collective approaches and plans that will provide support to those who are affected and infected. It spells out the structure, roles and responsibilities of all the partners and stakeholders in their collective response for HIV/AIDS programme management at the community level.
The community engagement strategy provides the framework that ensures improved partnership, collaboration, information sharing, coordination and reporting of all programme responses; describing the roles and responsibilities of the various sectors (NACA, SACA, LACA, Development Partners, Donor Agencies, Global Funds, PEPFAR and other entities) that are working at the National, State and Local Government levels for meaningful and greater involvement that will stimulate the desired uptake of HIV/AIDS services especially at the grassroots level.

In order to achieve engaging the community for increased awareness and effective uptake of HIV/AIDS services at the community level, various policies/documents developed by FMoH, NPHCDA, and other partners were harmonized into one National Policy for Community Engagement practice. This document has been translated into this training manual to serve as a guide to all health workers, service providers and partners. The document will therefore assist the health providers in various communities to appreciate their roles as community mobilizers and catalyst for behavior change among community members in their efforts to access health care facilities and services appropriately.

Community mobilization is the process of engaging community members to identify their priorities, resources, needs and solutions in such a way as to promote

representative participation, good governance, accountability and peaceful change. With community mobilization, participation is about meeting the interests of the whole community. When every member of the community has the chance, directly or through representation, to participate in the design, implementation and monitoring of community-level initiatives, there is a higher likelihood that the initiative or program will accurately reflect their real needs and interests. The approach takes into consideration the different experiences, needs and capabilities of various structures and groups in a community – women and men, youth and the elderly, persons with disabilities and the able bodied, ethnic/religious/language minorities and majorities. Rather than passive participation, we should aim to inspire self-mobilization, where communities organize and take initiative independent of any external pressures or influences.

The community is the place where health programmes need to be promoted; this is where people who need health services should be encouraged to access available and affordable health care at costs that are reasonable. There are evidences of the roles and responsibilities that community leaders, chiefs, paramount rulers, religious leaders and local champions have played in the past in organizing their people to accept government health programme. Though community leaderships have a role to play in the mobilization and sensitization of their members to accept government health programme, it is very important that they are carried along during the design and implementation efforts of all programme at all times. They need to be involved at all stages of interventions design, implementation and monitoring as well. Existing community structures such as Village Development Committees (VDC), District Heath Committees (DHC), Community Development Committees (CDC), Women Associations, Market Women Organizations, etc, are outlets that can be engaged meaningfully to sensitize their own members to accept and uptake health care services.

As end-users of health care services, communities have a stake in ensuring that services are well-provided, and they are also well-positioned to monitor the quality of services that they receive. With the benefit of local information, they can assess the specific obstacles facing facilities in providing services and they can seek to ensure that facilities have the necessary infrastructure, supplies and staff motivation to provide the services they are supposed to provide. Some of this can be done through volunteer efforts, such as donations for buying supplies, but most of the benefits of community participation can only be harnessed if there are specific mechanisms in place to enable them to do so. These mechanisms could be by establishing community funds for health to support their members who are not able to access health services because of lack of funds; organizing local transport associations to take members of communities to health centers at odd hours especially in locations where ambulances are not available; organize local Okada (motor cycle) riders as channels to transport their members to access remote health facilities. These kinds of mechanisms have helped to save lives of many community members in a timely manner. Community engagement and mobilization are therefore key to achieving improved uptake of HIV/AIDS and other health services at the various levels. This training manual is about how to ensure that community members are well engaged and given a chance to contribute to health issues that concern them and to be part of the solution that they desire to improve the quality of their own lives.

Introduction:

Recently NACA along with the stakeholders and partners in HIV/AIDS response developed the Community Engagement strategy that harmonized various community engagement models practiced by many development partners and organizations in Nigeria. The purpose of the strategy is to ensure uniformity in our collective interactions and engagement with the communities for the purpose of providing HIV/AIDS services. In addition to the strategy, training manual that will serves as a user's guide to enable proper understanding of the Community Engagement strategy, and also to ensure common practices across all sectors in their engagement with the local communities in programmes and interventions. Hopefully this should lead to improved and increased uptake of HIV/AIDS services across the country.

Reviews of programme with successful outcomes increasingly point to community engagement and involvement as a key aspect of their work. This includes working with various community structures, Community Based Organizations and systems to stimulate their interests in our programme intentions, demonstrate commitment to ensure that there exist community support strategies that would lead to sustainability of established programmes, especially as it has to do with expanded response and uptake of health services at the community level.

These community based structures include Community Based Organizations (CBOs), Non-Governmental Organizations (NGOs), Religious organizations, social institutions such as The Lion's club, Aged Group Associations, Women organizations, Catholic Mothers Associations, Muslim Sisters Association, Community Development Committees (CDC), Village Development Committees (VDC), etc. Members of these organizations are drawn from the communities where health facilities are situated or located. It is possible to work through these groups and structures to promote expanded uptake and access to health care delivery services especially with information sharing and awareness raising. Working with and through them is indirectly working with the community stakeholders since most members in these associations tend to be people in the community that are of high social standing. Recognizing that these institutions and structures can make a difference in promoting behavior change and encouraging the uptake of health care services is crucial to ensuring their commitment and involvement in promoting continuous access to the various community based health facilities and services.

About this Training Manual

This community engagement training manual is broken down into 6 modules. Each module has a set of objectives, narratives that guide presentations in a way that address the focus of the Community Engagement Policy. Each module has some group work or activities which would lead to increased participation and learning of participants. At the end of each module there are set of questions that would help participants to recall the lessons learned during each training session and how they would apply them to their field experiences and realities.

The users of this manual are development partners, stakeholders and Government health institutions that are working to increase uptake of HIV/AIDS services in Nigeria. The Manual sets out what health professionals, stakeholders and partners will do to make sure that the community members they engage with are carried along in their mobilization efforts and they can make informed decisions and have opportunities to shape health care delivery plans and services. The eventual intention is that we achieve increased uptake of HIV/AIDS services in Nigeria especially among rural communities. The Training Manual provides a framework within which all community engagement process and efforts to improve uptake of health services will be undertaken at the national, state, local government and Ward levels. It is not intended to impose new ways of working or reinvent the wheel; rather, it is more about strengthen or building on the undoubted good practices which already exist and capturing them in one document as already discussed in the community engagement strategy document.

Involving the community and collaborating with its members are cornerstones of efforts to improve public health. In the context of engagement, "community" has been understood in two ways. It is sometimes used to refer to clusters of those who are affected by the health issues being addressed. This use recognizes that the community as defined in this way has, historically, been left out of health improvement efforts even though it is supposed to be the beneficiary of those efforts. On the other hand, "community" can be used in a more general way, illustrated by referring to stakeholders such as academics, public health professionals, and clusters of people with common interests including policy makers as different communities. This use has the advantage of recognizing that every group has its own particular needs, culture and norms and that anyone can take the lead in the engagement efforts.

In this training manual, we recognize the need for particular attention to engagement of communities that are affected by health issues and to work with them collaboratively to define their issues/needs, proffer solutions and address or resolve their problems in ways that they will appreciate and take ownership of this process. We also promote the

idea that engagement for health improvement can be initiated and led by the community members rather than professional groups.

The training manual can be used to engage participants in one stretched training period, or can be used module by module depending on the time and availability of participants and facilitators. But it's important to underscore the need to work through modules 1 to 5 while using module 6 as models and best practices that would buttress the engagement practices as contained in the manual. Facilitators are therefore encouraged to read through the entire manual along with the Community Engagement Policy so that they would work with full perspective on the scope and issues to be addressed during the training sessions. It is also important that a training of trainer be organized for first time users of this manual to ensure full understanding and consistency of its use in all states of the Federation.

The starting point is promoting family health education:
The families, households and the communities are the locations where the HIV/AIDS epidemic ravages the most. When a family member is infected with HIV and is eventually down with AIDS, it is the family, households and the entire community members that bear the pains, the burden of care and support and provision of what it takes to manage the last days of the patient. It is therefore very important that appropriate mechanisms and structures be put in place so that health care service delivery points within the various communities where the LACAs are supposed to have coordinating responsibilities are accessible by family members and these must be strengthened for effective management of HIV/AIDS interventions and programme.

Family member's education programme should be put in place and should be structured in such a way that from time to time, health orientation and education programme are held in various communities to inform them about available health services and the joint responsibilities of families and government agents to eradicate diseases and promote total wellbeing for all in the various communities. There are several platforms for this kind of outreach. These include, the churches, mosques, age group meetings, occasional tribal and cultural meetings and even using town criers and information mobilization instruments as available and appropriate in each community.

Why involve local communities?
The community is where health issues and matters are burdened and they are the ones who know what their issues are regardless of what their levels of education and awareness are. Because the promotion of health for all is a matter for improving families and communities' health, Governments cannot achieve their laudable policies and programmes without significant community participation and engagement.

There is no lack of strategies, policies or procedures covering community engagement in Nigeria. What is lacking is a comprehensive framework and training manual that captures these overlapping initiatives and sets out how they relate to one another in order to reduce duplication. This should enable more meaningful consultation with community members and reduce the risk of consultation overload and fatigue.

Why do we need a Community Engagement Framework?
Health workers, civil society organizations, local councilors, statutory agencies, private and public sectors all have different understanding and different roles that they play in community engagement practice. Local government authorities are traditionally closer to the communities where local people are involved in the existing structures and decision-making mechanisms for community mobilization and engagement. The Voluntary, Community and Faith based sectors are more traditionally 'empowered' – and are able to support people and communities in doing things for themselves. When organizations engage with communities, they do so based on their values and programme goals and objectives.

So, it is important that this Framework recognize these different values and approaches but also sets out a vision that all partners can commit to establish a harmonize community engagement protocol. The implication from the Community Engagement Policy/Manual is that every stakeholder, along with its partners, will need to look again at its plans for public and community members' engagement and simplify this array of overlapping initiatives in order to improve and strengthen their consultation and engagement arrangements.

In order to secure coordinated consultation and engagement across these processes, we want the LACA and its partners to have the flexibility to draw up a much more comprehensive engagement strategy which captures the planned community engagement requirements of the individual partners and, where possible, combines activity at the grassroots level.
As a starting point, this document sets out the strategic framework to respond to these challenges. It must be followed by the development of skills, processes and relationships in order to succeed.

What do we want to achieve?
The Community Engagement Framework will ensure that health workers and stakeholders/partners actively seek and take the views of community members into account as a major part of the decision-making process to promote increased uptake of health care services at all service delivery points in Nigeria. It will ensure that these processes are resulting in improved service delivery and demonstrable change of users.

Although various stakeholders and partners are currently engaging with the community in a variety of ways, there is no routine evaluation of their effectiveness and consequently the extent to which the public understands what the stakeholders and partners are trying to achieve. The Community Engagement Framework/Training Manual will rectify this.

MODULE ONE:

Community Engagement Concepts

Module one speaks generally to the concepts and definitions of Community engagement and mobilization as a means to create awareness targeting local communities for full benefits of available health services and how to access them meaningfully.

Objectives of Module 1:

The objectives of module 1 are to:

1. Introduce participants to the concept and definition of community engagement
2. Define different levels of community engagement
3. Discuss principles and strategies of community engagement
4. Identify existing structures and mechanisms to work with in communities
5. Discuss the process of developing the engagement Action Plan

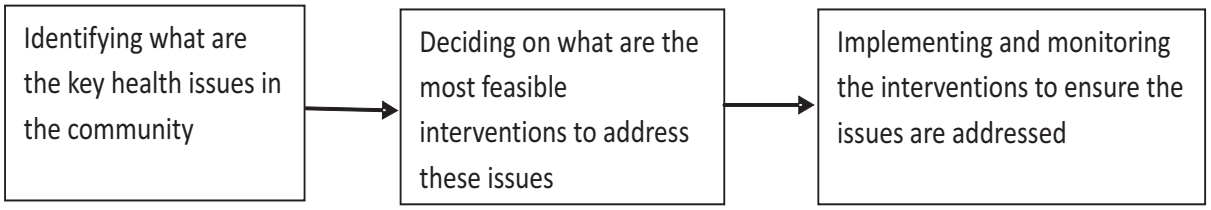
The What and Why of Community Engagement

Community engagement can be defined as the process of working collaboratively with and through groups of people affiliated by geographic proximity/boundaries, special interest, or similar situations to address issues affecting their well-being. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.

Community engagement also is about involving the community in the decision making processes, which is critical in the successful development of acceptable policies, programmes and interventions including the decisions by government to commit funding to the various community based projects and engagement practices.

Community engagement is increasingly acknowledged as a valuable process, not only for ensuring that communities and their members can participate in decisions that affect them and at a level that meets their expectations, but also to strengthen and enhance the relationship between communities and governments. Community engagement can take many forms, and partners can include organized groups, agencies, institutions, or individuals collaborators that may be engaged in health promotion, research, or policy making. Community engagement can also be seen as a continuum of community involvement starting from needs identification and analysis to developing programme responses to addressing those needs or gaps identified, and eventually being part of monitoring the outcomes of the various programmes and interventions that have been implemented.

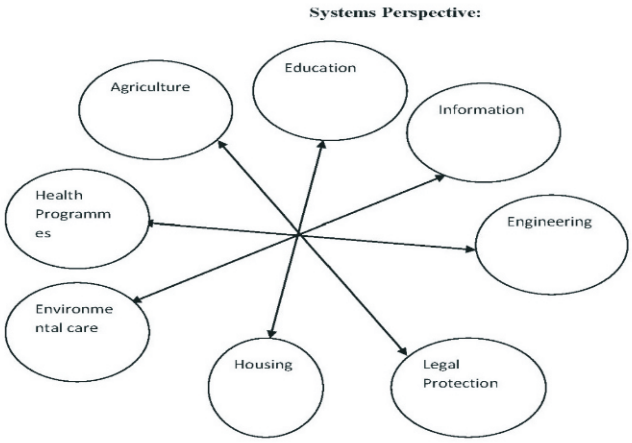
Stages in community engagement practice



In practice, community engagement is a blend of science and art. The science comes from sociology, political science, cultural anthropology, organizational development, psychology, social work, and other disciplines, and organizing concepts are drawn from the literature on community participation, community mobilization, constituency building, community psychology, and cultural influences. The art comes from the understanding, skill, and sensitivity used to apply and adapt the science in ways that fit the community of interest and the purposes of specific engagement efforts. The results of these efforts may be defined differently and can encompass a broad range of structures (e g, coalitions, partnerships, collaborations), but they all fall under the general fabric of community engagement and are treated similarly in this training manual.

Concepts of community:
There are many ways to think about a community. We will explore four of the most relevant, each of which provides different insights into the process of community engagement.

Systems Perspective:
From a systems perspective, a community is similar to a living creature, comprising of different parts that represent specialized functions, activities, or interests, each operating within specific boundaries to meet community needs. For example, schools focus on education, the transportation sector focuses on moving people and products, economic entities focus on enterprise and employment, faith organizations focus on the spiritual and physical well-being of people, and health care agencies focus on the prevention and treatment of diseases and injuries (Henry, 2011). For the community to function well, each part has to effectively carry out its role in relation to the whole organism. A healthy community has well-connected, interdependent sectors that share responsibility for recognizing and resolving problems and enhancing its well-being. Successfully addressing a community's complex problems requires integration, collaboration, and coordination of resources from all parts. From a systems perspective, collaboration is a logical approach to health improvement.



Social Perspective:
A community can also be defined by describing the social and political networks that link individuals, community organizations, and their leaders. Understanding these networks is critical to planning efforts in the engagement process as most times, the general community members can be reached via their leaders or their delegations who represent their interests. For example, tracing social ties among individuals may help engagement leaders to identify a community's leadership, understand its behavior patterns, identify its high-risk groups, and strengthen its networks.

Virtual Perspective:
Some communities map onto geographically defined areas, but today, individuals rely more and more on computer-mediated communications to access information, meet people, and make decisions that affect their lives. Examples of computer-mediated forms of communication include email, instant or text messaging, e-chat rooms, and social networking sites such as Facebook, YouTube, and Twitter. Social groups or groups with a common interest that interact in an organized fashion on the Internet are considered "virtual communities". Without question, these virtual communities are potential partners for community-engaged health promotion and research. And with the mobile phone increasing in use in both rural and urban communities, several virtual communities can be created and reached for increased change in behaviour on available health services.

Individual Perspective:
Individuals have their own sense of community membership that is beyond the definitions of community applied by researchers and engagement leaders. Moreover, they may have a sense of belonging to more than one community. In addition, their sense of membership can change over time and may affect their participation in community activities. The philosopher and psychologist William James shed light on this issue in his writings. James thought it important to consider two perspectives on identity: the "I," or how a person thinks about himself or herself, and the "me," or how others see and think about that person. Sometimes these two views agree and result in a shared sense of an identity, but other times they do not. People should not make assumptions about identity based on appearance, language, or cultural origin; nor should they make assumptions about an individual's perspective based on his or her

identity (James, 1890). Today, the multiple communities that might be relevant for any individual — including families, workplace, and social, religious, and political associations — suggest that individuals are thinking about themselves in more complex ways than was the norm in years past.

Levels of community engagement:
There are different levels of community engagement, ranging from simply informing people to helping people to help themselves. It is important to recognize how each stage builds on the other, and that the form of engagement should be appropriate for the purpose. In this manual, we are going to examine and focus on 5 levels of community engagement concepts which are contained in the table below.

Inform	One way communication providing balanced and objective information to assist understanding about something that is going to happen or has happened.
Consult	Two way communications designed to obtain public feedback about ideas on rationale, alternatives and proposals to inform decision-making.
Involve	Participatory process designed to help identify issues and views to ensure that concerns and aspiratio ns are understood a nd considered prior to decision-making.
Collaborate	Working together to develop understanding of all issues and interests to work out alternatives and identify preferred solutions that are most beneficial to the interests of the communities.
Empower	Providing opportunities and resources for communities to contribute to solutions by valuing local talents and skills and acknowledging their capacity to be decision makers in their own lives. This will help them to take the lead in install ing any initiatives and practices that can enhance the quality of their health and livelihood.

Information giving is the first step towards genuine community engagement and development. The emphasis is on a one-way flow of information and there is no channel for feedback. It is used to let people know what is happening in situations where decisions have already been made or no choices are available.

Consultation goes beyond information giving by actively seeking, listening to and taking account of people's views before making decisions or setting priorities. People are not however, allowed to develop their own ideas or put their own plans into action. This is an outcome associated with participation/empowerment.

Involving the community goes beyond just sharing information and consulting them; it has to do with making the community a part of the planning process of engagement through the eventual decision making and putting intervention in place to benefit them.

Collaboration is all about ensuring that the community is seen as a partner in the engagement process whose voice, resources and opinions form part of all stages of

engagement and eventually work with their local resources to make sure that the interventions address their peculiar initiatives. In this way, they see themselves as owner of the intervention or project and will make every effort to sustain the practice.

Principles of Community Engagement

Community Engagement is about developing and sustaining a working relationship between one or more community groups, to help them understand and act on the needs or issues that the community experience as they affect their livelihood.

From this definition, it follows that engagement is about:

- The development of relationships with the community
- Open and clear communication with the community
- Networking, listening and having fun
- Understanding the diverse people and places we work in.
- Viewing issues from community members' perspective and how they feel its impact on their lives

To ensure that community engagement is consistent, coherent and coordinated, the following principles must be adhered to.

- Community engagement should fit for purpose, using appropriate methods for different objectives and stages, different audiences and different issues.
- Effective engagement requires a commitment to better communication among the various parties that are concerned.
- Community engagement must be an integral part of the mainstream processes of government, agencies and partners.
- It must be clear from the start what is 'on offer'. The purpose of the community engagement should be explained together with what can and cannot be influenced, how the results will be used and what feedback will be given.
- Organizations should recognize that certain groups and communities often experience social exclusion, and the views of 'seldom heard' groups should be sought proactively using appropriate means of communication.
- Engaging with people to influence decision-making means involving them at the earliest stages in the planning of services and projects, rather than simply consulting them once the decision has been taken.
- Communities may wish to engage at different levels and some may not wish to become fully involved.
- Evaluation, monitoring and feedback should be built in at the outset.
- Successful engagement requires investment in terms of time and resources to build the capacity of organizations and communities in order to ensure people have access to the right skills and training to engage with one another more effectively.
- Where appropriate, we should support and facilitate communities in carrying out their own engagement activities so that they are not regarded as recipients on someone else's engagement.

Mechanisms and structures for effective community engagement and mobilization

- It is very important to recognize existing mechanisms and structures (VDC, CDC, and WDC) already in place so that the health care service delivery points within the various communities where the LACA are supposed to have coordinating responsibilities are strengthened for effective management of HIV/AIDS interventions and programme.
- Identify existing social networks, community based organizations and structures and work with them to raise awareness on HIV/AIDS services. This includes association of hairdressers, road side mechanics, association and network of hair barbers and such like networks.
- Government at all levels should demonstrate a high-level of political commitment and harness all available resources in collaboration with Partners, the private sector and communities to ensure that existing community based structures and systems are recognized, supported and encouraged to function as intended.
- Existing structures (VDC, WDC, CDCs) should demonstrate community ownership in their efforts to mobilize their members to access health services
- Development and implementing partners need to recognize the coordination roles and functions of the LACA and should be allowed to serve as such in all the LGAs.
- The LACA need to be truly constituted to recognize their coordinating function and act as such in working with community based structures to stimulate health promotion and access to health service delivery and opportunities in their various communities.
- Educating health workers as key agents for community mobilization is fundamental to its success.
- It is equally important to recognize and value the various channels of communication available and put them to effective use to mobilize community, not forgetting to appreciate the barriers that the channels may come with.

Community Mobilization is about engaging communities

- Community Mobilization is about engaging communities directly over their health and social issues, giving them opportunities to participate in decisions that concern their lives and existence.
- With community mobilization, participation is about meeting the interests of the whole community by engaging with clusters of community groups in the villages and towns taking health services to them right where they live.
- When every member of a community has the chance, directly or through representation, to participate in the design, implementation and monitoring of community-level initiatives, there is a higher likelihood that the program accurately reflects their real needs and interests

Community Engagement and Consultation Process

Establish your engagement objectives and plans:

- Whenever decisions are being made about issues that will affect the lives of local

communities, community engagement must always be a primary consideration. Citizens and stakeholders should be given the opportunity to participate at every stage of the decision-making process - from defining issues through to formulating and implementing the solutions.

- Effective and comprehensive planning is essential and required to ensure that community engagement meets the needs of those people undertaking the action and is carried out to the high standards.

Before you can develop an action plan, you first need to lay the foundations of your engagement by clarifying the overall aims of the engagement exercise.

Group work: Break the class into small groups of 5 to 10 members per group and discuss the following questions and then share the group work in plenary. The material in this section should serve as a guide but each group should consider the peculiarities of their own community and how they intend to engage with them for meaningful results

To do this group work, it is necessary to consider the key questions that are outlined below:

- What are your key objectives? Write them down in clear terms
- What level of engagement is required? Is it at community leadership or membership
- Who do you want to engage with?
- What engagement is being done elsewhere? Who has worked with this community in the past?
- Do you need to engage about engaging? In order words do you need to establish first the basis for your community engagement with this community?

What are your key objectives?

The first stage of the planning process is to clarify your objectives, in other words you need to ask yourself, what are you trying to achieve by engaging with the community? You need to consider why you are embarking on a community engagement exercise and what you hope to get out of it. This requires having an in-depth background knowledge about the community and their social enterprise. You need to identify who and what are the drivers for your engagement activity, what information is required, how the information will impact on policy or strategy development, and how information derived from your project can be learned from and shared across the stakeholders and partners.

The choice to engage communities in the decision making process depends on a number of factors which need to be considered in the planning process. These factors include, but are not limited to the following dimensions.

- Opportunities to facilitate understanding through information sharing
- Previous community engagement experiences
- Democratic right of individuals to be involved in decisions affecting them and contribute to community building
- The desirability of incorporating community values, interests and needs into decision making.
- Development of sustainable decisions

Identify target audience within the community

The next step in planning community engagement is to define your target audience – the communities with whom you want to engage. You need to identify the types of stakeholders that you want to engage with and decide how you'd engage them in a more structured way that will sustain their interests at that level. It is important to remember the differences between communities of interest and communities of place, and to recognize that individuals belong simultaneously to a number of both types of community.

Issues and levels of interest will emerge as work with stakeholders' progresses through the planning process. It is important to identify these matters as early as possible in the process and develop response strategies. Key aspects to consider are as follows:

- Needs, interests, issues and impacts - some of these may be clearly evident, however it is important to speak directly to key stakeholder to become aware of any unknown issues or other agendas.
- Likely positions – each stakeholder is likely to have a slightly different perspective and will take up their own position of interest on the problem or issue. It is useful to acknowledge these positions and discuss them openly to help everyone gain a broader perspective.
- Response strategies – understanding positions of interest will guide responses and assist to facilitate the process inclusively to bring people to the discussion of common ground.

It is essential that you plan any engagement activity within the overall context of ensuring that the outcome will reflect the diversity of the community population. This means that you must carefully consider how you will achieve this.

People will identify with different communities according to their circumstances and the issues under discussion. It will therefore sometimes be necessary to engage with a range of individuals, groups or communities in order to achieve your objective.

Step 1 - Work with key stakeholders and decision makers

Identifying who the decision makers are in the community, what their role is, and when and how they will make decisions is central to effective governance. Consider convening a project team, including a Community Engagement coordinator to take responsibility for the community engagement process. This approach will facilitate a shared and collaborative understanding and approach across relevant disciplines and departments within the Local Government Councils and ensure effective community engagement, communication and project management. It also provides opportunities to develop and integrate internal community engagement practices throughout Council's organizational culture and prepares staff for external community engagement.

Key points to getting it right when working with decision makers

- ✓ Clarify the roles of decision makers and when and how they will make decisions.
- ✓ Acknowledge the elected body of community leadership as the final decision maker.

- ✓ Identify who else may make operational decisions or recommendations to decisions makers throughout the community engagement process.
- ✓ Meet with Council Members as early as possible to clarify their expectations and gain their commitment to the process.
- ✓ Clarify the expectations of internal stakeholders and decision makers and external key stakeholders.
- ✓ Consider the appointment of a Community Engagement coordinator for each project.

Step 2 – Clarify the decisions to be made:
It is important to be clear about the decision to be made. Being *unclear* is a common reason for tension between Councils and communities and why some issues seem to remain unresolved over a long period of time. The key to clarifying the decision to be made is to ask those involved in the planning process (Council Members, the project team and key stakeholders) what they think the decision is that needs to be made. You would also want to clarify on what change is expected to take place in the community regarding their perception on health care service deliverable and how to access it.

Key points to getting it right - clarifying the decision to be made

- ✓ Be clear about the decision to be made.
- ✓ Meet with internal stakeholders (Council members and relevant staff) to clarify the decision that needs to be made.
- ✓ Draft a decision statement.
- ✓ Meet with external key stakeholders (for example, residents directly affected, community groups, businesses) to gather information and gain their perspective on the decision to be made.
- ✓ Redefine a decision statement that can be accepted by the majority of stakeholders.

Step 3 – Identify key stakeholders
A stakeholder is defined as someone who may be affected by or have a specific interest in the decision or issue under consideration. There are various ways to categorize stakeholders. Whatever option is used, it is important to *develop a consistent approach* to ensure equitable inclusion of all potential stakeholders who reflect the demographics of the community. Not only will this ensure a credible process and equitable representation, but the approach will help to develop community trust in the process. One way of categorizing stakeholders is to sort into primary, secondary and tertiary groups (a method used in project management).

Primary stakeholders are those who have a **direct interest** in an outcome such as:
LACA Members; and key community leadership, Community champions and opinion leaders/members, network of people living with HIV/AIDS, other agencies or organizations working directly in the community (WDC, CSO, CBOs and women organizations) that are providing non-health related services, who live/operate in the

near location of a project or will be directly affected by a project or decision. It is suggested that contact be made as early as possible with primary stakeholders to develop effective working relationships and to find out from them who else may need to be included in the process.

Secondary stakeholders are those who have a **general interest** in a project or issue such as:

- ✓ Project staff working on a project;
- ✓ People who live and work in the broader Project area;
- ✓ Business owners;
- ✓ Community groups in the LGA; and
- ✓ Consultants involved in a project.

Tertiary stakeholders are those that **do not always fit neatly** into the primary or secondary stakeholder category depending on the nature of the community engagement, such as:

- ✓ State and Federal Government authorities;
- ✓ Government agencies and organizations;
- ✓ Non-government agencies and organizations; and the media

What level of engagement is required?
Once you have set your overall objective, you need to consider the appropriate level or type of engagement that you require from the community in order to meet your objective. You need to identify the types of stakeholders that you want to engage with and decide how you'd engage them in a more structured way that will sustain their interests at that level. For example, if your decision has already been made then why waste resources on anything more than information giving? Furthermore, if you choose a level of involvement that is consulting or higher, you need to be sure that you are embarking on the engagement exercise with an open mind, are willing to accept new, innovative and perhaps controversial suggestions. Most importantly however, you must be prepared to change as a result of the outcome. The various levels of engagement are outlined in the table above – Levels of engagement.

What engagement is being done elsewhere?
Before embarking on what could be a resource intensive process of engagement, it is useful to carry out your own research, or 'audit', to identify what has already been done in that community by other partners in the past. This exercise has three main benefits:

1. **Identifying examples of best practice**

Don't re-invent the wheel. It is likely that you will be able to learn from other engagement projects that would have taken place. There may be different models of engagement that other organizations have used in the past to engage the community. You want to know how well this engagement practice went and what lessons they learned during the process.

2. Saving resources

It may be possible to link in with other projects or build on existing work to meet your needs. You may even be able to use the results from other engagement activities to eliminate the need for further engagement activities. And if you find other models already in existence, workable and well accepted by the community, it will make your effort easier by working with such models and even reduce your engagement time with the community.

3. Avoid duplication and streamline community engagement

All partner organizations in the health sector, both in the private and public, are constantly involved in community engagement, particularly information giving and consultation. At any time, there will be numerous consultation exercises taking place. Community members are consulted on numerous occasions and frequently about the same or similar topics. This will inevitably lead to consultation overload – the very detrimental effect of over-consulting with communities. Residents and other stakeholders will become tired of answering our questions, especially when they are not seeing any tangible outcomes. This will inevitably lead to cynicism, apathy, and a resistance to becoming involved. Perversely, too much engagement can lead to disempowerment.

The stakeholders and their partners should therefore be working to co-ordinate engagement exercises wherever possible by using one exercise or project to address a number of issues. The aim is to have less consultation but with the same outcomes – in other words, to 'streamline' the engagement process. The Consultation Database therefore assumes even greater importance in acting as an information resource across the partnership.

"Using one stone to kill many birds"

Nigeria has been experiencing cases of "Internally Displaced Persons" (IDP) as a result of natural disaster during raining periods and prolonged flooding; community clashes leading to exodus of community members' displacement; incident of ins urgency as a result of attacks by Boko Haram etc. Many Government Agencies are already targeting these communities with relief materials in their various locations. This engagement can be tagged along with health plans to enable HIV prevention and providing health care services to these communities of people. In this way we will maximize on the engagement opportunities and reduce costs of engagement and multiple interaction with the same community members.

Do you need to engage about engaging?

If you have decided that you wish to maximize community engagement (that is. you intend to engage on a level of involvement or higher) it may be necessary at this stage to approach your target community and 'engage' with them about how they want to be engaged. Although some groups will need to be assisted via capacity building, other groups within the community will have reached a fairly sophisticated level, for example, community leaders, gatekeepers, religious leaders and local community champions based on their previous engagement experiences.

You will need to reach agreement with the community about the objective(s). This may involve a revision to the original objective(s) to ensure they reflect community needs and priorities. You will then need to fully involve the community in planning and possibly implementing the engagement activity.

Developing the Engagement Action Plan
Having set your overall objectives, you will now be ready to prepare a detailed engagement or project plan to ensure that you meet your objectives.

Group work 2: break into your former groups and draw up your engagement plans using the questions below as a guide. Make sure that your plan truly reflects the reality of the community that you are targeting

A comprehensive engagement or project plan should answer the following questions:

- What is the most suitable method for engagement?
- Who is going to implement the engagement exercise?
- How are you going to encourage people to engage with you?
- How are you going to help people to make informed choices?
- How are you going to collect and analyze the data?
- How are you going to monitor and evaluate your exercise?
- How are you going to provide feedback to your participants?
- How are you going to share information across the partnership?
- What is the most suitable method for engagement?

Once the aims and objectives of the engagement exercise have been agreed, you must consider how you are going to engage with the community. You will need to identify the method or methods of engagement that are most suitable for your needs in order to ensure that you are achieving fitness for purpose.
There are a wide range of engagement methods that can be used and selecting those that are most appropriate is crucial if you are going to receive information that is relevant and of value. The techniques that are available all have advantages and disadvantages and once your objective has been agreed, the final choice may depend on a variety of factors. When selecting an appropriate method of engagement, ask

yourself the following questions:

- What resources are available?
- What type of information do you require?
- How can you enable everyone to participate?
- What training and skills are available/will be required?
- How does your target audience want to be engaged?
- What resources are available?
- What does the target audience know about the issues at stake and how will their react?

Community engagement can be time and resource intensive. This is dependent on the level of involvement that you are aiming to achieve and the audience with which you

want to engage. For example, if you want to hold focus group discussions with a particular hard-to-reach ethnic minority community, you need to consider the additional resources that will be required – employing interpreters, supplying translated written materials, etc. You therefore need to fully consider time and financial constraints and be realistic when identifying the most appropriate mechanisms of engagement.

What type of information do you require?
Here the main consideration should be how in-depth you would like your research to be. When choosing between quantitative and qualitative research, you must be mindful that research can require a high degree of skill and expertise if it is to be carried out well and produce meaningful results.

Quantitative – Quantitative research provides a large amount of data about predetermined questions. This type of research is useful for providing a snapshot of public opinions and attitudes and the results are measurable and can be used to benchmark. The disadvantage of quantitative research is that it is not suitable for exploring issues in depth. Entire target populations can participate in quantitative research or the research can be designed so that a smaller, representative sample is selected. The most popular mechanisms for quantitative research are surveys.

Qualitative – Qualitative research is used to explore issues in depth. A typical example of qualitative research is focus groups. The main advantage of qualitative research is that it allows participants to talk freely about issues, rather than simply respond to predetermined questions with set responses. You may also want to work with key informants in the community. These are special people in the community who have institutional knowledge about the issues in the community and could provide insight to what you are looking for.

However, the nature of this type of engagement means that it is not practical or even possible, to involve all members of your target population or even a fully representative sample. You are therefore unlikely to elicit the views that reflect those of the entire community. However, mechanisms such as focus groups are a useful way of engaging with hard-to-reach groups.

How can you enable everyone to participate?
Once you have defined your target community/communities, you need to ensure that your chosen mechanism(s) of engagement enables everyone within the community to participate. The nature of the community will dictate the types of methods that you are able to use, as well as how and when this can be done. Some methods of engagement can marginalize certain groups or sections of the community, particularly those hard-to-reach groups who often experience social exclusion. You must therefore ensure that the techniques you employ do not discriminate against anyone and remain consistent with representing the diversity of the population.
For example, when designing a questionnaire you should consider the barriers that may prevent certain sections of the community from participating – language, literacy, disability and so on. To overcome this problem, you should use a range of techniques such as combining a questionnaire with focus group discussions. This helps to ensure

that you have obtained a full range of perspectives and contributions. Sometimes too, conducting an in-depth interview with key informant may provide a clearer picture on the issues and information you want to bring out

What training & skills are available/will be required?
The different types of engagement require different levels of skills and expertise to ensure effective implementation and meaningful outcomes. Designing and implementing community engagement and analyzing and interpreting the results can require a high level of expertise in research methodology. Participants themselves may also require training and support to familiarize them with the issues about which they are being engaged and also about the organizational structures and processes. Young people in particular are likely to need training and support when involving them in decision-making.

How does your target audience want to engage?
Public service providers are becoming increasingly committed to engaging with communities about issues that affect their lives but we cannot assume that these communities will actually want to be involved to the level that you anticipate. They may actually be perfectly happy with the situation as it is or alternatively may not be interested or have the time or capacity to take part.
You therefore need to fully explain the proposed engagement process and its purpose to your potential participants. This requires openness and honesty about what they can hope to gain from the engagement process, the extent to which their involvement will impact on the decision-making process and the level of commitment that will be required from them. It may be worth offering a range of appropriate engagement mechanisms that they can choose from.

Who is going to implement the engagement exercise?
Here, a key consideration should be about how objective or subjective you want the engagement to be. Of course, all research/engagement should be as objective as possible. However, it is easy to design engagement activities that are fundamentally biased, even if it is done unintentionally. For example, it is relatively easy to design a biased questionnaire where the responses are influenced by the wording of the questions or the set responses that are offered.
Therefore, if you are addressing a sensitive issue where there may be hidden or conflicting agendas, one option would be to contract with an independent provider to carry out the research. There are many market research companies who have a great deal of experience with working with public sector organizations to engage with communities.
Although this approach is likely to be considerably more expensive, there are several benefits of working with independent providers:

- They have greater capacity in terms of skills and resources
- They are better able to be objective
- They are likely to have greater credibility, especially if the findings are controversial.

A cheaper option, however, would be to identify scope for working with a partner organization. For example, they may be willing to release an employee who is a trained facilitator to run focus groups on your behalf.

How are you going to encourage people to engage with you?
Community engagement not only requires a time commitment from the organization(s) involved but also the participants themselves. You must therefore consider how you are going to encourage people to give up their time to participate in the engagement process, and how you are going to maintain their interest without their asking for some sort of compensation for their time.

Issues that are relevant
People are most likely to become involved if:

- The issue is of interest or matters to them
- They stand to lose or gain something.
- They know that their opinion will count at the end of the process and will translate to a meaningful benefit for them.

However, you must always be open and honest from the outset about what can be achieved or influenced and the limitations and constraints within which you are operating. You should also be realistic about outputs and time-scales. Be clear about whether they can expect to see tangible outputs in the short term or if you are developing a long-term strategy that they might not see benefits for several years. In other words, you must be mindful of inadvertently raising expectations.

Make it fun!
It is not just young people who want to have fun – nobody wants to spend their spare time at dull, bureaucratic meetings, or completing long-winded questionnaires! You are far more likely to attract interest if you can devise innovative and even entertaining means of engaging, such as role-plays, or communicating via different mediums –– internet, films, CD ROMs, art-based consultation, methods, etc.
If you need to hold meetings, consider the format. Is it appropriate to hold structured meetings, with agendas, minutes and a chair? This is often seen as the easy way for public bodies to operate because we are more comfortable with this style. However, forums of this type may prove intimidating to someone who is not accustomed to meetings and the associated etiquette and procedures. This may inhibit them from contributing.

Providing refreshments
Providing refreshments is a small and relatively inexpensive gesture that shows that participation is valued. It is also worthwhile if you are holding your engagement exercise at lunch or teatime.

How are you going to help people to make informed choices?
If people are to influence the development of policy and strategy, they need to be given sufficient time and information to explore ideas and think them through, especially if the issues are complex. We cannot assume that participants have a prior knowledge of any issues that we are engaging about, particularly if it is an issue that does not directly impact on their day-to-day lives such as political arrangements.
Therefore, providing background information is sometimes necessary. Care must be taken to ensure that any background information is clear, concise, honest, and consistent with National Policy and Guidelines for community engagement values,

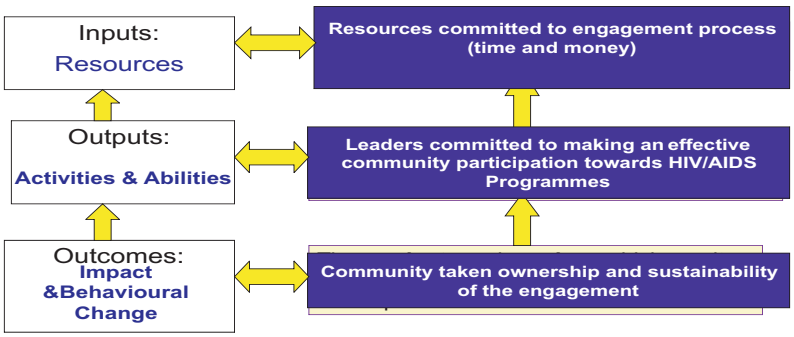
completely unbiased and clearly presents both sides of an argument. The information must also be in an appropriate format. You should also consider any barriers that your chosen format may impose, for example, language problems, literacy or sensory impairment.

How are you going to collect and analyze the data?
You should know how you are going to code, input and analyze your data from the outset. These are complex tasks that require expertise, and in the case of quantitative analysis, appropriate software, if the results are to be meaningful and accurate.

How are you going to monitor and evaluate your initiative?
A systematic process for monitoring and evaluating the process and outcomes of the engagement initiative should be built into your project plan from the outset although the monitoring and evaluation effort should be proportionate to the time and resources that have been committed to the exercise. The initiative should be monitored and evaluated against the agreed objective as well as whether it has adhered to the key principles of community engagement.

Monitoring involves an ongoing assessment of your project and facilitates the 'fine-tuning' and adjusting of the project to ensure that you are meeting your objectives and adhering to the principles that are laid out in your plan. Monitoring should take place at every stage of the engagement process. This may involve ensuring that you are reaching your target communities and meeting quotas that the project is keeping to the given timescale and that the participants are happy with the engagement process. Seeking constant feedback from participants is essential if you are to ensure that the initiative is going to be a success. Afterwards, seek further feedback so that you can learn for future exercises.

Evaluation involves assessing whether your project has achieved its objectives and has adhered to the principles of engagement. In order to evaluate the outcomes (that is, the impact of the engagement process on policy, strategy and project development), it may be necessary to complete an audit trail, from disseminating the results through to the development of policies and strategies. This helps to ensure accountability and transparency in the decision-making process. Lessons learned from the process should also be shared across the partners and you need to think about how this can best be achieved.
When monitoring and evaluating projects, you need to measure three aspects of your project:



Impact is usually noticeable/measurable after project intervention.

Inputs: Resources spent on community engagement (time and money) to achieve the overall aim. These are relatively easy to measure and are useful when carrying out cost/benefit analysis. However, they are not particularly meaningful when monitoring and evaluating your project in terms of the aims and objectives. However, this helps you to justify the resources that you have expended in your activities and efforts especially at a time like this when resources or funding for development support is reducing drastically.

Outputs: The outputs are the engagement activities (sometimes referred to as deliverables) that were carried out with the resources (for example number of completed questionnaires or interviews, the actual results of the engagement process and reports that are written, etc.) Again, these are easy to measure, and are also fairly meaningful in terms of the project aims and objectives.

Outcomes: Outcomes are the impacts or effects of the engagement activities on project, policy or strategy development. Measuring outcomes is the most meaningful exercise in terms of how far the aims of the community engagement initiative have been achieved. However, it is also the most challenging as many outcomes are strategic and therefore are less obvious and take a long time to realize. Furthermore, it is not always possible to identify the actual impact of community engagement. Differentiating between the role of the engagement activity and other external, local or organizational factors that may have influenced the development of policies, strategies or projects, can be difficult. However, although evaluating engagement is not a straight-forward task, it is essential.

Group Exercise: Break into groups of 5 to 10 participants and assign each group to a set of questions below which help your team to evaluate your community engagement initiatives. Most times, we are so buried in our activities and we lose site of the opportunity to evaluate our work and how else we could do things differently.

The following are questions that you may need to address when evaluating any community engagement initiative:

- Has the exercise achieved the overall objective(s)?
- Did you obtain the range of views that were required (that is, did you manage to engage with all sections of your target community, including the 'had-to-reach' groups?
- Did you meet the Partnership's principles of engagement?
- How did the outputs of community engagement impact on the key decisions that were made?
- Did the participants feel that engagement mattered?
- Were participants 'empowered'?
- What methods worked?
- What did not work?

- How would you do it differently?
- What lessons have been learned?
- How can these be passed on?
- What behaviour change has taken place and what additional improvement needs to be addressed?

Providing feedback to participants

Providing feedback is one of the most important stages of the engagement process, and it's all too often the one that is missed out. It is particularly necessary when the outcomes are relatively 'invisible', for example where strategies or policies have been developed, but there are no immediate tangible outputs. Telling people about how the information they provided will be or is being used shows people that their involvement is worthwhile and actually counts, thus helping to avoid apathy and a 'why bother' attitude. This in turn encourages future engagement.

Providing feedback is in itself a mechanism of engagement that requires the same planning process as the original exercise. When planning the feedback process, it is necessary to consider the most appropriate mechanism. It is worth asking participants how they would like to receive feedback. Would they prefer newsletters or meetings? Participants should be told from the outset how and when they should expect to receive feedback.

Looking back at what has been learned in Module 1

1. Define the concept and why it's important to engage with Communities in any intervention that would benefit them
2. What are the different levels of community engagement?
3. Define the different steps in developing plans to engage with the community
4. Describe the different types of stakeholders that could be engaged in the community and why it's important to engage with each type
5. Write out 5 key lessons that you have gained from this module and discuss how you are going to apply them in your work to improve on your community engagement practice.

Engagement Methods

MODULE TWO:

Different people or communities prefer different engagement methods and some methods work better for some activities than others. Whichever method you decide on, always consider access for all people or communities of interest including hard-to-reach groups.

Objectives of module 2:

1. Identify and discuss existing community-based structures and their relevance in the engagement process
2. Discuss the importance of political commitment to community engagement practice
3. Define advocacy as a tool for engaging and sustaining community engagement practice
4. Define and discuss the roles and functions of LACA and SACA in coordination of community engagement improvement practice for uptake of HIV services
5. Discuss the benefits of establishing layers of community mobilization officers at different levels – community, WAD, LGA, State and Federal levels
6. Discuss the opportunities of working with women groups in each community
7. Discuss the opportunities in identifying and working with community champions

Work with Existing Community-Based Structures:

Community engagement is all about seeking for best options and alternatives to dialogue with community leadership and members with the intention to meet their expressed needs in ways that they will appreciate and identify with. We do this by working with the right structures, defining roles and responsibilities of all partners and stakeholders in their collective efforts and response for HIV/AIDS programming and management at the various community levels.

It's about working with the voices within the communities to identify their concerns and how they think they are affected by life threatening health issues, and then seek out interventions that would enable them overcome these challenges. It's about working with them to access services local to their interests. But we have to identify community based structures, systems and mechanisms already in the communities through which we can reach out to them with our laudable programme agendas.

In some of the Local Government Area in Nigeria, there are Secondary Health Facilities

(hospitals), Primary health care centers, Service Delivery points, private health care facilities/services, pharmaceutical and drugs dispensing stores, and traditional Health service providers including traditional birth attendants where community people go to access health services when they have a need to do so. These health facilities are available and ready opportunities that can be used to increase awareness on HIV/AIDS services at the state and local government levels. Working with these facilities to promote health awareness among their clients is very critical to community engagement practices. No doubt, community members use any of these facilities as avenues for health treatment. Ensuring collaboration on information sharing, health education, and networking for improved community health behaviour promotion is vital and should be advocated among the facilities.

There are also community based networks and associations such as Barbers' Association, Association of Women hair dressers, Motor mechanic Association, Market Women Association, and many others like that who have great influence in the way that information can be passed across to their members. These associations and networks make up the community of peoples in various town and villages. When we engage these associations and networks with our preventions interventions, we create a wide interface among community members with a common message on available services for HIV/AIDS.

Working with these existing structures is fundamental to promoting community acceptance and utilization of available health services. Other community-based structures include Community Based Organizations (CBOs), Non-Governmental Organizations (NGOs), Religious/Faith-based organizations (Catholic Mothers Associations, Muslim Sisters Association), social institutions such as The Lion's club, Aged Group Associations, Women organizations, Ward Development Committees (WDC), Village Development Committees (VDC), etc. The members of these organizations are drawn from the communities where health facilities are based or located. It is possible to work through these groups and structures to promote expanded uptake and access to health care delivery services especially with information sharing and awareness raising. Working with and through them is indirectly working with the community leadership since most members in these associations tend to be people in the community that are of social standing. Recognizing that these institutions and structures can make a difference in promoting behavior change and encourage uptake of health care services is crucial to ensuring their commitment and involvement in promoting continuous access to the various community based health facilities.

The following is a list of community based institutions and structures to identify and work with.

- **Community leadership (Emirs, Obas, Eze and other levels of traditional leaders) via advocacy and sensitization**

This is a cluster of community groups that provide leadership, control and influence among community members in any village, town or LGA. Targeting them as champions to work with in promoting awareness on various HIV/AIDS interventions

is key to a successful uptake of HIV services. Because of their influence in their communities, and the fact that they are opinion leaders, they can easily gather their members together in a short notice for any community gathering or meeting.

- **Ward Development Committees (WDC), and Community Development Committees (CDC)**

Over the years, because of self-help intensions, many local communities have formed local community-based groups that they work with in order to channel issues of development around their health, including agriculture, economic development, social inclusion and even education with one voice to government and development agencies. These are true representation of the opinion of communities and they often serve as champions and stakeholders on the behalf their communities. It is very important that in all community engagement processes, these community groups should be recognized and carried along, particularly the WDC structure already put in place by the Primary Health Care Development Agency which play a key connecting role in health access and service uptake in Nigeria. It is also important to understand our entry behaviour into any community as if you engage the wrong person you could get a serious backlash.

- **CSO/CBO/ and Religious organizations**

Nigeria is very rich and diverse in our culture and orientation and we perceive issues most time from such platforms. With HIV/AIDS awareness increasing, many Civil Society organizations and Community based organizations have been established and are working with international development agencies to promote awareness and access to HIV/AIDS services in their communities. These are well informed organization to partner with on our community engagement efforts. It is important that we identify and cluster them into service types to ensure that they are not a clog in the community engagement effort. Working with the religious organizations provide a legitimate ground to bring value and integrity to our engagement efforts and to ensure that people who should be reached are giving a chance to participate by all means.

- **Work with the Association of People Living with HIV and AIDS**

People living with HIV and AIDS have formed associations in many communities in Nigeria and there is an increased awareness among their members of available services especially as provided by government and development partners. Efforts should be made to include the leadership and members of this association in all community engagement effort to ensure that they understand what services are available and affordable in their communities. They can serve as peer to peer announcers of government health delivery points where services can be easily accessed.
Over the past several decades, support groups for people living with HIV and AIDs (PLHIVs) in Nigeria have remained an important avenue through which PLHIVs discuss and develop strategies for coping with the effects of HIV on their mental and physical health and relationships with their families and communities. The National Association of People Living with HIV and AIDS in Nigeria (NAPHAN) oversees and provides technical support to these groups across the country.

When we plan programmes and outreaches we tend to ignore the people that are

directly affected and impacted by the disease – People Living and affected by HIV/AIDS. There is no doubt that they are a community who are well aware of what their needs are and how they want to be reached with our health services. Bringing them into our community mobilization plan and agenda is critical in all our community engagement endeavors. Their network and especially the leadership of this network is a very important group and an opportunity to work with to reach out to them on available health services that can benefit them.

The people living with HIV/AIDS have different needs, depending upon their age, level of education, marital status, and level of economic empowerment, Vocation, the culture they come from and their perception of the disease itself. In order to engage them meaningful and provide the kind of service that will benefit them, we must engage them at their community levels, know their individual and collective interests and needs, and address them by working with and through their network and leadership. In this way, we will be seeing to provide what will address both practical and felt needs of the communities of people living with HIV/AIDS targeting rural and urban centers.

The families, households and the communities are the locations where the HIV/AIDS epidemic impacts the most. Family member education programme should be put in place and structured in such a way that from time to time, health orientation and education programme are held in various communities to inform them about available health services.

- **Work with family clans or clusters**

In many villages in Nigeria, most families live in clusters or clan representing family lineage, so they uphold long time values, traditions and culture. This enable them promote and uphold sensitive cultural attributes that are worth transferring to their children and kin over time. Each family cluster or clan have family heads who represent them and promote their voices especially during engagement with government or donor agencies. We would need to identify who these family heads are and understand their cultural values and character in order for us to engage with them meaningfully.
Promoting health education and appropriate awareness through family heads is a natural way of reaching their entire family members especially on available health services in their communities.

Work with Political and Policy makers
A clear political commitment to HIV/AIDS response and equity in all sectors is essential to tackle the existing inequalities in the provision of health care delivery services. Policy makers, planners and health workers should note that health and its maintenance is a major social investment.

- Identify and work with Politicians in the local communities

Every community in Nigeria has a set of people that are politically minded and are representatives of the voices of their people especially in engaging with government agencies on health and social policy services and administration. It is very important

that we identify who these politicians are and what specific roles they play in their interaction with government concerning policies and health plans for their communities. Having a list of them and what interest they pose in the community or bring to bear is critical to any community engagement effort as they can serve as potential stakeholders for accountability on behalf of their communities. These people if well empowered can hold government accountable to the promises they made during election and their delivery time to add value to the health and social needs of community members.

Advocacy as a tool for encouraging community engagement and ownership

A successful ownership of programme response process at any community level starts with consensus building among the various key stakeholders, gatekeepers and community leadership through advocacy, sensitization and social mobilization at all levels. Advocacy is an ongoing process aiming at changing attitudes, actions, policies and laws by influencing people and organizations who control and manage power, systems and structures at different levels for the betterment of those people that are infected and affected by HIV/AIDS.

Advocacy is the deliberate process, based on demonstrated evidence, to directly and indirectly influence decision makers, stakeholders and relevant audiences to support and implement actions that contribute to the fulfillment of rights of community members or beneficiaries. Successful ownership of programme response process at any community level starts with consensus building among the various key stakeholders, gatekeepers and community leadership through advocacy, sensitization and social mobilization at all levels. Advocacy as a process will help to bring about long-lasting change in the policies, laws and practices of influential individuals, groups and institutions. Thus it is an action that should be directed at changing the policies, positions and programmes of any type of institution and in this case to enable community ownership and participation in their health seeking behaviors by increasing uptake of health care services at the Ward and Community health facilities.

Food for thought:

Advocating for improved uptake of HIV/AIDS activities and services should be championed by NACA Director General, SACA Executive Directors and LACA Chairmen respectively targeting community and religious leaders on the need to secure their buy-in and support for community ownership of HIV response. Through advocacy visits the community could be sensitized and mobilized to use existing structures in their communities to raise awareness through sensitization among their members to access services including that of HIV/AIDS. Community leaders can service as champion for change in their various communities. Once they are well trained and sensitized, they can carry their community members along in their health seeking behaviours.

Advocacy Process for improved social practice

Advocacy involves	Particularly when it is geared to …
Awareness raising, communications and media work	Enhance credibility and legitimacy as advocates promote visibility; deliver persuasive, evidence-based and solution-oriented messages to the public, decision-makers, stakeholders and those who influence them.
Communication for behaviour change	Create an enabling environment for effective implementation of policy changes to protect the rights of beneficiaries, as well as to allow their voices to be heard at the highest level.
Developing partnerships/ coalitions/ alliances	Generate organizational support and momentum behind issues, connect messengers with decision-makers, and utilize diversity to achieve common advocacy goals
Lobbying and negotiating	One-on-one discussions with decision-makers to influence them to change policy, practice or behaviour
Campaigning	Create and mobilize the public around the advocacy issue, change perceptions, and build support to influence decision-makers and stakeholders
Research/ publications	Illustrate the underlying causes and solutions to a problem, and draw recommendations which can be addressed by decision-makers and stakeholders
Work with beneficiaries	facilitate the creation of a platform for beneficiaries' voices to be heard and acted-on by decision-makers and stakeholders
Social mobilization	Engage multiple levels of society, including those who are marginalized, as allies and partners in overcoming barriers to implementation of programmes to protect their interests.
Conferences/ events	Bring together a variety of stakeholders and decision-makers to highlight the causes and identify the solutions to the issue, with follow-up that includes concrete and immediate action

LACA ownership and functions:
LACAs as coordinating entities should adopt the strategies to link up with the various community engagement structures (WDC, VDC, CDC, Women Groups, Local networks etc) in the various communities and provide clear leadership, coordination and support for the various engagements in their territories. It's therefore very important to further define the roles and responsibilities of the LACA in collaboration with other health agencies at the community and LGA levels in entrenching community engagement and participation in HIV/AIDS response at the grassroots level where interventions are expected to make the desired impact.

Engage Layers of community mobilization Officers
As a starting point, there will be a need to engage layers or levels of community mobilization officers who may probably be current staffs of the LGAs and State Government but having part of their remunerations supported on the payroll of NACA initially (through the Global Fund pipeline) to ensure effective coordination and smooth take off of this arrangement of increasing awareness within the Ward, LGA and the State. The mobilization officers will work through the various community outlets such as the gatekeepers, community based organizations, religious groups and associations, support groups, community/traditional leaders and the private health care providers within the catchment area to ginger/trigger their commitment to create awareness within their domain on the need to take advantage of available health services within their community range. Advocacy, sensitization and continuous awareness raising are what they will be doing from time to time to stimulate community member's utilization of health services.

Taking advantage of the cluster systems that we have at the community level whereby each Health Facility is supposed to be providing services to a cluster of communities within a given radius, each cluster will be managed by a Service Delivery Point (SDP) Mobilization Officer who will report to the Health Care Center (HCC) Mobilization Officer, who in turn will report to the State Mobilization (SM) officer. Once this hierarchy is established, institutionalized with a clear job description and is remunerated (a well-defined funding arrangements that will allow sustainability over time will need to be identified and agreed upon), the Health Center Mobilization officers and the SDP Mobilization officers will be responsible to the LACA within their LGA for coordination, monitoring and supervision of their work.

The State Community Mobilization officers will be responsible to the SACA and will coordinate the activities and reporting functions of the entire lower level Mobilizing Officers and feeding their activity reports to NACA. These layers of mobilization officers will work with the CSO, CBOs, NGOs and other community based institutions, networks and associations to link with community leadership in their awareness raising, advocacy and sensitization efforts as the case may be to stimulate uptake of HIV/AIDS services. (See diagram of community mobilizers in Appendix 1)
These arrangement need to be properly coordinated in alliance with the FMoH, NASCAP, SASCAP, SMoH and the NPHCDA. It's critical that a harmonization plan among the National and State Health planners and promotion agencies and ministries be put in place to ensure that there are no duplications of efforts or disharmony in the whole operation.

Engage women groups and associations

Women groups, local organizations and associations are powerful networks and institutions that can be sensitized to create awareness on available health services in their communities and therefore to spread the news among their fellow women on the importance of taking personal action for one's health care. Fundamentally, women and children are the most hit when accessing health programme and opportunities are concerned. They are often the neglected segments in the society especially where men's voices dominate those of women. Notwithstanding, women in various communities have established themselves into strong and viable organizations that can be trusted to work with health systems to create awareness among their peers for improved health services.

Engage trades associations such as barbers, hair dressers and mechanics

Trade associations and groups are a power network that we can work with to ensure pear to pear information and awareness raising to increase access to health services. These networks are well spread in many cities and local communities and they often meet at regular times for social and economic development discussions. Slating helath tips and updates on available services will enable access to health services. See more discussion on this in module 6

Establish and work with Community Health Promotion champions

Within each community, it is very important that community health promotion champions are identified, mobilized and structured to enable their engagement with the larger community groups and members to raise awareness on available health services in their various communities. These champions should be people of high standing in their communities, whose opinions are very well respected; who are also very ken in the health and general wellbeing of members of their communities and are willing to play key roles to volunteer and work with health workers during advocacy, sensitization and other health promotion meetings. These people will work in collaboration with CDC, VDC, women associations and other networks during any health promotion and behaviour change platforms to mobilize community members to come out to attend such meetings. These are key members of the communities who are influencers and can provide a direction for community participation and engagement in programme that would benefit them.

What are the lessons from this module? Break into small group and discuss the followings?

1. Identify and discuss existing community based structures and their relevance in the engagement process
2. Discuss the importance of political commitment to community engagement practice
3. Define advocacy as a tool for engaging and sustaining community engagement practice
4. Define and discuss the roles and functions of LACA and SACA in coordination of community engagement improvement practice for uptake of HIV services
5. Discuss the benefits of establishing layers of community mobilization officers at

different levels – community, WAD, LGA, State and Federal levels

6. Discuss the opportunities of working with women groups in each community
7. Discuss the opportunities in identifying and working with community champions

MODULE
THREE:

Reaching Diverse/Hard-to-reach groups in Community Engagement

Often, when we plan our programmes, we tend to ignore or leave out a large chunk of community members who are vulnerable and out-of-reach; partly due to poor awareness of their needs, as well as our poor planning to create out-reach opportunities to ensure that they are well covered by our programmes. Not minding our limitations, it is very critical and important that all members of the communities are given equal opportunity and access to our health care services.

Objectives of module 3

The objectives of module 3 are to:

1. Identify the diverse groups in the community and their members who are hard-to-reach with our health and social services
1. Discuss their peculiarities and needs and why they must not be left out in community engagement
2. Discuss cultural barriers and obstacles that impact on effective community engagement practice

It is essential that community engagement activities reflect the diversity of community population. The term 'hard-to-reach' is widely used to describe those groups or communities who experience social exclusion and disempowerment. They are generally perceived by agencies as being by their nature difficult to access. However, it is important to note that many of these communities are not actually that hard-to-reach and do not consider themselves as such. It is simply that organizations have not put enough effort into seeking their views.

Defining hard-to-reach groups

It is essential that when formulating your engagement strategy, particular consideration is given to engaging with groups that are defined as hard to reach. A hard-to-reach group is any group or section of the community that is difficult to access for any reason such as:

- Physical inaccessibility (e.g., disability, older or frail people)
- Language barriers
- Cultural perceptions and traditions (e.g., disadvantaged young people)
- Social expectations (e.g. children and young people who are often not considered as appropriate to be engaged with and who themselves often do not expect to be taken seriously).

Thus, hard-to-reach groups may include:

- Internally Displaced Persons
- Asylum seekers
- Children and young people in slums
- Drug users
- Faith communities
- Gay, lesbian and bi-sexual men and women, transsexual and transgendered people
- Homeless people
- Minority ethnic communities
- Offenders/ex-offenders
- Older people (especially frail and/or isolated older people)
- People with disabilities
- People with learning difficulties
- People with mental health problems and are quite mobile
- People who travel or commute for long time outside their normal environment
- Single parents
- Small business owners that move from location to location to sell their produces
- Travelers
- Tourists
- Victims of domestic abuse
- Young men of working age
- Prisons inmates

However, what is important to note is that defining all sectors of the above categories as hard-to-reach is both simplistic and misleading. Consideration needs to be given to the particular characteristics of population sub-groups. For example, in many areas, minority ethnic communities are generally well integrated into society and therefore are not difficult to access. There are also those who have been displaced by communal conflicts and wars, tribal, natural/environmental disaster and victims of floods that are dislocated from their homes and would need to be reached with health care services.
Therefore when identifying your hard-to-reach groups, it is first necessary to break down the local population into specific sectors. You should also remember the overarching requirement to remain consistent with representing the diversity of the population within the community.

How to identify hard-to-reach sectors
The Community Leaders or gatekeeper may be able to assist in providing demographic profiles of the areas or communities under consideration. However, data may not be available at a level that allows you to identify these hard-to-reach sectors. If this is the case, you may need to talk to intermediary community groups who will be able to provide a different, localized perspective on who are the hard-to-reach groups within your target community.

Typical characteristics of hard-to-reach groups
A study of accessing hard-to-reach groups has identified several defining characteristics of hard-to-reach groups.

- **Numerical size and concentration**

It is more difficult to engage with groups who are relatively small in number, and are widely dispersed. However, individual sectors of the community should not be neglected simply because they represent a small population of an area.

- **Internal Organization**

Regardless of size, groups may be hard-to-reach if they are not well-organized in terms of having an established network of community organizations or agencies that can be approached to assist in engaging with the target groups. However, what is important to note is that although a 'community' may appear well-organized, the community leaders are likely to be the most vocal members and therefore may not be representative. This may lead to some elements of the community remaining 'hard-to-reach'. Efforts should be made to ensure that even the community leaders are not acting in their own personal interests thereby disallowing community members from accessing health care services and opportunities.

- **Socio-economic deprivation**

Groups that are experiencing acute social and economic deprivation may be considered as being 'hard-to-reach'. For example, 'disaffected' very poor community members who are beggars or handicapped are typically considered as being 'hard-to-reach'.

- **Social Invisibility**

A number of communities are considered to be socially invisible. One such example is the population of men and women who consider themselves to be gay, lesbian or bisexual but do not lead openly 'gay' lives. Mechanisms to reach these types of people should be evolved and thought through carefully to ensure that their interests are covered in our outreach programme; particularly if they already belong to a network or an association already. This will help to reach the larger membership through the leadership of their network or associations.

- **Cultural and ideological barriers**

Cultural expectations or social restrictions may make engagement with any organizations or individuals outside of the family unit difficult. For example, in some Muslim communities or groups there are social restrictions upon women, who may be expected to refrain from social interaction, particularly with men from outside the immediate family. Such cultural values should be respected and therefore approaches to addressing some of these sensitive cultures should be thought through carefully. For example by using women facilitators to visit Muslim women in purdah, or any other restricted community boundaries.

- **Distinctive service needs**

Many hard-to-reach communities and groups have very specific problems and needs. These may include people with disabilities, learning difficulties or mental health problems. In spite of their peculiar situation, they must not be left out in our community engagement process. Opportunities should be created to enable them voice their views on how they feel when they are excluded from health and social

services because of their conditions. They should be involved in formulating interventions that would benefit them and include them in the broader community as homogenous members.

Accessing hard-to-reach groups
Once you have identified your hard-to-reach groups, you need to identify ways of accessing the groups. You should have already audited work that has already been undertaken in your area of interest. This may have highlighted any hard-to-reach groups that you will need to engage with, as well as having paved the way for gaining access to the groups.
If however, the audit does not help you, you may need to think logically and creatively of ways to access these groups. This could be via informal networks, social venues, or local organizations who work with these groups.

Enabling hard-to-reach groups to participate
Once you have identified and accessed your hard-to-reach groups, it is necessary to take measures that will help to overcome the barriers that prevented them from participating in the first place. This may involve using interpreters, using visual aids, adapting facilities for disabled people, providing care for dependent's', etc.
You should also try to be flexible over the timing, location and transport issues, and also endeavor to use neutral or 'safe' buildings for exercises. For example, it would not be appropriate to use a police station to explore issues around youth offending!

Adopt a Peer Process Engagement Strategy
Adopting a peer process by employing members of the community to undertake the engagement exercise can be extremely effective in overcoming barriers. People are more likely to respond to messages from similar or related groups.

Reaching out to Traditional Birth Attendants
Traditional healers and Traditional Birth Attendants (TBA) serve as the best source of information to reaching a wider segment of rural communities. They are very well patronized not minding their limitations and capabilities. It's important to build their capacity to know and distinguish between helpful and harmful practices. Practices should be categorized into those that are clearly beneficial or clearly harmful. The information provided should be expressed in simple but quantitative form, starting from simple matters, such as personal hygiene, and gradually progressing towards more comprehensive health education, fostering behavioral changes and community action for health. The language for communication should be the same as that of the local people, audio-visual aids used must be produced locally and be appropriate, and finally the educational programme should be carried out by trained and experienced personnel from the locality.

Community-based activities should support increased family participation in their own health care. This should include educating them on what services they should expect from PHC and the various Service Delivery Points, as well as activities/messages on promotion of healthy lifestyles and prevention and early treatment of common illnesses. The PHC should address several aspects of

communications and health promotion linked to building awareness and achieving behavior change. It should include communications approaches directed at the family and community level. To enhance the utilization of the health services by people, it is most important that they should recognize the need for such services. This need will only be felt if they start to value health as a worthwhile asset. For this, they need adequate, relevant, scientific information and education about health, disease and hazardous environments.

Lagos State AIDS Control Agency has used the opportunities of engaging clusters of community groups such as Hairdressers and barbers association, traditional birth attendants, association of road side mechanics etc, to champion the promotion and acceptance of HCT services. They also have moonlight programme targeting out-to-reach communities especially in the night hours. On their outreach programme, they have used the State Governor as a champion to promote HCT programme.

In River State, the community leaders have teamed up as champions to promote HCT in their various communities. Working with and through the various community groups, they are able to lead awareness campaign for social mobilization and behavior change communication efforts. They have used their positions to interact with traditional healers and birth attendants to promote improved access to health care services.

What are the lessons from module 3?

1. Define and discuss who are the hard-to-reach groups in your communities
2. Discuss the cultural and ideological barriers that impact on meaningful community engagement practice
3. Discuss the importance and opportunities of working with peers to create a wider outreach to their members, network and communities
4. What opportunities are there in working with Traditional birth attendants in the community engagement effort?

MODULE
FOUR

Roles and Responsibilities of various stakeholders

Engaging communities requires that various stakeholders understand clearly what their roles are and how to collaborate to ensure that the engagement process is well structured and that there are no overlapping of role, functions and even application or deployment of resources.

Objectives of module 4:
The objective of module 4 is to:

- Identify and discuss the roles and responsibilities of different stakeholders and the added value they bring to the community engagement practice
- Build consensus among various partners and stakeholders to ensure non-duplication of engagement efforts at the community level

Building consensus among various partners
A successful ownership of programme response process at any community level starts with consensus building among Government Agencies, various key development and implementing partners, stakeholders, gatekeepers and community leadership through advocacy, sensitization and social mobilization at all levels. There is a need for a Sector-wide /national approach to health education/promotion/behavior change. The importance of working with existing structures has been emphasized in this manual. Creating parallel structures can lead to overburdening and duplication of roles and responsibilities especially when the same community groups are brought in by different interest parties to support their own programme. And this has been in many cases with development partners who provide support because they have their agenda to fulfill. Harmonization of programme and collaboration among the various institutions should be promoted at all times. Various Federal Government health agencies, public and private sectors need to work together using the PHC as entry points for creating awareness among the larger community members to improve their health seeking behaviors.

It is very important to map the different services and locations where implementing partners, stakeholders and government agencies are working and supporting HIV/AIDS interventions and programme in all the LGAs and States of Nigeria. A comprehensive mapping will indicate who is funding which programme and which communities are they working in. This will help in the accountability of programme funding in different locations where supports are supposed to be provided by partners

and stakeholders.
There should be regular meetings of implementing partners and stakeholders to share information on their programme activities and the level of results they are achieving in the various locations where they are working. These meeting should be coordinated and it should be regular. Coordinating platforms should be established and made to work with support from all agencies, institutions and stakeholders.
The various government Ministries, Agencies and Departments need to be conscious of the collaborative role they are expected to play in the fight against HIV/AIDS, and therefore to use their various programmes as avenue to stimulate community engagement for education, information sharing, awareness raising, sensitization of community leaderships and strengthening their linkages for effective and efficient collaboration. Collaboration with other related sectors in the improvement of PHC as part of total socioeconomic development is very important. It has been emphasized that no sector involved in socio-economic development, especially the health sector, can function properly in isolation.

Encouraging and sustaining sectoral collaboration
Many social factors such as education, housing, transport and communications influence health, and so does economic factors too. Therefore, collaboration with the relevant sectors is especially important for worthwhile mutual benefits. Collaborative efforts focused on economic development and progress leads to better health. The various agencies in the health sector need to see their various functions as supportive of the overall health plan of Nigeria and Nigerians. Therefore, there should be an effort to improve their working approach to stimulate collective action rather than working vertically on their individual national programme.

Educational institutions play an important role in the health status of the community, especially in the field of prevention through meaningful peer education and information sharing. Teachers can help in the early detection of ill health in students. Students are used as messengers of health to the community. Literacy programme have been shown to have a great impact on equity-oriented development in rural areas. The educational status of the mother plays a pivotal role in the health of the family. As maternal education among rural and nomadic groups is relatively lacking, adult educational programme would be of great help. The mass media can contribute effectively to the dissemination of health messages to the population at large. The health sector must play a leading role in health supportive public policies. Health activities should be undertaken concurrently with such measures as the improvement of nutrition, particularly that of children and mothers.

Coordination of health-related activities should be devoid of duplication. To make inter-sectoral coordination a reality, concerted efforts should be made to demonstrate how ill health and disease are closely related to illiteracy, poverty, poor sanitation and environmental conditions, etc. PHC lays emphasis on health care that is essential, practical, scientifically sound, coordinated, accessible, appropriately delivered, and affordable. One route to achievement of improved health outcomes within these parameters is the formation of partnerships. Partnerships adopting the philosophy and five principles of primary health care (PHC) focus on health promotion and prevention of illness and disability, maximum community participation, accessibility to health and

health services, interdisciplinary and inter-sectoral collaboration, and use of appropriate technologies such as resources and strategies.
The synergy that will result from working with other agencies that are active in the health sector is recognized. The UNDAF captures the linkages with development partners and the UN system (UNICEF; UNFPA; UNDP and UNAIDS) in particular. UNDAF2 provides a unique opportunity for the UN system in Nigeria to work together to "deliver as one" in 6 states and the Federal Capital Territory (FCT). With active participation and support from WHO, other coordination platforms have been developed and strengthened. The ICC, Country Coordinating Mechanism (CCM), Health Systems Forum, Malaria Partnership; IMNCH partnership are examples. These platforms especially the CCM has moved ahead to develop a system based on the "three ones" for HIV/AIDS as the basis for support to implementation of activities. In some states, partners (including DFID, CIDA, the UN System, USAID and the World Bank) are working under the leadership of the State governments towards what might eventually be a Health Sector-Wide Approach (SWAp).

Roles of Communities

- The communities are where the implementation actions are taking place. They need to own and support all implementation efforts. They need to be carried along at every point of programme development and implementation initiatives
- There are various existing community structures that need to be recognized, appreciated and supported to work meaningfully (CBOs, CDC, and VDC etc.)
- Community leaderships have a role to play in the mobilization, sensitization and champion the HIV interventions implementation efforts.
- Traditional healers and Traditional Birth Attendants (TBA) serve as the best source of information to reaching a wider segment of the local communities. They are very well patronized not minding their limitations and capabilities. It's important to build their capacity to know and distinguish between helpful and harmful practices.

Roles of Civil Society Organizations

- The Civil Society Organizations (CSOs) have continued to be a strong link in the continuum of Health Service Support Networks that complement the efforts of government in health service delivery.
- They are also important in the implementation of HIV and AIDS programme. Because they are community based and have access to the various community structures and interests, and because of their ability to reach out to community members without much bottlenecks, they are able to serve as effective and efficient support networks to enable access to available health services.
- CSOs provide strategic opportunities to increase access to services and geographical coverage of services; they reach marginalized vulnerable and underserved community groups with ease.
- The CSOs have an added advantage of adopting community-based interventions thus facilitating community empowerment, participation and ownership of the HIV and AIDS epidemic.

- CSOs provide range of services either as standalone or integrated services depending on organization's capability and comparative advantage

Roles of Partners

A successful ownership of programme response process at any community level starts with consensus building among Government Agencies, the various key development and implementing partners, stakeholders, gatekeepers and community leadership through advocacy, sensitization and social mobilization at all levels.

Partners need to work with existing structures to avoid duplication of roles and responsibilities especially when the same community groups are brought in by different interest parties to support their own programme.

CSO mapping

Partners should take advantage of CSOs mapping that was done in the process of HAF implementation by identifying various CSOs that are working in specific HIV intervention areas in the various communities, LGAs and in the State. Regular coordination meetings of partners should be organized and coordinated for proper information sharing, experience sharing and learning of best practices. There should be regular meetings of implementing partners and stakeholders to share information on their programme activities and the level of results they are achieving in the various locations where they are working.

What are the lessons from module 4?

1. Discuss the importance of building consensus among partners in our community engagement efforts
2. Outline the roles and responsibilities of various partners and discuss why these roles are essential to community engagement exercise

MODULE
FIVE

Translating Outcomes into Policy

Outreach to communities to create awareness is very important; but important still is how we manage the outcome of that engagement with our data and what we do with the data to inform health policy decision and programme improvement.

Objectives of Module 5
The objective of this module is to:

- Discuss how you'd analyze your data and information that you have gathered from the field and translate them for meaningful management information for policy action

You should have been clear from the outset how the information that has been collected, is to be used in terms of informing policy, strategy and project development.

Analyzing and interpreting your findings
As already mentioned, data analysis can be a complex process that requires knowledge and skills in research methodology and statistical analysis. If the skills are not available within your organization, it may be worth contracting this process out to an external provider, or asking another partner who does have the expertise.
Qualitative data (from unstructured interviews, focus groups, etc.) is the most difficult to analyze, as it is not structured and there are no standard analysis processes that you can follow. It is useful to analyze qualitative data by themes that have emerged, in order to identify key issues.

Quantitative data is more simple to analyze, although requires a greater knowledge of statistical procedures. For most case, using frequencies and percentages will suffice as many people understand and can relate to this level of information. Depending on the design of your research, you should be able to 'drill down' into your data and produce 'cross-tabs' – tables that break down results by demographics, such as age, gender and ethnicity. This helps you to identify any significant patterns and trends, and is critical in ensuring that service delivery meets the needs of all our communities.
One note of caution is that when you have produced your frequencies, and percentages, you need to be wary of how you use your research, and be aware of when your results are significant and require further analysis or action, and when they should be disregarded. Wherever possible you should try to place your results into context, for example, comparing satisfaction scores to national/family benchmarks/trends, or the previous results.

When you are interpreting your findings and drawing inferences, it is essential that you remain objective and not allow your biases to becloud the outcome of your finding. Your analysis may come under scrutiny from participants and other key stakeholders, especially if the subject is politically sensitive or controversial. You must therefore ensure that you are able to justify any conclusions that you come to.

Reporting on your results

Reporting on your results serves the following main purposes:

- It informs managers and decision-makers of your findings, or the outputs of the community engagement, together with any appropriate recommendations in terms of project, policy or strategy or business development.
- It is a mechanism for providing feedback to participants in the engagement process.
- It is a mechanism for you to share your findings and experiences with partner agencies and other interested stakeholders.
- In light of this you may need to present your findings in a variety of ways.

A formal, in-depth report written specifically for your organization – this will be the most complex report, and should include detailed analysis and descriptive statistics if applicable, together with key recommendations.

A summary report that can be accessible to participants, the public and partner organizations

- Presentations are also a useful way of communicating your findings. They help you to reach sections of the community who you would not normally reach particularly if they are entertaining.
- Inputting into shared databases –– a number of databases exist which will be shared across the partnership to enable the headline information to be published.

However, no matter how you are reporting on your findings, you should always remember the following:

- Be clear and concise, avoiding jargon and baffling people with confusing statistics –– even people who work within your organization. Lengthy papers are unlikely to be ready by many people and your key message can be lost. Remember to think "outside in", that is, put yourself outside the organization and ask how best you can you make your information understandable.
- A picture can paint a thousand words –– diagrams, charts and pictures have great visual impact and can convey your message a lot more strongly than text.

MODULE
SIX

Models of Community Engagement Practices

Community engagement and mobilization is not new in Nigeria particularly since HIV/AIDS interventions have been mounted by several partners and stakeholders. But ensuring uniformity among various partners and stakeholders to avoid duplication and utilization of resources have been one major challenge over the years. Models of learning and best practices exist in Nigeria that can serve as yardstick to measure our collective engagement efforts.

Objectives of module 6

The objectives of this module are:

1. To showcase specific and unique models of community engagement practices in 6 states of Nigeria that have really worked and are worthy of emulation
2. Showcase engagement practices by international partners in Nigeria and other best practices in selected 4 nations
3. To link these experiences with our future community engagement plans

Nigerian experiences from selected states

A. Bauchi State community mobilization practice

Community Mobilization in Bauchi State is a well-established practice with a functional structure as shown in the flow chart below. The state has developed a strategy for the purpose of Social Mobilization under an Organization called '**ENABLING COMMUNITY ACTION**' headed by the State First Lady. The goal of Community Mobilization in the state is to 'Strengthen roles of households and communities in promotion, practice, and delivery of HIV/AIDS, MCH,FP,RH interventions'; with the following objectives:

- To strengthen WDC/VDC to coordinate community-based HIV/AIDS,MCH,FP and RH activities
- To Promote community participation in the delivery of HIV/AIDS, MCH,FP and RH
- To improve health seeking behaviors of households, families and communities for ANC, Immunization, FP, malaria and HIV/AIDS services
- To identify resources within the community that can promote and support HIV/AIDS, MCH, FP, and RH services
- To advocate for quality HIV/AIDS,FP, and RH services

B. River State Community Engagement Experience

River State Agency for the Control of AIDS (RVSACA) has taken on a new dimension to community engagement to improve access to HIV/AIDS services through advocacy and sensitization programme targeting political, community and religious leaders in some LGAs and communities in River State. As a result of the mandate by NACA which encouraged the SACAs to step up their efforts for greater involvement of local communities and their leaders to rise up to the challenge of tackling the HIV/AIDS epidemic by taking ownership of the HIV/AIDS response, a high level stakeholders' meeting was inaugurated in 2013 titled, "Stakeholders consultative meeting on ownership of local government HIV response and community driven interventions". This stakeholders forum is expected to catalyze the much needed community action and explore veritable community driven interventions that will provide effective and efficient solutions to the HIV scourge. The objective of this forum is to dialogue with community stakeholders and opinion leaders on the dangers posed by HIV/AIDS and explore veritable community driven intervention that will provide effective and efficient solutions to the scourge.

This high level advocacy team was established as a result of an advocacy meetings held with the Government of River State concerning the high prevalence of HIV in the state. The advocacy effort brought Traditional leaders, some political leaders, religious leaders and Local government Council Chairmen together to discuss how they can work together to own the HIV response and drive the epidemic to a zero prevalence. In Gokana LGA, HIV Advocacy Committee was set up to work with the LACA to raise awareness in all their communities. This also led to the establishment of Community Development Committees and Community Action Committees on AIDS that were charged with the responsibility of sensitizing community members on available health services. The CDC meets monthly to discuss on health and development issues in their communities and advice community members on available services and how to access them. The CDC also works with the youth groups on peer education and supporting the community leadership in their efforts to address the need for expanded access to health services. In Ahoada, the Eze through the support of SACA and LACA established Kingdom Action Committee on AIDS (KACA) which works with the LACA to raise awareness on HIV/AIDS situation in the various communities. The CACAs and KACA in communities where they have been established have requested for training so that they can have appropriate skills to engage their community members on health education and promotion of access to health services.

At another forum, the Executive Director of River State Agency for the control of AIDS along with his team members conducted a round of sensitization meetings to the Chairman of Council of Chiefs and traditional leaders in River State. The purpose of the meeting was to seek for an audience to speak with the Council of chiefs during their meetings on the state of HIV infection rates in their various communities. This visit, along with the visit to the LGA Chairmen enabled the traditional leaders to have a true perspective of the spread of HIV epidemic in their communities and how their communities are being impacted. In Opobo-Nkoro LGA and Abua-Odual LGA the Chairmen have demonstrated a high level of ownership and commitment to funding the activities of the LACA on a monthly basis. This empowered the LACA in the two

LGAs to commence support for the CACAs in their communities ensuring that proper HIV sensitization programme are ongoing and sustained.
In order to ensure that this project works, SACA worked with the Ministry of Local Government Council to establish indicators for monitoring the performance of this initiative. They also conducted sensitization meetings with the LGA Chairmen to request for their full and unalloyed support for the response ownership in their council, wards and community levels.

FHI360 has established 1 ART center and 7 PMTCT centers where community members are encouraged to go for HIV treatment services. They also work with Traditional Birth Attendants (TBAs) on the importance of referrals and linkages of their services to available PHC centers in their communities, recognizing that the TBAs play a strategic role in the delivery and health management of pregnant women and nursing mothers. Some basic referral systems have been established where the TBAs can refer their clients with difficult conditions to designated doctors closest to their areas of operations.

Community leaders and stakeholders at the inaugural meeting to discuss the initiative for increased community ownership and participation in health promotion campaign in River State.

C. LSACA Community Engagement Initiatives

Lagos State Agency for the Control of AIDS (LSACA) has taken the community engagement initiatives to a new level targeting community groups and their clusters with HCT awareness and services. In 2012, the agency introduced a 1.3 by '13 initiative which has to do with a target they established to reach 1.3 million people in the state with HIV/AIDS testing and counseling services by year 2013. This established target drove the agency and some of the LACAs to come up with several community engagement initiatives which are described below.

Involving Government & Traditional leaders as role models and instruments of change

LSACA has recognized the important role the traditional leaders play in sensitizing their community members to be more aware of their health care needs and to be introduced to available HIV/AIDS services in their communities. Because of the series of advocacy to the Baales, the Obas and other traditional chiefs in the state, many awareness raising programme now take place in the Oba's palaces and compounds, showing and demonstrating their support for community owership of HIV response in the state. They have also taken this to a higher level where the State Governor himself is seen on their HIV Mobile HCT Service vehicle as well as LAGBUS public buses in the state saying, "I know my status what about you?" This high level campaign by the Governor himself is a huge support for HIV/AIDS programme at the state and local levels and encouraging community members to venture out for counselling and testing services in their various communities.

Governor Fasola leads the mobile counseling

Working with National Association of Automobile Technicians (NATA)

In every nook and corner of Lagos state, a number of automotive technicians and mechanics can be seen at strategic locations who provide technical services in repair of vehicles to their customers. Because of the important functions of this association and the number of people they meet daily, LSACA has targeted them for training on HCT and Interpersonal Communication (IPC) skills. This community now provide HIV information and counseling services to their peers, linking them to testing centers where they can be screened and provided with additional follow up information for those who tested positive and may need treatment servcies.

Reaching out to Association of Hair dressers and barbers

LSACA and the LACAs have introduced the association of hair dressers and barbers in the state to HCT information and HIV services via training on how to provide appropriate HIV/AIDS awareness to ther peers. The barbers were trained on how to sterilize their instruments and were also provided appropriate sterilizing equipment.

Working with and through Traditional Birth Attendants Clinics

Traditional birth attendants are a very strong element in health care delivery especially among pregnant women in Lagos state. TBAs have formed their association and many

of them operate their clinics in their homes. Because of the number of clients they see regularly, LSACA through the LACAs and some CSOs with funding from the State Government, FHI and APIN, have linked with the leadership of this association to sensitize them on PMTCT and train them of universal precautions and referral skills especially when they find some clients that test positive for HIV. For example in Agege LGA the linkages with the TBAs have worked so well that they have this testimory to share, "More people now access the HCT services in the LGA due to the sensitization conducted, we recorded more people in 2012 – 1711 as against 1082 in 2011.We also enjoy a good relationship with the TBA's who now refer their clients to us for HCT. About 38 TBA clients have visited. We have been able to key into their fortnightlymeetings."

The LACAs also have conducted outreaches to Community Development Associations and Community Development Committees to use these structure for appropriate HCT information sharing and linking them to available health services in their communities. They also conducted similar outreaches to market women association for HCT sensitization and information sharing.

In the month of January 2013, sensitization meeting with TBA's on follow up of HIV services in PHC was carried out and 100 participants were in attendance. They were all counseled and tested. 95 were negative while 5 females were positive out of 100 screened

Interpersonal communication training for youths and Mobile outreaches

The youths are a strong group in Lagos state who are often the most vulnerable when HIV infection issues are on the table. LSACA through the CSOs have provided counseling skills to youths in the state who are now peer educators and mobilize clients for testing during community based HCT outreaches, World AIDS day and other HIV sensitization meetings and programme. They also work with the youths and CSOs and the AIDS Action Managers to conduct Moon light HCT services targeting some most at risk population in the night especially in locations where they meet for their social activities under the shadow of darkness. The mobile HCT services is taken to such gatherings and counselling and testing services are provided to them. The mobile outreach services are also provided to some hard-to-reach communities in the riverine areas to enable them have access to HCT services which are not usually available in their communities due to poor access to HCT centers.

Nutritional care and Support for PLWHA members via their Support Groups

In providing nutritional support for members of HIV/AIDS support groups, Alimosho LACA is now working with Sweet Sensation, a resturant in Lagos to provide food for some support groups during their monthly meeting as a means of boosting their

nutritional needs. This has encouraged many support group members to renew their efforts in coming out for their monthly meetings and interact among their peers for sharing of coping strategies.

> *"A resource provider, Sweet Sensation Confectionary supplied F ood packs for PLWA in Alimosho weekly for a period of six month August 2012 to Jan 2013. It also collaborated with Alimosho LACA to celebrate WAD for PLWA".*

Outreach to Prison inmates and prison workers
LSACA has not left the inmates behind in their awareness raising and HCT services. They have trained 130 HCT counselors including 40 youth corpers who provide HIV awareness and HCT services to various target groups across the state including inmates and prison workers. This crop of youths have introduced a new level of information sharing and skills building among their peers on outreach and information sharing efforts in Lagos state.

D. Abia State Community Engagement Experience

In a bid to improve access and uptake of HIV and AIDs services, the Abia State Agency for the Control of AIDS (ABSACA) has developed strategies in engaging communities through the use of town criers/announcers in providing information in the community of the available Health services. The town announcers are trained on HIV/AIDS and general health related issues (this practice was adopted because of the seemingly fact that the announcer is known to the people i.e. the people can easily relate and identify with them, speaks the local dialect, the community people are comfortable with them and not afraid to ask them questions). According to ABSACA M&E Officer, the town criers serve as the voice in the community and this has helped to increase awareness and access to HIV/AIDS services, they also link the community to the health centre.

The use of sporting activity (such as football):
This strategy was adopted by Society for Family Health (SFH) to mobilize the community especially young people towards accessing HCT services.

The placement of branded messages at strategic locations in the communities:
These branded messages are used to generate and invoke the consciousness of the people on some health related realities as well as help to create demand for such services (These practices are adopted by SFH)

E. BENSACA Community Engagement Practice/Experience

Engagement of IPC conductors in 23 L.G.As:
Benue State Agency for the Control of AIDS (BENSACA) has taken on a promising practice to community engagement to improve access to HIV/AIDS services through training of 400 community volunteers (2 persons by ward) as interpersonal communication conductors in the 23 LGAs in Benue State. The IPC conductors are trained to create awareness on HIV, to mobilize community members to access services in health facility, to provide linkages between the community member and available

services. The IPC conductors are community volunteers who are trained by some IPs in the State such as ENR. They meet on a monthly basis to create awareness and provide information on HIV to community members, mobilize community members to access services in health facility, create demand for services and provide linkages between the community member and available services. The IPC conductors are also monitored by the LACA coordinator and M&E monthly in order to ensure that this strategy works. The engagement has helped in the reduction of stigma, increased attendance of ANC; it has also recorded high multiplier effect in that in a month one IPC conductor reaches one to two hundred people.

In order to ensure that this strategy works, the Executive Director of Benue State Agency for the Control of AIDS along with her team members conducted training of LACA Coordinators and M&E Officers for effective implementation of prevention strategies by community volunteers (IPC Conductors) in Benue State, to establish indicators for monitoring the performance of the IPC at the various LGA, community and ward levels, as well as to solicit for their full and unalloyed support for the response ownership in their council, wards and community levels. This engagement has helped in the reduction of stigma, increased attendance of ANC; it has also recorded high multiplier effect in that in a month one IPC conductor reaches one to two hundred people.

Engagement with LGA Chairpersons' wives:
BENSACA has taken on a promising practice to community engagement to improve access to HIV/AIDS services through building synergy with local government chairmen's wives, gender desk officers and LACA coordinators in promoting PMTCT services in Benue State. The Executive Director of Benue State AIDS Control Agency along with her team members organized a three day stakeholder fora to effectively engage local government chairmen's wives on the need to improve access to PMTCT Pediatric ART services in Benue State. The fora were expected to build synergy between SACA, local government chairmen's wives, gender desk officers and LACA coordinators in providing the needed support in promoting and improving PMTCT in the State.

The community people are facilitated to access health facilities in various communities through the LACA stakeholder's forums, the LACA stakeholder forum is held on a monthly basis and are being attended by key stakeholders in the LGA such as the traditional and religious leaders, village head communities, community drivers of change, community development committee chairmen, women group, LACA members e.tc they discuss bottlenecks to uptake of services and actions taken to improve lapses. The various groups such as the community drivers of change, the community development committee chairmen, and opinion leaders are charged with the responsibility of mobilizing members for uptake of services. They meet monthly to discuss on health and development issues in their communities and advice community members on available services and how to access them. The LACA members on the other hand visits wards, markets, schools, churches with mobilization messages to intimate men, women and children of available services and where they are.

Community Involvement and impact
Agatu LACA board makes use of platforms such as the traditional and religious leaders to effectively engage with and reach out to community members. The traditional leaders mobilize their subjects to take health improvement behaviours and actions. The communities are involved in improving access through the use of open community meeting, community dialogue, community involvement meeting, and community coalition committee. These strategies are used by the community people to generate needs and prioritize them as regards HIV activity as well as other issues. Through the platforms the community people are able to identify myths and norms that constitute barriers to the uptake of HIV/AIDS services, donate lands or rooms to be used as temporary health posts, construct roads, and mobilize communal labor for service provision.

Women groups/Associations in Agatu LGA
The women group or associations are essential and formidable group in the various communities they help in mobilizing community women especially their members to access the available services in the health facilities nearest to them. They assume ownership of some health facilities by providing rooms to be used as temporary health post, build pit latrines as part of waste management. They also enforce some fine on their members especially clinic defaulters.

F. Kebbi State community Engagement practice

Kebbi State Agency for the Control of HIV/AIDS (KSACA) has commenced working through traditional institutions and community leaders to stimulate community engagement of HIV/AIDS services in the state. Working with the Emirs as agents of change, and using these traditional institutions as opportunities to attract community members to use health facilities and services, KSACA has identified community organizations such as Muslim Health Workers Ummah (MUHEWU), Federation of Muslim Women of Nigeria (FOMWAN) Kebbi State Chapter, Jama'atu Nasril Islam (JNI) Gwandu Emirate Chapter, Planned Parenthood Federation of Nigeria, Kebbi Chapter, as entry points to work with local communities to create demand for health care support, raise awareness and sensitize them to uptake health services in the state. Some of the activities of these organizations include:

- Advocacy visit to Royal Highness, district heads, Chief Imams and LGA Chairmen
- Sensitization of Traditional and religious leaders
- Holding seminars with traditional, religious and political leaders.
- Training workshop for women community volunteers for HIV/AIDS campaign
- Sensitization in Islamiyya schools for women
- House to House HIV/AIDS prevention campaign

Working with Traditional Birth Attendants to raise their awareness on their roles in promoting uptake of health services and linking them to PHC service delivery points are strong efforts of KSACA to increase community awareness in their state. The TBAs have been trained on HIV/AIDS counseling and home-based care and support services. They also link their clients to support groups in the various communities.

Engagement models by Development Partners in Nigeria

1. Pathfinder International's best practices on the COMPASS project

The five-year Community Participation for Action in the Social Sector (COMPASS) Project (2005-2009) was implemented under the Cooperative Agreement #620-A-00-04-00125-00 between Pathfinder International and USAID. It empowered communities by expanding participation and ownership of healthcare and education at the local level in 51 local government areas in four states (Bauchi, Kano, Lagos and Nasarawa) and Federal Capital Territory for improved health and educational outcomes. Pathfinder is proud to say these communities still have functional Community Coalitions (CC) supporting health facilities to this day. For example, in 2013, CC supported renovation of Dala Comprehensive Health Centre, Dala LGA and Zakirai Comprehensive Health Centre, Gabasawa LGA, all in Kano state.

Strategies in the community

In order to achieve community empowerment in health and education, the project identified and focused on core areas of basic education, reproductive health and family planning as well as child survival to yield significant results. A set of cross cutting activities included community mobilization and communication, performance improvement, institutional capacity building, fostering an enabling environment through policy and advocacy.

Community mobilization and communication was a critical component to provide mechanisms for community involvement and participation in quality improvement, community mobilization for behavior change and advocacy to improve the social service delivery environment.

To stimulate community participation, the project used a combination of community mobilization and problem- solving strategies and mechanisms, including Community Action Cycle (CAC), Partnership Defined Quality (PDQ), and Quality Improvement Team (QIT), Community Coalition (CC) and LGA forum.

Community Action Cycle (CAC)

By using the CAC to identify and resolve problems, community groups developed problem solving and self-reliance skills that they applied to social service improvement and other development efforts. The sequence of phases of the CAC was:

1. Prepare to mobilize: Select a health issue; Gather information about the health issue and about the community, Identify resources and constraints
2. Organize the community for action: Orient the community so they become familiar with the issues, Build relationships, trust, credibility and a sense of ownership within the community, Invite community participation, Develop a 'core group' of participants
3. Explore health and education issues : Decide the objectives, Explore the issues with the core group, With the core group explore the issue with the broader community, Analyze the information, Set priorities for action
4. Plan together : Decide the planning process objectives, Determine who will be involved in planning, their roles and responsibilities, Prepare the planning session, Facilitate the planning session to create a community action plan
5. Act together : Define the core teams role in accompanying community action,

Strengthen the community's capacity to carry out their action plan, Monitor progress, Solve problems, advise and mediate conflicts

6. Evaluate together : Determine who wants to learn what from the evaluation, Form an evaluation plan with community members and other interested parties, Develop an evaluation plan and instruments, Conduct the evaluation, Analyze the results with the evaluation team members, Provide feedback to the community, Document and share lessons learnt and recommendations for the future, Prepare to reorganize. If the degree of progress is not impressive, return to step 2 and through a community action identify gaps. If, however, progress is satisfactory move forward to step 7
7. Prepare to scale up: Return to the vision to scale up from the beginning of the project, Determine the effectiveness of the approach, Assess the potential to scale up, Consolidate, define and refine the approach, Build a consensus to scale up, Advocate for supportive policies, Define the roles, relationships and responsibilities of all, Secure funding and other resources, Maintain a M&E system

Community Coalition (CC)

This is a structure formed at community level that includes representatives of all interested organizations (CBOs, FBOs, PTAs, women groups, youth groups, QITs) in a community. The organizations come together to combine their human, material, and monetary resources to improve health. It represents the broader community and coordinates and assists the QIT in its activities, including fundraising and advocacy. By following this, ownership and demand increased at community and household levels, the approach increased the effectiveness and efficiency of both household care taking and delivery of social services.

The general functions of a CC are: Management and Coordination, Advocacy, Education and Community Mobilization, Exchange of visits and Sharing of ideas, Fund raising.

Steps to form a CC included:

- Setting of rules and ways of operation written in a community led developed constitution for the CC.
- Establish a central leadership- election of officials to run the coalition (Proterm Chairperson, Secretary, Treasurer) till permanent officials elected
- CC has different members with different occupations so that CC has different skills, abilities & resources at disposal.
- Create atmosphere so that all will work well together.
- Gain support from outside the community to help with new ideas and resources.
- Collaborating with other communities with similar problems
- General meeting of all members to approve constitution, elect permanent executives, decide dues to be paid by members, approve opening of bank account and signatories.
- Begin process of registration with relevant bodies (LGC, CAC, State Ministry)

Successes of Community Coalition (CC)

1. Health service utilization for family planning, ante-natal care, facility deliveries and routine immunizations, was considerably higher in facilities with CCs and QITs than in matched facilities without these structures. There was also an increased access to HIV Counseling and Testing services.
2. Improvements in infrastructure and service provider/community relations and regular monitoring of services by QITs led to a better quality education and health services. Specific issues such as confidentiality , client respect, and student absenteeism addressed
3. Funds for health improvements were leveraged through donations and advocacy to contribute to infrastructure, equipment, drugs, and supplies for health
4. Both men and women were sensitized on immunizations, safe motherhood, family planning, and enrollment in school particularly for girls.
5. CCs growing with increasing membership and growing activities.

Examples of 100 Women Groups in 3 communities and their practices

The Sabon Birni 100 women group was formed during the program year one and now has 130 members. The group meets weekly to discuss group affairs and share health information. It also employs an innovative savings mechanism in which each member contributes N90 weekly into two separate buckets (the sum of first pot is provided to one member on a rotating basis after each meeting and the other pot stays with the group for various group activities). When an individual member receives the weekly pot, the objective is that they use it for some business activity. Regarding the group funds, they are used for group activities such as refreshments for group meetings and emergency funds to help a group or community member in need. The group funds are also used to provide business loans with interest to select business members; a total of 70 loans have been distributed to date. The group also employs a pass-the-gift strategy to distribute goats to the entire group. In the first year, forty members received goats and the next year forty new members were each given an offspring from the previous forty goats and so on. The group has also completed the registration process which enabled them to get a loan from the International Fund for Agricultural Development (IFAD) for cassava farming.

The Yabo ***100 women group*** was formed in October 2011 and now has 300 members. The group meets monthly and has a focus on health education and small business promotion. Group members do not pay regular contributions, but the group's leaders make contributions and the group also receives outside donations. The group funds are used for health outreach visits, community projects such as small school renovations, and emergency funds to help a group or community member in need. The group funds are also used to provide business loans to select members; a total of 92 loans have been disbursed to date with only three loans having problems with defaulting. 25 group members benefited from vocational training in perfume and soap making from TSHIP

[1]Seed grants are actually no interest loans of 50,000 N for the group for a period of four to six months. As these loans funds are paid back to Life Helpers, TSHIP will need to work with Life Helpers to determine what to do with them.

grantee, Life Helpers Initiative (Life Helpers), and they then trained an additional 15 members. The original 25 members are currently engaged in a joint group business utilizing this training and the seed grant received from Life Helpers. Also, some group members are benefiting from group loans provided by Partners for Development (PfD). PfD has provided ten loans to ten five-person groups amounting to 10,000 N per individual for a three month period. Eligible members had a viable business and had to be seen as responsible by group leadership. The group is currently not registered, but it has stated that would like to undertake the time consuming process of registration so that it can access more loans in the future.

The Bodinga 100 women group was formed during the program year two and there are now 170 members. The group employs a savings mechanism in which some members (right now there are 92 contributing members) contribute 300 N per week and each week the pot is given to one contributing members on a rotating basis. For group members that have not received the contribution pot, they are eligible to receive a loan of up to 2,000 N from group funds. In addition, 25 group members benefited from vocational training in perfume, soap, and bead making from Life Helpers and they then trained an additional 50 members. The 75 members are currently engaged in a joint group business utilizing this training and the seed grant received from Life Helpers. All profits from this joint business currently stay within the group and group members are not allowed to utilize these vocational skills towards person income generation activities. The group is currently not registered, but it has stated that it would like to register so that it can access more loans in the future.

Facility Health Committees - Building Healthier Communities

In a continuing effort to ensure sustainability of the project, PATHS2 has established committees to manage health facilities in communities throughout the five states where they support with health systems strengthening. These are called Facility Health Committees (FHC), Ward Health Committees, or Local Health Committees depending on the state. Each committee gets two rounds of training from PATHS2 on what health services the people are entitled to at the facilities, the roles and responsibilities of the committee members, and how to improve health care in the community using advocacy, community mobilization, fund-raising, and other strategies. Lagos State Health Education Officer Omowunmi George says this training is a "beautiful idea" that enables the people to identify problems, prioritize them, and, if guided, to come up with solutions. Since 2010, PATHS2 helped establish 303 of these committees. The committees are typically made up of the facility Officer-in-Charge and 12 to 15 community members, selected by the community itself. The committee works with facility staff to promote improvements in health services and client satisfaction. They get resources from the government and other stakeholders to improve services within the facility, and then they monitor facility performance and progress in improving services The committees establish and maintain dialogue with the whole community—particularly women, the poorest, non-indigenes and those with special health needs—to understand their views about the health services, and to let them know what the committee is doing to improve these. They also make sure the facility has a sustainable drug supply system.

Facility Community Outreach (FCO) initiative

Facility-Community Outreach (FCO) is a major platform to deliver the PATHS2 goal of increasing the capacity of citizens to make informed decisions about health care, with an emphasis on maternal and child care. It has two types: main outreach and mini outreach. The purpose of the main outreach is to improve the relationship between health workers and the community, encourage community members to use the health facility, and enlighten the community about priority maternal health issues, especially danger signs in pregnancy. Drama, songs and other tools are employed for health promotional activities during the FCO. For the main outreach, which PATHS2 attends along with the traditional leader, local government representatives, church representatives, health workers and about 200 to 1,000 community members, the venue is usually a large field that can accommodate all the community members. Sometimes the health facility itself can be used, depending on how large it is. The PATHS2 consultant mobilizes the community members for the outreach, with the help of the FHC members and community leaders. The mini outreach is a similar type of effort that takes place in the smaller villages within the communities. Anywhere from 50 to 100 community members are engaged to reinforce messages delivered during the main outreach. Data from facilities where events were held showed an average increase of 42% one year after the event in the number of women giving birth at the facility. These events are one reason why 50% of women in PATHS2 target areas are now visiting their health facility at least four times during their pregnancy for antenatal care.

2. FHI360 Experience: Engagement with TBAs and Facility-based volunteers

FHI360 a global health and development organization working on family planning, reproductive health, HIV and AIDS has built local capacity for the delivery of sustainable, high quality, comprehensive HIV/AIDS prevention treatment care and support services. Acknowledging the significant role Traditional Birth Attendants (TBAs) play in the communities in the delivery and health management of pregnant women, FHI is strengthening community PMTCT services through trained PMTCT/HCT volunteers and TBAs in various communities across 18 comprehensives sites. They support two PMTCT/HCT volunteers to provide assistance to Traditional Birth Attendants (TBAs) in providing PMTCT/HCT services to pregnant women, The TBAs are trained on HIV Prevention and the need to take precautionary measures, to provide counseling services, referral and linkages to pregnant women who tested positive to comprehensive sites in their areas of operation, they also ensure that TBAs buy into the SIDHAS project. SIDHAS which stands for Strengthening Integrated Delivery of HIV/AIDS services is a five year project designed to contribute to the delivery of sustainable, high quality, comprehensive HIV/AIDS prevention treatment care and support services. The engaged PMTCT/HCT volunteers support facilities to do outreaches in communities, mobilize community members for HIV/AIDS services, provide counseling and testing services to TBAs clients and refer clients with difficult cases for further investigation and treatment at comprehensive sites closet to their areas of operation.

Formation of Client Tracking Team:
FHI 360 has helped in the formation of client tracking team which is made up of facility based staff to track defaulters' loss to follow up in supported facilities. This practice has helped to track positive clients who have died as well as those on transfer, those being brainwashed by pastor to discontinue treatment to return and continue their treatment. The tracking team also uses facility based support group members to contact and encourage their colleagues to continue accessing treatment and services.

Activation of Public and Private Facilities:
FHI 360 has provided training and activation of public and private facilities in both rural and urban areas to PMTCT standalone sites. Also in order to scale up PMTCT services, ABSACA in collaboration with the Ministry of Health has converted the PHC sites in the state into PMTCT sites, this is to ensure increase in uptake of PMTCT services and compliance at the community level.

Engagement with community based organizations:
The faith-based organizations and Community based organizations are important resource in the community, based on the fact that they are on the front line in the HIV response. This approach of engaging community organizations is being adopted and practiced by FHI-360 to mobilize the community effectively to access and uptake HIV/AIDS services. FHI-360 currently identifies, collaborates and works with three (3) credible and efficient community based organizations in the SIDHAS project to provide an improved access to HIV/AIDS services in various communities; to demand creation on the services available, to provide care and support to PLHIV. FHI 360 provides financial and technical resources to the identified community based organizations on a sustained basis.

Engagement models from selected Nations

1. Community mobilization and interventions among sex workers in India

India ranks second in the world in the overall burden of HIV/AIDS, with official estimates of approximately 2.5 million persons living with HIV infection. Karnataka ranks in HIV prevalence out of all the States in India, with an estimated 270,000 persons living with HIV/AIDS out of its population of an approximately 55 million. This amounts to about 10% of Indian national estimates. An important feature of the HIV/AIDS epidemic in Karnataka, as in India, is its remarkable heterogeneity and uneven geographic distribution across states and districts. At this stage of the epidemic, this heterogeneity offers an important window of opportunity for HIV prevention and control, by allowing a focus on those areas and populations that are at highest risk.

Sankalp is a focused prevention project of the Karnataka Health Promotion Trust (KHPT) that has emerged in response to the situation of risk and vulnerability to HIV in the context of sex work in Karnataka and the need to contain the epidemic. *Sankalp*is supported by *Avahan*, the India AIDS Initiative of the Bill & Melinda Gates Foundation, to scale up HIV prevention in the urban areas of 13 districts of Karnataka, India. *Sankalp*'s project design is based on evidence that appropriately targeted focused

prevention can effectively stabilize and even reverse the HIV prevalence rates. It works with high-risk groups who are key to the epidemic dynamics and response, including female sex workers (FSWs), men who have sex with men (MSM), and the transgendered persons (*hijras).*

The *Sankalp* Project operates from a risk and vulnerability reduction framework to reduce the transmission of STIs and HIV. It views sex work as an occupation, and sex workers as human beings, men and women like any other, in need of and entitled to good health, dignity and a life free of violence and stigma in their own right. It enables a focus on improving conditions and situations that deprive sex workers of the right to live and work safely. It recognizes that HIV is often not the primary concern of sex workers who have critical needs for information and services beyond HIV. It focuses on environmental and structural determinants in the context of sex workers' vulnerability to HIV.

Evidence from empirical and theoretical studies on the *Sankalp* intervention suggests, among others, two important preventive interventions that led to reduced HIV transmission: 1) behavior change interventions for high-risk groups, including sex workers and their clients, through correct and consistent condom use; and 2) reduction in the burden of treatable sexually transmitted infections, especially those causing genital ulcers.

The challenge for Karnataka, as for India, is to take these preventive interventions to a sufficient scale to arrest the HIV epidemic. To respond to this challenge, the Karnataka Health Promotion Trust, in partnership with local NGOs, female sex workers, men who have sex with men, and *hijras* (a transgender community), has been implementing HIV preventive interventions in Karnataka since 2004, now covering 16 districts in the state. The Bill & Melinda Gates Foundation, as part of its India AIDS Initiative, *Avahan*, have supported these efforts.

The *Sankalp* intervention recognizes **High-risk Groups** as the female sex workers, men who have sex with men, and transgender/*hijras*. These groups are key to the epidemic's dynamics and response. The Sankap project's **Risk reduction strategies** focus on the immediate factors of sexual transmission of HIV. In the *Sankalp* project, specific strategies include providing correct knowledge about STIs and HIV prevention, differentiating outreach and ensuring total coverage, promoting male and female condoms and lubricants, and ensuring access to health services for STI treatment and other health problems. Risk reduction addresses the immediate factors of sexual transmission due to sex work as an occupation. The situations that create risk are low-risk perception, multi-partner sex with high partner load, low condom and lubricant use, and high STI prevalence. The barriers to addressing risk behavior are poor access to information, varied typology of sex work and volume of sex partners, poor access to commodities, e.g., condoms and lubricants, and poor access to health services.

Drop-in centers (DICs) provide a safe space for high-risk groups to come together. The centers are often basically equipped, but have clean rooms that accommodate 50-150 people, and provide bathing and resting facilities. They are often housed next door to

the program-managed medical clinic. With no similar refuge available, DICs have become the hub of community life, serving from 5 to 11 contact points, or hotspots, where high-risk groups solicit and practice.

The project recruits Regional Resource Trainer (RRT) who are experienced persons working in the field of HIV or training whom the project has identified to build the capacity of outreach teams, as well as monitor and document the project's training. These trainers act as mentors, resource persons to the volunteers and peer educators and provide general guidance during project monitoring and redesign.

Strategies for risk and vulnerability reduction

Vulnerability reduction strategies address underlying factors of sex work, transmission and needs emerging from HIV infection, such as poverty, human rights, gender relations, legal frameworks and the care and support for sex workers living with HIV and AIDS and their families. In the *Sankalp* project, specific strategies include: facilitating awareness and access to rights and entitlements through provision of basic amenities, sensitizing key influencers both in the sex work circuit and wider community, building crisis response teams and advocating with government representatives for policy change, and building a sense of common identity and common purpose leading to participation and ownership of the project.

Vulnerability reduction also addresses underlying environmental factors affecting HIV transmission. The situations that create vulnerability are social inequities, stigma and discrimination, violence and harassment and lack of empowerment. The barriers to addressing vulnerability are poverty and lack of basic needs, negative social attitudes, lack of a legal frameworks and criminalization of sex work, and lack of community mobilization. Risk reduction strategies include: providing correct knowledge about STIs and HIV prevention, differentiating outreach and ensuring total coverage, promoting male and female condoms and lubricants, and ensuring access to health services for STI treatment and other health problems.

Understanding outreach

Purposeful outreach is concerned with behavior change through the provision of consistent and quality HIV prevention efforts. The *Sankalp* project's outreach is planned through the assessment of specific barriers faced by sex workers, both as individuals and as communities. It focuses on increasing condom use and timely; and complete treatment of STIs. It seeks to promote these changes in behavior and to sustain them at the individual and community levels on two fronts: safer sexual behavior and health-seeking behavior.

A community-led outreach strategy has been found effective to promote behavior and other changes among the high-risk groups including FSWs, MSM and *hijras*. The role of Peer Facilitators and Outreach Workers is to enable these high-risk groups to identify barriers to STI and HIV risk and vulnerability reduction, and to plan ways to address them. They use dialogue-based communication or interpersonal communication (IPC), through one-to-one interaction, group interaction or peer counseling to facilitate critical reflection among the community.

Sankalp also recognizes that the meaning and purpose of outreach for the project and the community may be different, and seeks to strike a balance between the needs and interests of the two. Achieving this balance entails listening to and understanding both the individuals and the community by being sensitive to the variations and nuances of the needs of FSWs, MSM and *hijras*. For example, while the project is concerned with reaching out to all FSWs and their regular partners, in the case of MSM and *hijras*, its outreach must encompass even those who are not engaged in sex work, since the boundary between commercial and casual sex is fluid.

Experience shows that to achieve increased condom use and timely and complete treatment of STIs the project needs to comprehensively address the sex workers' needs in addition to their sexual practices. Therefore it is vital that outreach addresses and/or supports interventions that reduce both risk and vulnerability.

Guiding principles of outreach

- Respect for the high-risk community that values each human being and respects their rights to confidentiality, dignity, and a safe and secure life and work environment.
- Teamwork that bridges gaps between project staff, service providers and community, through building relationships of mutual respect, trust, acceptance and learning, and delivery of quality outreach and services.
- Self-representation and empowerment that builds community capacity for participation, leadership and to assume the role as "natural owners" of HIV prevention programs for increased solutions to problems.

Peer Facilitators: These are representative members of high-risk groups who serve as a link between the program and the community. They manage the program on the ground through outreach and operate to serve a population with whom they have a similar occupational, behavioral, social, or environmental experience and among whom they are trusted and viewed as role models. Peer Facilitators work with high-risk groups in their community to influence attitudes and provide support to change risky behaviors. They work with the project part-time and are paid honorarium to compensate for their time. Peer Facilitators are trained to personalize unique approaches that are appropriate and relevant to their peers. While internal and external factors that inhibit behavior change may be identified, they may be difficult to address thereby limiting total coverage

Peer Facilitators manage dual accountabilities to the project and to their peers. They represent their peers when providing inputs into program decisions and strategies, yet devise mechanisms such as periodic peer group meetings to understand and effectively articulate the concerns of their peers. Female Peer Facilitators with low education levels require may training and support from literate staff with an emphasis on visual records to aid the process of planning, implementation and monitoring. Over time, there is a tendency for Peer Facilitators and Outreach Workers to lose some of their advantages as "insiders," due to their close association with the NGO implementing partner. Sometimes this causes them to be viewed as project staff or

"outsiders," even though they are from the high-risk group themselves. This can compromise their ability to maintain a trusting relationship with the community members, and to understand their needs and concerns.

MSM have higher education levels compared to FSWs and have been recruited either as part-time Peer Facilitators in 'taluks' or small towns, or as full-time Outreach Workers in larger cities, based on the geographical demands. However, the NGO usually inspire trust in MSM and *hijras*, and prepare staff not recruited from among these high-risk groups to work with them as a team, learn from them and support them.

Peer Facilitator recruitment process

To ensure total geographic coverage of populations that is at highest risk, Peer Facilitators are recruited by NGO partners after guaranteeing that there is no overlapping social network with other Peer Facilitators. The new recruits act as unpaid volunteers for a month and work with a social network of about 15-20 members of the high-risk groups. The job entails providing information, distributing condoms and mobilizing the community to access clinical services. During this period, the NGO project staff keenly observes and assesses the trainee, and seeks feedback from the community. Subsequently, there is a day-long formal selection process in which project staff and community participate in assessing the month long performance in the field including knowledge, communication skills and work outputs. Based on a positive assessment, the Peer Facilitator is assigned the responsibility of the position.

These are the main criteria for selection of Peer Facilitators

- Members of the community, and the high risk group
- Recognized leaders among their peers who are accepted and have influence
- Highly motivated and interested in the wellbeing of their community
- Skilled in communication and social mobilization

As the capacities of Peer Facilitators and Outreach Workers are enhanced in the course of their work and learning, they are provided with opportunities to grow into positions of greater responsibility in the project as full-time Outreach Workers and/or Field Supervisors respectively, ensuring that the community members assume greater responsibility and accountability for the program.

Peer Group Meetings

One of the partner NGOs facilitates community meetings on a quarterly basis. Each Peer Facilitator organizes a get together for about 50 peers at the DIC. It is a time for social networking, providing feedback on the project, and building a sense of group identity. These get-togethers serve many purposes. First the sex workers come together and celebrate an occasion. This builds solidarity. The project also uses this opportunity to involve the community in giving feedback on the peer's and the projects work. This ensures that the community understands that the project and the peer are accountable to the community and also gives them a sense of ownership. The project also gets feedback directly from the community members on the project services and the peer's work.

Managing the constraints of a community-led approach
Peer Facilitators have to balance the project's need for performance with the community's interest in empowerment. The demands of a target-oriented project limit their ability to respond to all the needs of the community beyond the project objectives. These needs must be prioritized as all responses must reduce the community's vulnerability to STIs and HIV and in turn increase their health-seeking behavior.

2. Community Health and Consumer Participation – the Chinese experience

The People's Republic of China with its basic socialistic structure medically relates to the individual as the basic unit, the family as a social institution, and the community as to both patient and practitioner. The constitutional principles of the Shensi-Kansu-Ninghoiu border region, which were passed by the Third Consultative Council of that border region on April 23, 1936 affirm in item three (3) of the section "Rights of the People" the people's right to freedom from ill health. In support of this right, the document declares that "public health education and the supply of medicine, medical services and medical equipment shall be developed." Subsequent articles of the constitution of the People's Republic of China have been equally supportive. A large number of public health laws have been enacted. Their common theme is prevention, rather than treatment; extension of public health services to the masses, especially the poor, the geographically isolated, the minorities, the women and children; and the application of all possible resources to public health work, especially the People's liberation army. The value of the individual worker is dramatically illustrated in China's progress in digital and severed limb re-implantation. In one individual worker, seen by the NMA delegation, the individual's upper limb was useful after removal of a giant tumor from the shoulder and upper limb. All individuals receive some coverage of medical services. Individuals in the Communities receive coverage by small deductions from each individual's salary. Government employees receive free coverage but pay for their dependents by a small wage deduction. There is free coverage for those unable to pay, and the elderly.

Treatment does not necessarily or primarily result or depend on the individual or patient seeking the doctor and the patient's willingness to undergo treatment. The communities and/or government's definition of the illnesses requiring treatment are given priority. Where the community and the government have different priorities, the government priority is given first action. The best example of this is seen in the infectious and contagious diseases. In eliminating syphilis, medical practitioners including many in the People's Liberation Army, trained community (local) opinion leaders to convince the residents to report symptoms. Ultimately, kinsmen brought their relatives in for treatment and syphilis was eliminated.

Currently the government's priority to improve the people's health focuses on the prevention of debilitating diseases, in particular parasitic diseases. Methods of handling livestock and hygiene in regard to cannery and food preparation in general were very impressive. This could have only come about by education in updated health and agricultural methods, a primary tool of preventive services. The community acting as both practitioner and patient has educated both the individual patients and the health worker, including the physician, to accept the best of Western medicine and the best of traditional medicine using the combination to help all people.

The community participates actively in the selection of individuals who will serve the community as physicians in the future. It also selects its other medical workers, including the "barefoot doctor." This responsibility is very important because in China, the healer is prestigious and, in a broad sense, becomes a social voice. In China, of course, medical workers are responsible for implementing the wishes of society; they are true civil servants who serve both the government and the community. In giving the community the power of selecting medical workers, the power of the profession is curtailed in determining its membership and the role of the family in placing its members in prestigious occupations is vastly diminished.

The People's Republic of China has achieved a high degree of community responsibility and consumer participation. The resultant beneficiaries are the people themselves with wide-spread coverage, reasonable effectiveness and the ability to control the profession as well as the services received.

3. Community Mobilization and Participation in NEPAL on the ICDS

The Integrated Child Development Scheme (ICDS) is basically a community based programme and its success depends on active community participation. In ICDS, community participation is voluntary and democratic involvement of elders, local and religious leaders, institutions and organizations. It includes community action and decision - making in planning, implementation and monitoring of the programme which leads to self-reliance, ownership and sustainability of the programme. In NEPAL, community participation and engagement for improvement of integrated child Development Scheme focus on specific understanding and definitions as follows:

Community refers to a village or a group of villages with families inhabiting them, who are dependent on one another in their day to day transactions of mutual advantages.

Community Participation is active involvement of people in planning, implementing and monitoring of ICDS programme which is for their well-being. **Community participation** is not just utilization of services and being passive users.

Community Mobilization is the process of bringing together or empowering members of the community from various sectors to raise awareness on and demand for a particular development programme. It facilitates change and development taking into account the felt needs of the community and leads to community organization.

Community Organization is the process of organizing the community in such a way that they can identify and prioritize their needs and objectives, develop confidence and will to achieve them by finding resources through cooperative and collaborative attitude, practices and community participation.

In NEPAL the process of eliciting Community Participation on their ICDS includes

1. Assessing Community's felt needs through community meetings and

outreaches
2. Build up rapport with community members and their leadership
3. Educate / mobilize / organize community for action on the programme areas they feel will meet their needs the most
4. Involve Community in planning, implementation and monitoring the programme

Techniques of Eliciting Community Participation

- Mother's meeting and Community meeting
- Advocacy campaign targeting key community groups and their leadership
- Street play, skit or drama
- Use of folk media and folk songs
- Balmela / exhibition / sports meet
- Use of PLA techniques

Established indicators of determining community participation

- Community brings and collects children from AWC
- Contributes materials for PSE activities
- Helps in cooking and serving food at AWC
- Supports in maintaining AWC
- Provides food during gap period / shortage
- Provides place for AWC and storage facilities
- Visits AWC and help in solving the problem of AWW

Points to Remember for Active Community Participation in NEPAL

- Know your community well & understand community's problems and their needs
- Be aware of existing beliefs and practices prevalent in the community
- Always listen to community members carefully
- Do not introduce new interventions that are contradictory to existing practices and beliefs.
- Try to analyze community dynamics and adjust in that situation
- Involve community in ICDS programme right from the beginning
- Give respect/importance to negative experience of the community, if any, and try to minimize the negative feeling not only by sharing but also by doing

4. Uganda – The AIDS Support Organization (TASO)

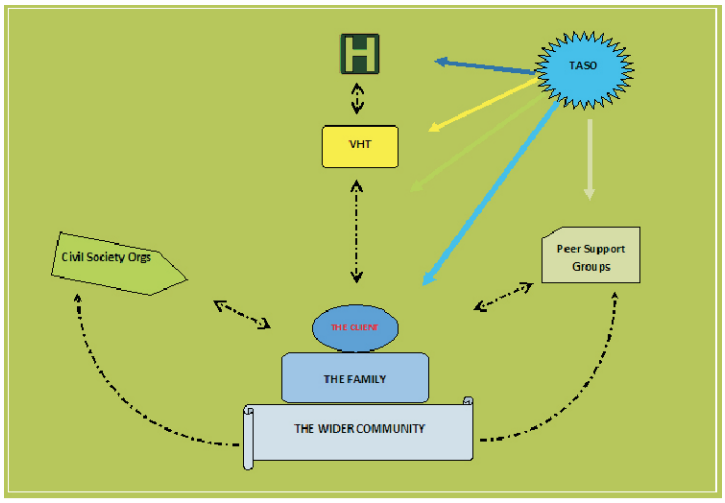
TASO is an indigenous Ugandan NGO deeply involved in the fight against HIV/AIDS with a vision to see "A World without HIV" in our lifetime. It was formed 25 years ago by people affected by HIV/AIDS and its mission is to "contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of persons, families and communities affected by HIV infection and disease." TASO provides a wide range of community based services including combined HIV prevention

interventions, treatment, care and support services for PLWHA, Advocacy and promotion of Positive Health Dignity and Prevention (PHDP), Advocacy.

Key TASO Activities include:

- TASO provides treatment, care and support to 100,000 clients (PHAs) annually through its 11 service centres across country.
- It trains over 2,500 health workers (including community volunteers) annually through its 4 regional training centres.
- It provides training and technical support to various Community Based Organizations in Uganda.
- It acts as a channel thought which resources are passed on to the communities.

TASO's Community Care Model



TASO Intervention Strategies that have enabled them to improve on their HIV/AIDS response which have brought them into international limelight include:

- Working with community leaders through the existing administrative, cultural and social structures to build momentum for action against HIV/AIDS.
- Building the capacity of community volunteers through training, mentoring, and ongoing support supervision to enhance service delivery.
- Training community leaders to provide effective leadership and oversight over HIV/AIDS programs.
- Regular reviews to enhance learning and adaptation.
- Proactive engagement with PLHIV throughout the project planning, implementation, and review cycle.
- Providing critical infrastructural support that may be necessary to ensure success; such as bicycles for transport, a microscope for the local community health centre, etc.
- Community based provision of critical services including ARVs through appropriate distribution mechanisms.

Over the years, TASO has trained 6,000 community volunteers round the country; these provide voluntary services to their community members. Each year, up to 300 members of Village Health Teams (VHT) benefits from improved capacity. At least 250 health workers in various health facilities benefit each year from various capacity building interventions including training, mentoring, support supervision, etc.

What has worked for TASO community engagement initiatives?

- Involving the communities in the design and implementation of prevention and care services.
- Community based delivery of HIV prevention, care and treatment services have enhanced community access and uptake of those services.
- Involvement of people living with HIV helped turn the tide; especially in fighting stigma, and educating the public, and mobilizing community volunteers.
- Task shifting to well-trained lay service providers has "boosted" the workforce.
- Engaging the community leaders enhanced services.

Critical Success Factors that aided TASO's community engagement initiatives include:

- Buy-in and support from the national and local leaders.
- Involvement of people living with HIV/AIDS.
- Full engagement with the communities in defining their priorities, agreeing action plans, implementing and monitoring strategies.
- Providing appropriate training for all categories of community volunteers and support groups.
- Legal framework for (or at least no objection to) task shifting; this facilitates community involvement.
- Establishing a sustainable mechanism for the motivation of community volunteers.

TASO works with several partners to ensure success of their community based interventions. They recognize the tremendous contribution of each partner/stakeholder and truly appreciate what each partner brings on board to support their local initiatives. Some of these partners include:

- The Government of Uganda provides an enabling environment, good will, and other support through MOH, MOFPED, UAC, and other agencies.
- The donors; i.e. PEPFAR (USAID & CDC), and others.
- PLWHAs volunteer their time, energy, experiences, and emotions into the fight against AIDS.
- The CSOs do a great job in reaching out to the people.
- Community Volunteers including the Village Health Teams are a wonderful resource.

Appendix: 1

Engagement of layers of Community Mobilization Officers and their key lines of responsibilities