Sustainable Community Engagement Strategy

-A GUIDE FOR COLLECTIVE ACTION FOR INCREASED UPTAKE OF HIV/AIDS AND OTHER HEALTH SERVICES

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Abbreviations and Acronyms

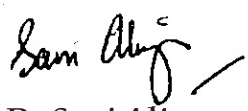
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ANC	Ante Natal Care
CACA	Community Action Committee on AIDS
CAS	Community Analysis Sessions
CBHI	Community Based Health Insurance
CDC	Community Development committees
CSO	Civil Society Organizations
DDC	District Development Committee
DFID	Department for International Development
FBO	Faith Based Organization
FGD	Focus Group Discussion
FGN	Federal Government of Nigeria
FHI	Family Health International
HCT	HIV Counseling and Testing
HCW	Healthcare Workers
HIV	Human Immunodeficiency Virus
IMNCH	Integrated Maternal Neonatal and Child Health
KACA	Kingdom Action Committee on AIDS
LACA	Local (Government) Action Committee on HIV/AIDS
LGA	Local Government Area
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
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
SACA	State Agency for Control of AIDS
SMoE	State Ministry of Education
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
VDC	Village Development Committees
VHW	Village Health worker
WDC	Ward Development Committees
WHS	Ward Health Service
WMHCP	Ward Minimum Health Care Package

Preface

The National Agency for the Control of AIDS (NACA) is the apex institution in Nigeria's multi-sectoral HIV/AIDS response architecture. It is mandated to provide overall coordination of the national response while state aAgencies 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 concerted efforts to halt and reverse spread of the HIV and AIDS epidemic in Nigeria, major challenges still exist on how to engage the community. A community engagement strategy would involves all relevant stakeholders in decisions and plans to prevent new HIV infections and would result in collective strategies that will provide support to those who are affected and infected. It would spell 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. This would in turn provide a framework that will ensure improved partnership, collaboration, information sharing, coordination and reporting of all programme response; 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 of CSOs and CBOs in the uptake of HIV/AIDS services especially at the grassroots level.

In order to engage the community for increased awareness and effective uptake of HIV/AIDS services at the local and community levels, various policies and documents developed by the FMoH and partners were harmonized into one national policy for community engagement. Since the community is the closest to the people, this would assist them to enhance their competence in dealing with the epidemic that has, so far, been extremely inadequate..



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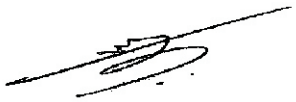
Acknowledgements

The National Agency for the Control of AIDS (NACA) wishes to acknowledge the immense contributions of the World Bank, UNAIDS, MSH-Pro-Act, Action Aid Nigeria and Pathfinder, for providing strategic technical direction and guidance in the development of this community mobilization strategy to guide HIV/AIDS prevention and management in Nigeria. We also recognize the immense input of the various stakeholders, community leaders, and the SACAs in six selected states from each geographical zone that the consultants visited 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 from their busy schedules to give us their perspective on community mobilization efforts in their different domains.

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 practice and invariably lead to improved HIV/AIDS response initiatives in Nigeria. My gratitude goes to the consultants; Mr Joshua I. Samson and Dr (Hajia) Yelwa Usman, who competently put this document together and whose dedication and commitment made the development of the document possible.

Finally, to the secretariat of the process, at the Department of Partnerships Coordination and Support, NACA, led by Mr Mohammed A. Raheem, Dr Uduak Essen, Mr Danjuma Garba, Kemi Ladeinde, Miss Victoria Igbe, Irima Odo and to all NACA staff that participated in the development of this document, your contributions are truly appreciated.



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Executive Summary

Quality health is a fundamental right of all Nigerian citizens. While primary health care (PHC) centers are relatively uniformly distributed throughout local government areas (LGAs) in Nigeria, the rural people tend to underuse the basic health services, including some free HIV/AIDS treatment, care and support services. Review of Nigeria's previous attempts at developing the national primary health care system indicated that the main problems, among others, were inadequate community mobilization, engagement and participation, inadequate orientation and education of the health manpower and inequitable distribution of resources.

The overall objective of a national health policy is to improve accessibility of the population to primary health care as well as to secondary and tertiary care. The Nigerian *National Health Policy* identified primary health care (PHC) as the main focus and entry point for delivering effective, efficient, quality, accessible and affordable health services, to a wider proportion of the population through four approaches:

- Promotion of community participation in planning, management, monitoring and evaluation of the local government health system i.e. the PHC system;
- Improved inter-sectoral collaboration in primary care delivery including HIV/AIDS services;
- Enhancing functional integration at all levels of the health system;
- Strengthening of the managerial process for health development at all levels.

Capacity building and empowerment of communities to ensure ownership through orientation, mobilization and community engagement as regards training, information sharing and continuous dialogue, could further enhance the utilization of PHC services by rural populations including uptake of HIV treatment, care and support services.
It has been previously stated that rural people do not take advantage of the opportunities and therefore tend to under-use the basic health services. Although there is no universal solution to this problem, some strategies have been outlined which could result in enhancing the use of health services by rural communities. Considering that there has been a huge investment in HIV/AIDS response globally and in Nigeria in particular, concerted effort must be made to ensure that all national programmes work in synergy. This can happen by using available and appropriate health structures at the LGA, ward and community levels to engage community members for meaningful and sustainable access to health services. Promoting community participation is a skill which must be taught to community health workers and backed up with support services. The genuine commitment of medical staff to community self-help is crucial to the motivation process. Motivation within the community quickly breaks down if materials, expertise, and salaries fail to arrive when promised.

The participation of communities in defining problems, planning, implementation and evaluation of community resources makes them feel responsible, not only for their own health, but also that of others. All members of the community can be involved in some aspect of health programmes. In rural areas especially, the cooperation of local people is fundamental. Their participation can be encouraged by disseminating relevant health information, increased literacy and making the necessary institutional

arrangements, working through and with community leaders. Mutual support between the community and the government is highly needed. The approaches to the delivery of PHC for rural populations should, therefore, be practical and feasible.

It is almost universally acknowledged by national and international health planners that community engagement and participation is critical to the successful implementation of primary health care (PHC). This includes expanded increase and uptake of HIV treatment, care and support services through layers of mobilization efforts. Attempts have been made to describe the role of community mobilizers at the various community, local government and state levels. These layers of key actors will play a central role in the efforts to advocate and mobilize community members to access health services within range of their dwelling places. It is therefore the aim of this document to stimulate all stakeholders to work conscientiously with community based institutions, community leaders and community members to increase access to health care services in all communities at the LGA level in Nigeria. This also means encouraging development partners, donors and government agencies to work together collaboratively to achieve health for all as contained in the Nigerian Health Policy.

CHAPTER 1

Introduction

In spite of concerted efforts to halt and reverse the spread of HIV and AIDS epidemic in Nigeria, there are still major challenges on how to engage the community for maximum uptake of health services even with the numerous number of service points and providers that government continues to provide across the country. It is in this respect that a community engagement strategy was developed to serve as a framework for community engagement practices by all development sectors in Nigeria. This community engagement strategy 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 for engagement and defines roles and responsibilities of all the partners and stakeholders in their collective response for HIV/AIDS programme management at the community level.

Community engagement is increasingly acknowledged as a valuable process, not only for ensuring that communities can participate in the decisions that affect them and at a level that meets their expectations and needs, but also to strengthen and enhance the relationship between communities and governments and their agencies. Essentially the concept is about public participation that facilitates engaging people in decision making at a local level especially as it affects health outcomes and improved service uptakes at health facility levels.

However, many biomedical and behavioural HIV/AIDS programmes aimed at prevention, care and treatment have disappointing outcomes because of a lack of effective community engagement and mobilization strategy. Review of programmes with successful outcomes increasingly point to some level of community engagement and involvement practices as a key aspect of their work. This includes working with existing community-based structures and systems to stimulate and secure the attention and interests of community members; invariably leading to their acceptance of programmes and interventions and demonstrating their 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 to health services at the community level.

Over the last two decades, research and practice in health promotion has increasingly employed community engagement practice, defined as the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. In general, the goals of community engagement are to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations among health providers and their beneficiaries. This is what has informed this national strategy for community engagement and mobilization for improved uptake of health services. It is a rich resource to guide common practices in community engagement at all levels.

This community engagement strategy therefore, provides a framework within which all community engagement practices to increase uptake of HIV/AIDS/health services can be undertaken at the national, state and local government levels. It is not intended to impose new ways of working; it is more about building on the already existing good practices and capturing them in one document. The framework sets out what health professionals and their partners should do to make sure that community members can make informed decisions and have opportunities to shape health care delivery services in Nigeria.

Involving the community and collaborating with its members are cornerstones of efforts to improve public health. In the context of engagement, "community" is used in in two ways. On the one hand, it is sometimes used to refer to those who are affected by the health issues being addressed. 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, by referring to stakeholders such as academics, public health professionals, and clusters of people with common interests. This use has the advantage of recognizing that every group has its own particular culture and norms and therefore in engaging with them, we must consider their peculiarities, divergent interests and cultures, and perceptions about health outcomes.

In the strategy presented in this document, we recognize the need to focus on engaging communities that are affected by HIV/AIDS issues and to work with them collaboratively to define their issues, proffer solutions and address or resolve their problems in ways that they will appreciate and so take ownership of this process. We also promote the idea that engagement for health improvement can be initiated and led by "lay" community members rather than professional groups. Regardless, we recognize that the groups involved in community engagement have their own particular norms and that all partners concerned in this engagement process and collaboration will have lessons to learn about each other and the collaborative process. Moreover, we fully appreciate that all who are involved in engaging a community must be responsive to the needs of that community as perceived or defined by the community itself.

The community engagement strategy presented here, therefore provides a framework that ensures improved partnership, collaboration, information sharing, coordination

and reporting of all programme responses. it also describes 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.

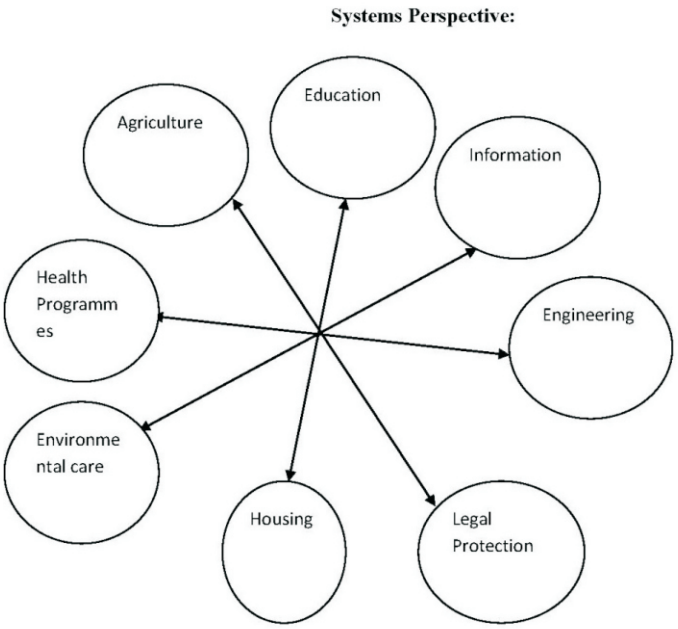
Community eengagement defined

Concepts of community

There are many ways to think about community. We will explore four of the most relevant, each of which provides different insight 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 a 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, community members can be reached via their leaders or their delegations who represent their interests. For example, tracing social ties among individuals may help us to identify a community's leadership, understand its behaviour 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. However, the urban centers seem to have more of these groups than the rural communities. So when planning to use virtual perspective groups, it will be necessary to find out what communication networks and opportunities are available in such a community.

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 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, 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
The strategy proffered here, recognizes that 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. Here, we are going to examine and focus on five 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 communication 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 aspirations are understood and considered prior to decision making.
Collaborate	Working together to develop understanding of all issues and interests to work out alterna tives 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 capac ity to be decision makers in their own lives. This will help them to take the lead in implementing initiatives and establishing practices that can enhance the quality of their health and livelihood.

CHAPTER 2

Community engagement models

In the introduction of this document, we recognized that it was important to engage communities at a level that they would appreciate and understand for meaningful uptake of HIV/AIDS and other health services. In order to be successful in the engagement process, we recommend two approaches: one is to identify community-based structures, systems and opportunities already in existence, which have been patronized in the past by various implementing partners and agents of government and engage with them for increased awareness and uptake of HIV/AIDS services. The second is to identify "communities" within local government areas to target improved access to health care services. This chapter will focus on these two methods.

Model 1: Identify and work with existing community-based structures
Community engagement is about seeking for best options and alternatives to dialogue with community leadership and members., The intention is to meet their expressed needs in ways that they will appreciate and identify with. We do this by working with the right structures and 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 local services that are pertinent to their interests. But we have to identify community based structures, systems and mechanisms that are already in the community through which we can reach them.

In some of the local government areas in Nigeria, there are secondary health facilities (hospitals), primary health care centers, service delivery points, private health care facilities/services, pharmaceutical and drug dispensing stores, and traditional health service providers. There are also traditional birth attendants who community people go to access health services when they need to do so. These health facilities are available and ready opportunities that can be used to increase awareness of HIV/AIDS services at the state and local government levels. Working with these facilities to promote health awareness among their clients is critical to community engagement practices. No doubt, community members use these facilities 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 **community based networks and associations** such as Barbers' Association, Association of Women Hair dressers, Motor Mechanic Association, Market Women Association, and many others. These associations have great influence in the way that information can be passed across to their members. The associations and networks make up the community of people in various town and villages. When we engage these associations and networks with prevention 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 Association, Muslim Sisters Association), social institutions such as The Lion's Club, Aged Group Associations, Women Organizations, Community Development Committees (CDC), 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 of these associations tend to be people in the community that are held in high regard. Recognizing that these institutions and structures can make a difference in promoting behaviour 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.

Model 2: Establish health promotion champions
Within each community, it is 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 that are held in high regard in their communities, whose opinions are respected; who are deeply interested in the health and general well-being of the members of their communities and are willing to play key roles as volunteers to work with health workers during advocacy, sensitization and other health promotion meetings. These people would work in collaboration with the CDC, VDC, women associations and other networks during any health promotion and behaviour change programme to mobilize community members to come out to attend such meetings.

It may be necessary to revisit the previous practice of health inspectors or health promotion officers or community liaison officers. These officers were responsible for raising awareness among community members on available health programmes and

services and how health consumers could benefit from these services . The health inspectors or health environmental officers went around the various communities to advice on what constitutes environmental health hazard, and helping community members to appreciate the importance of taking responsibility for ensuring a clean environment. The officers' duties included raising communities' consciousness on various health programmes in their environment, working with community leadership to encourage rural community members to visit the facilities when they need to and educating them on the health benefits of attending health care facilities. They also helped to address socio-cultural practices that have hindered people from attending health facilities and benefiting from modern health services. They were indeed the link between the community and the health facilities and they were people with good standing in their communities and were well respected.

Model 3: Develop a map/list of community-based structures in all LGAs
In order to know what structures are already on ground, it is important to first conduct a mapping of all CSOs, NGOs, CBOs, VDCs, CDC etc. in all local government areas and cluster them in their areas of competencies and services. This map will then be used as a guide to allocate engagement priorities for managing resources during community awareness and sensitization programmes. It will also inform the choice of who is working where and in what capacity, so that their engagement will add value for money spent.

Model 4: Focus on family, community awareness and education
The families, households and communities are where HIV/AIDS epidemic impacts the most. When a family member is infected with HIV and is eventually down with AIDS, it is the family, household and entire community that bear the pains, and take on the burden of care and support, of the terminally ill patient. We need to target families for education, information and awareness raising on all issues relating to their health and general wellbeing. The health promotion champions can work with community leadership to develop sensitization programmes targeting families in the various clusters within villages and in the wider community.

We are at a point in the history of HIV/AIDS response in Nigeria where we need to take advantage of the various structures and opportunities available in the various communities. By doing this, it would help to increase awareness and uptake of available HIV/AIDS services through the various secondary and primary health facilities and service delivery points. Since HIV/AIDS response is supposed to be multi-sectoral, it has become necessary to involve the various stakeholders in the communities and identify and work with key working mechanisms (as mentioned above) that can enable ownership of the response at that level as well as set up appropriate enabling structures to support these mechanisms.

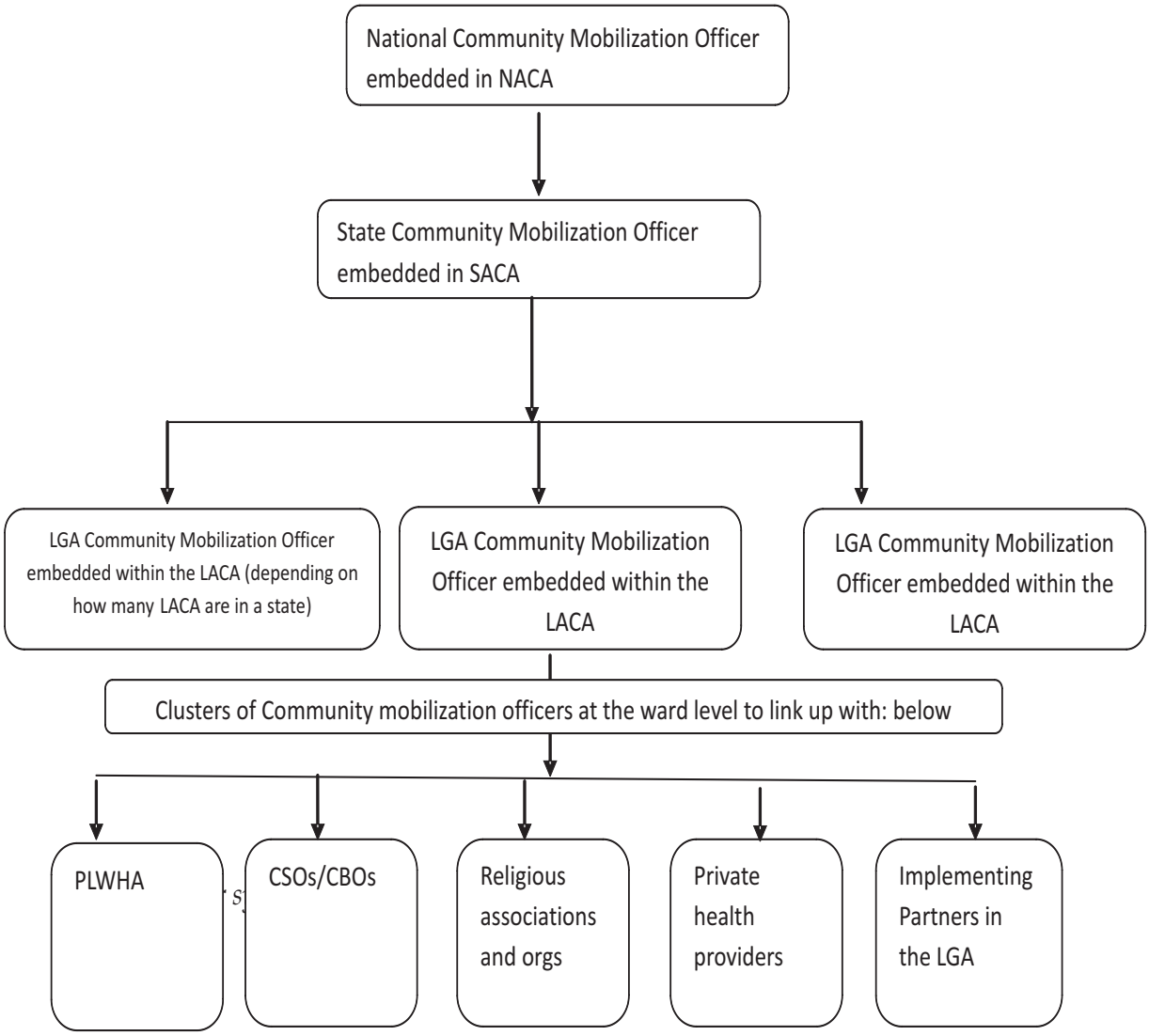
Model 5: Establish layers of community mobilization officers
Working with existing structures is fundamental to promoting community acceptance and utilization of available health services. In addition to working with community champions who are members of community leadership, we can also engage layers of community mobilization officers at the state and LGA levels. These officials will have the mandate of raising awareness via sensitization and advocacy targeting

community/institutional leaders on the need to draw the attention of community members to health/HIV/AIDS services in their communities. They would also educate community members on how to access these services in a timely manner – to improve their health seeking behaviour. These layers of community mobilizers will be employees of government at the state, LGA and wards levels where community mobilization officers would have the mandate to raise awareness within their cluster/domain on the need for increased community awareness, participation and utilization of available health services. However, it's very important that each health facility should have a mobilization officer who is saddled with the key responsibility of working with existing community structures (CDC, VDC, network of associations and community leadership) in their effort to create awareness within the health facility's catchment area on the available health services.

Mobilization officers will work through various community outlets such as the gatekeepers, community based organizations, religious groups and associations, support groups, community/traditional leaders and private health care providers within the catchment area. They will enlist their commitment in responding and creating awareness within their domain on the need to take advantage of available health services. The mobilization officers would need to constantly engage in advocacy and sensitization with community leadership and their members.

Genuine community engagement requires a rights-based, capacity-building approach and sustained financial and technical investment. Building on existing structures, rather than working in parallel to them will improve programme efficiency, effectiveness and sustainability.

Engagement of layers of community mobilization officers and their key responsibilities



It is very important to take advantage of the cluster systems that are 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 centre (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, the health centre 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 all the lower level mobilizing

officers. 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 to stimulate uptake of HIV/AIDS services.
These arrangements need to be properly coordinated in strategic alliance with the FMoH, NASCAP, SASCAP, SMoH and the NPHCDA. It is 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 is no duplication of effort or disharmony in the whole operation.

Methodology for engaging communities
Over 60 per cent of the country's population lives in the rural areas. The vast majority of rural dwellers are farmers and gatherers who live on the ever diminishing resources of land, water and fadama. Regrettably, this population is the most vulnerable to diseases and spread of HIV/AIDS. There is the need to evolve means and procedures of reaching this population with health programmes and provision of health services.
The agricultural sector has developed a well-articulated strategy particularly among the communities living within the fadama areas. The fadama is a low marshy land providing opportunities for farming, fishing and grazing. In order to preserve and conserve the resource, designers of the agricultural programme came up with a community driven approach. This approach recognizes the importance of community ownership of the programme through their participation in the design, implementation and monitoring of the programme. This structure identifies the various layers and defines the roles of each stratum.

The structure is an improvement on the traditional age long techniques of improving community participation. In addition to participatory rural appraisal (PRA), communities also use a variety of other techniques to strengthen their implementation capacity in a participatory way. These techniques have worked in urban as well as rural areas. The process involves the following steps:

- Diagnosis
- Identification of priorities
- Problem and solution analysis
- Elaboration of action plans
- Ensuring fuller participation of vulnerable groups
- Strengthening community organizations
- Strengthening community based accountability

Diagnosis
Teams working in the communities will have to discuss with the villagers to identify which tools may be the most suitable. Field experience shows that the most-used tools are village mapping, the transect, semi-structured interviews, the Venn Diagram, and HIV/AIDS analysis.

Village Mapping
In this exercise, various groups in the village make a drawing of how they see their village. Groups decide for themselves what they want to represent on their map and how. Usually, this exercise generates much enthusiasm among participants. Since mapping is done separately by various social groups, it enhances the voice of each, and fosters a dialogue between them.

Semi-structured interviews
The semi-structured interview (SSI) is an ideal tool to better understand a particular issue. It falls somewhere between a general discussion and an organized survey. To ensure free expression by the vulnerable, the SSI is carried out in sub-groups. It throws light on the activities of the various socio-professional groups, village organizations and administrative organizations involved with the community, as well as on the utilization of resources.

The transect method
This consists of a walk through a village and surrounding land, or through an urban neighbourhood. During this walk, villagers discuss in detail the various aspects of their physical environment: soil, water supply, sanitation, roads, land issues, erosion. The findings and major conclusions of the walk are then sketched as a diagram which can be shared with other members of the community. Mixed groups — men, women, young, old, all walking together—enhance debate.

The Venn diagram
The Venn diagram is a method for visualizing and analyzing the relationships between the various actors in the village, internal and external. By drawing this diagram, villagers express their perception of relations between groups in the village, and relations with outsiders such as local authorities, political representatives and private and public service providers. Each group in the village draws its own diagram. This highlights cases where some groups benefit more from external service providers than others. For example, female heads of households typically have less access to extension agents than larger farmers.

HIV/AIDS analysis
Getting villagers to discuss AIDS requires sensitivity and tact. Many people avoid this subject which touches on sexuality and death. Fear, shame, and denial inhibit discussion. However, only open discussions can disclose problems related to the epidemic like lowered production, medical and nursing needs, care for orphans, and use of condoms. Tackling AIDS needs all the usual tools plus specific ones such as the mapping of areas where various groups are more likely to contract AIDS.

Other diagnostic tools and techniques include: historical background (villagers retrace the history of the community); seasonal schedule of activities (various groups trace their main activities throughout the year); storyboard (use of drawings to discuss various topics — especially useful in areas with high illiteracy rates); and daily schedule (analysis of the daily workload of various groups). Detailed descriptions of

how to implement these tools can be found in the village participation manual.

Multi-sectoral approach to community participation
There is no doubt that most communities still see health care delivery as a social service. The expectation still remains, to a large extent, that government should provide the resources, design and implementation arrangement for health care delivery. This age long belief, though still strong, is gradually giving way. Some individuals and communities have accepted the challenge to pay for diagnosis and treatment of life threatening ailments such as diabetes, cancer and hypertension. Individuals now pay for genuine drugs and are willing to contribute towards the health insurance scheme. This has confirmed the common saying that health is wealth.

The community should be made to see the prevention and treatment of HIV/AIDS as a developmental programme that will give individuals a longer and healthy life to embark on economic ventures for their wellbeing. The structure under the fadama programme, as described above emphasized the need to improve on income generation for the people within the fadama resource in order to protect the resource. The health services and indeed the prevention and treatment of HIV/AIDS can be introduced into their programme and implemented through similar techniques and along the structured outline. This should create a very strong linkage between the wellbeing of the rural populace and their economic emancipation.

Procedure for integration
The first task is to get the community to identify health care service as a priority. In determining priorities, communities identify their priorities through a diagnostic approach. In diagnostic exercises, villagers usually develop a long list (sometimes over one hundred) of problems. Priorities must be set by the community, with safeguards to try and ensure the inclusiveness of all groups and sections including the vulnerable group. Several well-known techniques can be used by the various groups to identify their priority problems. These include pair-wise comparison, ranking, voting, etc. The very act of wrestling with priorities helps people develop skills in coalition-building, in judging trade-offs, in appreciating the need for user charges to increase resources and expand the number of priorities that can be accommodated.

The next stage is the problem and solution analysis. Priority problems identified by communities are often large, complex, and very difficult to handle. Their perceived magnitude is one reason why communities failed before to address the problems. The technique of the "problem tree" helps villagers analyze their priorities. The "problem tree" is a representation of the causes that lead to a problem (the "root") and its consequences (the "branches"). The construction of the "problem tree" raises awareness among participants that problems which at first may seem very large and difficult to address originate in several factors that can be influenced by the villagers themselves. Demystification through elaboration of the "problem tree" is a powerful tool to improve user groups' awareness of their capacity to actually influence their environment. Participants then discuss the "solution tree". Specific actions are discussed to address the identified causes of the priority problem.

The last stage is the elaboration of the action plan. The actions identified through the "solution tree" now need to be developed and translated into practical action plans. First, in mixed groups, people should discuss what specific actions are needed to address each aspect of priority problems, and what resources and assistance these actions entail. Facilitators can now enrich and strengthen the action plans.

Establish partners' coordination meetings

It is also necessary to identify the presence of international implementing partners and agencies that are working in some LGAs and communities that do not recognize the coordinating functions of the LACA and the SACA and are therefore not reporting to them.

This has happened over the years due to lack of proper or clearly defined roles and functions in reporting of programme results. These partners and agencies must be made to understand that their services and support in HIV/AIDS response in any community are supposed to be coordinated and reported through the LACA and SACA to the NACA.

It is therefore important that a network of implementing partners (a kind of loose association) working in a particular LGA also be established. The purpose of this is to enable information sharing on the range of services that they provide, which local partners they are working with, their target beneficiaries and cost of their programmes.

A mechanism for regular meetings and information sharing should be put in place in all the LGAs. The LACA should coordinate these meetings with the mobilizing officers forwarding the minutes of these meetings to the LACA, the SACA and NACA. Since international or implementing partner would be part of the LACA, they can be encouraged to fund some of the LACA meetings.

Key actors within the LGA to promote access to health services

Within each LGA there are CBOs, FBOs, Support Groups, Women Organizations that are poised to provide community based information and awareness raising services. These groups would be outlets and channels through which funds can be provided to manage the information and awareness raising strategies and efforts at the LGA and community levels.

It is critical that a network be established by these various institutions that enable them to come together regularly to discuss and share ideas on how their work impacts on HIV/AIDS interventions in their communities. It is also critical that a database of these institutions be generated and shared among them. The database will describe who is doing what and where and how they can collaborate in their intervention efforts.

Funding LACA coordinating functions

Funding for LACA's coordinating functions has continued to be a huge challenge over the past several years. Unlike NACA and the SACAs, the LACAs do not have direct access to regular government or agency funding to carry out their coordinating responsibilities. Although there are established budget line items from the LGA to support LACA meetings, these funds are not regular or even available and so are inadequate in supporting LACA activities within the LGAs.

The inability of many LGA chairmen to fulfil their commitment to provide adequate funding for this budget line has hindered some of the good intentions and work of

some LACA in Nigeria. Considering the multi-sectoral nature of the LACA in its membership constitution, its management and leadership should be reviewed to give it some degree of autonomy from government control. It should be community driven with government providing oversight functions rather than controlling functions. We suggest that for each LGA, there should be a central pool of resources from contributions from implementing partners and other health/service providers who are working in those LGAs, which can be used to support LACA's coordinating efforts.

A workable mechanism to achieving this is to work with implementing partners within any LGA to provide and contribute a percentage of their programme response cost for HIV/AIDS into the resource pool for supporting LACA coordinating functions. Evidently there will be a disparity of this resource pool across the various LGAs as there are some LGAs that do not have IPs working on HIV/AIDS programme. Where such gaps exist, focus should be on generating interest of private sector health providers/promoters within the LGA to contribute a quota to the pooled-resource of the LGA.

CHAPTER 3

Engagement of communities and entities

Changing community members' mindset for meaningful engagement
In order for community engagement efforts to be successful, one needs to change the mindset of community based organizations and members from depending solely on funds from implementing partners before they can volunteer to carry out community mobilization. Conscious effort needs to be made to initiate community ownership of interventions and responses.
Targeting community leadership (*emirs*, *obas*, *ezes* and other levels of traditional leaders) is critical to improving community participation, acceptance and ownership of health response at that level. This can be achieved through advocacy and sensitization, enlightening them on the need for greater involvement in sensitizing their community members to uptake health services, including HIV/AIDS services.

Key elements and usefulness of community mobilization and engagement

- Community engagement efforts should address various levels of the social environment, rather than only individual behaviour, to bring about desired change.
- Building on existing community structures – rather than working parallel to them – improves programme efficiency, effectiveness and sustainability;
- Community health behaviour is influenced by culture and social orientation. To ensure that engagement efforts are locally relevant and culturally and linguistically appropriate, they must be developed from a knowledge and respect for the targeted community's culture.
- People participate when they feel a sense of community; see their involvement and the issues as relevant and worth their time, and view the process and organizational climate of participation as open and supportive of their right to have a voice in the process.
- While it cannot be externally imposed on a community, a sense of empowerment – the ability to take action, influence and make decisions on critical issues – is crucial to successful engagement efforts.
- Community mobilization and self-determination need constant nurturing. Before individuals and organizations can gain control and influence and become contributors and partners in community health decision-making and

action, they may need additional knowledge, skills and resources.

- Coalitions, when adequately supported, can be useful vehicles for mobilizing and using community assets for health decision-making and action.
- Participation is influenced by whether community members believe that the benefits of participation outweigh the costs. Community leaders can use their understanding of perceived costs to develop appropriate incentives for participation.
- Community engagement is relevant and needed for the scale-up of comprehensive four-prong PMTCT programmes;
- Engaging leadership at all levels – facility, community, district and national – is an important key to the success of community engagement. This can further be strengthened if there is a high level advocacy team led by the NACA Director General, targeting state governors and council members on the need to encourage ownership of the HIV/AIDS response at the state and LGA levels. This can trickle down to the communities where the chiefs, *emirs*, traditional leaders and religious leaders can also lend their voices to stimulate collective action by communities to manage their health.
- Meaningful community engagement requires a capacity-building approach and sustained investment of financial and technical support. Health workers require continuous capacity building and change of attitudes to enable them manage the comprehensive PHC programmes. Health workers need to own the local HIV/AIDS response and demonstrate client-support-service attitudes that will attract patients and other clients to use health facilities in the various communities.
- Effective community engagement requires a rights-based approach that empowers individuals and communities to take greater control of their health and health care;
- Meaningful involvement of networks and communities of people living with HIV will enhance PMTCT scale-up;
- Local pre-intervention participative research is an essential first step in the capacity-building process and helps to ensure the relevance and sustainability of programmes;
- Monitoring, innovation and information sharing will be critical to the scale-up of practices in community engagement, including the introduction of mobile and other technologies to improve programme management and implementation.

As programmes expand, effort should be made to support and not undermine work that communities are already doing; rather, emphasis should be to actively identify and build on such efforts.

Points to Remember for active community participation

- Know the community well and understand their problems and needs
- Be aware of beliefs and practices prevalent in the community

- Always listen to community members carefully
- Do not introduce new interventions that are contrary to existing practices and beliefs.
- Try to analyze community dynamics and adjust to the situation
- Involve community in health programme planning right from the beginning
- Respect and do not trivialize negative experiences or feelings

Work with network of people living with HIV/AIDS

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. Discussions focus 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 planning programmes one tends 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 the community mobilization plan is critical in all community engagement endeavours. There are already networks of people living with HIV/AID at the national and state levels and even in some LGAs and rural areas. These networks, especially their leadership, these is a very important group to reach out to and to work with 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, 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 the community level, know their individual and collective interests and needs, and address them by working with and through their network and leadership. In this way, we would have addressed both the practical and felt needs of the communities of people living with HIV/AIDS at the rural and urban centres.

Engaging women groups and associations

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

Women from nomadic and rural communities constitute a major health risk group that requires greater attention, health education and support. If women are actively involved and treated as responsible and concerned members, they can play an enormously effective part, not just in improving the overall health status, but in achieving greater social justice within their own communities as well. The PHC, being people-oriented, should make use of all channels – various women groups and networks - through which people express their concerns over health and health supportive policies and programmes. A social climate can be created in which various groups in the society accept the health practices recommended, and thereby help individuals make wiser choices. An enlightened community (that is, a public that knows its rights and responsibilities, supported by political will and awareness at all levels of government) holds the key to making health for all a reality. Health workers at the various health service delivery points and at the PHC levels need to take this opportunity for awareness creation among the women associations and groups as one of their key responsibilities to enable greater access to available health care services. Health workers need to make concerted effort to reach out to the various women groups and networks in their catchment areas for this awareness creation and health seeking behaviour programme.

Work with traditional birth attendants and healers

Traditional healers and traditional birth attendants (TBA) serve as the best sources of information sharing when targeting community members that patronize their services. Their services should be categorized into those that are clearly beneficial and those that are 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 behavioural change and community action for health. The language of communication should be the same as that of the local people, audiovisual 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 (World Health Organization, 1991).

Health personnel must be aware of the harmful effects of rapid intervention without proper focus on carrying the beneficiaries along. It is easier to change practices rather than beliefs because the latter are deeply entrenched, especially among rural people. The commitment of rural people to religion can be utilized to support the health messages through quotation from the Quran and *hadith* and the Bible. Local beliefs can be interpreted to fit in with desired health practices. Traditional media, such as folk songs and drama shows, are very useful in educating illiterate people, especially rural women, who need a rigorous campaign to effectively utilize the maternal and child health services provided at the PHC centers. Health information should be available to the public using the communication media they know and use regularly. Adequate knowledge and desirable attitudes about health are necessary for appropriate practices.

Work with internally displaced persons

Nigeria has continued to experience a large number of displaced people as a result of communal clashes and nomadic movements and the impact on local farmers. These have caused mass displacement of villagers from their settlements. More recently, the actions of Boko Haram, resulting in displacing a large number of community members from their homes and villages into make shift locations has exposed these people to a lot of health risks and hazards including sexually transmitted infections and even HIV. Though government has programmes of rehabilitation for these people, it is important that community engagement practice takes into consideration programmes that are already addressing this community of people and how health services can be mainstreamed into such programmes to avoid duplication of efforts and operational costs.

Engaging the mass and social Media (local information carrier)

The mass media has continued to serve as a great outreach instrument for education, information, awareness raising and social mobilization targeting the urban as well as rural communities. The radio and television are powerful mass media where strategic information can be passed across to members of different communities in a relatively short time and at minimal cost. Radio jingles, use of folklore, community dramas, home videos and many more such social instruments for behaviour change and communication are ready avenues targeting communities to increase their knowledge and acceptance of health services. Information passed through this media should be such that each community can understand, appreciate and link with their cultures without distorting their beliefs and values.

The mobile telephones have increasingly improved communication in rural communities. Short text messages are increasingly providing timely information and this can be used to share information by health workers and community champions in their outreach messages to various communities.

Work with hard to reach communities

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 madev enough effort to seek their views.

Defining hard-to-reach groups

It is essential that when formulating your engagement strategy, that 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 who is difficult to access for any reason such as:

- Physical inaccessibility (e.g., disability, older or frail people)
- Language or tribal groups
- 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:

- Children and young people in interior communities
- Drug users who don't associate with any particular social network that we know of
- Faith communities
- Gay, lesbian and bi-sexual men and women, transsexual and transgendered people
- Homeless people, especially in urban centres who have no particular location or fixed address
- 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
- People who commute to work
- Single parents
- Small businesses
- Travellers
- Tourists
- Victims of domestic abuse
- Young men of working age

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 particular characteristics of the population sub-group. There are also those who have been displaced by communal conflict and war, natural/environmental disaster and victims of flood that are dislocated from their homes and would need to be reached with health care services.

When identifying 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

Community leaders or gatekeepers 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.

CHAPTER 4

Ensuring alignment and using right tools

Collaboration and partnership among ministries, departments and agencies
The primary health care (PHC) outlets and their various service delivery points are already in place in various communities in Nigeria. Their services are meant to be readily available to community members. These institutions are assets that all partners can work with in their effort to reach community members on health services. Collaboration with the PHC focuses on how to create conditions for health care providers everywhere to work together in the most effective and efficient way with the aim of producing the best health outcomes. 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.

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 benefit. Collaborative efforts that are focused on economic development and progress will lead to better health outcomes. The various agencies in the health sector need to see their various functions as supportive of the overall health plan of Nigeria and Nigerians. There should be an effort to improve their working approach to stimulate collective action rather than working vertically on individual national programmes.

Educational institutions play an important role in the health status of a community, especially in the area of prevention, through peer education and information sharing. Teachers can help in the early detection of ill health in students. Students can be used as peer educators and messengers of health to the community. Literacy programmes have been shown to have a great impact on equity-oriented development in rural areas (World Health Organization, 1991). 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 programmes would be of great help. The mass media can contribute effectively to the dissemination of health messages to the general population. 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. (World Health Organization, 1991). Primary health care 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 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.

Advocacy as a tool for community engagement and ownership
Advocacy is the deliberate process, based on demonstrated evidence, to directly and indirectly influence decision makers, stakeholders and relevant audience 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.

Advocacy is an ongoing process aimed at change of 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 affected by the issue. 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 behaviours by increasing uptake of health care services at the ward and community health facilities.

Advocating for improved uptake of HIV/AIDS activities and services should be driven by the NACA director general, SACA executive directors and LACA chairmen respectively. They should target community and religious leaders in order 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 among their members to access services including that of HIV/AIDS. Community leaders can serve as champions for change in their various communities. Once they are sensitized and trained, they can carry their community members along in their health seeking behaviours.

Advocacy at facility management level should focus on offering various services, while staff should be sensitized to raise awareness of services and for the staff providing the services to accept the responsibility through reorientation and training. Health facilities should look beyond government and developmental partners to mobilize resources from the community where they serve (NGOs, FBOs, private organizations, companies etc within their catchment area) for effective HIV/AIDS services among others.

Resource mobilization is important, therefore through advocacy, attempts should be made at all levels of government to employ and deploy skilled personnel, provide needed equipment and materials, budget and release funds to each effective service delivery point. Development partners are to provide technical support and logistics for proper implementation. Every effort should be made to ensure that implementation

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

Training and retraining of health workers

It has been emphasized that training of health workers in different categories to take ownership of health care delivery and to provide quality health services is key to ensuring engagement of community members to take appropriate action for their health. A health worker is an asset to the primary health care programme. The training curriculum should include strategies for engaging communities to access health care services working with community leaders, community groups and associations. And for those who are already employed to work in the PHC and service delivery points, it is very important that their knowledge and skills should be tested from time to time to determine how up-to-date they are on the information that they pass across to health consumers. It is also important to check their attitude as these have a great implication for communities' perception, acceptance and access of health services at the various service delivery points.

Partnership with community entities

Health promotion for improved access to quality health services should be a partnership and collaboration effort among various stakeholders – health planners, health providers, health consumers and the community leadership, even including the health providers in the private for profit sector and the voluntary organizations. It is important that the community leadership is carried along in all health policy making and implementation to ensure that all programmes have their buy-in and support. The various existing structures at the community level can play significant roles as channels for raising awareness on the availability of health services in their communities. Community engagement efforts should address multiple levels of the social environment, rather than only individual behaviours, to bring about desired changes. Building on existing community structures – rather than working in parallel to them – improves programme efficiency, effectiveness and sustainability. Health behaviour is influenced by culture. To ensure that engagement efforts are locally relevant and culturally and linguistically appropriate, they must be developed from knowledge and respect for the targeted community's culture. People participate when they feel a sense of community; see their involvement and the issues as relevant and worth their time, and view the process and organizational climate of participation as open and supportive of their right to have a voice in the process.

Working with women groups, organizations and associations provide a great opportunity to reach a wider network of women and communities. Working with these groups should be seen as a great opportunity and an asset which health workers and community mobilizers should take advantage of to promote expanded access to health

services at all levels. There are experiences shared from responses from some states, which worked with women organizations. to sensitize their members for improved access to health services; for example, the 100 Women group in Bauchi working with traditional birth attendants and their network and associations. These should be seen as models of learning for other states that are yet to start such initiatives.

Taking action to improve engagement practices

It is not enough to put a strategy document in place, it has to be internalized and used by all stakeholders particularly health care and service providers in their daily business endeavours. The discussion, so far has not necessarily presented new initiatives; rather it has organized already existing practices albeit in different locations that is unique to the implementers. Consequently, with this awareness, it is important that we encourage national adoption of these practices so that we have a homogeneous community engagement strategy that is uniformly distributed and provides common guidance in all communities in Nigeria where there is promotion of access to health programmes and services.

The importance of intersectoral collaboration has been emphasized. Vertical programming generally has a tendency to burden community members' participation as it seems to repeat similar efforts targeting the same people again and again. Consensus building among various stakeholders, partners and funders via information sharing and coordination meetings is vital to ensuring that our programmes have collective direction and impact among the communities we are targeting for maximum value. Efforts to work with the various layers of community mobilizers and ensuring that LACA coordinating functions are well stimulated and funded to take the proper role in the coordination mechanism should be highly encouraged. It is therefore important to clearly define roles and responsibilities of stakeholders, communities and partners so that mutual understanding and approach to supporting community engagement strategy will be achieved.

CHAPTER 5

Roles and responsibilities of stakeholders

Roles of communities

- The communities are where the implementation actions take place. They need to own and support all implementation efforts. They need to be carried along at every point of programme planning, development and implementation
- There are various existing community structures that need to be recognized, appreciated and supported to work meaningfully (CBOs, CDC, and VDC etc.)
- Leadership of communities have a role to play in mobilizing, sensitizing and championing HIV intervention efforts.
- Traditional healers and traditional birth attendants (TBA) are the best sources of information to reaching a wider segment of the local communities. They are very well patronized despite their limited competencies. It's important to build their capacity to distinguish between helpful and harmful practices.

Roles of CSOs

- 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 programmes. Because they are community based and have access to various community structures and interests, and because of their ability to reach out to community members without much formality, 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 a range of services either as stand-alone or integrated services depending on the organization's capability and comparative advantage

Role of partners

- A successful ownership of programme response process at the 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 efforts especially when the same community groups are brought in by different interest parties to support their programmes.

Mapping of civil society organizations

Partners should take advantage of the CSO mapping that was done during the World Bank HPDD II HAF implementation by identifying various CSOs that are working in specific HIV intervention in the various communities, LGAs and in the state.

Regular coordination meetings of partners

There should be regular meetings of implementing partners and stakeholders to share information on their programme activities and their achievements in the various locations where they work.

ANNEX

Best practices and sustainable community engagement process

PATHS2 community engagement strategy
Since 2008, PATHS2 has been working with national, state and local governments as well as communities to strengthen the Nigerian health system to ensure accountability of the health delivery system in the focused states in Nigeria. Their strategy for ensuring maximum uptake of health services are centred on ensuring physical and financial access to quality health care services for the poor, particularly women and children. This includes:

- Strengthening governance and accountability
- Advocacy to create an enabling environment
- Innovative political engagement
- Improving facility infrastructure
- Training health care workers
- Ensuring that the right health sector policies are in place; strengthening stewardship of the health sector
- Improving systems at all levels to support delivery of services; and promoting healthy behaviour change

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

Facility community outreach initiative in Enugu State
This is a face-to-face communication approach that PATHS2 has started. The approach encourages community members to access health services through information sharing and health education. This is linked to health services that are provided on a 24 hour basis at all facilities PATHS2 is supporting. The idea is to get the community,

especially women, to use a health facility for antenatal care and delivery, as well as to increase women's knowledge about the danger signs of pregnancy. This initiative has succeeded in strengthening health workers' interpersonal communication and advocacy skills and the conduct of community outreach. It has also brought women to antenatal care and inspired them to commit to having their babies at the facility.

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 in the five states 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.

The committees are typically made up of the facility officer-in-charge and 12 to 15 community members, selected by the community. The committee works with facility staff to promote improvement 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 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.

TShip working with ward development committees
Under the guidance of the TSHIP project, ward development committees (WDC) were formed across the states where TShip worked. The WDC comprise all the interest groups in a ward (CSOs, FBOs, trade unions and artisans, women, men and youth groups, health personnel, teachers, agricultural officers, traditional and religious leaders, and the voiceless). These groups come together to volunteer a part of their time to the development of their ward, especially in the area of health intervention. A WDC has an elected executive who runs the affairs of the committee for a specified period.
The TShip mentored the WDCs to establish structures to support and drive their programmes. Such structures include:

- Village Development Committees (VDCs) formed around cluster villages or settlements to conduct grassroots mobilization. Chairmen and secretaries of VDCs are automatic members of the WDCs and have voting power to vote and be voted for to an elected position in the WDC.
- Emergency Transport System (ETS) to provide swift and free or low-cost transportation for women with post-partum haemorrhage, complicated labour, and children under five to the catchment health facility, and to referral points.
- Drug Revolving Fund (DRF) to provide basic life-saving drugs at low cost to community members
- A volunteer scheme for home visits to provide key life-saving messages to

pregnant and post-partum women on ante natal care, birth preparedness, delivery at a health facility with skilled provider, malaria prevention using IPTs, LLIN and environmental sanitation, child spacing, child and expectant mother immunization, nutrition, diarrhea control using ORS/SSS.
- Sub-committees to decentralize WDC activities in key programme areas for efficiency and maximum output.

Other support provided by TSHIP to the WDCs include coaching and mentoring to organize events to help address certain health problems. The events include:
- Town hall meetings
- Community dialogue
- Monthly, quarterly, bi-annual and annual review meetings
- Leverage celebration days or campaigns with potential for passing key health messages such as: World Malaria Day, World Population Day, World Breastfeeding Week, MNCH week, Sallah and Christmas , IPDs, measles campaign etc.
- Fund raising campaigns

The 100 women group coalitions – The Tship project experience
Gender consideration, particularly giving women a voice, is a key part of the community engagement component of the Tship Project. In view of this, Tship formed a coalition of women groups referred to as the "100 Women Group Coalitions" as an advocacy and community mobilization structure to improve communication on women's health seeking behaviour in Bauchi and Sokoto states.

The *100 Women Group* (WG) is a coalition building process that brings together, non-governmental organizations (NGOs), community-based organizations (CBOs) and faith-based organizations (FBOs) through networking to identify health and other development issues within their communities; and through participatory dialogue, they identify strategies to address them. Women from different social and economic background volunteer to come together to form the 100 WG in order to work together for social and economic benefits.

The goal of the 100 women group is to create a platform; a safe space for women to express themselves freely, articulate their demands, discuss, strategize on how to tackle health and other related socio-economic issues and challenges in their families and communities. Consequently, they have contributed to increased demand and use of high impact maternal, newborn, child health, family planning and reproductive health services and the overall reduction in child and maternal mortality rates. The women groups provide a cohesive forum to discuss critical health issues and to put this knowledge into action. Further, they provide an opportunity to engage in other key activities that can further empower group members ultimately leading to greater family health outcomes. One such activity is entrepreneurship promotion such as saving and lending initiatives and vocational training.
- The 100 WG is an empowering process that creates an alternative structure for

women to identify their priority issues and develop strategies on how to tackle those issues

- It helps women to advocate and lobby in order to bring these issues to the front burner of the community, LGA and the state, and thus influence decisions
- Essentially a 100 Women Group is a coalition, groups of organizations and individuals working together to achieve a common purpose. They use this forum to amplify their voices.
- Forming coalitions with other groups of similar values, interests, and goals allow members to combine their resources and become more powerful than when they act alone. Through coalitions, weaker members within the group can increase their power.

Pathfinder International's best practices on the COMPASS project

The five-year Community Participation for Action in the Social Sector (COMPASS) project (2005-2009) 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 the Federal Capital Territory for improved health and educational outcomes.

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. Pertinent to this process was a set of cross cutting activities which included community mobilization and communication, performance improvement, institutional capacity building and 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 behaviour 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 on 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, 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 the 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 team's role in accompanying community action, strengthen the community's capacity to carry out their action plan, monitor progress, solve problems, advise and mediate conflict
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 the 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 visits and sharing of ideas and fund raising.

Steps to form a CC include:

- Setting of rules and operation procedure written in a community led developed constitution for the CC.
- Establishing a central leadership - appointment of officials to run the coalition (e.g. protem chairperson, secretary, treasurer) till permanent officials are elected
- Attracting different members with different occupations so that the CC has different skills, abilities and resources at its disposal
- Create atmosphere that is conducive to teamwork
- Gain support from outside the community to help with new ideas and resources

- Collaboration with other communities with similar problems
- Holding a general meeting of all members to approve constitution, elect permanent executives, decide dues to be paid by members, approve opening of bank account and appointing signatories.
- Begin process of registration with relevant bodies (LGC, CAC, state ministry)

Success 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 equivalent facilities without these structures. There was also increased access to HIV counselling and testing services.
2. Improvement in infrastructure and service provider/community relations and regular monitoring of services by QITs led to better quality education and health services. Specific issues such as confidentiality, client respect, and student absenteeism were addressed
3. Funds for health improvement were leveraged through donations and advocacy to contribute to infrastructure, equipment, drugs, and supplies for health
4. Both men and women were sensitized on immunization, safe motherhood, family planning, and enrollment in school particularly for girls.
5. The CCs growing with increased membership and activities.

NPHCDA-PHAID: Work with ward development committees

The National Primary Health Care Development Agency (NPHCDA) through the PEPFAR-funded Programme for HIV/AIDS Integration and Decentralisation in Nigeria (PHAID) engaged communities between November 2013 and February 2014. They facilitated and activated latent Ward Development Committees (WDCs) in wards were the programme had trained PHC health workers. The aim of engaging the communities through the WDCs was to strengthen and leverage vital community links to increase uptake and promote demand for HIV/AIDS services in health facilities.

The capacity of members of 156 WDCs in four states (Benue, Kaduna, Lagos and Nasarawa states) were strengthened to conduct community mobilization activities aimed at increasing demand for HIV services in PHC facilities. A study was conducted by the programme in the last quarter of 2014 to evaluate its WDC strengthening activities and interventions towards demand creation for HIV services at PHC level. The findings revealed an increase in the uptake of HIV services in most of the PHC facilities six months following PHAID interventions to the WDCs compared to six months prior to the PHAID WDC interventions.

Communities were also engaged through the programme in the last quarter of 2016 during which advocacy meetings were held with six key traditional leaders in the FCT (four in the Abuja Municipal Area Council (AMAC) and two in the Bwari Area Council). These two area councils in the FCT were selected because they are part of the

high priority LGAs in the country with high prevalence for HIV/AIDS. The outcome of these meetings include the commitment of the six traditional leaders to support their Ward Development Committees especially in their conduct of HIV/AIDS centered social mobilization activities and to directly participate in promoting awareness of HIV/AIDS within their wards and communities. They also committed to facilitating the elimination of common barriers to uptake and utilization of HIV/AIDS services within their wards and communities.

Community mobilization and interventions among sex workers in India

India ranks second in the world in the overall burden of HIV/AIDS, with an official estimate of approximately 2.5 million persons living with HIV infection. Karnataka is the state with the highest HIV prevalence 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 that it is remarkably heterogeneous and has an 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 focus on those areas and populations that are at highest risk.

Sankalp is a focused prevention project of the Karnataka Health Promotion Trust (KHPT). It emerged in response to the situation of risk and vulnerability to HIV as a result 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 HIV prevalence rates. It works with high-risk groups who are key to the epidemic's dynamics and response, including female sex workers (FSWs), men who have sex with men (MSM), and 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. 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 need 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) behaviour 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. It was in response to this challenge, that the Karnataka Health Promotion Trust, partnered with local NGOs and high-risk groups, to implement HIV preventive interventions in Karnataka. They have been working since 2004 and now cover 16 districts in the state.

The *Sankalp* intervention recognizes ***high-risk groups*** as consisting of female sex workers, men who have sex with men, and transgender/*hijras*. These groups are key to the epidemic's dynamics and response. The *Sankalp* project's ***risk reduction strategies*** focus on the 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 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 behaviour 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 centres (DICs) provide a safe space for high-risk groups to come together. The centres 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 programme-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 trainers (RRT) who are experienced persons working in the field of HIV or training that 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 of 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 framework 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 behaviour 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 behaviour and to sustain them at the individual and community levels on two fronts: safer sexual behaviour and health-seeking behaviour.

A community-led outreach strategy has been found effective to promote behaviour and other changes among 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-on-one interaction, group interaction or peer counselling to facilitate critical reflection among the community.

Sankalp also recognizes that the meaning and purpose of outreach for the project and the community may differ, and seeks to strike a balance between the needs and interests of the two. Achieving this balance entails listening to and understanding both the individual 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.

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 programmes for increased solution to problems.

Peer Facilitators: These are representative members of high-risk groups who serve as a link between the programme and the community. They manage the programme in communities through outreach and operate to serve a population with whom they have a similar occupational, behavioural, 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 behaviours. 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 behaviour change may be identified, they may be difficult to address thereby limiting total coverage

Peer facilitators are accountable to both the project and to their peers. They represent their peers when providing input into programme 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 educational status may require 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 community members, and understanding their needs and concerns.

MSM have higher educational status 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 inspires 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 are 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, 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; they are accepted and have influence

- Highly motivated and interested in the wellbeing of their community
- Skilled in communication and social mobilization

As the capacity 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 programme.

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 receives feedback directly from the community members on their 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 behaviour.

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 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 by China's progress in digital and severed limb re-implantation. In one worker, seen by the NMA delegation, the individual's upper limb was useful after removal of a giant tumour 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 a token sum for their dependents, which is deducted from their wages. 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 community's 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 precedence. The best example of this is seen in the treatment of infectious and contagious diseases. In eliminating syphilis, medical practitioners including many in the People's liberation army, trained community (local) opinion leaders to convince 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 patient 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, 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 to select medical workers, the role of the family in placing its members in a prestigious occupation 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.

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 and involves 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 focuses 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 to achieve them by finding resources through cooperative and collaborative attitude, practices and community participation.

In Nepal the process of eliciting community participation on the ICDS includes

1. Assessing community's felt needs through meetings and outreach
2. Building up rapport with community members and their leadership
3. Educating / mobilizing / organizing community for action on the programme areas they feel will meet their needs the most
4. Involving community in planning, implementation and monitoring of the programme

Who can be involved in eliciting community participation?
The following members from the community may help in eliciting community participation:

- Panchayati Raj members
- Sarpanch
- Religious and local leaders
- Mahila Mandal
- Youth club members
- Self - help groups

Techniques of eliciting community participation

- Mothers' 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 helps in solving the problem of AWW

Points to remember for active community participation in NEPAL

- Know your community well and understand the community's problems and their needs
- Be aware of existing beliefs and practices 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 to the 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 negative feelings not only by sharing but also by doing

The AIDS support organization (TASO) community engagement practices

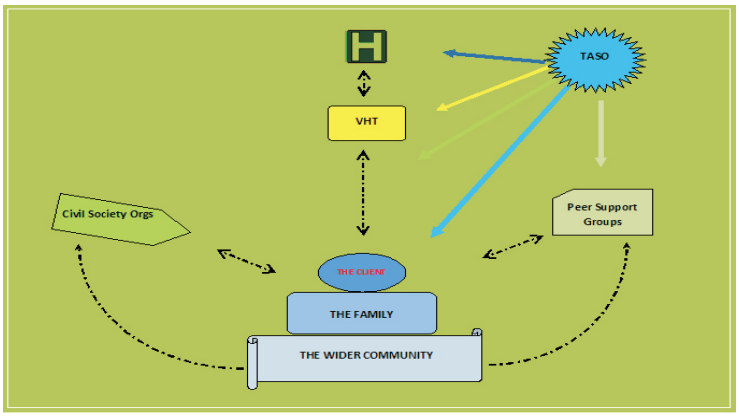
The AIDS support organization (TASO) is an indigenous Ugandan NGO involved in the fight against HIV/AIDS with a vision to see "A World without HIV" in our lifetime. It was formed 25 years ago by people affected by HIV/AIDS and its mission is to "contribute to a process of preventing HIV infection, restoring 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 and advocacy and promotion of positive health, dignity and prevention (PHDP).

Key TASO activities include the following:

- Provide treatment, care and support to 100,000 clients (PHAs) annually through its 11 service centers across country.
- Train over 2,500 health workers (including community volunteers) annually through its four regional training centers.
- Provide training and technical support to various community based organizations in Uganda.

Acts as a channel through 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 and 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 programmes.
- 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 center, etc.
- Community based provision of critical services including ARVs through appropriate distribution mechanisms.

Over the years, TASO has trained 6,000 community volunteers around the country; these provide voluntary services to their community members. Each year, up to 300 members of village health teams (VHT) benefit 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.
TASO community engagement initiatives succeeded because of:

- Involving the communities in the design and implementation of prevention and care services.
- Community based delivery of HIV prevention, care and treatment services that has led to enhanced community access and uptake of those services.
- Involvement of people living with HIV, which helped turn the tide; especially in fighting stigma, and educating the public, and mobilizing community volunteers.

- Task shifting to well-trained lay service providers that has "boosted" the workforce.
- Engaging community leaders which has enhanced services.

Critical success factors that aided TASO's community engagement initiatives include:

- Buy-in and support from national and local leaders.
- Involvement of people living with HIV/AIDS.
- Full engagement with the communities in defining their priorities, agreeing on 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.
- 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 that are a wonderful resource.

Best practices from field experience in six states of Nigeria

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 wife of the governor. 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 behaviours 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

The Rivers State community engagement experience

Rivers State Agency for the Control of AIDS (RVSACA) took on a new dimension to community engagement to improve access to HIV/AIDS services through advocacy and sensitization. The programmes targeted political, community and religious leaders in some LGAs and communities in the state. The NACA, mandated SACAs to step up 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; it was a consultative meeting on ownership of local government HIV response and community driven interventions. This stakeholders' forum was 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 the forum was 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.

A high level advocacy team was established evolving from advocacy meetings held with the Government of River States concerning the high prevalence of HIV in the state. The advocacy effort brought together traditional leaders, some political leaders, religious leaders and local government council chairmen to discuss how they can work together to own the HIV response and drive the epidemic to zero prevalence. In Gokana LGA, a 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 (CACA). The committees were charged with the responsibility of sensitizing community members to 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 youth groups on peer education and supports 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 the 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 Rivers 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 the state. The purpose of the meeting was to seek for 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 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 programmes are ongoing and sustained.

In order to ensure that the project worked, 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 support for the response ownership in their council, wards and community levels.
FHI360 has established one ART centre and seven PMTCT centres 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 Rivers State.

LSACA community engagement initiatives

Lagos State Agency for the Control of AIDS (LSACA) has taken 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, that is, their target was to reach 1.3 million people in the state with HIV/AIDS testing and counselling 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

Lagos SACA recognized the important role traditional leaders play in sensitizing their community members to be more aware of their health care needs if they were to successfully introduce HIV/AIDS services to their communities. Because of the several advocacy to the *baales*, the *obas* and other traditional chiefs in the state, many awareness raising programmes now take place in the palaces and compounds of traditional leaders. This demonstrates their support for community owership of HIV response in the state. They have also taken it to a higher level where even the state governor 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 is a huge support for HIV/AIDS programme at the state and local levels; it encourages community members to venture out for counselling and testing services in their various communities.

Governor Fasola leads the mobile counselling

Working with national association of automobile technicians (NATA)

In every nook and corner of Lagos State, a number of automobile mechanics can be seen at strategic locations; they provide technical services, fixing vehicles of their customers. Because of the important functions of this association and the number of people they meet daily, LSACA targeted them for training on HCT and interpersonal communication (IPC) skills. This community now provide HIV information and counselling services to their peers. They link them to testing centres where they can be screened and provided with additional information for those who test positive and may need treatment.

Reaching out to association of hair dressers and barbers
Lagos SACA and the LACAs have introduced the association of hair dressers and barbers in the state to HCT information and HIV services through 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 attendant clinics
Traditional birth attendants are a very strong element in health care delivery especially among pregnant women in Lagos State. The TBAs have formed an association and many of them operate their clinics from 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 connected with the leadership of this association to sensitize them on PMTCT and train them on universal precautions and referral skills especially when they come accross some clients that test positive for HIV. For example in Agege LGA linkages with the TBAs have worked so well that they have this testimory to share:

> *"More people now access HCT services in the LGA due to the sensitization conducted, we recorded more people in 2012 – 1,711 as against 1,082 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 fortnightly meetings."*

The LACAs have also conducted outreach programmes to community development associations and community development committees. They use these structures for appropriate HCT information sharing, linking them to available health services in their communities. They similarly conducted outreach programmes to market women association on 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

Interpersonal communication training for youths and mobile outreach
The youths are a strong group in Lagos State; they are often the most vulnerable group with regards to discussions on HIV infection. The LSACA through the CSOs have provided counselling skills to youths in the state who are now peer educators. They mobilize clients for testing during community based HCT outreach, World AIDS day

and other HIV sensitization programmes. They also work with CSOs and AIDS action managers to provide HCT services targeting some most at risk populations , especially in locations where they meet for social activities under the shadow of darkness. The mobile HCT service is taken to such gatherings and counselling and testing services are provided to them. 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
Alimosho LACA works with Sweet Sensation, a resturant in Lagos, to provide food for some support groups during their monthly meetings. This is a means of providing nutritional support to these members It has encouraged many support group members to renew their efforts to attend monthly meetings and interact with peers to share coping strategies.

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

Outreach to prison inmates and prison workers
Lagos SACA has not left the inmates behind in their awareness raising and HCT services. They have trained 130 HCT counsellors 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.

Community engagement – The Abia state experience
In a bid to improve access and uptake of HIV and AIDs services, the Abia State Agency for the Control of AIDS (ABSACA) employed the use of town criers/announcers to provide information to the community on the available health services. The town criers were trained on HIV/AIDS and general health related issues (this approach was adopted because the town criers are known to the people, the people can easily relate and identify with them, they speak 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 centres.

The use of sporting activity (such as football)
This strategy was adopted by the 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 raise 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)

Engagement with TBAs and facility-based volunteers – FHI360 experience:
FHI 360 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 and PMTCT/HCT services to pregnant women.

The TBAs were trained on HIV prevention and how to take precautionary measures, provide counselling services, referral and linkages to pregnant women who test positive to comprehensive sites in their areas of operation, they also ensure that TBAs buy into the SIDHAS project. The acronym, 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 PMTCT/HCT volunteers that were engaged, support facilities to conduct outreach programmes in communities, mobilize community members for HIV/AIDS services, provide counselling and testing services to TBA clients and refer clients with difficult cases for further investigation and treatment at comprehensive sites closest to their areas of operation.

Engagement with community based organizations
Faith-based and community based organizations are important resource in the community, because they are on the front burner of the HIV response. The approach of engaging community organizations has been adopted by FHI 360 to mobilize the community effectively to access and uptake HIV/AIDS services. FHI 360 currently collaborates and works with three credible and efficient community based organizations in the SIDHAS project to provide improved access to HIV/AIDS services in various communities; and provide care and support to PLHIV. FHI - 360 provides financial and technical support to the selected community based organizations on a regular basis.

Formation of client tracking team
FHI 360 has helped in the formation of a client tracking team which is made up of facility based staff to track defaulters' who do not follow up. This practice has helped to track down positive clients who have died as well as those on transfer and those that have been brainwashed by their pastors to discontinue treatment, to return and continue with their treatment. The tracking team also uses facility based 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 stand-alone 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.

Community engagement practice – The BENSACA experience

Engagement of IPC conductors in 23 LGAs

Benue State Agency for the Control of AIDS (BENSACA) adopted an ingenious strategy to community engagement in order to improve access to HIV/AIDS services. The strategy involved training of 400 community volunteers (two persons in each ward) as interpersonal communication conductors in the 23 LGAs in the state. The IPC conductors were trained to raise awareness on HIV, mobilize community members to access services in health facilities, and provide linkages between community members and available services. The IPC conductors are community volunteers who were trained by some IPs in the state. They meet on a monthly basis. The IPC conductors are monitored by the LACA coordinator and a M&E team once a month.

In order to ensure that the strategy works, the executive director of the Benue State Agency for the Control of AIDS, along with team members trained LACA coordinators and M&E officers. The training was to ensure effective implementation of prevention strategies by community volunteers (IPC conductors) in the state. They established indicators for monitoring performance of the IPCs at the various LGA, community and ward levels, as well as how to obtain their full support for the response ownership in their council, wards and community levels. This engagement has helped in the reduction of stigma and 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 wives of LGA chairmen

The promising strategy of the Benue State Agency for the Control of AIDS involved building synergy with wives of local government chairmen, gender desk officers and LACA coordinators in promoting PMTCT services in Benue State. The Executive Director of Benue State AIDS Control Agency along with team members held a three-day stakeholder forum to sensitize these groups of people on the need to improve access to PMTCT pediatric ART services in Benue State. The forum helped to build synergy between SACA, wives of local government chairmen, gender desk officers and LACA coordinators in providing the needed support for promoting and improving PMTCT in the state.

People in the community are urged to use the health facilities in various communities through LACA stakeholders forums. The LACA stakeholder's forum is held on a monthly basis and are attended by key stakeholders in the LGA such as traditional and religious leaders, village heads, community drivers of change, community development committee chairmen, women groups, LACA members e.tc they discuss barriers 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 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 visit wards, markets, schools, churches with mobilization messages to inform men, women and children of available services and where they are.

Community involvement and impact

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

Women groups/Associations in Agatu LGA

The women groups or associations are formidable groups in the various communities. They help in mobilizing community women, especially their members to access 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 and build pit latrines as part of waste management. They also enforce some fine on members especially clinic defaulters.

Kebbi State community engagement practice

Kebbi State Agency for the Control of HIV/AIDS (KSACA) works through traditional institutions and community leaders to stimulate community engagement of HIV/AIDS services in the state. They work with the *emirs* as agents of change, and use these traditional institutions as opportunities to attract community members to use health facilities and services. Consequently, 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 and 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 the royal highness, district heads, chief *imams* and LGA chairmen
- Sensitization of traditional and religious leaders
- Holding of seminars with traditional, religious and political leaders
- Training workshop for women community volunteers for HIV/AIDS campaign
- Sensitization in Islamiyah schools for women
- House to house HIV/AIDS prevention campaign

Working with traditional birth attendants to raise 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 the state. The TBAs have been trained on HIV/AIDS counselling and home-based care and support services. They also link their clients to support groups in the various communities.

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