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PREFACE

This package of four (4) modules has been designed to help sub-national level local government agencies, civil society organisations, and community groups to start or accelerate and implement a local-level response to the HIV/AIDS epidemic. Developed in Ghana in 1999 for the District Response Initiative on HIV/AIDS, the package has had the benefit of several revisions as a result of feedback from several sub-Saharan African countries implementing Local Responses to HIV/AIDS. The modules can thus be easily adapted for those countries wishing to implement local responses, or specifically, the District Response Initiative (DRI).

The concept of this facilitated package is the result of two related and complementary developments. First, was the realisation that scaling-up the District Response Initiative through intensive technical support was time and resource consuming. Second, was the increasing demand from local stakeholders in several countries for strategies to respond more effectively to HIV/AIDS and the need for reliable institutional processes through which to implement national strategies and channel both technical and financial resources.

The team charged with developing the modules has worked extensively with UNAIDS and national co-ordination bodies on strategic planning and management for HIV/AIDS whilst facilitating implementation of programmes at district level. Lessons drawn underscore the necessity for flexibility of approaches and tools.

Thus this facilitated DRI package has been developed as an evolving tool to respond to the changing pace of the epidemic. It is hoped that users will provide useful feedback for the further enrichment of the modules. It is sincerely hoped that the package will enable stakeholders to generate and sustain their own local institution and community based responses to HIV/AIDS. Finally, it is the wish of the team that the use of the modules will facilitate a more rapid expansion of local responses so that the fight against HIV/AIDS will be rapidly taken to every community where, indeed, the war against HIV and AIDS will be won or lost.

MODULE 1
INCEPTION REPORT AND ADVOCACY

1. INTRODUCTION

Module 1 guides the user through the inception phase of the District Response Initiative (DRI) and provides start-up information guide on local advocacy for HIV/AIDS.

2. DRI INCEPTION REPORT

The Inception Report is a document that combines elements of the HIV/AIDS **Situation** and **Response Analyses** for the district. It is designed to provide an examination of the district in relation to the HIV/AIDS epidemic. The information it contains will form the basis of continued dialogue and action, as well as the formulation of a Strategic Plan for HIV/AIDS.

Experience suggests that the development of the Inception Report creates what is likely to be the first time, a wide spectrum of local-level stakeholders (public and private) assemble to discuss HIV/AIDS and its impact. In itself, this is an accomplishment and enriches the production of the report.

The document is to direct planning efforts to reduce the district's vulnerability to the HIV/AIDS epidemic and design effective strategies to meet the continually mounting developmental challenge it poses.

The format suggested in the following pages is a means of standardising the output of the many and various districts undertaking a local-level response to HIV/AIDS. It will enable those at the regional and provincial levels to familiarise themselves with the situation in each particular district, identify and anticipate problem areas as well as assess regional trends in vulnerability and offer meaningful support.

This format, and the prompts it contains, should be used in conjunction with the DRI ***Guide for Documentation and Report Writing*** to be found in the Facilitators Guide. These, along with the experience, knowledge and insight of the Team members, and information obtained through Community Assessments (Module 2), should produce an Inception Report of clarity, depth and influence. *Alternatively for a quickened DRI start, a Local Profile may be produced in place of the Inception Report. This is a summarised report on the districts HIV/AIDS situation, response, gaps, and impact on the district. A format is attached as Annex 1.*

In writing the Inception Report, the following structure may be considered:

2.1 Preface

This section of the report should give a broad overview of who was interviewed and who offered assistance in order to complete the task. Both public and private contributions should be highlighted. It could start with:

We wish to acknowledge the co-operation and assistance given by. ..... .

The district's address should be inserted to accompany that of the Ministry or overall responsible national body, to enable those who read the Inception Report and are interested in further investigation or clarification to contact any of the sources given.

2.2 Introduction

This section of the report should introduce the document to the reader. To do this effectively you will have to provide background on:

1. What this document is and what it intends to do?
2. With who and for whom was it written?
3. What was the procedure for writing the document? How did you go about it? Who was interviewed? What documents were consulted, etc.? (Annexes 2 & 3 provide a suggested list of people to be interviewed and documents to be consulted)
4. How is the report constructed? What does each section cover?

2.3 District Demographic & Economic Profile

2.3 .1 Geography & Demography

This section should cover the physical features of the district that may have some bearing on the spread of the HIV/AIDS epidemic, e.g. small land area, shared borders, physical features such as high mountains or swamps, etc.

Population size and densities should also be covered, as well as the age and gender distribution pattern for the district. Include the percentage of people living in rural, as compared to urban areas.

2.3.2 Local Economy

What elements make up your district's economy and what percentage of the population (both males and females) is engaged in each? What is the cost of living? How many households are below the poverty line? How do people (again, males and females) make ends meet?

2.3.3 Mobility & Migration

Is there a high degree of mobility in the district? If so, from where to where, why, when and how often? What forces people to move either temporarily or for longer periods of time? What is the road network like? Is it easy to move throughout the district, is movement restricted by road condition or season? Who are the mobile segments of the population? Where do they go? Is movement generally within the district or from out of the district, or from outside into the district?

Socio-Cultural Factors

What are the cultural factors, either presently or historical, that promote or inhibit the epidemic? Are there cultural occasions that bring great numbers of people together at a particular time, e.g. festivals? Are there cultural practices that accelerate or restrict sexual knowledge, introduce persons to adulthood earlier, promote or restrict mixed sex behaviours, or reinforce certain gender biased occupations or services? Are there other socio-cultural influences that are important within your district?

2.4 Social Sector Analysis

2.4.1 Education

Facilities and Enrolment **-** What educational facilities (including tertiary institutions) are available in your district? What is the enrolment, by class and by gender? What percentage of school going age does this enrolment figure represent? What is the percentage of students that come from outside the district? What are the drop out rates (for boys and girls) and the reasons for drop out? What percentage of the district's annual budget is spent on education?

School Health Programmes **-** What health programmes (national or district initiated) are run in the schools? How often? Is there any HIV/AIDS-specific content in these programmes? About how many students are reached each term, each year, by these programmes? Who collaborates (or does not collaborate) in putting on programmes in the schools?

2.4.2 Health

Facilities **-** How many health facilities (both public and private) at the various levels are available in the district? How many health sub-districts are there? What is the main referral hospital(s) in the district? How many pharmacists are there in the district? How many chemists?

What types of services, which may be related in some way to HIV/AIDS, are available at these facilities (i.e. antenatal, MCH/FP, STD treatment, etc)?

***Personnel* -** What is the Health staff composition at the district? Is there a doctor(s) on the staff? How many nurses are on the staff? How many are community nurses?

***Programmes and Activities* -** What HIV/AIDS or HIV/AIDS-related activities have been planned? How many were actually carried out? Programmes could include actual IE&C programmes, in-service training for staff, recruitment and training of community staff, intensification of Family Planning (FP) activities, etc. These should be stated for each of the last two years to give some comparative data.

Disease Control

- *STD/HIV/AIDS:*

What is the HIV/AIDS prevalence rate in the district? Where is testing carried out? Is there pre- and post-test counselling for those tested? Is there private sector testing? Are these figures incorporated into the district/local health authority figures? How many HIV positive cases has there been this year? Last year? Where are laboratory facilities located? Are figures for STDs disaggregated? What is the prevalence for ulcerative STDs? Are there gender-disaggregated figures for STD treatment, for HIV/AIDS cases?

- *Tuberculosis (TB):*

What are the figures for TB cases this year? For last year? What are the gender-disaggregated figures for both years? Has there been an increase or decrease?

***Utilisation* -** What was the total OPD utilisation for this year (to date)? Does this represent an increase or decrease (by how much) over last year's figures? What was the figure for last year? What is the number of antenatal registrants for the year, and for last year? Is this an increase or decrease?

***Traditional Medicine* -** What are the most commonly used forms of traditional medical practice? Are there any linkages, formal or informal, between orthodox and traditional medicine? Is there any formal or informal referral system? What is the character of the relationship between the orthodox and traditional medical fields (co-operative, antagonistic, suspicious, etc.)?

***Information Collection and Sharing* -** Where are all the sources of information on: HIV/AIDS incidence and prevalence, STD treatment, AIDS-related deaths, HIV+ blood screening, HIV+ antenatal cases, childhood HIV/AIDS cases, etc.?

***Finance* -** Is the District Health Administration a certified cost centre under say Sector-wide program? What was the health sector budget for the last two years? What was the revenue collected in the same period? How much in terms of donor funds has the district health sector received in the last two or three years. Is there a consistent budgetary allocation for HIV/AIDS? If so, what is it?

2.4.3 Social Welfare

***Activities and Operations* -** What is the department's action plan for this year, and last year? What proportion of staff time is spent for each of the Social Welfare programme components (i.e. Child Rights and Protection, Justice and Administration and Community Care)? Is the district staff involved in any district initiative that is HIV/AIDS or health-related? If so, what is it, and who initiated it? How effective (and frequent) have been the office's outreach programmes?

***The District Social Welfare Office* -** What is the staff complement at the office (professional and support)? Has there been much staff turnover? What equipment/furniture is there? Is the office located in the same block or compound as

the Assembly or Administration, or is it far away? What is the character of the relationship between the District Assembly and the Social Welfare Office? What is the character of the relationship between the Social Welfare Office and the communities/Traditional Authorities? What collaboration on activities has there been in the past, or is presently?

2.5 Local Institutional Environment.

2.5.1 Revenue

Is the revenue base of the district strong or weak? What are the traditional sources of revenue? Is revenue collection effective or ineffective? How much of the district's budget is spent on the social sector (health & education in particular)?

2.5.2 Institutional Arrangements

Are there any local level institutions below the district? What are their areas of interest?

2.6 District Development Plan & Implications For HIV/AIDS

Under this heading, there should be an analysis of the district's development plan relative to the impact of planned activities on HIV/AIDS. In short, this should be a section-by-section impact assessment of development on HIV/AIDS in the district. Each component of the plan should be described along with its objectives. This should be followed by an analysis relating the component as described to the HIV/AIDS epidemic. Below are some examples of issues and questions that need to be considered.

2.6.1 Social Development

What impact might educational programmes have on HIV/AIDS in the district? What about health sector or youth programmes? Will other programmes increase or inhibit migration or rural-urban drift? What implications might this have?

2.6.2 Economic Development

Creating an industrial estate within the district could bring into the district large numbers of imported labour, greater commercial traffic with large numbers of truck drivers staying over in the area while loading or off-loading and, with more wage earners in the district, there may be a commensurate increase in commercial sex workers.

2.6.3 Infrastructure Development

Feeder road development may have certain positive economic benefits but it has a number of hidden impacts on HIV/AIDS: opening areas to greater amounts of road traffic bring more people into formerly restricted areas, increasing exposure to negative social factors like casual or transactional sex; frequency of traffic into and out of the remoter rural areas will increase, increasing also the frequency of exposure to negative social factors; development of roads requires workers to be engaged along the route for extended periods of time, usually away from home, and may engage in casual sex in towns along the way, or in an urban centre on pay day, etc.

2.6.4 Environmental Development.

If the thrust of the component is to maintain the environment by increasing good environmental practices by extending education to more farmers and hunters in the rural areas, then this objective may be an opportunity to disseminate HIV/AIDS material and IE&C to communities as well as solicit their views on the issue.

2.6.5 Spatial Development.

Increasing service delivery to zonal hubs will increase the populations moving to these areas. An increase in the population of any one particular area means an increase in the population density. Population density may have a negative impact on the HIV/AIDS epidemic by bringing large numbers of people together in an environment of limited employment and increased cost of living.

2.7 Community Vulnerability Assessment

This section is a combination of three elements. First, the preliminary analysis of determinants and the vulnerability assessment done as part of the first consensus building meeting should form the basis. Second, what is learned throughout the process of analysing the documentation and interview material should deepen the understanding. Third, the information and analysis from the community assessments should provide an additional perspective that should also find representation in the vulnerability assessment.

2.8 Impact Of The Epidemic On The Local Level

This section should state what local impact there has been if known. It should also look forward to what the impact of the epidemic is likely to be on the local economy, the workforce, demography social services (schools, health services etc.) and social cohesion. Any planned impact studies should be noted.

2. 9. Analysis Of Opportunities For Local Response

Each sub-section should be built around three things: 1) the situation (e.g. staff, experiences, knowledge, success, failures, strengths and weaknesses, etc.), 2) the response (e.g. current and planned HIV/AIDS programmes, partnerships, budget allocations to HIV/AIDS activities, etc.), and 3) where their comparative advantage lies. The sub-sections are:

- *The District and Decentralised Departments.*
- *International Agencies,*
- *NGOs.*
- *Community Based Organisations.*
- *Traditional Authorities*

The Inception Report does not attempt to make a comparative study but, broadly, where do organisations (even individuals) under these classifications fit into: A) management or B) implementation. Is the organisation more suited to planning, monitoring and evaluation, or resource mobilisation (and thus Management), or to IEC, community mobilisation, training, etc. (and thus implementation)?

2.10 Conclusions

What conclusions can be drawn from all the preceding information and analysis? This is an opportunity to point out weaknesses or gaps that have been revealed through the writing of the Inception Report. It affords a place to point the way forward and make some preliminary recommendations in terms of how the response can be strengthened, where efforts might have the most benefit, and what is necessary for the DRI to take off in the district.

2.11 Locally Proposed Actions For DRI

Specifically, what are the next steps for the DRI? What actions are going to take place, how soon and when? Knowing a basic timeline, you will be prepared to forecast activities somehow and describe where the district wants to be within the next few months.

2.12 List of References

List all references cited in the drafting of your Inception Report including all documentation collected and consulted, as well as all other material that had an informative role to play.

2.13 Local Contacts

List all the people with whom discussions or interviews were held in the process of researching and writing this Inception Report for any follow-ups that will be required. A format for this contact directory is provided as Annex 4.

3.0 USING ADVOCACY: A GUIDE FOR PRACTITIONERS

This guide is a modified and condensed version of the UNAIDS document: _Using Advocacy to Support the International Partnership Against AIDS in Africa: A Guide for Practitioners_, published in Geneva in 1999. The modification has been done with a view of making it relevant to the local context while keeping the original concepts.

Advocacy is an important and powerful tool and to be applied effectively it must be understood. The UNAIDS guide represents some of the current thinking on the subject and will provide a firm foundation for advocacy in support of the District Response Initiative, and beyond.

3.1 Introduction to the Guide

This guide is intended as a practical tool for those planning and implementing advocacy activities within the framework of a district response to HIV/AIDS.

Many of the world's most effective advocacy movements have been led by "ordinary people" who are well informed, committed, and affected by an issue or situation.

The most successful advocates:

- Maximise their resources by carefully choosing target audiences that carry particular weight within the country or a local community.
- Package their advocacy arguments to make them compelling to their audience.
- Develop messages and strategies to move target audiences to action.

This guide discusses effective advocacy strategies and tactics, such as organising advocacy campaigns, collaborating with other organisations, meeting with political leaders, developing effective materials, and working with the media.

3.2 What Is Advocacy?

Advocacy is communication designed to get specific target audiences (e.g. political leaders) to show commitment to specific ideas (e.g. AIDS as the greatest threat to Ghana's survival and development). This commitment may be demonstrated through active propagation of the advocacy view, legislation, or making financial contributions. Successful advocacy involves changing the *status quo* by winning more influential audiences and leaders over to the side of the advocates.

Advocacy is not advertising or public relations, or media relations, or community communication *per se*. It uses these tools to achieve its primary task of getting targeted audiences to lend their support to specific causes (e.g. AIDS communication) through creation of better understanding of the issues (direct and implied) and the engendering of commitment to putting AIDS on the public's agenda.

Advocacy does not always go unchallenged. There are often persons or institutions that act to discourage the change supported by the advocate. Advocates on AIDS can face both inadvertent and conscious opposition.

TEN OBSTACLES FOR ADVOCATES TO OVERCOME

1. ***Denial*** *- the refusal of political and opinion leaders to acknowledge or respond to HIV/AIDS.*
2. ***Fear*** *- fear of becoming overwhelmed, fear of political opposition, fear of negative publicity, fear of social rejection, fear of the stigma attached to HIV/AIDS.*
3. ***Inadequate information*** *about the extent of HIV/AIDS or its true impact.*
4. ***Insufficient resource allocations*** *for health care, social services, or accessible Voluntary Counselling & Testing.*
5. ***Failure to protect the human rights*** *of persons living with HIV/AIDS.*
6. ***Uneasiness over public discussion of sexuality****, and over the challenging of cultural and social taboos.*
7. ***Fatalistic attitudes*** *and the belief that the further spread of HIV/AIDS is inevitable.*
8. *Concern that expanding the response to HIV/AIDS will absorb a* ***disproportionate amount*** *of scarce public funds.*
9. ***Failure to pursue policies*** *that are known to be effective.*
10. ***Failure of the international community to adequately respond*** *to the emergency nature of the AIDS crisis.*

3.3 Planning an Advocacy Campaign

A successful advocacy campaign requires clear articulation of the guideposts for action:

- Principles
- Vision
- Goal
- Objectives

3.3.1 Principles

Advocacy principles are broad statements of intention that help guide advocacy planning and action. Successful advocacy strategies will be constructed around a set of shared principles.

3.3.2 Vision

The advocacy vision provides a unifying idea for the planning and articulation of goals, objectives, strategies, and tactics. A clear vision, based on principles, enhances the ability of advocates to work together and guides important decisions by advocates.

3.3.3 Goal

The advocacy goal elaborates on the vision by adding important information on the *what* and *why*. Internally, the advocacy goal helps to keep advocates focused on their central purposes. Externally, it summarises the advocacy programme for the benefit of outside publics, such as community groups, the media, audiences, and partners.

3.3.4 Objectives

Advocacy objectives provide the specific, measurable steps towards reaching our goal. Objectives usually identify specific actions to be undertaken and timeframes for their completion. Objectives can be categorised as:

- Short-term (to be achieved in the immediate time period, e.g. one year or so);
- Medium-term (to be accomplished in the not-too-distant future, e.g. two/three years);
- Long-term (to be accomplished in a relatively distant time, e.g. five years).

They can also be further categorised into:

- Geographical scope: (e.g. national, regional, international);
- Target audiences: government officials, NGO and private sector operatives;
- Purpose: building awareness, expression of commitment, increasing public dialogue, or taking specific actions such as fundraising or promoting legislative amendments.

3.4 Building Effective Advocacy Partnerships

Certain guidelines are pertinent in the building of a successful partnership:

- *Be inclusive.* Everyone involved in the partnership must feel that his or her opinion will be heard and respected.
- *Agree on clear objectives.* Successful partnerships set goals, and members agree that all activities are designed to accomplish these goals.
- *Decide how decisions will be made.* Partnerships often operate by consensus. Where consensus is not possible, some partnerships allow a majority or "super-majority" to carry the day. In either event, clear rules about decision-making are very helpful.
- *Adopt strong communication mechanisms.* Partnerships may wither when some members feel they are outside the communications "loop." Therefore, it is vital to find effective means to communicate important group news to members.
- *Plan for disputes.* Assume that disputes *might* arise within the partnership. Although they may be upsetting and time-consuming, disputes may also indicate the passion that partnership members have for the partnership and its activities - a good thing when it comes to advocacy. Partnerships that find ways to work through disagreements tend to be stronger afterwards. Unless you are willing to see group members walk away, try not to allow disgruntled members to remain isolated too long.

3.5 Advocacy Strategies

A good advocacy strategy turns visions, principles, and objectives into action. It provides a broad plan and approach for achieving the advocacy objectives.

Advocacy strategy development should define:

- Key facts from the situation analysis, and the primary advocacy problem(s) (e.g. lack of sufficient commitment to AIDS campaigns by specific groups).
- Goal and key communication objectives (outlining aims to be achieved through communication, e.g. awareness, actions, fundraising, expressions of commitment, etc.).

  People in an advocacy partnership need to have a common mindset about the strategies and methods to be used. To this end, agreement will be needed in, among others:

- *Advocacy orientation:* the organisation of consultative meetings, workshops or brainstorming sessions to produce plans of action relating to the vision, goal, and objectives.
- *Leadership and group dynamics:* to get opinion and/or political leaders to "lend their voices", there is need to understand leadership dynamics in different communities and to identify targets.

- *Modern publicity methods:* a modern campaign is an integration of marketing, advertising, public relations, news making, community mobilisation, and other IEC methods. Advocacy is central to its success. Examples of these from the private, public, and NGO sectors may be usefully adopted.
- *Local resource mobilisation:* all communities have at least some of the vital resources necessary for successful advocacy. Local resources will need to be identified to ensure that local actors claim part ownership of the programmes.
- *Bad press and negative publicity:* advocacy may backfire or draw negative responses from some publics. There is therefore the need to agree on how to manage bad press reportage and negative publicity.
- *National culture and communication - facilitators and constraints:* as in every situation of social change, some aspects of national or local culture that can facilitate advocacy; there are as many that can work against it.
- *Dealing with failures and opposition (government and public):* advocacy may fail. Confrontation and antagonism may be encountered instead of support, for reasons that might not be advocacy-related. It is helpful to know of past and present advocacy successes and failures.

3.6 Identifying Advocacy Targets

With limited resources, the most effective advocates select a limited number of targets, prioritising key individuals and organisations that are most likely to influence policy makers and public opinion. Understanding and focusing on the desired audience is a key to successful advocacy. What follows is a list of influential groups or sectors that exist in most societies. While it pays to focus on these sectors, there is no single recipe for effective political action.

3.6.1 Political leaders and Government officials

Success in responding to HIV/AIDS rests on the ability to galvanise political leadership such as heads of state and government officials to generate a significantly greater level of political and public commitment to an accelerated response.

Sometimes, civil servants may best influence policies related to HIV/AIDS, though the advocacy message may need trimming because civil servants sometimes have influence over only one component of HIV/AIDS policy.

3.6.2 Opinion Leaders

People with little or no influence on public policy-making bodies may yet be able to mobilise public opinion. They may be sports figures, music artistes, writers, academics, etc. Advocates can encourage such individuals to speak out publicly on HIV/AIDS and to encourage others in their fields to do so as well.

3.6.3 The Media

The media can carry a sense of urgency around an accelerated response in challenging ignorance and denial. They play a key role in setting the political agenda.

3.6.4 People Living With HIV/AIDS (PLWHA)

People living with HIV/AIDS are an important resource, and advocates benefit from routinely integrating people with HIV/AIDS into their activities. Their human-interest stories will prove compelling to advocacy targets; they will again have a clear understanding and knowledge of the most influential people and institutions in the locality, region, or country.

3.6.5 Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs)

A broad range of national sectors can play an effective role in the fight against HIV/AIDS. Key networks of support and advocates need to be identified in the non-governmental community and plans drawn up to involve them in the promotion of

issues on which they have particular expertise or influence. However, given the tension that often exists between governments and NGOs careful consideration may need to be given to how partnerships can best be structured in this area.

3.6.6 Religious Leaders

Meetings with key religious leaders and with lay groups that have influence on religious institutions can also be effective. Advocates can emphasise the impact of HIV/AIDS on the national or local population and religious leaders can be encouraged publicly to display compassion toward persons living with the disease. Religious entities that have social welfare or relief operations can be encouraged to integrate HIV-related services into their activities, to the extent they have not done so already.

3.6.7 Business Groups And Trade Unions

Business groups or individual companies need to be approached to be sponsors for local-level responses and become involved in community and workplace initiatives. National business associations should also be approached, as well as multinationals with interest in the area. Trade unions can become powerful allies.

3.6.8 Young People

If the objectives of reducing the transmission of HIV among young people are to be met, a special effort must be directed at them.

3.6.9 AIDS Researchers

AIDS researchers could become an influential group of partners. They could be approached to set an emergency research agenda for addressing the special needs of the response.

3.7 Message Development: Marshalling Your Facts

Effective advocacy depends on *facts*. Unless you are able to prove you know what you are talking about - and that what you are talking about is important to you - the persons you are seeking to influence have little reason to heed your message.

UNAIDS publications. UNAIDS and its co-sponsors produce a large number of publications, reports and briefing materials on a regular basis. The UNAIDS/WHO *Report on the Global HIV/AIDS Epidemic*, for example, published every two years provides an overall analysis of the state of the epidemic. It includes country-by-country data on population, reported AIDS cases and HIV prevalence in key populations, number of people living with HIV, number of AIDS orphans, and AIDS deaths. The UNAIDS "Best Practices" series of technical updates, points of view, case studies, policy guidelines and other key materials is also a rich source.

3.8 Key Advocacy Messages

For local-level responses to effect real change, they must successfully transmit two key messages to advocacy audiences and those whose actions can affect the response locally and nationally:

- *AIDS in the nation is more than an epidemic. It is a human and development crisis. The country's present and future development are being threatened by the rapid spread and spiralling consequences of AIDS.*

Our advocacy must emphasise the impact of HIV/AIDS on adults, children, families, communities, economies and future development.

Effective measures to meet this emergency exist. Today, a new political momentum gaining ground in the nation and across Africa represents a unique opportunity to scale-up effective action to curb the epidemic and alleviate its disastrous impact.

Our advocacy must convince policy makers and those who can influence them that actions can be taken to help bring HIV/AIDS under control. It must emphasise the successful examples of effective HIV policies in Africa and the country, the willingness of donors and multilateral institutions to work in solidarity with the country, and the specific steps

that each advocacy target must take in order to support the goals of local responses.

All messages need to be adapted to address the specific target audiences that are being addressed and to the local situation.

3.9 Packaging the Message

Facts may be essential to effective advocacy, but facts alone are not sufficient. The advocate's challenge is to make his or her messages stand out from the universe of information. An HIV/AIDS fact sheet could help in Advocacy. An example is shown as Annex 5.

3.9.1 Make Them Relevant

Messages are most compelling when they are tailored to the specific interests of your audience. Depending on your target group, you may want to focus on the economic impact of HIV/AIDS, the role of STD control in the fight against HIV/AIDS, or the impact of the epidemic on households and the district.

3.9.2 Make Them Strong

HIV/AIDS is already wiping out development gains in Africa that took decades to achieve. Remember that your advocacy should try to generate an *emergency-style* response.

Your message will be strengthened - and your audience more likely to be moved into action - if you successfully communicate the human dimension of the epidemic. Good ways to do that include using the personal story of a person living with HIV/AIDS to illustrate the point or, better yet, having such a person accompany you to key advocacy meetings.

3.9.3 Make Them Positive

While it is important to emphasise facts and statistics that convey the seriousness of the epidemic, it is also important to emphasise progress and hope. Use messages that highlight success stories and accomplishments, to show that action against AIDS does make a difference.

3.9.4 Keep Them Simple

One of the greatest challenges for advocates is developing clear and simple advocacy messages.

Advocacy messages are most effective when they are clear, to the point, focused on a desired outcome and easy for a layperson to understand.

- *Poor presentation:*
  In 1998, HIV incidence among girls aged 15-19 in the southern region was determined to be 8%.
- *Better presentation:*
  In the southern part of our country, one in 12 girls between the ages of 15 and 19 became infected with HIV last year.

In addition, do not assume your audience understands the implications of your arguments. If you intend your audience to draw a particular conclusion, it is usually best to state it.

3.9.5 Make Them Politically And Culturally Sensitive

HIV/AIDS advocacy work addresses sensitive issues that may stir controversy or provoke confrontation. In general, it is best for advocacy to be presented in non-political terms.

3.9.5 Write Them Down

Conversations alone can occasionally persuade, but advocacy meetings will be more effective if you leave some written materials behind. Written information reinforces your verbal message, and also serves as a later reminder that prompts the reader to action even in your absence.

3.9.10 Make Them Interesting

Lead with the principal message, use statistics to illustrate the point, then remind the reader of the conclusion. Keep written materials brief. Graphs and pie charts are sometimes clearer and more persuasive than words alone.

3.10 Advocacy Tactics

The best tactics will depend on the problem and resources available for meeting the advocacy objectives.

For example, the support of policy makers and opinion makers is frequently a key element in the success of advocacy. Useful tactics are:

- Categorising policy makers and opinion leaders based on their history of involvement in AIDS issues. Design an advocacy map of those to approach for their support.
- Identifying the best "lever" for obtaining the support of the specific target audience: people are usually motivated by self-interest.
- Anticipating for counter-arguments to your advocacy position.

3.10.1 Making Presentations

Delivering a strong oral presentation can go a long way in building advocacy support. Public conferences, meetings, and press events offer an important platform for reaching key audiences.

In general, it is best to limit the length of your presentation and to always leave time for questions.

3.10.2 Checklist For Making A Presentation

1. *Know your audience*. Your presentation should include information they want to hear, but not only what they expect to hear.
2. *Know your topic*. Have plenty of information and be prepared to give examples and answer questions.
3. *Do not try to improvise*. Even the most experienced presenters develop an outline and think about what they are going to say.
4. *Headline your presentation*. Tell them what you are going to tell them, tell them, and then tell them what you have just told them.
5. *Be enthusiastic and energetic throughout your presentation.* Make your talk come alive by using illustrations, analogies and personal observations.
6. *When possible incorporate attractive, easy to understand visuals.* Make sure they are clear and complement your talk effectively.
7. *Finish on a high note.*

3.10.2 Exercising Interpersonal Influence

Presentation may also be made on a one-on-one basis or in a small group e.g. ministers, directors, chief executives of private sector organisations and NGOs, the media or community leaders.

3.10.3 Organising Events

Events, such as World AIDS Day, can also be a platform for raising awareness about HIV/AIDS and for reaching out to target audiences. Consider inviting leaders from target audiences to visit and participate in such events. The attendance of important figures or government officials may also make the event more enticing for the media

3.10.4 Organising And Participating In Conferences

Summit meetings and conferences that address issues related to HIV/AIDS offer an excellent opportunity for target audiences to meet and learn more about relevant advocacy work. Seeking a speaking opportunity at such an event, or ensuring that your advocacy materials are distributed there, may help to bring positive and productive attention to the cause.

3.10.5Arranging Field Visits

One of the best ways for advocacy targets to learn more about HIV/AIDS is to visit sites and facilities working on AIDS issues. Through on-site visits, target audiences can gain a direct insight and understanding of the work you do.

3.11 Using The News Media To Strengthen Your Advocacy

Newspapers, television and radio play an important role in shaping public perceptions and defining political agendas. Devising a media strategy and integrating media

relations into your work can be key to successful advocacy.

3.11.1 Making Media Lists

A working media outreach list is the foundation of your efforts. A strong media list should include:

- Reporters from national newspapers who regularly cover HIV/AIDS or health or development issues.
- Editors of national newspapers.
- News programmers from national/local radio stations.
- Reporters and/or news programmers from television stations.
- Reporters and/or bureau chiefs for leading international news organs, such as CNN, BBC, VOA, Reuters, etc.

The media list should include the name of the reporter or editor and the media outlet(s) they work for, along with his/her address, telephone number, fax number, and (where available) e-mail address. You will need to call the newspapers and radio/television stations to obtain and/or verify contact information.

3.11.2 Creating Media Advisories

The media contact list will serve as a critical reference guide for all your media activities. Its principal purpose, though, will be to ensure the widest possible distribution of media advisories and press releases. A media advisory does exactly what the name implies - it advises the media about upcoming newsworthy events.

Many types of events are appropriate subjects for media advisories, including speeches, press conferences, World AIDS Day events, etc. For example:

- Advocates might work with national health officials to plan a press conference to announce the latest HIV/AIDS surveillance figures.
- To highlight the role of religious leaders in the response to HIV/AIDS - and to encourage other religious leaders to take part.
- Public events planned for World AIDS Day may provide a good opportunity to get political leaders to make site visits.

3.11.3 Issuing Press Releases

Press releases are most useful for explaining a news story in more detail. For example, when a new local HIV/AIDS activity or programme is initiated, you may want to distribute a press release that describes the main features of the activity or programme.

Checklist For The Preparation Of A Press Release

√ A press release should provide the who, what, where, when and why of the issue or event being promoted.

√ A good press release is succinct, usually no longer than two pages.

√ The best press releases begin with a powerful headline that grabs the reader's attention and summarises the most relevant information.

√ Print the release on special letterhead along with the office's address, phone, and fax numbers.

√ Always try to include strong quotes from top government officials, directors or chief executives and/or other HIV/AIDS advocates. Quotes offer a good opportunity to add variety and a human perspective to the issue.

√ To draw reporters' attention to the release, follow up by calling media organisations and reporters and offering additional information and interview opportunities.

√ Press releases should be delivered by the fastest means - usually by fax or messenger.

3.11.4 Cultivating Key Reporters

It can be very productive to meet with reporters who are in a position to report on HIV/AIDS issues. In targeting reporters, it also helps to look for by-lines in well-written health or human-interest stories and request a meeting with the writers.

When meeting reporters, seek opportunities to educate them about

HIV/AIDS and its impact in your district, and encourage them to report in HIV/AIDS.

3.11.5 Giving Interviews

Positioning yourself and the Team as experts to be quoted in HIV-related stories in your district, regionally or nationally, requires that you provide reporters and news organisations with your contact address information and that you are in frequent enough contact with reporters that they will think of you when a story arises.

When a reporter calls to interview you for a story, it is generally acceptable to ask if you can call the reporter back in five or ten minutes; this will give you time to collect your thoughts.

3.11.6 Arranging Media Field Visits

The best way for journalists to learn about HIV/AIDS prevention and care is to go and see for themselves. Field visits to relevant sites (e.g. hospitals, classrooms, AIDS prevention programmes) can help in building quality relationships with reporters and improving HIV/AIDS coverage.

In arranging field visits, remember to:

- √ Obtain approval from the organisation/programme to be visited well in advance.
- √ Explain all necessary logistics and relevant cultural information to the participant prior to the visit.
- √ Provide the visitor with background information in advance or at the beginning of the visit.
- √ Explain to all photographers and camera crews the areas they are, and are not, allowed to photograph.
- √ Following any field visit, arrange a debriefing session to reinforce issues discussed, answer follow-up questions, clear up potential misunderstandings, and encourage publication of an article or TV news coverage of the issue.

3.11.7 Writing Articles

Many newspapers routinely publish opinion articles by guest columnists. It is a good idea to contact such persons to ensure you are aware of the newspaper's rules and practices regarding publication of articles.

Articles should be brief, concise, factual and compelling. It is helpful to emphasise both the human dimension of HIV/AIDS and the fact that decisive action can help to bring the epidemic under control.

3.11.8 Letters To The Editor

Letters tend to be a popular section of any newspaper, and can be an excellent way to influence public opinion.

You may write a letter in advance of World AIDS Day or World TB Day.

Letters to the editor should be ***brief.*** Editors may either throw away long letters or edit them in ways that may alter the message you hoped to communicate.

ANNEX 1

FORMAT FOR DISTRICT HIV/AIDS PROFILE

The district HIV/AIDS profile seeks to give a brief but broad indication of the status of the district in terms of HIV/AIDS and what steps have been undertaken to address the effects of the epidemic. It also highlights the gaps in the responses and provides options on the way forward to mitigating the spread of the virus.

A brief format for the write-up of the profile is given below.

1. Situation Analysis

- Population
- HIV/AIDS awareness.
- Reported cases of HIV/AIDS
- Determinants
- Vulnerable groups

2. Response Analysis

- District Response
- Decentralised Departments Response
- NGOs, CBOs, other private sector organizations
- Traditional Healers etc.

3.Gaps & weaknesses in response

4. Impact of HIV/AIDS on the district

- *Economic*
- *Social*
-

ANNEX 2

INTERVIEW CHECKLIST

	DISTRICT POLITICAL HEAD
	DISTRICT ADMINISTRATIVE HEAD
	DISTRICT DEVELOPMENT PLANNING OFFICER
	HEAD OF DISTRICT HEALTH SERVICES
	DISTRICT DIRECTOR OF SOCIAL WELFARE
	DISTRICT DIRECTOR OF EDUCATION
	DISTRICT DIRECTOR OF AGRICULTURE
	COMMUNITY DEVELOPMENT REPRESENTATIVE
	BIRTHS AND DEATHS REGISTRAR
	NGO REPRESENTATIVES
	PLWHA REPRESENTATIVES
	TRADITIONAL MEDICINE PRACTITIONERS REPRESENTATIVE
	TRADITIONAL AUTHORITIES
	COMMUNITY BASED ORGANISATIONS
	REPRESENTATIVES FROM CIVIL SOCIETY ORGANISATIONS
	REPRESENTATIVES FROM YOUTH ORGANISATIONS
	REPRESENTATIVES FROM OTHER PRIVATE SECTOR GROUPS
	REPRESENTATIVES FROM OTHER VULNERABLE GROUPS

ANNEX 3

DOCUMENTATION CHECKLIST

	DISTRICT MEDIUM-TERM DEVELOPMENT PLAN
	DISTRICT HEALTH ADMINISTRATION ANNUAL REPORT *(previous & current years)*
	DISTRICT HEALTH ADMINISTRATION HIV/AIDS ACTION PLAN *(previous & current years)*
	DISTRICT EDUCATION OFFICE: FIGURES ON NUMBER OF INSTITUTIONS
	DISTRICT EDUCATION OFFICE: FIGURES ON STUDENT ENROLMENT *(previous & current years)*
	DISTRICT EDUCATION OFFICE: SCHOOL HEALTH PROGRAMME ACTION PLAN/ACTIVITY REPORT *(previous & current years)*
	SOCIAL WELFARE: QUARTERLY REPORTS *(previous & current years)*
	SOCIAL WELFARE: ACTION PLAN *(previous & current years)*
	DISTRICT OFFICE: BUDGET SUMMARY *(previous & current years)*
	DISTRICT OFFICE: TRIAL BALANCE *(current year)*
	LIST OF NGOs OPERATING IN THE DISTRICT
	NGO DOCUMENTS: ANNUAL REPORTS, HIV/AIDS, HEALTH-RELATED, EXTENSION, COMMUNITY MOBILISATION, MONITORING AND EVALUATION, ETC.
	NATIONAL YOUTH COUNCIL: ANY HIV/AIDS-RELATED OR HEALTH DOCUMENTS

ANNEX 4

DRI CONTACT DIRECTORY

	NAME	ORGANISATION	ADDRESS	TELEPHONE	E-MAIL

ANNEX 5

HIV/AIDS FACT SHEET

HIV/AIDS – AN AFRICAN EMERGENCY.

- **4.2million South Africans carry the virus**
- **Life expectancy in Zimbabwe down about 18 yrs.**
- **860,000 African children lost teachers in 1999.**

IN GHANA

- **It is estimated that 200 people get infected with HIV daily.**
- **114,000 Ghanaians have officially died of AIDS between 1986 – 2000,.**
- **120,000 AIDS orphans as at year 2000, expected to increase to 160,000 in 5 years.**
- **Estimated number of HIV infected persons in 2000 was 400,000.**
- **Projected number of people with HIV/AIDS by 2005 is 1,200,000**

HIV/AIDS will touch EVERYONE. ACT NOW.

This is a suggested HIV/AIDS facts sheet. Try composing an original one for your district. Areas to consider will include life expectancy, mortality/morbidity rates, and age of first sex for girls, impact assessment information, professional breakdown, maternal to child transmission, PLWHA, etc.

MODULE 2

UNDERSTANDING COMMUNITY MOBILISATION FOR HIV/AIDS

1.0 INTRODUCTION

Module 1 guides local-level stakeholders through consensus building, information gathering and usage, advocacy and the production of an Inception Report. Module 2 provides the user with an overview of community assessment and mobilisation and the methodology for undertaking these activities.

This paper is a contribution made by the Christian Health Association of Ghana (CHAG) through their collaboration with UNAIDS in the area of community mobilisation around HIV/AIDS and was written by the co-ordinator.
It provides a background of concepts and tools for community mobilisation and assessment.

2.0 COMMUNITY MOBILISATION

The first section discusses the characteristics of a community and seeks to provide a working definition of the term. The second section lists criteria for consideration when planning a mobilisation exercise. Section three provides some background on Participatory Rural Appraisal (PRA) and how it relates to community mobilisation.

2.1. Defining "Community"

According to **UNAIDS**, a community is "a group of people who have something in common and will act together in their common interest".

A person may belong to several community sub-groups such as the residential neighbourhood, the people he/she works with, or the religious group he/she fellowships in.

It is important to know who defines the community. Outsider definitions are useful but not complete. Until people identify themselves as a community and share some sense of belonging, there is no real community.

2.2 Characteristics of a "mobilised community"

UNAIDS understands a "mobilised community" to have most or all the following characteristics:

- Members are aware - in a detailed and realistic way - of their individual and collective vulnerability to HIV/AIDS.
- Members are motivated to do something about their vulnerability.
- Members have practical knowledge of the different options they can take to reduce their vulnerability.
- Members take action within their capabilities, applying their own strengths and investing their own resources - including money, labour, materials or whatever else they have to contribute.
- Members participate in decision-making on what actions to take, evaluate the results, and take responsibility for both success and failure.
- The community seeks outside assistance and cooperation when needed.

2.3 Planning Community Mobilisation

The success of community mobilisation depends very much on how it is planned and organised. Several issues require critical

consideration in planning for community mobilisation some of which are mentioned below.

2.3.1 Waves Of Community Response To HIV/AIDS

1. Denial;
2. Fear, stigma, isolation and rejection;
3. Awareness and knowledge about modes of transmission leading to acceptance;
4. Community tolerance, support, and solidarity leading to Community-Based Care.

2.3.2 Advocacy And Assistance

UNAIDS will advocate for and help with the design of programmes which:

1. Uphold the rights and dignity of people both infected and affected by HIV/AIDS.
2. Ensure active participation by a broad and representative group of community members as much as possible.
3. Provide for equal partnership and mutual respect between the community and external facilitators.
4. Build capacity and ensure sustainability.
5. Build on the realities of living with HIV and AIDS while maintaining hope based on community collective action.
6. Maximize the use of community resources while identifying and using additional external resources where needed.

2.3.3 Nurturing And Sustaining Community Mobilisation

A community becomes mobilised when a particular group of people become aware of a shared concern or common need, and decide together to take action in order to create shared benefits. This action may be helped by the participation of an external facilitator, and either a person or another organization must come from within the concerned group otherwise it will not be sustained overtime.

2.3.4 Mobilising the Community for What?

Community mobilisation for HIV/AIDS should among others include these two (2) basic objectives:

1. To prevent the further spread of the HIV infection; and
2. To provide social and economic support to those affected and infected. (This may use the strategy of Home-Based Care).

2.3.5 Focus On Person Living With HIV/AIDS

Community mobilisation should help address the needs/concerns of PLWHA. Experience of the CHAG-UNAIDS programme shows that the PLWHA have the following key needs/concerns:

- Stigmatisation and discrimination
- Poverty resulting mainly from prolonged illness and the consequent loss of job or inability to work. This is expressed in the difficulty or failure to obtain the necessities of life i.e. food, clothing and health care.

2.3.6 Counsellors/Coordinators

Most of the Counsellors and Coordinators of the CHAG-UNAIDS programme at the District or institutional level are health personnel. With the shortage of health personnel (especially nurses) in almost all health institutions, it is becoming increasingly difficult for the staff who are already very committed to perform effectively on the HIV/AIDS programme. The strategy adopted is to empower communities, i.e. mobilise them, have a functional Committee to manage the HIV/AIDS programme and have motivated Community Volunteers who will embark upon health educational and Home-Based Care activities.

2.4 Participatory Rural Appraisal In Community Mobilisation

This section provides some background on Participatory Rural Appraisal (PRA) and how it relates to community mobilisation.

2.4.1 Defining Participatory Rural Appraisal

Participatory Rural Appraisal (PRA) is a specific form of Rapid Rural Appraisal (RRA), a research technique developed in the late 1970s and early 1980s by researchers in international development as an alternative and complement to conventional sample surveys. *PRA is a way of learning from, and with, community members to investigate, analyse, evaluate constraints and opportunities, and make informed and timely decisions regarding development*.

PRA requires **attitudes** favouring:

- participation
- respect for community members
- interest in what they know, say, show, and do
- patience, not rushing, and not interrupting
- listening, not lecturing
- humility
- methods that empower community members to express, share, enhance, and analyse their knowledge
- simplicity

2.4.2 Features of Participatory Rural Appraisal

The main features of Participatory Rural Appraisal are:

Triangulation*:*
A form of crosschecking. Accuracy is achieved through diverse information and different kinds of sources of information, not statistical reliability. Triangulation is done in relation to:

- composition of the team
- sources of information (people, places, etc.)
- mix of techniques

Multi-disciplinary Team**:** The members of the PRA team should have different skills and backgrounds. The different viewpoints of team members will complement each other and will provide a more comprehensive picture. In this way the team will approach the topic of the appraisal from different viewpoints, which gives new and deeper insights. All members of the PRA team are involved in all aspects of the study: design, data collection, and analysis (not just in data collection as in a conventional survey). The PRA team should always include women and, whenever possible, community members. PRA is a learning experience in which the participants also learn from each other.

Mix of Techniques: The PRA techniques are taken from a wide range of tools, which are tailored to the specific requirements of the study.

Flexibility and Informality**:** Plans and research methods are semi-structured and are revised; adapted, and modified as the PRA fieldwork proceeds.

In the Community**:** The main aspect of the PRA is learning from, with, and by members of the community - PARTICIPATION! The team should empathize with the community members and be able to see the lives and the problems through the eyes of the community members (in anthropology this is known as anaemic perspective). Most of the activities are done jointly with community members or by them on their own (e.g., planning, mapping, and analysis). PRA is generally too short for outsiders to become insiders.

Therefore it is important to have community members (insiders) participate in the appraisal. Involving community members can greatly facilitate interpretation, understanding, and analysis of collected data.

Optimal Ignorance and Appropriate Imprecision**:** The PRA team must avoid being fastidious over collection of data (as in sample surveys), which is not really needed for the purpose of the PRA (this is decided through on-the-spot analysis). The team asks itself. "What kind of information is required, for what purposes, and how accurate does it have to be?

The team constantly reviews and analyses its findings in order to determine in which direction to proceed. It builds up understanding and narrows the focus of PRA as it accumulates knowledge.

Offsetting Biases and Being Self-Critical: The PRA team actively seeks out the poorest, women, and other disadvantaged groups in remote areas, during the worst time of the year, at any time of day, and avoids talking only to the well-off, the better educated, the articulate, and the men. The team also has to be careful to analyse its own biases in order to prevent the PRA from turning into development tourism and rumour collection. The team reflects on what is said and not said, seen and not seen, who is met and not met, and tries to identify possible sources of error and how they influence the interpretation of the gathered information. The team must also try to avoid value judgements about others.

2.4.3 Possible Dangers And Shortcomings Of PRA

- difficulty of finding the right team
- going too quickly may lead to superficiality
- desire of statistics and quantitative data
- desire for the security of a fixed questionnaire
- difficulty of finding the poorest and least educated, especially women
- lack of rapport with the community
- failure to listen and lack of humility and respect
- seeing only part of a situation or problem
- making value judgements about others
- being misled by myth and gossip
- generalizing based on too little information or too few informants
- lecturing instead of listening and learning
- raising expectations in the community where the PRA is carried out
- imposing "our" ideas, categories and values without realizing it. This makes it difficult to learn from "them", makes "them" appear ignorant when they are not
- male teams and neglect of women

2.4.4 Overview Of PRA Techniques

PRA makes use of a wide range of techniques. In any given PRA, the research team will select the most appropriate and useful set of techniques. The team should also experiment, invent and adapt methods. Some techniques include:

- Direct Observation, Observation Indicator Checklists
- Semi-Structured interview
- Focus Group Discussions
- Mapping and Modelling
- Social/Participatory Mapping
- Historical and Future Mapping, Mobility Mapping
- Transect (Walks)
- Seasonal/Historical Seasonal Calendar
- Historical Profile
- Livelihood Analysis
- Flow/Causal Diagram
- Venn/Institutional Diagram
- Systems Diagram
- Pie Chart
- Histogram
- Participant Observation (do-it-yourself, learning by doing)
- Oral Histories
- Workshops
- Case Studies and Portraits
- Proverbs/ Stories

3.0 UNDERTAKING COMMUNITY ASSESSMENT & MOBILISATION

This section provides a method for determining:

1. Local-level attitudes, practices and behaviour regarding HIV/AIDS.
2. Community responses to HIV/AIDS.
3. Community wishes/strategies (i.e. what they want to do or have done about the HIV/AIDS situation?)
4. What resources the community is willing and able to commit.

This set of activities will provide the DRI Management Team, decentralised departments and civil society organisations with basic, yet critical baseline information that can be used to measure impact and

behavioural change at the local-level. It will also result in a community HIV/AIDS action programme.

3.1 Procedure for undertaking Community Assessment and Mobilisation.

Phase one - Assessment

1. Select an ***experienced*** team of up to eight (8) people to go to the communities to perform the first phase of mobilisation and assessment activities (ensure that Social Welfare and Community Development are involved).
2. The team should receive at least a 1-2 day training/orientation for the task from trained resource persons from UNAIDS/CHAG.
3. Designate a member of the DRI Management Team to be the focal person for the collection and collation of all documentation. This person, in conjunction with other members of the Team, will facilitate the process.
4. Select at least three communities that adequately represent the district and set up a community visit schedule to conduct the PRA and Focus Group Discussion (FGD) activities. Each community should take approximately 1-2 days to complete. Ensure that focus groups represent the youth, men, and women. Once the expertise is acquired locally, more communities can be assessed and mobilised each year to increase coverage. For details of the methodology used, see ***Guidelines for Community Mobilisation under Section 3.4*** and ***Community Assessment Questionnaire under Section 3.5***
5. Community visits are undertaken, documented and submitted to the designated member of the DRI Management Team.
6. The DRI Team together with other stakeholders analyses the documentation and produces a report to be reviewed by the communities on the second visit, following the format provided.

Phase Two - Mobilisation

1. The implementation team who undertook the original assessment will return to each community with a member(s) of the DRI Management Team. *NB: where the communities are numerous visits may be clustered to save time and resources.*
2. Convene a Focus Group Discussion with key figures such as traditional authorities, opinion leaders, Unit Committee members, Assemblymen, Schoolteachers, clinic attendants etc. and present the analysis of the assessments to achieve consensus on the outcome and to ensure that it is an adequate representation of the community's voice.
3. After arriving at consensus, the community wishes/action, and the available and required resources are used to outline a short list of activities for a Community Action Programme for HIV/AIDS.
4. The DRI Management Team will monitor and assist with documenting the progress of these Community Action Programmes (e.g. attending community events, tracking of financial disbursements, field visits etc.)

3.2 Qualities of the Mobiliser

The mobiliser should have the following additional qualities:

- Leadership
- Practical
- Work effectively without close supervision
- Reasonable and systematic
- Knowledgeable and capable of transforming the knowledge into action without being all knowing
- Analytical and on-the-spot decision maker
- Optimistic and have faith in what he/she is doing
- Conversational and able to involve others
- Innovative

A Mobiliser should avoid:

- Distancing himself/herself from the people
- Not believing in the message, i.e. "They said that...........
- Thinking you are better and above the people you are mobilising
- Imposing himself and his personal decisions on the people.

3.3 Factors That Hinder Community Mobilisation

- Language barrier
- Poor leadership
- Political insecurity
- High level of poverty
- Religious, political and cultural differences
- Poor infrastructure e.g. bad roads
- Poor timing
- An attitude of dependency on government and NG0s by communities
- Uncompromising and prejudiced community
- Poor attitude and weak qualities of the mobiliser.

3.4 Output from Community Assessment and Mobilisation

A short report should be produced for each community outlining the attitudes, practices and behaviours regarding HIV/AIDS, their responses to the epidemic, strategies or what they want to do about HIV/AIDS, and what resources they are willing and able to commit. The following format should be followed:

- Summary
- Introduction
- Methodology (e.g. who were the team members, process for the selection of the communities, participants, PRA activities, etc.)
- Results (i.e. attitudes, practices and behaviours, responses, strategies and resources.

3.5 Guidelines For Community Mobilisation

1. **Personnel (Mobilisers)**

- Eight (8) people shall be trained to do the mobilisation.
- Qualification: Interest, desire to work on the HIV/AIDS Programme and availability (i.e. time)
- At least two (2) of the eight people should be women

2. **Communities to be Mobilised- 3**

- 2 days are needed for each community.

An additional day will be needed where mobilisers are not skillful enough.

3. **Preparing Communities for Mobilisation**

- Never mention HIV/AIDS to the chief and elders when you first meet them to prepare them for the mobilisation.
- Tell the chief and elders that a team of about ten (10) will visit them at an agreed time and day to discuss with the entire community general developmental issues.

4. **Time Of Visiting The Community**

- The time should suit the convenience of the community.
- Where the mobilisers have a choice or can suggest, it should be when most farmers have come back from the farm i.e. around 2.30 pm.
- The mornings of each day shall be used for theory and rehearsal of the PRA method of mobilisation. Additionally, evaluation of the previous day's work and analysis of the data collected shall be done.

5. **Report**

A report should be written on the Baseline Data that will be collected and analysed during the mobilisation. Areas the report will cover shall include:
- Knowledge
- Attitudes
- Beliefs
- Practices
- Support Systems/resources the community has (human and material) in managing the HIV/AIDS Programme.

6. **Material Resources Needed For The Mobilisation**

- A meeting room (with capacity for about 10 people) or out in the open
- Flip chart paper (about 20) or chalk and chalk board
- Markers (black, red and blue). Two or three of each colour.
- Card (hard) Papers – size similar to the Flip Chart (to be used by the community members. About 28 of this – 8 for each community.

7. **Official Opening**

Arrange for the District Political head or a key person, from the District office to do the opening, which should be between 15-20 minutes.

3.6 Community Assessment Questionnaire

A) Knowledge, Attitudes, Practices & Behaviour Study

1) What do you do during your leisure hours?
2) What do you know about HIV?
3) What do you know about AIDS?
4) What are signs and symptoms of AIDS?
5) What are your sources of information on HIV/AIDS?
6) Which of the sources mentioned have you found helpful?
7) How do you think HIV is transmitted?
8) How can one prevent him/herself from getting HIV?
9) What common sexually transmitted diseases (STDs) do you know?
10) Which are the sources of treatment of STDs?
11) Which of the preventive measures for STDs is practiced in your community?
12) What should be the sources of support for PLWA in this community?
13) Which persons or groups are most vulnerable to HIV infection?

B) Community Responses To HIV/AIDS

1) Which people can educate members of the community on HIV/AIDS and why?Do you think you have people suffering from HIV/AIDS in this community?
2) What has been the community's response/reaction to HIV/AIDS in this community?
3) Which individual or institution is helping to reduce the spread of HIV/AIDS in your community?

C) Community Strategies

1) What do you think should be done to prevent people from getting HIV?
2) What should be done for PLWHA?
3) Who should provide care for PLWHA?

D) Community Resources

1) What resources are available in your community for the prevention of HIV infection?
2) What resources are available in your community for the care of PLWAs?

3.7 Follow Up Activities

1) Training of selected community assessors who will in turn repeat the process in other 2 communities
2) Community Assessment Team goes with selected DRI Community Assessors (4) to conduct the assessment in one community.
3) Community Assessment Team and the DRI Community Assessors together analyses the collected information for 1 community.
4) DRI Community Assessors and a member of DRI Management Team continue with the community assessment, data collection, analyses and write up.
5) Community Assessment Team and the DRI Community Assessors go back to the community and present results to elders, opinion leaders, group leaders etc. to validate and build consensus on:
   - Activities of the next 6 – 12 months
   - Who to do what? (Roles & responsibilities for community)
   - What local resources will be provided
   - What other resources are required.

MODULE 3
DISTRICT STRATEGIC PLANNING GUIDE

1. INTRODUCTION

Module 1 guides local-level stakeholders through consensus building, information gathering and usage, advocacy and the production of an Inception Report. Module 2 explores community assessment and mobilisation.

Module 3 is largely workshop/group work – based and leads to the production of a Strategic Plan or Framework: analysing the internal (workplace) and external (target group) environment, developing a Mission Statement, formulating strategies and considering resource mobilisation.

It is important to understand that the Strategic Planning process is part of the wider Strategic Management, which involves a cycle of planning, implementation, monitoring, and re-planning.

Strategic Planning is key to increasing the number of stakeholders and expanding the scope of the Response. Strategic Planning may be viewed as goal oriented and driven by problems and needs identified at the Inception phase.

Module 3 aims to:

1. Serve as a workshop tool and reference material for the District Response Initiative **(DRI)** Management Team, local level practitioners, and other groups.
2. Guide local level practitioners and decision-makers through district strategic planning for HIV/AIDS or issues involving multi-sectoral groups.
3. Provide the local level with a simple and realistic approach to meet the multi-facetted challenges posed by changing trends in district development planning and strategic management. It is an approach that is suitable for both donor-supported as well as district-funded programmes.

2. STRATEGIC PLANNING FOR HIV/AIDS

Strategic Planning is viewed by both public and private sectors as orthodox planning with an added emphasis on implementation. It is *a process of examining the current situation and responses in any thematic area, defining a mission, developing objectives and the means to meet those objectives, as well as developing the methods and mechanisms to measure the results.* The principal features and *added value* of the Strategic Planning process are:

- It builds consensus and encourages teamwork and multi-sectoral action among key local government personnel, Decentralised Departments and Civil Society Organisations.
- It requires flexibility and responsiveness through the development, documentation and prioritisation of a number of strategies and choosing the best available response.
- It promotes delegation of responsibility and requires good communication and information sharing.
- It helps to link available resources to objectives.
- It establishes ownership and commitment through validation and agreement.
- It focuses on success and the documentation of achievements over time.
- It enhances cross-district and cross-sectoral learning.
- As the process of district Strategic Planning for HIV/AIDS proceeds, certain fundamental questions must be addressed. These are:

1. What is the current local level HIV/AIDS **situation** and what is the **response**?
2. What does the district intend to do about HIV/AIDS and its **impact**?
3. How does the district achieve its HIV/AIDS related mission and objectives?
4. What resources does the district need to achieve its mission and objectives?
5. How best can the district monitor, document, learn from, and share its experiences in dealing with HIV/AIDS?

3. DEVELOPING AN HIV/AIDS STRATEGIC PLANNING FRAMEWORK

3.1 Steps Involved In Strategic Planning.

The process of Local level Strategic Planning involves four key interrelated steps:

Step 1: **Situation and Response Analysis** involves an analysis of the HIV/AIDS status of the district (already outlined at the inception phase). The output of this analysis is a short report on the district's overall HIV/AIDS determinants, key vulnerable groups, available resources and responses to the epidemic to date.

Step 2: **Development of the district's Mission and objectives for HIV/AIDS** that outlines what the district desires to achieve within a 3 to 5 year period (medium-term).

Step 3: **Strategy formulation** is regarded as the critical feature of the strategic planning process. The output here is a careful selection and documentation of prioritised strategies for achieving the district's stated medium-term objectives together with an idea of what resources may be required.

Step 4: **Annual Action Planning** is the most frequently recurring aspect of the Strategic Planning Process and involves detailing out specific activities for implementation in the year. This will be repeated every year in line with the national annual planning and budgeting cycle.

Figure 1 below provides a schematic representation of the strategic planning process.

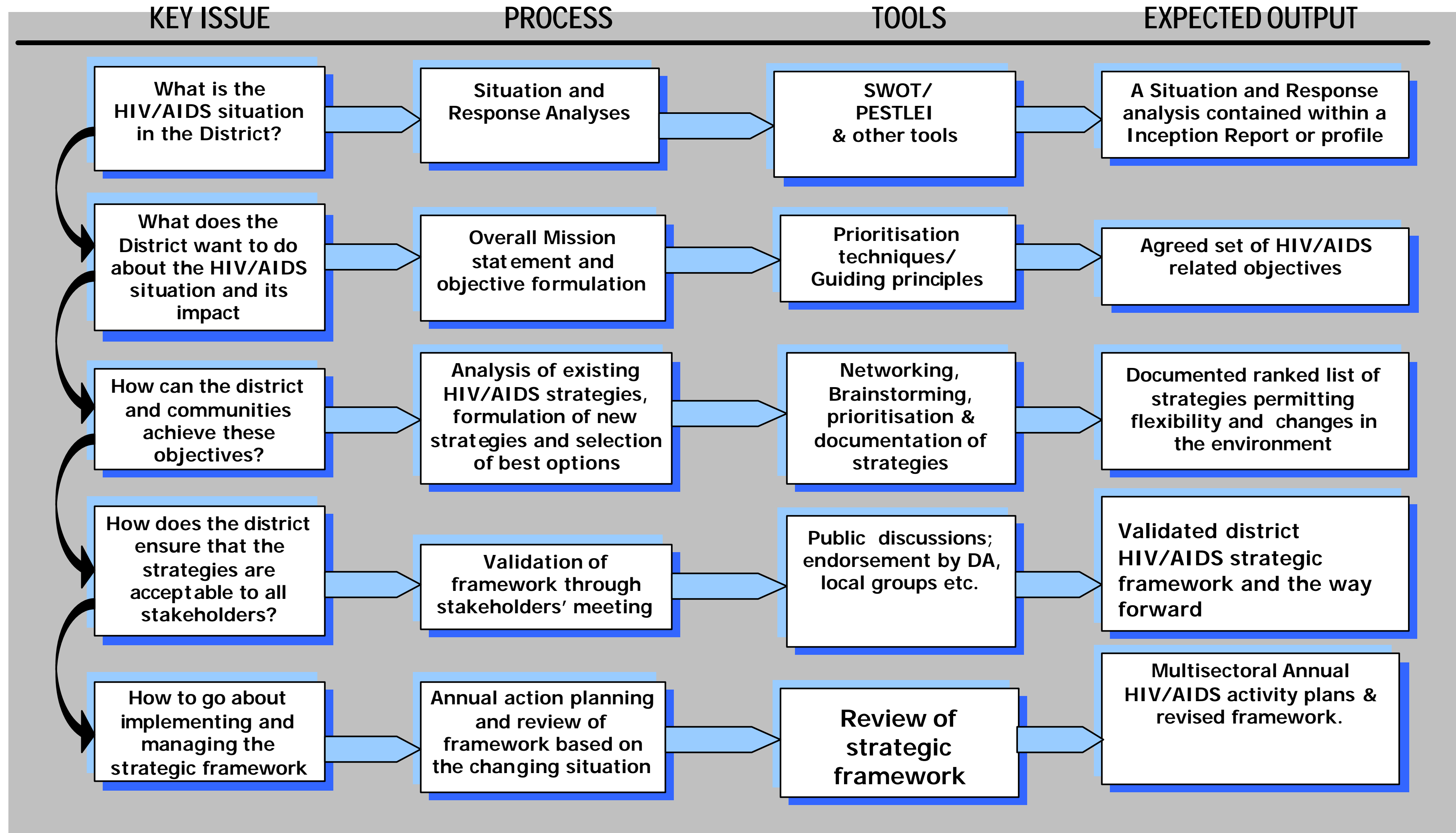

Fig. 1: Strategic Planning Framework Development for HIV/AIDS

3.2 The Situation and Response Analysis

The Situation and Response Analysis, taken together, answer the question, **"where are we now in relation to HIV/AIDS?"** Separately, however, each has a particular focus. The Situation Analysis examines such things as the economy, poverty, mobility and migration, infrastructure, socio-cultural issues, population distribution and densities, the geography and available human and financial resources. Fundamentally, it seeks to provide a broad picture of the district and address the question: "if nothing was being done about HIV/AIDS, what are the factors driving the epidemic?"

The Response Analysis looks at how the local level has responded to the challenge of HIV/AIDS. It seeks to address the questions: "what has been done to combat the spread of HIV/AIDS in our district and what resources have been used? Has it been strong or weak and in what ways?"

There are a number of familiar tools that can be used to analyse the HIV/AIDS situation and responses in the district. Examples of the Situation and Response Analysis outline can be found in the **DRI Tool Box** in the Facilitators Guide.

3.3 Mission and Objectives

The mission statement: The Mission Statement describes the direction of the District's HIV/AIDS efforts within the medium term (3-5 years) and provides a general statement of philosophy. Essentially, a mission statement addresses such questions as "What do we do?" and "What do we want to do?" in the medium-term. An example is: "To prevent the further spread of the HIV/AIDS epidemic by providing greater access to primary health care in the district within the next three years." A Mission Statement can be said to represent the overall goal in relation to HIV/AIDS.

A Mission Statement that truly reflects local level direction and commitment comes about through a consultative and participatory process. The mission statement should be objective and clearly stated.

3.3.1 Developing the Mission Statement

A Mission Statement takes into account the changing situation and response to HIV/AIDS, the history of the epidemic and its impact upon the communities, as well as the changing composition and capacities of the local level political authorities and Civil Society.

To be effective, a Mission Statement must be:

- **Achievable.** A mission statement should stretch the capacities and capabilities of local stakeholders, but should also be realistic and not aimed for goals that do not match the local reality or abilities.
- **Motivational.** A well-defined mission statement provides a shared sense of purpose and is able to thread together efforts at the local level to meet the challenge of HIV/AIDS.
- **Specific.** The mission statement must be specific and clear in order to provide guidance and direction.
- **Descriptive.** A mission statement must broadly describe what action(s) are intended and whom these actions are supposed to serve.

3.3.2 Setting Objectives

Objectives constitute benchmarks that guide the strategic direction of local level efforts. Objectives are desired future outcomes and are what is to be achieved through the on-going operations of the strategic plan. Objectives are usually formulated to meet the five **SMART** criteria.

It should be remembered when setting objectives that changes, especially those relating to the behaviour necessary to impact on HIV/AIDS, only occur over an extended period of time. Thus, it is important to underscore that objectives must be *achievable* and *realistic*.

3.4 Strategic Plan Formulation

Strategy formulation is perhaps the most important but taxing phase of strategic planning. It is in fact the path through which you can achieve your objectives and

ultimately, your mission. Strategy formulation thus answers the question **" how do we get there?"**

Simply put, strategies are carefully selected choices of approaches, methods and options for achieving stated objectives. It thus demands consensus between key stakeholders and careful **prioritisation** based on agreed criteria.

In this context, strategies should have the following attributes:

- Responsiveness to the socio-economic environment
- Promote team effort
- Provide flexibility
- Create ownership and commitment
- Encourage the development and documentation of alternatives to choose from especially when situations change unexpectedly.

Finally, strategies must aim to:

1. Maximise benefits to communities
2. Minimise cost (i.e. be cost effective)
3. Reduce risk of non-attainment of objectives
4. Must satisfy as many stakeholders as possible

A simple example: in deciding to provide care for PLWHA in your locality, various strategies/options are possible:

- Use the existing hospital in-patient beds and services.
- Design and build a special institution.
- Develop skills and systems for home-based care.

Which of these options is likely to fulfil the above criteria for the benefit of your district? How best to decide on these options is not an individual task but a collective one or a team effort based on consensus.

3.4.1 Factors to Consider in Developing a Strategy.

1. Get all stakeholders together (should be representative).
2. Examine your situation and responses thoroughly.
3. Make sure the stated objectives are easily understood and attainable.
4. Know what resources (Financial, human, material etc.) are at your disposal.
5. List all strategies/options available.
6. Decide on the best strategy/option given your local situation, but rank other strategies which could be considered in case the selected strategy fails due to changing circumstances.

3.4.2 Techniques For Strategy Development.

- Brainstorming sessions and discussions.
- Networking, using critical path approach in project management.
- Logical Framework Approach

3.4.3 Benefits of developing a clear set of Strategies

With a well-laid out strategy development and management, the following benefits will accrue to the local authority/council:

- Ownership of the framework by the council.
- Loyalty from all actors towards the implementation of activities/plans.
- Realisation of quality outputs as the end result.

3.5 Writing the District Strategic Planning Document/Framework

- The purpose for writing the HIV/AIDS district strategic planning document is to provide the districts with a **flexible framework** from which more detailed activities will be identified and costed for implementation.
- The process for writing a HIV/AIDS district strategic planning framework ends at the strategy level. The Strategic Planning Framework will be validated by the major stakeholders after which costed activities are implemented.

3.5.1 Principles For The Preparation of the District Strategic Planning Framework:

The following basic principles should guide the preparation of the HIV/AIDS strategic planning framework.

- The framework must be prepared with the districts' Long/Medium Term Plan vision and other development initiatives in mind, i.e. comment on the future impact that HIV will have on development in the district.
- The framework must be based on a Situation and Response analysis with a clear focus on prioritisation of resources and activities.
- The framework should take stock of existing projects, sector activities, community initiatives and proposals.
- All key stakeholders should be involved in the process at all stages e.g. the community through community consultations, decentralised departments, local agencies and NGOs, etc. to promote legitimacy and ownership.
- In suggesting the allocation of resources, transparency, flexibility and effectiveness (i.e. where will the resources have the most impact) should be the key.
- The framework should be designed to facilitate a revolving process that undertakes evaluation of situations and responses periodically and assesses which strategies and activities have been successful.

3.5.2 Format For Writing The Strategic Planning Document:

The following format is suggested for writing the district strategic planning document/ framework.

1. Executive Summary
2. Introduction
3. HIV/AIDS mission Statement
4. Summary of Situational and Response Analysis
5. Objectives
6. Prioritised strategies
7. Resource mobilisation
8. Arrangements for advocacy, coordination, monitoring and documentation of strategies and activities that contribute to attaining objectives.

3.5.3 Validation And Finalisation Of The Plan:

Once the strategic planning framework has been developed it must be discussed, verified and agreed to by a representative district-wide workshop which should include traditional authorities, NGOs, CBOs, community opinion leaders, etc. At this workshop, organizations and institutions already active in the district will make inputs and amendments they consider relevant and necessary in order to maximise the utility and impact of the activities planned. It is the source of commitment to the plan and its objectives and serves as a point reference for the development of the response.

3.5.4 Annual Action Planning:

The validated strategic planning framework is the basis for developing the annual action plan. The focus of the annual action plan should be on what set of activities can reasonably be implemented within the financial and human resource capabilities of the district.

The Action Plan should include the activity, cost, responsible party and timeframe

3.5.5 Focal Areas For Strategic Planning:

Activities under the Strategic Plan must be built around, but not limited to the three thematic areas suggested below, and designed by the implementers:

- **Management/Co-ordination activities:** Implementing management activities is the responsibility of DRI Management Team and they will develop and articulate important management activities.
- **Internal Activities:** work place based, and targeted at the people at the various assembly secretariats and involved in the DRI programme.

- **External / Community Activities:** Through the community assessments and mobilisations the communities will articulate actions they are able to undertake based upon their perceived vulnerabilities and available resources. These will be guided and funded through the DRI Management Team.

  Those institutions and organizations already active in the district will be able to design and develop activities to address the key strategies in the Strategic Plan. These will be coordinated and funded through the DRI Management Team.

4. RESOURCE MOBILISATION

Implementation of all action plans need resources. Thus, resources and their mobilisation must be considered at the **beginning** of the situation and response analyses and the Strategic Planning process. Consideration given to **all potential human, financial, material and other kinds of resources** will determine the district's available resources and suggest a mobilisation strategy. Resource mobilisation is greatly enhanced through the involvement of all key stakeholders at the **start** of the Strategic Planning process to cultivate their interest, understanding, and commitment.

4.1 Eight principles of Resource Mobilisation (RM):

1. RM should be based on real and available human and financial resources in the district.
2. RM must reflect the priority given to strategies and options.
3. All avenues must be explored imaginatively for resource mobilisation.
4. Be creative and dynamic. It is **imperative** to avoid a pre-determined, carved-in-stone resource "shopping list."
5. Resources meant for the overall strategic management overheads of the district HIV/AIDS plan (advocacy, co-ordination, monitoring, and documentation) must clearly be distinguished from resources required for the actual field implementation of action plans.
6. Resource mobilisation must be based on a clear and transparent costing method.
7. Individual projects and activities will be costed by the implementing agencies or stakeholders who may have separate sources of funding.
9. The DRI Management Team must identify and document **all** the different sources of funds, whether received through NGOs, the Assembly, the Management Team itself, or any other body.

Under the capacity building aspect of the DRI, local stakeholders' skill and ability to both mobilise and use resources more efficiently will be increased. Support provided to local stakeholders therefore will initially cover the areas of advocacy, co-ordination of planned activities, monitoring and evaluation, and the documentation and dissemination of successes and experiences of HIV/AIDS activities at the local level.

The stakeholders at the national, in particular, will closely monitor the use of financial resources, level and by the international donor partners.

ANNEX 1

FORMAT FOR DRI STRATEGIC PLANNING FRAMEWORK DOCUMENT

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1.3 List of ranked determinants ......
1.4 Key vulnerable groups in district
1.5 Impact of HIV/AIDS on the District ......
1.6 Responses to HIV/AIDS situation. ......

2.0 MISSION STATEMENT ......

3.0 OBJECTIVES ......

4.0 PRIORITISED STRATEGIES ......

5.0 RESOURCE MOBILISATION ......

5.1 Arrangements for Advocacy ......

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7.0 MONITORING AND CO-ORDINATION ......

MODULE 4

MANAGING THE LOCAL RESPONSE

1.0 INTRODUCTION

Module 1 takes local-level stakeholders through consensus building, information gathering and usage, advocacy and the production of an Inception Report or a profile. Module 2 explores community assessment and mobilisation.

Module 3 is largely workshop/group work –based and leads to the production of a Strategic Plan or Framework.
Module 4 provides the user with the basic implementation approach to the local response, as the most important aspect of DRI is ensuring that implementation of plans and activities take place effectively. Based on current experience, implementation can be divided into 3 broad stages: Inception, Capacity Building and Activity Execution.

1.1 Inception Stage

This involves the sensitisation of local level actors to the need for sustained and strengthened political will and commitment at both institutional and community levels. In nearly all cases, Inception Visits mark the first time members of local government, the private sector, NGOs and communities meet to discuss the issue of HIV/AIDS. Relevant information from available documents, key informants, observations, meetings and anecdotal information to develop local-level situation and response analyses is gathered.

1.2 Capacity Building Stage

Consultants and other resource persons provide initial capacity building inputs which enable local level stakeholders to develop the skills for planning for HIV/AIDS and culminates in medium-term District Strategic Frameworks and yearly Action Plans. These plans should also link-up with community action programmes.

1.3 Activity Execution Stage

This stage involves the execution and management of planned activities addressing identified vulnerable groups within the prioritised HIV/AIDS strategies. Examples of the activities to be implemented will include community assessments, drama performances, youth talks, workshop for traditional leaders, identification and formation of PLWHA associations, etc.

2.0 MANAGING IMPLEMENTATION

Overall management of the local HIV/AIDS response is critical and is the responsibility of the multi-sectoral District Response Initiative Management Team **(DRIMT)**. The members of the team, which must be set-up by the close of the inception stage, are drawn from both government and NGO/Private sector institutions operating at the district level. On the average, the DRIMT is composed of between seven and eight representatives from the Health Sector, the Education Sector, Social Welfare/Community Development, the District Administration and the NGO/Private Sector. The district political head is expected to be an ex- officio member to provide the political bite to the functioning of the team and the overall process. The DRIMT must report primarily to the district and then to UNAIDS via the oversight sector Ministry on a quarterly basis.

The responsibilities of the DRI Management Team include:

- **Advocacy** for the expansion of the HIV/AIDS response in the district and an increase in the number of actors and institutions involved.
- **Support** district HIV/AIDS response activities to ensure a concerted, multi-sectoral effort.
- **Plan and manage** the medium-term strategic planning framework and the validation process.
- **Develop an annual plan of activities** from the strategic framework by identifying, costing and ensuring funding of activities.
- **Monitoring and evaluating** the process by assisting with indicator selection, data collection and analysis particularly where it concerns communities.
- **Maintain an HIV/AIDS information centre** stocked with available HIV/AIDS literature and information collected through monitoring and documentation.
- **Co-ordinate** DRI and other HIV/AIDS activities in the district for implementation.

2.1 Community Implementation

A major implementation strategy of the DRI involves steadily increasing the number of communities undertaking basic HIV/AIDS prevention and care activities. The community mobilisation and assessment module(Module 2) sets out how communities can be brought on board.

All districts will indicate in their annual plans, the number of additional communities to be assessed and supported in that particular year. Once the community assessments have been completed, modest funding for community activities will be channelled through the DRI Management Team to support the HIV/AIDS community action programmes. The communities will account for and report back on the use of funds to the DRI Management Team.

2.2 Financial Control

Funding for the DRI is sourced from the district's own resources and central level funds currently from the UN Theme Group on HIV/AIDS and some contribution from bilateral donors. Accounting for funds is therefore an important aspect of the management of the Initiative. Funds are lodged in the **DRI account** with disbursements made upon requests to the signatories of the account - the District Administrative head and one of the two DRIMT members, who are signatories to the account.

Quarterly financial reports on funds received and utilised are submitted to the oversight sector Ministry and UNAIDS, copies of which must be sent to the District office.

Implementation progress is measured through the submission of Activity Reports quarterly. A sample of the Financial and Activity Reporting formats (Annexe 1) are provided in this module and form the basis for self-assessment and overall monitoring as illustrated in the next section.

3.0 MEASURING PROGRESS: MONITORING AND EVALUATION

Implementing the District Response Initiative provides an important opportunity to measure success and document challenges associated with multi-action and multisectoral activities. **First** experience has shown that the information gathered must be useful and meaningful to enhance local-level implementation by communities, local government etc. **Second,** the reports and documents should serve other key stakeholders at the regional, national and international levels as best practice and policy lessons.

The utility of the "twin-track" strategy in monitoring. Clearly, a multifaceted approach to gathering and

using **quantitative** and **qualitative** information is required. The DRI is built around the concept of a "twin-track" strategy.

The "Twin-Track" strategy involves:

1. **Providing the needed technical inputs for local-level stakeholders to strategically plan, manage and document their own multi-sectoral response to HIV/AIDS.**

2. **Offering funding and technical support for on-going and new local-level and community initiatives.**

In terms of monitoring progress, this approach will enhance the technical capacity of district level actors to improve **strategic management** of local HIV/AIDS initiatives i.e. improve the cycle of planning, implementation and learning. The emphasis is to keep monitoring **simple** by selecting straightforward quantitative indicators, collecting, analysing and using data at the local institutional level e.g. Ministry of Health sentinel surveillance, condoms distributed etc. On the qualitative level, the "twin-track" support means that communities can be aided to measure their own behavioural changes. This is why it is important for each district to conduct a number of community assessments, which will provide an indication of attitudes, behaviour and practices that can be tracked across time.

3.1 Enhancing Local-Level Management Capacity To Monitor

Data Collection. The concept of building on what already exists is an important one within the DRI. The multi-sectoral DRI Management Team is responsible for the collection and collation of all relevant information and documentation.

Quantitative Data. The Team will facilitate basic data gathering. For example, quantitative data on STDs treated, sales and distribution of condoms. Numbers of HIV/AIDS-related programmes carried out in schools and on radio, the amount of money allocated to HIV/AIDS from the District's resources etc. With the membership representing, among others, the Department of Social Welfare, District Health Administration, District Education Office, the private sector and the District council, a multi-sectoral basis for analysis is ensured.

NGO Inputs in Monitoring. In addition, many districts have NGOs working within them that collect relevant information on areas, such as the number of PLWHA under home-based care, and ability and level of the providers. Numbers of commercial sex workers attending regular HIV/AIDS awareness meetings and the numbers using condoms, tracking distribution and use of condoms, etc.

Sentinel Surveillance: Monitoring for reduction in incidence. Sentinel sites are a critical source of data in the district and provide a key indicator for not only measuring progress but serves as a kind of advocacy tool for action. Additionally, Voluntary Counselling and Testing (VCT) totals provide a useful indicator of the progress of the epidemic and importantly a measure of changing attitudes to denial, stigma, and discrimination.

3.2 Monitoring On-Going And New Activities.

Qualitative documentation. As mentioned earlier, the DRI Management Team will assist communities to document experiences, progress and failures, providing a more qualitative flavour of events.

A local institutional memory and community voice. As a monitoring instrument, an archive of such documents will begin to establish local-level institutional memory. In the districts currently implementing the DRI, documentation on HIV/AIDS and activities implemented is limited. Better monitoring

must ensure that documents and records of a local response to HIV/AIDS are maintained.

Each DRI Management Team will, based on the community assessments, record community activities and changes in attitudes etc. over time. The definition of "community" has largely been left up to the discretion of the districts. One district, for example, with two universities, a nursing college and a prominent secondary school, identified the large transient populations on the campuses as a cohort needing assessment, tracking and a voice in the DRI process.

The Community Assessment is designed to capture local-level data for qualitative monitoring.

- **Baseline information on the community's behaviour and practices vis-à-vis HIV/AIDS should be collected at the start. The 1998 Demographic and Health Survey, shows that awareness and knowledge of HIV/AIDS is near 98%. So it is important now to obtain information on community behaviour and practices.**
- **From the community's response simple monitoring of changes in attitudes and behaviours can be effected. An insight into the quality of life for those infected and affected by HIV/AIDS can be recorded.**
- **The community's strategies or activities to be implemented must be documented and reviewed annually.**
- **The human and financial resources committed by the community should be recorded on a yearly basis.**

Assessments in at least three communities in each district will provide a representative sample of community based information for the country. This **"local voice"** will be the key qualitative component for monitoring progress and success in the fight against HIV/AIDS. A synthesis of these will provide valuable input into national and international level HIV/AIDS policy, planning and practice.

3.3 Monitoring: Adding Value at the Regional-Level

Proposed monitoring functions:

At the sub-national (regional/provincial) level, the programme will as far as possible use existing institutional structures in the region, and where required, build the necessary institutional capacity. The close association of the initiative with the **Regional/Provincial Councils** reflects its important political mobilisation functions and overall harmonisation and advisory roles. The **Regional/Provincial Councils** will provide the necessary administrative and logistical support, such as a regional-level location for the programme and a centralised repository for information. The regional HIV/AIDS committee through the regional secretariat will receive and recommend action on the synthesised DRI reports. The regional role of information clearing-house and manager for all data received from the districts puts them in a pivotal position to: **1)** use the information by providing the relevant regional framework in harmony with the national HIV/AIDS Strategic Framework; and **2)** use the collated district experiences as an advocacy tool to influence national HIV/AIDS policy and planning.

Expanding opportunities:

Regionalisation of the DRI will open doors to an unprecedented wealth of local level information and experience. Based on the current community assessment approach, baseline information is likely to be rapidly obtained for several communities in the region alone. Valuable information on their behaviours and practices, their response to the HIV/AIDS epidemic and coping strategies can be shared. Access

to such information, especially as it is accumulated, synthesised and tracked over time, will provide national level policy makers a good opportunity to monitor progress and revise policy and national strategy as the epidemic progresses.

3.4 Evaluation

For the DRI to be nationally significant in responding to the HIV/AIDS epidemic, it requires scaling-up to cover as many communities and districts as possible. The Initiative will make it possible for districts to plan, implement and manage their own HIV/AIDS related activities. Periodic evaluation or stocktaking of DRI HIV/AIDS activity implementation will provide an opportunity for both **qualitative** and **quantitative** assessment of progress.

Whilst the self-assessment focus underscores the autonomy that communities together with local institutions need in the management and control of their own HIV/AIDS success stories, it is not an easy approach to entertain on the national level. Thus the periodic evaluations will need to take the form of 1) targeted impact studies and/or 2) stakeholder reviews which may be on a regional or national basis to provide national level overview of progress of the epidemic and the necessary policy reforms in the country.

ANNEX 1

DRI MANAGEMENT TEAM

FINANCIAL & ACTIVITY REPORT

SECTION 1: DRI Data	
1.1 District Name	**1.2** DRI Report No.:
1.3 DRI Budget	**1.4** Report Period:

SECTION 2: Activity Progress ***(include specific outputs)***
2.1 Summarise achievements and specific outputs for the period:
2.2 Detail major problems identified and actions planned or taken to overcome them:

Prepared by:	*Signature:*	*Date:*

SECTION 3: Financial Report			
3.1 Cash Position	Funds Received	Funds Spent	Balance Available

3.2 Specify disbursement as per budget

Activity	Amount Budgeted	Expenditure	Balance	
Community Assessment	$	$	$	$
Strategic Planning	$	$	$	$
Documentation Center	**$**	$	**$**	**$**
Advocacy	$	$	$	$
TOTAL	$	$	$	$

3.3 Copy of Bank Statement Attached? Yes: No: Date:

3.4 Summarise current financial status, identify problems and corrective actions.

Prepared by: *Signature:* *Date:*