

# FACILITATOR'S MANUAL

## COMMUNITY ORGANIZATIONAL DEVELOPMENT AS A TOOL FOR PREVENTION, STIGMA AND CARE IN HIV/AIDS

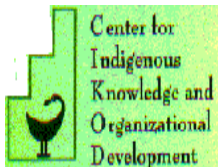


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## Glossary

PREVENT	Traditional Institutions and Positive People Preventing HIV/AIDS
CIKOD	Centre for Indigenous Knowledge and Organizational Development
NAP+	National Association of Persons Living with AIDS
COD	Community Organizational Development
CIRM	Community Institutions and Resource Mapping
CVAP	Community Visioning and Action Planning
COSA	Community Organisational Self Assessment
CIS	Community Institutional Strengthening
LeSA	Learning, Sharing And Assessing

## INTRODUCTION

### **Background to the PREVENT Project**

Traditional Authorities and Positive people Preventing HIV, code named PREVENT is a partnership project between the Centre for Indigenous Knowledge and Organizational Development, CARE International and Network of Persons Living with HIV (NAP+). The project was implemented from 2008 to December 2010 in three regions, Brong Ahafo, Western and Ashanti Regions. The project was aimed at developing an environment with hugely reduced level of stigma where communities in partnership with key stakeholders such as the district Assembly, Ghana health Services, Information Services Department and Social Welfare will engage in activities on the continuum of prevention, care and stigma.

The major objective of the project was that, by December 2010, communities in the targeted regions will be HIV/ AIDS competent communities serving as an example for replication. In implementing the project, the partners' roles were clearly defined.

The project was a collaborative initiative by CARE international, CIKOD and NAP+. In this collaboration, CARE played the leadership role and co-ordinated the activities of all the partners as well as managed the logistics and reporting to the donors. CIKOD played the main facilitating role in respect of building the capacities of traditional institutions for their involvement in the project. CIKOD used the community organisational development (COD) approach as a participatory tool for the capacity strengthening of the traditional authorities for engaging with the project. NAP+, participated at the national level and at the three target regional levels. The national structure was strengthened to provide support for PLWHAS in support groups and served as a resource to local change processes in addressing stigma and prevention issues.

A total of 54,000 people were targeted in 36 communities in the three regions.

As part of CIKOD's strategy, Traditional leaders and other community institutions were mapped in the communities and trained, community associations were formed, community dialogue fora were facilitated between communities and district stakeholders, learning visits were organised for traditional queens and festivals and traditional platforms were facilitated for HIV education programmes.

A number of achievements have been recorded so far. This includes:

1. 84 chiefs and queens trained in basic facts about HIV/AIDS
2. 180 community action research teams were formed
3. 32 community Associations formed
4. 16 queens from selected districts participate in exchange learning visits
5. 12 district citizen dialogue forums facilitated between communities and district stakeholders
6. 32 communities supported by district health directorates to carry out Know-your status campaigns

The projects sought to disseminate best practices and achievements in Houses of chiefs, traditional councils, district Assemblies, etc to allow for learning and sharing success stories.

## **Objectives of the Manual**

The COD process was adopted as the main approach for strengthening traditional institutions to address issues of Prevention, stigma and Care in HIV/AIDS. The objective of this manual is to provide a training tool for sharing the best practices that emerged from using the COD approach. The ultimate goal is to facilitate a widespread adoption of the COD approach by development workers who are seeking to work with traditional institutions and mechanisms for addressing stigma, care and prevention of HV/AIDS at the community level. The specific objectives of the manual are :

1. Provide a comprehensive principle for working with community Institutions
2. Provide a culturally sensitive approach to community profiling of information, entry, mapping, action planning, community dialogue, institutional strengthening , monitoring and sharing lessons.

## **Who can use this guide?**

This guide is designed primarily for field staffs, NGOs, Houses of chiefs, District Assemblies, and Health Directorates working in the area of HIV/AIDS and health related issues.

The manual consist of processes of entry and community preparation, steps to take to strengthen the capacity of institutions and facilitate their active engagement and ownership in external interventions like PREVENT, steps to plan and implement initiatives.

## **Conclusion**

The manual should be seen as an innovative approach to participatory community-based development. It will add value to the conventional approaches of addressing HIV issues in the community by ensuring active engagement of traditional institutions and mechanisms in the project. The manual provides some answers to the challenges of community participation, ownership and sustainability of activities and initiatives after donor funding is withdrawn.

## **TOOLS IN COMMUNITY ORGANIZATIONAL DEVELOPMENT**

### **Community Institutions and Resource Mapping (CIRM)**

The purpose is for communities to map out the existing institutions, both indigenous and formal, as well as the natural, socio-cultural and spiritual resources in the community and their potentials as starting points for community development. CIRM is a participatory approach for community entry and diagnosis as it guides the community through a self-examination process and exposes what structures and resources, human as well as natural that are already at hand in the community. CIRM can be further facilitated, to motivate community visioning on possible self-reliant community initiatives and action plans to achieve the vision with support from external resources

### **Community Visioning and Action Planning (CVAP)**

CVAP is another component of the COD framework and a natural next step after the CIRM, as it helps the community decide how best to make use of its resources. In short the CVAP is an identification of the development direction it wants to go and how to get there in the context of the institutions and resources available in the community..

It consists of two parts. First there is a visioning-process where the community brings up visions and dreams relating to the resources at its hands. At the core of the visioning process is to have the community reflect on where it wants to go as a community - what future it sees for itself.

After the visioning process follows the programming where the community prioritizes its development needs, develops concrete action plans and agrees on how best to make use of the resources identified through the CIRM. The purpose of C To have the community make a vision about the future based on its available resources and develop an action programme to help it make the vision come true.

### **Community Organisational Self Assessment (COSA)**

The COSA is a methodology that enables communities to perform a self-examination process. COSA is based on the underlying assumption that communities already have some organisational capacities which they have been and still are using to manage their own development processes. During the COSA the community will become aware of its current capacities and what capacities it lacks in order to make the vision identified in the CVAP come true. COSA can be carried out with the whole community or individual groups that have been specifically tasked with implementing the action plans. The purpose of COSA is to guide the community group through a self-examination process in order to identify its organisational capacity potentials and/or gaps.

### **Community Institutional Strengthening (CIS)**

Through the CIRM a wide range of local institutions might be identified, however some of these may not be strong enough to carry out their functions or take on new responsibilities as dictated by the developmental needs of the community. Therefore the CIS has been developed to address the institutional capacity gaps to enable communities implement their development initiatives. The purpose of CIS is to address the organisational gaps of community groups in order to enhance their capacity to take on new responsibilities related to the development of the community.

## **Learning, Sharing And Assessing (LeSA))**

LeSA is a community peer review mechanism that enables communities with similar development agendas to exchange developmental experiences and knowledge.

The LeSA methodology has been developed in order to guide communities to learn from each other and share experiences amongst themselves – Learning, Sharing and Assessing (LeSA). The background of LeSA is the fact that most evaluations of development projects leave little or no opportunity for the community itself to actually learn from the knowledge derived. The purpose of LeSA is to facilitate a community peer review process to enhance natural assessment for the purpose of learning and sharing among communities engaged in similar activities.

**UNIT ONE**  
**GUIDING PRINCIPLES FOR WORKING WITH INDIGENOUS INSTITUTIONS AND**  
**MECHANISMS FOR ADDRESSING PREVENTION, STIGMA AND CARE IN**  
**HIV/AIDS**

**Session 1: General Issues**

**1.1 General objective of topic**

To identify and assess indigenous institutions and their mechanisms to address prevention, stigma and care in HIV/AIDS in local communities. The objective can be achieved by understanding the guiding principles that relate to indigenous institutions and the mechanisms to address epidemics (such as HIV and AIDS) via prevention, stigma and care.

**1.2 Resources needed**

Human and material resources are needed.

Human resource: A team with at least a member well conversant with HIV/AIDS issues, cultural knowledge, as well as skills in communication, literacy, drama and art.

Material resources: These may to some extent depend on the venue. However, the following will be relevant: Pictorial objects and charts, film projector, camera, flip chart (sheets) and writing/drawing tools.

**1.3 Duration:**

**1.4 Introduction: HIV/AIDS, prevention, stigma and care from a cultural perspective**

*1.4.1 What is HIV/AIDS?*

HIV and AIDS are acronyms. HIV means *Human Immunodeficiency Virus* and AIDS means *Acquired Immune Deficiency Syndrome*. HIV is the pathogen that causes AIDS. It is transmitted only between human beings. It is not transmitted between humans and animals. HIV breaks down the immune system, or makes it “deficient.” This means that the body cannot protect itself from diseases.

AIDS is not hereditary, but acquired (obtained) through an event or activity which leads to infection with HIV. When one is diagnosed of AIDS, it means that the person has been diagnosed with a collection of symptoms and signs of a number of diseases as a result of multiple infections known as opportunistic infections. There is no known cure for AIDS. However, it can be treated with Highly Active Anti-Retroviral Therapy (HAART).

Culturally, there are certain infections (or diseases) that affect humans but with no known cure. The interpretations given to such infections may differ from healer to healer, community to community and culture to culture. It is possible to have some of such infections similar to or same as HIV/AIDS. How such infections were/are prevented, diagnosed, treated, ‘cured’ and care given to patients are worthy of study.

*1.4.2 How do we prevent HIV infection?*

Three main modes of infection have been described in Ghana. These are unprotected heterosexual activity (80%), mother-to-child transmission (MTTC) (15%) and use of infected piercing objects (5%). All these modes are common in every community. Since HIV is not curable, the need to prevent it becomes crucial.

Culturally, sex is regarded sacred, and reserved for those the community regard as matured, and have thus gone through certain rites of passage such as 'bragoro' or 'dipo'. It is a taboo to have sex before such rites of passage. Various indigenous institutions in Ghana therefore use cultural ethics and laws to regulate sexual activities. These include stories, wise sayings and proverbs, as well as strict sanctions and other punitive measures against those who go against such ethics and rules. These were held strongly because culturally, the society is governed by human, material and spiritual worlds. The spiritual attachment enhances the dignity and sacredness of such rites, hence, their adherence.

Nevertheless, there is also the need to tease out some cultural practices that enhance heterosexual activities which in turn promote HIV transmission. It is imperative to identify these practices and address their potential impacts on HIV transmission as a means to curtailing the spread of the virus.

Though heterosexual activity is the main mode of infection, MTTC and use of piercing instruments cannot be ignored. For instance:

1. What cultural practice(s) involves the use of piercing objects? How is it done?
2. Which institutions (indigenous and formal) are involved?
3. How can these be done to prevent HIV infection?

Answers to these questions become significant in HIV prevention issues.

Currently, rural communities have also been exposed to western cultures, education and technology. To what extent do these affect cultural values that relate to sexual activities? How do the youth in rural communities respond to new cultural exposures? Such issues are relevant in HIV prevention through visioning and planning.

#### *1.4.3 What is stigma?*

Stigma refers to the prejudice and discrimination directed at people. In many cases people living with HIV are stigmatized. It can result in people living with HIV and AIDS being rejected from their community, shunned, discriminated against or even physically hurt. Reasons such as ignorance and fear account for stigma. Ignorance and fear are usually embedded in misconceptions about HIV and AIDS.

In cultural communities, people use stigma mostly to achieve good behaviours. People compose songs and poems about known thieves, the sexually immoral and drunks. They sing and recite these during festivals and communal activities. It is however a taboo to stigmatize the sick, vulnerable and disable. So:

1. How do individual and indigenous institutions address issues relating to HIV stigma in cultural communities? What account for fear of HIV and AIDS?
2. What traditional measures are available to addressing stigma?

It must be emphasised that dealing with stigma will not only enhance preventing behaviour, but also promote care.

#### *1.4.3 Care and tradition*

Caring for one another is a communal duty of every member of any traditional society in Ghana. Values such as sharing, mutual aid, interdependence, love, compassion, social relations and harmony are some of the cultural values. These manifest communally in a caring society. To address this issue, one needs to find answers to the following:

1. What are the various traditional structures/institutions responsible to promote care for children, adults, aged, the sick, and the invalid?
2. Which persons in the society take care of the sick including AIDS patients?
3. What challenges exist in giving care to the sick including AIDS patients?

These and other related issues need to be well discussed to promote care and support for people living with HIV/AIDS.

### **1.5 Guiding principles for working with indigenous institutions**

Generally, three main principles become crucial when working with traditional societies and indigenous institutions and their mechanisms to implement any project or programme such as addressing prevention, stigma and care for HIV/AIDS. These are preparation of self, preparation of the community and attitude (respect for cultural values and appreciation of worldviews).

- Preparation of the self: Every member of the team must prepare himself or herself in other to achieve stated objective(s). The following steps are recommended.
  - You need to ‘de-school’. This involves unlearning the negative perceptions that we acquired through western education and religion about African traditions and their worldviews.
  - You need to ‘re-school’. After being ‘de-schooled’, you need to be ‘re-schooled’. This will require that we become open minded and look at the culture and traditions of the community from an appreciative enquiry perspective. It requires moving from evaluating traditional people from a western worldview to the traditional Ghanaian worldview. Only then will the field worker begin to appreciate the values and worth of indigenous knowledge and practices.
- Preparation of the community: This is a ‘symbiotic’ process. While the community must prepare to receive you, you must fully prepare to be accepted. Though these may differ from community to the other, the following steps can serve as a guide.
  - Power analysis: This is to analyse the various institutions and their corresponding power and authority. This will enable you to follow the appropriate protocol.
  - Community entry: When power analysis is well done, it enhances fruitful community entry process. In entering the community you need to know:
    - when to enter and through which process
    - who to lead the team (usually, an adult male who understands the cultural norms of the community)
    - language and expressions to use. For example, how to greet and respond to greetings. It must be noted that is not acceptable to speak in proverbs at

- the palace, and without permission in the mist of elders and chiefs outside the palace (see Box 1).
- materials permissible in the community must be used. For example, among the Akans, you have to present two bottles of schnapps when visiting a paramount chief. How you dress is very crucial here too.
  - when and where is it appropriate for the exercise? And who should facilitate or lead? (not clear what this means)
- Attitude (respect for community worldviews): How successful the programme will become largely depend on the attitude of members of the team. But if preparation of self is well conducted you can have cordial and harmonious interactions. You must have pro-attitude towards the community by:
    - appreciating their ‘cosmovision’ or worldviews and spirituality. The worldviews commonly relate to beliefs (about God, gods, ancestors, totems, reincarnation, etc.), and customs (such as rites of passage, leadership, etc.).
    - respect for cultural values such as respect for aged, fidelity and chastity, faithfulness in relationships, etc.

Clarity of the programme is also crucial. Issues to discuss must be explained (in the language of participants/community) very well to achieve mutual understanding. Group work is usually appropriate since it reinforces and build on already existing communal behaviour of traditional communities. Tools to use to internalise issues (HIV prevention, stigma and care) include role play, drama, story telling, etc.

## Session 2: Practice

### Tasks of facilitator

The facilitator is the focal person around which all activities revolve. S/he needs to have in-depth knowledge not only on COD tools, but also PRA as well as issues in HIV/AIDS. The facilitator must be guided by the following.

Table 1.1:

<b>Facilitator’s Tasks</b>	
Purpose	To facilitate internalisation To achieve group work effectiveness To promote participation
Duration	20 minutes
Tasks	<p><b>Discussion:</b> Lead all discussions on how to address HIV prevention, stigma and care in traditional societies.</p> <p><b>Group composition:</b> Conduct group analyses to identify group dynamics. He/she must consider group characteristics such as sex, age, status and group accordingly. To encourage member participation and utilisation in each group, the minimum size must be four (4) and maximum size must be six (6).</p> <p><b>Literacy issues:</b> If none of a group is literate, choose a member from</p>

	<p>the team to assist such a group in all literal activities.</p> <p><b>Tasks and timelines:</b> Give specific tasks and timelines to each group. Tasks can differ per group. However, timelines must be uniform to ensure equal participation during group work, group presentation of outcome and other general activities.</p> <p><b>Facilitator assistant:</b> Select an assistant from the team to help in facilitating the discussions. This must be different from the one who will be writing the report.</p>
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## 1.6 Internalisation

The use of participatory activities leads to fruitful internalisation process. Use of traditional methods of reinforcing understanding is appropriate. Methods such as story-telling, drama, role-play, etc can be used.

## 1.7 Group tasks on HIV prevention, stigma and care

Each group must select a *moderator* and a *secretary*. The *moderator* regulates and coordinates group discussions and other activities while the *secretary* writes issues, plans and roles assigned (if drama/role play will be used). The *secretary* or any member from the group as decided by the group must present issues discussed using any appropriate material. If a role play or drama is the choice, then those to represent the group will present it.

Table 1.2:

<b>Group Tasks</b>	
Purpose	To assess indigenous institutional mechanisms for addressing prevention, stigma and care
Duration per task	30 minutes
Task A	<ol style="list-style-type: none"> <li>1. Which pre-existing cultural practices:               <ol style="list-style-type: none"> <li>a. enhance HIV transmission,</li> <li>b. encourage stigma and discrimination, and</li> <li>c. discourage care and support?</li> </ol> </li> <li>2. Which institutions/persons are responsible for these practices in a, b, c?</li> <li>3. What measures must be instituted to check the development of these practices and institutions/persons in a, b, c?</li> </ol>
Task B	<ol style="list-style-type: none"> <li>1. Which pre-existing cultural practices:               <ol style="list-style-type: none"> <li>a. prevent HIV transmission,</li> <li>b. discourage stigma and discrimination, and</li> <li>c. promote care and support?</li> </ol> </li> <li>2. Which institutions/persons are responsible for these practices in a, b, c?</li> <li>3. What measures must be instituted to check the development of these practices and institutions/persons in a, b, c?</li> </ol>

## 1.8 Presentation plan

Group presentation must be done orderly. For example, if the group names were Group 1 or A, Group 2 or B, etc, then the presentation must follow in that order (numerically or alphabetically).

This enhances smooth presentation and avoids forgetfulness of unnecessary discussion on which group to present first, second, and so on.

In cases where real names were assigned to groups, presentation arrangement must be done before the group work.

### **1.9 Presentation of outcome**

Each group, led by the secretary (or any member selected) must present the outcome of group work. During presentation, group members can seek the attention of the secretary and make some interventions such as corrections or further explanation to an issue if they deem necessary.

Two methods are available in group presentation. These are:

1. All the members face the other participants while the secretary presents the outcome. Depending on the presentation material being used, the members can either stand or sit. It is ideal however, if the secretary or whoever is to present the outcome stands to enhance accessibility.
2. Only the secretary or whoever is assigned by group stands before all participants to present outcome. The rest of the group members sit with the rest of the participants.

These methods do not apply if the presentation is a role play or drama.

### **1.10 Discussions of issues arising from activities and presentations**

Discussion must proceed immediately after group presentation of outcome. Issues arising from the presentation must be discussed orderly according to the outline of tasks. Discussions can take the form of questions, contributions and suggestions. The following are guidelines.

1. The group that presents an outcome must begin the discussion with their contributions and clarifications.
2. The group must first respond to questions raised before other members express views.
3. Members of a group that presents an outcome can ask questions relating to views from other participants on an issue.
4. Any participant who wishes to make an input must first 'catch the eye' of the facilitator by raising the hand or by proxy (if physically challenged).
5. Each issue must be addressed exhaustively by all before a next issue is introduced. This must not however affect quality time).
6. Assistant facilitator must record/write all tacit, factual and non factual issues for facilitator synthesis.

***Stress-Out:** If the facilitator realises that participants look tired, dull, etc. which affects effective discussions, he must ask any of the participants (or him/herself) to introduce any activity (with song(s)) to refresh or stress-out the body and mind.*

### **1.11 Syntheses**

The facilitator must, after all group presentations coordinate all ideas generated, issues raised as well as recommendations made into a comprehensive coherence under prevention, stigma and care. This factual coherence must relate to the guiding principles for working with indigenous

institutions. The facilitator must bear in mind issues discussed earlier on preparation of self and preparation of community. The following are guidelines.

1. Synthesise issues discussed under each of the following; prevention, stigma and care (see Box 2).
2. Write syntheses on a board/flip chart and verbally communicate them to participants for validation/approval.
3. Allow participants who wish to make useful modification(s) to syntheses.

**Note:** Indigenous institutions believe in both factual and tacit knowledge, and that their ontology and epistemology relate to the natural, social and spirit worlds.

### 1.12 Conclusions

Conclusion must comprise highlights on how to work with indigenous institutions to prevent HIV/AIDS, address stigma and promote care. This must be participatory to reinforce new issues learnt and build on existing knowledge. In order to prevent re-discussion of issues, the facilitator can use the question-answer method to guide the process. The following questions are relevant.

1. How do we work with indigenous institutions to prevent HIV/AIDS?
2. How do we work with indigenous institutions to address stigma?
3. How do we work with indigenous institutions to promote care?



Source: Kurian (2006)

## Facilitator's notes

### Box 1.1: How to work with indigenous institutions

Indigenous institutions are locally instituted institutions that regulate, coordinate, promote and provide physical, socioeconomic, cultural and spiritual needs and general welfare of community members. These institutions are instituted based on indigenous knowledge of the people comprising beliefs, customs and practices. These include chieftaincy, *asafo*, clans, *nnoboa*, priesthood, women's and men's groups, etc.

Each of these institutions has guiding traditional/cultural principles that guide it. Therefore to work with any needs careful understanding about their functions/roles, framework within which it operates, and the underpinning principles that guide their activities. Two main preparations are recommended; **preparation of self** and **preparation of the institution**.

As a facilitator, or programme officer, what you say, how you say it and when you say it are crucial lingua franca. The success of the programme/project depends largely on effective use of traditional lingua franca. In one's lingua franca is his/her attitude. It also depicts cultural virtues such as respect, humility, love, patience, communal, etc. Anything contrary is a recipe for programme failure. For instance;

*'a case is known about a project officer who corrected a chief in state (which is a taboo). The community immediately rejected the project due to the attitude of the said project officer'.*

When such a situation happens, it does not only affect the impending programme, but other future programmes by same or any other organisation with similar agenda. With HIV issues being sensitive, it is very imperative for facilitators to employ utmost prudence in expression.

### Box 1.2: Key issues in Prevention, Stigma and Care

Saving lives is the paramount goal of all HIV programmes. Successful HIV programmes utilize all approaches known to be effective, not implementing one or a few select actions in isolation. These are to address prevention, stigma and care.

**Prevention:** Frameworks that have been implemented over the years include:

- **A B C** (Abstinence, Be faithful, Condom use)
- **A B** (Abstinence, Be faithful)
- **S A V E** (Safer practices, Available medications, Voluntary counselling and testing, Empowerment through education)

**Stigma:** The issue of stigma manifests in all facets of human life and behaviour. HIV-related stigma is multi-layered. That is, it tends to build upon and reinforce negative connotations by associating HIV and AIDS with already-marginalized behaviours. It manifests at three main levels. These are:

- Individual level (self-stigmatization)
- Family
- Community level
- Institutional level and
- National level.

Stigma has negative effect on prevention and care. When stigma is acted upon, it leads to discrimination which also leads to human rights violation. It must therefore be addressed from a multi-facet dimensions.

**Care:**

Care refers to all clinical, physical (material), psychosocial and spiritual assistance tailored at addressing the specific needs of people living with HIV/AIDS. Care-giving is a continuum of activities from the time of HIV detection through the stages of AIDS till death. Two types of care-giving exist. These are *formal* (provided at government/private hospitals/clinics) and *informal* (usually home-based and community-based).

## UNIT TWO

### COMMUNITY INSTITUTIONAL AND RESOURCES MAPPING FOR HIV/AIDS PREVENTION, STIGMA AND CARE

#### Session 1: General Issues

##### 2.1 General objective of topic

To profile community institutions and resources that address HIV prevention, stigma and care in the community.

##### 2.2 Materials needed

Human resource: A team conversant with use of COD tools specifically CIRM (see ...) for HIV/AIDS prevention, stigma and care.

Material resources: Flip charts, markers, other relevant stationery, camera (if consented), other logistics including pictorial objects, laptop and/or film projector, etc.

##### 2.3 Duration

##### 2.4 Introduction

CIRM is a participatory approach that guides the community through a self-examination process. It enables communities or groups to identify and map the various formal, non-formal and informal structures as well as human, natural and spiritual resources (see Box 2.2) that exist in the community. Thus, for communities to facilitate self-reliant initiatives such as prevention of HIV, addressing stigma and promoting care, CIRM can be used to identify existing resources and the need for selective external support. CIRM becomes the platform or starting point for CVAP (see Unit Three).

#### **Purpose of CIRM:**

The purpose is for communities to map out the existing institutions, both indigenous and non-indigenous, as well as the natural, socio-cultural and spiritual resources in the community and their potentials as starting points for HIV education on prevention, stigma and care.

##### 2.4.1 *Composition of CIRM Team*

- The CIRM team must comprise minimum of five and maximum of seven.
- Generally, least two members of the team must either be males or females. However, if target community is predominantly female (e.g. women groups), it is advisable to have two-thirds female team and vice-versa.
- The team must understand not only issues in HIV but also the traditional structures and dynamics that make up a community.
- Members of the team must have or be introduced to basic skills in participatory rural appraisal (PRA) as well as ethical issues in research and data collection.

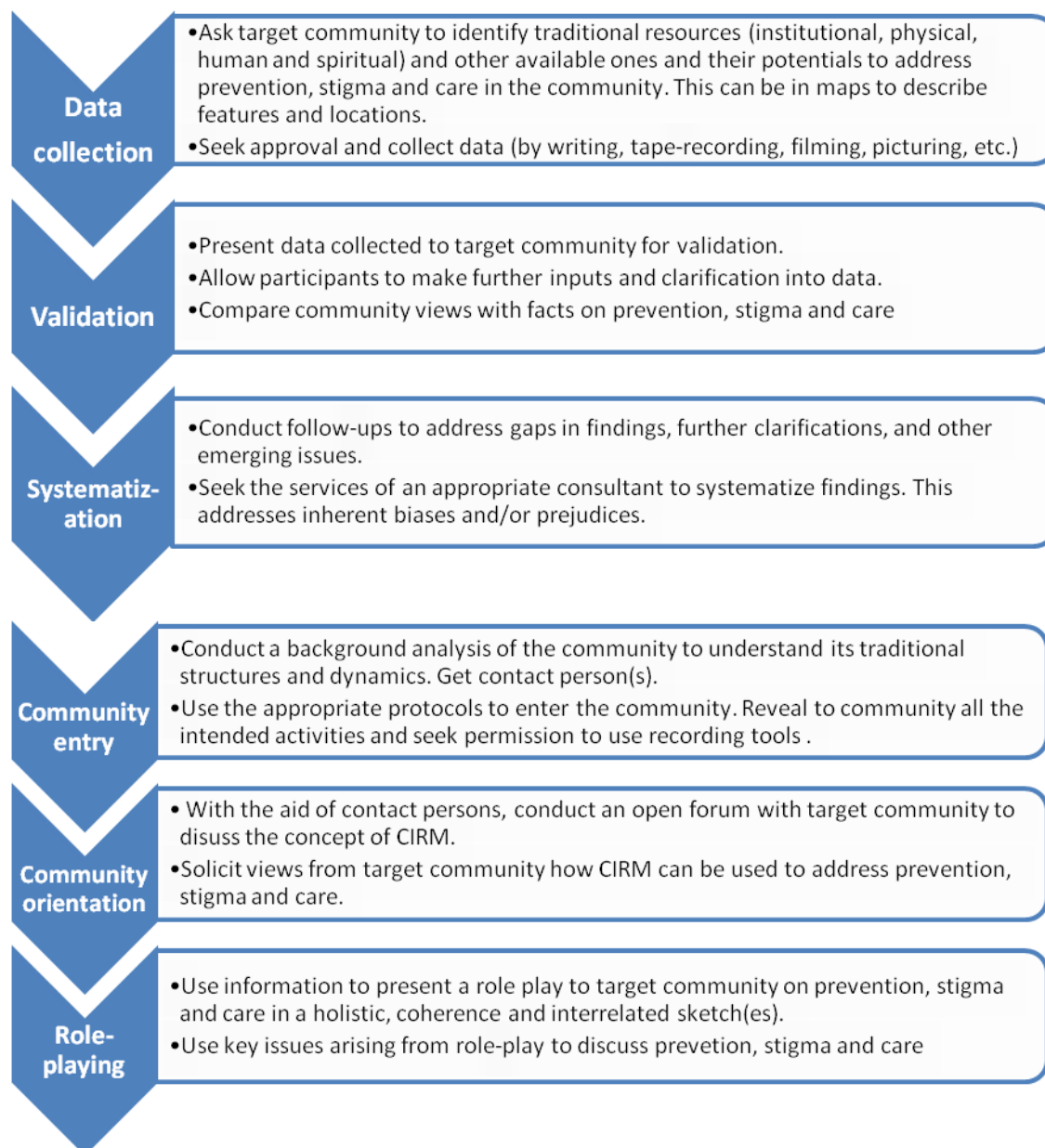
##### 2.4.2 *Steps to facilitate CIRM*

CIRM comprises a number of participatory processes or steps. In addressing issues regarding HIV prevention, stigma and care, attention must be paid to these interrelated steps. These are

community entry, community orientation, formation and preparation of CIRM Team, data collection, documentation and validation, and systematization.

HIV prevention, stigma and care programmes in communities become relevant to the local people and their indigenous institutions with this tool because it is culturally participatory and traditionally significant not only to specific indigenous institutions but the entire cultural landscape. Below are the steps to address the issues of HIV using CIRM.

### **CIRM Process for HIV prevention, stigma and care**



## Session 2: Practice

### 2.6 Tasks of facilitator

The tasks of the facilitator may not be different from those at the internalisation stage. If participatory method (s) that would be employed will differ from the method used at the internationalisation stage, then the facilitator must, among others, be guided by the following.

Table 2.1:

Facilitator's Tasks	
Purpose	To build on internalisation To guide the construction of identification mapping for CIRM
Duration	15minutes
Tasks	1. Group participants appropriately taking into cognisance group dynamics. 2. Define clearly and specifically group tasks. 3. Discuss and agree with participants symbols and their meanings to be used during mapping. 3. Encourage participants to draw from and transfer local knowledge in local observation mapping. 5. Provide writing materials (e.g. flip sheets, other drawing materials, etc) to groups.

### 2.5 Internalisation

The process of internalisation, as has earlier been discussed is crucial for further interactions and learning. The process involves use of practical ways of reinforcing understanding gained with regard to the concept of CIRM. Since participants already know the various institutions for specific community engagements, the focus of the internalisation process must target these institutions as a starting point for effective interaction on intended the issues about HIV. For effective internalisation, all participants must be involved. Grouping participants to address the following issues can achieve purpose.

1. Identify and map out (not to scale) indigenous and non-indigenous institutions that address health issues.
2. Show the relationship(s) between such institutions.
3. Identify and show, with examples, the natural, socio-cultural and spiritual resources available.
4. Map these resources with the institutions identified in 1 and show how they are harnessed and used to address their health needs.

### 2.7 Group tasks on HIV prevention, stigma and care

Participants after going through internalisation must transfer skills and knowledge gained onto actual group tasks. This time, the focus will be on CIRM and HIV prevention, stigma and care. Using similar or same skills at internalisation stage, group tasks should comprise the following.

Table 2.2

<b>Group Tasks</b>	
Purpose	To develop action plans to address prevention, stigma and promote care
Duration per task	45 minutes
Task A  <b>Institutional mapping and relationships</b>	1. Identify and map all indigenous institutions in the community.  2. Identify and map all non-indigenous institutions in the community.  3. Indicate which of these institutions are appropriate to facilitate HIV prevention, stigma and care activities.  4. Show the inter-linkages and interrelationship(s) between these institutions and their potential to facilitate prevention, stigma and care activities.
Task B  <b>Resource mapping</b>	1. Identify and map all resources in the community.  2. Indicate with symbols which of these resources are natural, economic, socio-cultural, political and spiritual.  3. Which of these resources have the potentials to be tapped for issues in HIV prevention, stigma and care?  4. Show the inter-linkages and interrelationship(s) between these institutions and their potential to facilitate prevention, stigma and care activities.

## 2.8 Presentation plan

Group presentation must always be done orderly. The plan may be same as discussed earlier in 1.8 of Unit One.

## 2.9 Presentation of outcome

Guidelines to group presentation outcome as discussed earlier apply here too (refer to Unit One, 1.9).

***Stress-Out:** If the facilitator realises that participants look tired, dull, etc. which affects effective discussions, he must ask any of the participants (or him/herself) to introduce any activity (with song(s)) to refresh or stress-out the body and mind.*

## 2.10 Discussions of issues arising from presentations

Discussion guidelines and procedures are similar to those of Unit One (1.10). However, emphasis must be placed on institutional and resource analysis when discussing the inter-linkages and interrelationships between institutions and resources respectively. This is very important to estimate potential institutional and resource conflicts that can occur in addressing prevention, stigma and care issues.

## **2.11 Syntheses**

The processes of syntheses are not very different from those discussed earlier in Unit One (1.11) which indicate what the facilitator needs to do. It is appropriate also to do the following.

1. Refer to map(s) when the need arises to affirm knowledge, address inconsistencies and indicate relevant emerging issues.
2. Ensure validity of issues and also relate them to existing [legal] frameworks to consistency or otherwise for possible remedial suggestions from participants.
3. Avoid re-discussion as much as possible.

## **2.12 Conclusions**

Conclusion must comprise key relevant issues that have been discussed and validated as facts or acceptable consensus views. The purpose is to reinforce learning (also known as take-home knowledge). The facilitator must be guided by the following.

1. Summarised take-home knowledge on writing board or by PowerPoint presentation highlighting only key issues relevant to prevention, stigma and care.
2. Be conscious to avoid re-discussions.
3. If some issues are still unresolved, or there are emerging inconsistencies refer to them and schedule date and time for discussions on them. Give these to participants as take-home task(s).
4. Indicate that next process after CIRM is community visioning and action planning (CVAP). This is discussed in the next unit.

## Facilitator's notes

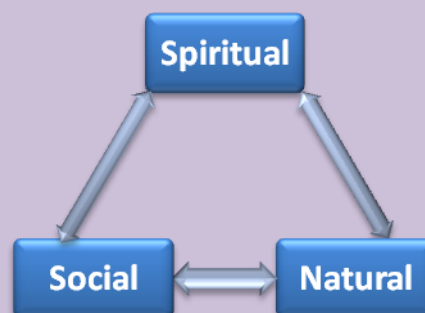
### Box 2.1 Essence of CIRM for HIV prevention, stigma and care

The multi-dimensional and multi-faceted nature of HIV and its related issues call for an eclectic approach to address the epidemic. Therefore development actors need to understand the need to employ tools that can identify existing structures within local communities, and draw out various resources in the community for such purpose.

CIRM is one of such tools developed by CIKOD to unearth community structures and resources which have the potentials for community development in general and for other specific programmes and project such as to address HIV prevention and stigma as well as to promote care and support for persons living with HIV/AIDS (PLHIVAs), orphans and vulnerable children (OVC).

CIRM is a PRA tool and therefore considers the worldviews and needs of the community. Thus, existing traditional institutions and indigenous resources become crucial in CIRM process. Development actors therefore need not impose on any community external institutions and resources. Rather, through active participation, a community must identify appropriate external institution(s) and resource(s) to complement existing ones.

### Box 2.2 Indigenous worldviews and HIV



The worldviews of indigenous communities comprise the interrelatedness, interconnectedness and interdependence of three main resources as depicted by the multidirectional cycle above. These are spiritual, social and natural resources. To address HIV related issues in indigenous communities, one needs to recognise the essence of worldviews and how such worldviews explain the issues being addressed and the relevant resources appropriate to be used. It must be emphasised that traditional worldviews differ from community to community and culture to culture.

**Blank sheet(s) for relevant issues**

**UNIT THREE**  
**COMMUNITY VISIONING AND ACTION PLANNING FOR HIV/AIDS**  
**PREVENTION,**  
**STIGMA AND CARE**

**Session 1: General Issues**

**3.1 General objective:**

To facilitate community visioning and planning to address prevention, stigma and care in HIV/AIDS.

**3.2 Materials needed**

Human resource: A team conversant with use of COD tools specifically CVAP (see ...) for HIV/AIDS prevention, stigma and care.

Material resources: Flip charts, markers, other relevant stationery, camera (if consented), other logistics including pictorial objects, laptop and/or film projector, etc.

**3.3 Duration:**

**3.4 Introduction to CVAP and HIV prevention, stigma and care**

CVAP helps a community to decide how best to make use of its indigenous resources to plan. Using it as a tool to addressing prevention, stigma and promoting care, CVAP involves identifying the direction of a community towards achieving prevention, stigma and care targets in the short term, medium term and the long term.

**Purpose of CVAP:**

To enable communities have a conclusive vision statement prioritising appropriate prevention and anti- stigma measures as well as promoting care towards an appreciable levels, and developing action plans to achieving the vision.

The CVAP goes through four main processes. These are the visioning, programming or prioritisation, action planning.



**3.4.1 Steps to facilitate CVAP**

The steps for CVAP explain the various deliberations (also known as CVAP workshop) designed to discuss two main processes to address prevention, stigma and care. These processes are **visioning** and **programming**.

During the **visioning** process participants express their views about future aspirations they expect for the community in terms of preventing HIV infection, dealing with stigma and stigma-related discrimination as well as promoting care-giving for persons living with HIV/AIDS and orphans and vulnerable children (OVC) with or without HIV. This becomes the **vision statement** of the community about HIV prevention, stigma and care. The following steps are appropriate during visioning.

1. What were the state of HIV prevention, stigma and care in the community about ten (10) years ago?
2. What are the current state of issues about prevention, stigma and care in the community?
3. What do we aspire to achieve in the next ten (10) years with regard to prevention, stigma and care?

**Note:** If these steps are well addressed specifically, it provides a defined framework for programming.

The process of **programming** provides guidance to the community or participants to prioritize aspirations during visioning to facilitate the drawing of achievable action plans taking into account available local and judicious selection of external resources. The following steps are worth considering.

1. How do we achieve our set visions/aspirations (vision) regarding prevention, stigma and care?
2. What programmes, projects and activities can achieve these visions/aspirations?
3. What timelines guide each programme, project and activity?
4. Which local resources and external resources are available for these programmes, projects and activities?
5. What shall be the process, output and outcome of the programmes, projects and activities at the community and traditional area?
6. Who shall be responsible and accountable to the following:
  - a. Implementation of programmes, projects and activities?
  - b. Periodic monitoring and evaluation of programmes, projects and activities?
  - c. Documentation of implementation, monitoring and evaluation processes?
  - d. Legal issues of programmes, projects and activities?

Having addressed the issues above, a concrete action plan can be formulated. The plans must be **SMART** (see Box 2.2). After formulation, the plans must be approved through participation and consensus by all participants/community. This becomes the **action plan** of the community.

For the purposes of legality and/or authentication, an appropriate process can be used to bind all members or the community to the action plan. In some cases, any, combination of or all of the following may be applicable:

- Community contract (signed by representatives)
- Memorandum of Understanding (MoU) (signed by representatives)
- Rituals and sacrifices (performed by appropriate persons)

These become crucial owing to a number of reasons.

1. It signifies *consensus ad idem* (meeting of minds) of all participants.
2. It addresses issues regarding legality and authentication.

3. It establishes a platform for evidence, continuity and sustainability through communal commitment.
4. It appreciates worldviews and respect for cultural values; an indication of human-physical-spirit interdependence, interconnectedness and interrelationship for a unifying success.

## Session 2: Practice

### 3.6 Tasks of facilitator

The tasks of the facilitator largely depend on the method(s) used at the internalisation process which also informs group tasks and facilitation. Apart from tasks specifically stated and explained in UNIT 3, the facilitator must be ingenious. The following steps serve as guidelines to assist groups (see also Box 3.1).

Table 3.1:

<b>Facilitator's Tasks</b>	
Purpose	To facilitate internalisation To guide development of action plans
Duration	15minutes
Tasks	<ol style="list-style-type: none"> <li>1. Develop three sessions to address the three main group tasks.</li> <li>2. Define clearly and specifically group tasks.</li> <li>2. Show how groups must address tasks.</li> <li>3. Illustrate to group the form and structure of presentation taking into account any method(s) prescribed by group.</li> <li>4. Group participants into desirable groups and assign tasks accordingly. Each group must address all tasks.</li> <li>5. Provide writing materials (e.g. flip sheets, markers, etc) to groups.</li> </ol>

### 3.5 Internalisation

The internalisation process is to reinforce learning and build on previous knowledge gained through experience from formal, non-formal and informal avenues. A practical issue such as environment conservation can be used for internalisation. For instance, use of *forecast mapping* (see Box 3.2) can be adopted to internalise issues relating to prevention, stigma and care. Other appropriate methods (e.g. drama, role-play, etc.) which are participatory are recommended.

### 3.7 Group tasks on HIV prevention, stigma and care

Apart from selecting a group moderator and a secretary, group tasks must focus on visioning and programming to address prevention, stigma and care. Three main categories of tasks have been classified under CVAP.

Table 3.2:

<b>Group Tasks</b>	
Purpose	To develop action plans to address prevention, stigma and promote care
Duration per task	30 minutes
Task A	<ol style="list-style-type: none"> <li>1. a) What were the states of HIV prevention, stigma and care issues ten (10) years ago?</li> <li>b) Which institutions and persons were involved in each of these core issues?</li> <li>c) What were the challenges faced in addressing each of these core</li> </ol>

<b>Visioning</b>	<p>issues?</p> <p>2. a) What are the current states of HIV prevention, stigma and care issues?  b) Which institutions and persons are involved in each of these issues?  c) What are the current challenges facing prevention, stigma and care issues?</p> <p>3. What are our aspirations and expectations in the next ten (10) years regarding prevention, stigma and care issues?</p>
<b>Task B Programming</b>	<p>1. What practices/measures/activities must be put in place?  2. How do we achieve our set visions/aspirations (vision) regarding prevention, stigma and care?  3. What programmes, projects and activities can achieve these visions/aspirations?  4. What timelines guide each programme, project and activity?  5. Which local resources and external resources are available for these programmes, projects and activities?  6. What shall be the process, output and outcome of the programmes, projects and activities at the community and traditional area?  7. Who shall be responsible and accountable to the following:  a. Implementation of programmes, projects and activities?  b. Periodic monitoring and evaluation of programmes, projects and activities?  c. Documentation of implementation, monitoring and evaluation processes?  d. Legal issues of programmes, projects and activities?</p>
<b>Task C Action-Plan formulation</b>	<p>1. Formulation of concrete plans based on programming.  2. Develop sustainability/continuity maps.  3. Authenticate, legalize and decentralise action plans.</p>

**Note:** If participants are residents, the last task can be given as homework. This prevents monotony or boredom associated with longer time spent on same issue.

### 3.8 Presentation plan

Group presentation must always be done orderly. The plan may be same as discussed in earlier unit (refer to Unit One, 1.8).

### 3.9 Presentation of outcome

Guidelines to group presentation outcome as discussed earlier apply here too (refer to Unit One, 1.9). But based on these tasks (Task A, B, C) the following guidelines must be followed.

1. All groups must present (in an orderly manner) their outcomes on Task A.
2. After discussion, groups present Task B.
3. After discussion, groups present Task C.

This approach is imperative because:

1. Each group will be assigned all tasks (i.e. Task A, B, C).
2. Tasks A, B and C are interrelated.

### **3.10 Discussions of issues arising from presentations**

Discussion guidelines and procedures are similar to those of Unit One (1.10). However, based on these specific group tasks (Task A, B, C) the following guidelines are relevant.

1. Participants must discuss Task A as presented by all the groups that have been assigned the task.
2. After, Task B must be discussed immediately after presentation.
3. After, Task C must be discussed as such.
4. Discuss issues of vulnerable populations (children, women and disabled) in relation to main issues if participants did not touch on any.
5. The assistant facilitator must record issues accordingly. This is very important because the facilitator will use the issues recorded for syntheses.

The discussion must follow this procedure because the tasks are interrelated to the other.

***Stress-Out:** If the facilitator realises that participants look tired, dull, etc. which affects effective discussions, he must ask any of the participants (or him/herself) to introduce any activity (with song(s)) to refresh or stress-out the body and mind.*

### **3.11 Syntheses**

The processes of syntheses are not very different from those discussed earlier in Unit One (1.11) which indicate what the facilitator needs to do. A good synthesis largely depends on the effectiveness of the facilitator assistant and the factual coherence of his/her recordings about using CVAP to prevent HIV, address stigma and promote care.

The following guidelines are important to consider.

1. Write synthesis of each task on the board/flip chart and communicate it verbally in the appropriate language (s) to participants for consideration, validation and consensus. All other issues that come up must be written and communicated as such.
2. Allow participants who wish to make useful modification(s) to each synthesis of each task.
3. Discuss with participants and distinguish between factual and tacit and implicit facts in relation to their ontology and epistemology and how these are interrelated.
4. Outline these interrelationships on and show how they influence CVAP with respect to prevention, stigma and care.
5. Link issues discussed with the various action plans formulated. Allow for further relevant modification(s) to the formulated action plans.

### **3.12 Conclusions**

Conclusion must comprise key relevant issues that need to be emphasised. The following are guidelines to the facilitator.

1. Make a brief or summarised presentation highlighting key issues discussed and consented.
2. Be conscious to avoid re-discussions.
3. If some issues are still unresolved, refer to them and point out when they would be discussed.

4. Next process after formulation of plans is community organisational self assessment COSA which is discussed in the next unit.

### Facilitator's notes

<p><b>Box 3.1 CVAP, prevention, stigma and care</b></p> <p>CVAP is a way to help the community become aware of its dreams and visions regarding its own HIV programmes and more importantly sensitize it on the way to obtain its goal. If the community can formulate a concrete HIV programme or action plan and fit it into the national and local HIV framework agenda of the local government much can be obtained.</p> <p>There is therefore the need, when using CVAP, to have, for instance, the national HIV/AIDS Strategic Framework (currently, the 2006-2011 framework) as well as other local (i.e. District Assembly) plans during training programmes with indigenous institutions and other local groups. This is to avoid overlaps, deviations but ensure consistency with existing national and local frameworks to achieve common objectives and goal.</p>	<p><b>Box 3.2 Concepts</b></p> <p><b>SMART</b> is an acronym that depicts features of a plan. Thus, an action plan must be <b>S</b>pecific (S), <b>M</b>easurable (M), <b>A</b>chievable (A), <b>R</b>ealistic (R) and <b>T</b>ime-bound (T). When formulating action plans to address HIV prevention, stigma and care issues using CVAP, the plans ought to be SMART.</p> <p><b>Forecast mapping</b> has been used as a research tool to assess environmental sustainability in local communities. The tool has three main activities.</p> <ol style="list-style-type: none"> <li>1. Participants describe by drawing a community Resource (e.g. grove) map (not to scale) of two decade ago.</li> <li>2. Participants describe the state of the resource by drawing a representation map of the resource.</li> <li>3. Participants forecast the likely state of the resource the next two decades and describe it by drawing a representational map taking into account natural and anthropogenic factors.</li> </ol>
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**Blank sheet(s) for relevant issues**

## UNIT FOUR

### COMMUNITY ORGANIZATIONAL SELF ASSESSMENT TO ADDRESS PREVENTION, STIGMA AND CARE IN HIV/AIDS

#### Session 1: General Issues

##### 4.1 General objective of topic

To assess community organizational capacities (strengths and gaps) to address HIV prevention, stigma and care.

##### 4.2 Materials needed

Human resource: A team conversant with use of COD tools specifically COSA (see ...) for HIV/AIDS prevention, stigma and care.

Material resources: Flip charts, markers, other relevant stationery, camera (if consented), other logistics including pictorial objects, laptop and/or film projector, etc.

##### 4.3 Duration:

##### 4.4 Introduction to COSA in the context of prevention, stigma and care in HIV/AIDS

In the previous unit, participants were introduced to CIRM as a tool to map community institutions and resources and their potentials to address prevention, stigma and care in HIV/AIDS. In order to ensure that these institutions or organisations become capable to perform intended tasks, there is the need to assess their capacities (strength and gaps/weaknesses) so as to develop tailored capacity skills to strengthen and address such gaps. SWOT analysis (see Box 4.2) serves as guidance during the assessment process.

##### **Purpose of COSA**

To guide community groups through a self-examination process in order to assess their organisational strength and gaps for prevention, stigma and care in HIV/AIDS.

Capacities may vary from one community to the other. Nevertheless, they must be grouped under social capacities comprising institutional, human and political, physical and/or natural capacities and spiritual capacities. Various methods exist to assess these capacities. One of such appropriate methods is focus group discussions (FGDs). For effective FGDs, a minimum of six (6) and a maximum of twelve (12) participants must constitute a homogenous group. This is to encourage active participation, ensure effective group management and control.

##### 4.4.1 Steps to facilitate COSA

The steps to facilitate COSA explain the relevant guidelines to facilitators for effective capacity assessment. Primarily, there are two related steps in COSA with series of activities.

The related steps are:

- Facilitate community forum to assess capacities. To do this effectively, community must be grouped into homogenous units such as females and males, adults and youth, farmers and fishermen/fishmongers, etc.

- Facilitate focus group discussions to assess capacities. This involves a sample of key members who can provide adequate information about capacities of organisations they relate with directly or indirectly.
- Use complementary methods such as role-play or drama to internalise some of the issues.

## Session 2: Practice

### 4.5 Tasks of Facilitator

The general tasks for the facilitator as discussed in Unit One apply. In addition, the facilitator must be guided by the following.

Table 4.1

<b>Facilitator's Tasks</b>	
Purpose	To facilitate internalisation To provide guidance to use of role-play or drama
Duration	15minutes
Tasks	1. Coordinate the community fora. 2. Ensure effective selection of group members for FGDs. 3. Define clearly and specifically group tasks. 4. Provide needed materials for group activities.

### 4.6 Internalisation

The internalisation stage requires that participants assess various activities or projects of similar kind. Preferably, a role-play or drama will be insightful. The following issues serve as content for the internalisation.

- What development projects have you carried out in recent times over the last ten (10) years?
- Which of these were health-related?
- What factors facilitated effective implementation of the project?
- What factors became challenges to the implementation of the project?
- How did you address these barriers?
- Which aspect(s) of the project was not implemented as a result of these barriers?

### 4.7 Group tasks on HIV prevention, stigma and care

Group tasks must relate to method(s) adopted during internalisation to enhance transfer of knowledge and skills. But specifically, it must relate to prevention, stigma and care in HIV/AIDS.

Table 4.2

<b>Group Tasks</b>	
Purpose	To assess capacities (strength and gaps) among indigenous organisations
Duration	45minutes
Tasks	1. How can you achieve effective implementation of PREVENT? 2. What specific challenges do you foresee in the implementation of PREVENT.
Strengths and gaps	3. How can these challenges be addressed? 4. What support do you need to ensure effective implementation of PREVENT.

#### **4.8 Group presentation plan**

Unless otherwise agreed upon, group presentation plan must be similar to that earlier discussed.

#### **4.9 Presentation of group outcome**

If presentation of outcome takes the form of a role-play or drama, participants as well as the facilitator (including facilitator assistant) must write down issues that emerge from the activity. If presentation paper-based, then the appropriate sheet(s) provided for the activity must be displayed. Procedure may follow those discussed earlier.

#### **4.10 Discussions of issues arising from presentations**

Discussions must proceed immediately after presentation of each group. During discussion, facilitator assistant must record and highlight key and emerging issues that relate directly or indirectly to PREVENT as discussed earlier. Facilitator must act decisively to discover issues that need further clarifications to avoid doubts and ambiguity.

***Stress-Out:** If the facilitator realises that participants look tired, dull, etc. which affects effective discussions, he must ask any of the participants (or him/herself) to introduce any activity (with song(s)) to refresh or stress-out the body and mind.*

#### **4.11 Syntheses**

An effective synthesis to a large extent also depends on effectiveness of the facilitator assistant who records key factual and non-factual issues presented and discussed in relation to capacity assessment for HIV prevention, stigma and care. The facilitator must collate all these issues coherently and present them to participants. Where there are conflicting issues, the facilitator must highlight and address them with participants. Guidelines to syntheses are similar to those discussed earlier (e.g. Unit Three).

#### **4.12 Conclusion**

Conclusion reaffirms knowledge shared, learnt and gained. The very key issues with addresses the objectives must be emphasised. See guidelines in earlier units (e.g. Unit Three). Facilitator must also indicate that an effective COSA process is a good platform for CIS.

## Facilitator's notes

### **Box 4.1 COSA and HIV prevention, stigma and care**

All community organisational development (COD) tools have an inherent aim of focusing and relying on already existing indigenous structures in communities for development. Thus, for such indigenous structures to have the required capacities to be able to perform effectively to achieve the intended objectives of PREVENT, then there is the need to assess their capacities, hence COSA.

COSA as a participatory assessment tool becomes a community-based option. It is, among others, used to determine the strengths and gaps within the institutional, human, material and spiritual resources available to the community which are necessary for prevention, stigma and care in HIV/AIDS. When combined with other assessment tools such as SWOT Analysis, one gets a clearer picture about the strengths and weaknesses (gaps) as well as opportunities and threats to PREVENT in the community.

### **SWOT Analysis**

SWOT is an acronym of Strengths, Weaknesses, Opportunities and Threats as shown in the figure below. It is a basic tool used to assess institutional capacities in relation to an impending project. It can be used to complement COSA for PREVENT. In that regard, the capacities of existing indigenous as well as other local institutions must be assessed to determine their existing and potential:

- Strengths in pursuance of implementation of PREVENT,
- Weaknesses that can affect implementation of PREVENT,
- Opportunities that provide favourable environment for implementation of PREVENT, and
- Threats which can impede effective implementation and success of PREVENT.

**Blank sheet(s) for relevant issues**

## UNIT FIVE

### COMMUNITY INSTITUTIONAL STRENGTHENING TO ADDRESS HIV/AIDS PREVENTION, STIGMA AND CARE

#### Session 1: General Issues

##### 5.1 General objective of topic

To strengthen the capacities of community institutions to implement PREVENT.

##### 5.2 Materials needed

Human resource: A team conversant with use of COD tools specifically CIS (see ...) for HIV/AIDS prevention, stigma and care as well as indigenous knowledge in story-telling, parable construction and proverb-use.

Material resources: Flip charts, markers, other relevant stationery, camera (if consented), other logistics including pictorial objects, laptop and/or film projector, etc.

##### 5.3 Duration:

##### 5.4 Introduction to CIS in the context of PREVENT

The next tool to implement after COSA is CIS. After strengths and gaps have assessed in relation to PREVENT, there is the need to strengthen community institutions with appropriate needed human, material and spiritual supports to address institutional capacity gaps to implement activities for prevention, stigma and care in HIV/AIDS.

###### **Purpose of CIS**

To address institutional gaps of community groups in order to strengthen their capacity to implement activities for prevention, stigma and care in HIV/AIDS in the community.

CIS can take the form of training workshops to provide technical skills, inspirational lectures by invited resource persons such as experts from academic, medical and political domains. Use of tacit or factual stories and case studies constitute the basis of group discussions.

###### 5.4.1 Steps to facilitate CIS

Basically, the intent of CIS is to strengthen existing institutions to take up new responsibilities such as implementing PREVENT. The following are some of the basic steps for CIS facilitators.

1. Review findings from COSA to identify strengths and gaps of target institutions.
2. Organise institutional fora or discussions on objective of CIS.
3. Dialogue with institutional stakeholders to identify institutions and/or aspects of institutions that need specific immediate and future support and where to access such support. These may include:
  - i. Knowledge on basic facts on HIV/AIDS.
  - ii. Skills for public speaking and facilitation

- iii. Co-ordinated initiatives on HIV/AIDS in the community
  - iv. Access to services from district level stakeholders
  - v. Access to kits for testing
  - vi. Etc.
4. Plan with institutions for CIS activities such as exposure visits, capacity-strengthening workshops, to strengthen, broaden and provide technical, communication, etc. skills.
  5. Facilitate citizen-government dialogue for communities to make demands to stakeholders to address their capacity gaps
  6. Conduct participatory monitoring and evaluations (formative and summative) (Box 5.1) to ensure effectiveness of activities.

## Session 2: Practice

### 5.5 Tasks of Facilitator

The general tasks for the facilitator as discussed in Unit One apply. In addition, the facilitator must be guided by the following in relation to steps to facilitate CIS.

Table 5.1

<b>Facilitator's Tasks</b>	
Purpose	To facilitate internalisation To strengthen existing institutions to implement PREVENT.
Duration	
Tasks	1. Review COSA. 2. Organise institutional fora. 3. Define specific present and future support and where to access them. 4. Facilitate capacity-building activities. 5. Conduct participatory monitoring and evaluation.

### 5.6 Internalisation

The facilitator must guide participants to internalise the steps to CIS with any appropriate method(s) such as use of case-studies, experiential learning approach, etc. The process can internalise issues relating to the following questions.

- What was the state of your institution ten years ago in terms of strengths and gaps?
- What activities was your institution engaged in ten years ago?
- What is the state of your institution currently in terms of strengths and gaps?
- What activities is your institution engaged in currently?
- What other roles can your institution perform in relation to prevention, stigma and care in HIV/AIDS?
- What specific support would your institution need to perform these roles?
- Where can you access these supports?

### 5.7 Group work to practice CIS for prevention, stigma and care

As discussed earlier, group tasks must relate to issues discussed at internalisation. However, they must be PREVENT specific as follows.

Table 5.2

<b>Group Tasks</b>	
Purpose	To strengthen existing institutions to implement PREVENT
Duration	45minutes
Tasks	1. What health related activities have your institution undertaken in the last ten years? Which of these are on-going?
Institutional strengthening	2. Which of these activities relate to sexual and reproductive health issues? 3. What specific supports do you need to take up new responsibility such as PREVENT? 4. Where can these supports be accessed?

### **5.8 Presentation of the outcome of the group work**

Presentations can take the forms of real case-studies of institutions, story-telling and flip-chart write-ups or frameworks. Facilitator must encourage diverse use of methods to promote effective learning and communication skills. This also prevents monotony of presentation of outcomes.

### **5.9 Discussions of issues arising from activities and presentations**

As earlier indicated, discussions must follow immediately after each group presentation to enhance consistent flow of issues. This format avoids the problems associated with recall when dealing with the unlettered.

Facilitator and his/her assistant must record key issues that touch on the objective of CIS. Emerging issues, non-factual matters, ambiguous and contradictory statements or actions must be flagged for further discussion, clarity and corrections. This calls for rapt attention on the part of the facilitator and his/her assistant.

### **5.10 Syntheses**

Synthesising issues discussed is important because it addresses ambiguities, contradictions, and distinguishes factual from tacit knowledge. The role of the facilitator is to collate ideas into factual coherence on how to facilitate CIS for PREVENT. Facilitator must make reference to objective, steps and group work presented to form a coherent framework on CIS for PREVENT.

### **5.11 Conclusion**

To conclude, facilitator must summarise synthesis and provide key issues very relevant to achieving the objective of CIS for PREVENT. It must be concise and accurate to constitute 'take-home knowledge'.

## Facilitator's notes

### **Box 5.1 Using CIS as a good practice for prevention, stigma and care**

Institutional capacity strengthening at the community level encompasses various aspects of the institution itself and the community at large. Hence, facilitators need to factor in institutional capacity strengthening within a larger context to address prevention, stigma and care. Three main guidelines are crucial not only to the facilitator but the target institutions in the community.

***Understanding the local and national contexts:*** A good understanding of local contexts is very essential in that it gives you the idea about what constitutes an enabling environment for CIS and PREVENT. However, strengthening the capacity of institutions within local contexts must fit into the larger national contexts. Thus, with respect to PREVENT, CIS must also focus on the national strategic framework for HIV/AIDS of 2005-2011 or any national framework.

***Identifying and accessing support sources:*** It is imperative for local institutions to be guided to identify other local and external sources for support and also how to access such support. Care must be taken to identify and access sources of support which share similar vision and interests in PREVENT. This calls for support –source analysis in order to be selective. This, when done very well avoids external ownership of PREVENT owing to sponsorship.

***Case learning and lesson sharing:*** CIS must be designed to maximise learning and capacity strengthening at each of the three basic levels of capacity development namely, the individual, organisation and or local context(or enabling environment). Emphasis must be placed on building understanding about what works and what does not work in terms of improving the enabling environment. In some cases, independent assessors must be engaged to conduct participatory monitoring and evaluations with clients and beneficiaries.

**Blank sheet(s) for relevant issues**

**UNIT SIX**  
**LEARNING, SHARE AND ASSESSING COMMUNITY EXPERIENCES FOR HIV**  
**PREVENTION**  
**STIGMA AND CARE**

**Session 1: General Issues**

**6.1 General objective of topic**

To strengthen the capacities of community institutions to implement PREVENT.

**6.2 Materials needed**

Human resource: A team conversant with indigenous knowledge and cultural issues, basic budgetary, communication and writing skills.

Material resources: Camera other logistics (funds), including pictorial objects, stationery, laptop and/or film projector, etc.

**6.3 Duration:**

**6.4 Introduction to LeSA in the context of PREVENT**

LeSA is a community peer review mechanism that enables communities with similar development agenda to exchange experiences and knowledge within the scope of HIV/AIDS with specific reference to PREVENT. That adage that ‘two heads are better than one’ makes LeSA very imperative in the fight against HIV/AIDS within indigenous contexts. LeSA therefore serves as a platform for communities to learn from knowledge gained through geo-cultural learning and sharing.

**Purpose of LeSA**

To facilitate a community peer review process through cross-cultural interactions on prevention, stigma and care in HIV/AIDS

LeSA comprises three fundamental and interrelated pillars, namely, learning, sharing and assessment. That is, communities go through a cycle of learning, sharing and assessing knowledge shares as shown in Figure 6.1. This approach does not only improve community development process, but also encourages networking and inter-connectedness.

Figure 6.1

### Process-cycle of LeSA

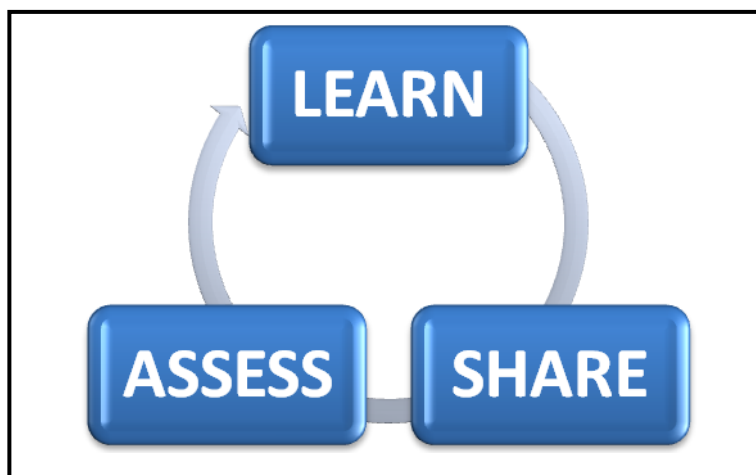


Figure 6.1 explains LeSA as a cyclical experience that is interconnected. Using PREVENT as a case, learning takes place after a community has gone through the other COD tools, and implemented PREVENT. Knowledge gained is then shared with other communities especially with similar interests. During sharing, communities assess the approaches and effects of PREVENT which also brings about learning through sharing.

It must be noted that on each of the pillars, the three pillars manifest. That is, learning, sharing and assessing (all) take place at each of the pillars (i.e. learning, sharing and assessing). This makes LeSA uniquely holistic in nature and practice. It is a tool that can be used to foster harmony among various communities for PREVENT.

#### 6.4.1 Steps to facilitate LeSA

Communities can design their own approaches to LeSA. However, these are the general steps that are applicable to all groups using LeSA.

1. Plan for the LeSA: To plan for LeSA take into account the following:
  - a. Issues to share and assess with host community under PREVENT: Three main issues comprises PREVENT, i.e. prevention, stigma and care. Each issue can be discussed at a visit. To ensure positive LeSA, there must be exchanges of visits to discuss each of these issues.
  - b. Number of participants per visit: The number of participants depends on a number of factors which must be considered during selection of participants. To select participants LeSA, take into account gender and generational considerations (male-female, youth-adult-aged) roles and responsibilities of each participant as well as other considerations such as status. Other factors to consider include time and cost.
  - c. Time frame: Timing is very important when planning for cross-cultural visit to learn, share and assess knowledge. Timing must be discussed mutually by the host and visiting community to ensure convenience. Factors to consider include weather conditions as well as social activities such as festivals, puberty rites, etc that can coincide with LeSA visits to achieve optimisation of LeSA.

- d. Cost sharing (travel, board, lodging): Cost must be well estimated and sources of support both in cash and kind must be identified. It is advisable to rely on local sources which are reliable. Nevertheless, efforts must be made to apply for external support from organisations and individuals with common interests. Care must however be taken to avoid external influences due to support granted.
2. Facilitate the sharing process between the visiting team and host community: This steps primarily borders on arrangements made between the host and visiting group. It involves schedules and activities consented. In some cases, a third partner can be assigned the duty to facilitate the process. Such a third partner must not however, impose decisions on the LeSA groups.
  3. Participatory evaluation: Evaluation occurs at two main levels:
    - a. Evaluate issues discussed in PREVENT to improve upon performance.
    - b. Evaluate issues relating to visits to improve on subsequent ones.
  4. Widening the sharing through community radio: It is important to let others know what has been done, what is being done and what would be done. To let the wider community become aware of PREVENT after LeSA, use affordable but fast and wide-reaching media to transmit knowledge to local and larger community. Community radio, use of internet and other means to reach many.

## Session 2: Practice

### 6.5 Tasks of Facilitator

The general tasks for the facilitator as discussed in Unit One apply. In addition, the facilitator must be guided by the following to enhance effective LeSA for PREVENT.

Table 6.1

<b>Facilitator's Tasks</b>	
Purpose	To facilitate internalisation To outline strategies for effective LeSA.
Duration	
Tasks	1. Review PREVENT. 2. Group participants into desirable number. 3. Identify issues to discuss in PREVENT during visits. Give a different issue to a different group. 4. Assist participants to draw a schedule/timetable for LeSA. 5. Assist and facilitate drawing of LeSA budgets. 6. Outline steps in participatory evaluation. 7. Assist to identify affordable but fast and wide-reaching media.

### 6.6 Internalisation

Internalising LeSA is to practice the steps to facilitate effective LeSA. Facilitator must do the following:

1. Discuss the steps to facilitate LeSA with participants.

2. Group participants into two or three geo-cultural (cultural set-ups in different geographical locations) groups depending on the background characteristics of participants.
3. Assist participants to identify issues for LeSA at first and subsequent exchange visit.
4. Task group to plan for first LeSA visit. Participants must use the steps to facilitate LeSA as a guide.
5. Facilitate a role-play or drama of first LeSA visit by various groups.

### 6.7 Group work to practice LeSA

Group work must relate to group internalisation to reinforce knowledge. Facilitator's team must assist with literary activities especially with basic skills in drawing a simple budget. The following serves as a guide to developing group tasks.

Table 6.2

<b>Group Tasks</b>	
Purpose	To promote LeSA for PREVENT
Duration	45minutes
Tasks	<ol style="list-style-type: none"> <li>1. Identify issue in PREVENT for LeSA.</li> <li>2. Identify which group to be host and visiting group.</li> <li>3. Draw a timetable for first LeSA.</li> </ol>
<b>Practicing LeSA</b>	<ol style="list-style-type: none"> <li>4. Show factors that will influence group member selection for LeSA.</li> <li>5. Draw a LeSA budget.</li> <li>6. Conduct participatory evaluation.</li> <li>7. Identify affordable fast and wide-coverage media.</li> </ol>

### 6.8 Presentation of outcome of group work

Presentation of group work practicing LeSA takes more than one method. Most appropriate method is drama or role-play. In addition, paper or PowerPoint presentation can be used to present timetable and budget.

### 6.9 Discussions of issues arising from activities and presentations

The format for presentation may not differ from those discussed in preceding units. As earlier indicated, discussions must follow immediately after presentation of outcome from each group.

### 6.10 Syntheses

Issues discussed forms the basis for synthesis. Issues learnt, shared and assessed during group work must reflect inherent facts about PREVENT. Inaccuracies, ambiguities and contradiction that are not well addressed must finally be made clear at this stage. This is crucial for accurate presentation of PREVENT.

### 6.11 Conclusions

Conclusion procedures or steps may not differ from those discussed earlier but in reference to LeSA.

Facilitator's notes: Box 1 (a brief about how to facilitate LeSA for HIV prevention, stigma and care)

Blank sheet(s) for relevant issues

## **UNIT SEVEN: INTRA-COMMUNITY CO-ORDINATION AND NETWORKING**

### **Session 1:**

Materials needed

Duration

- Introduction (brief explanation on need for intra community co-ordination and networking)
- 7. General objective of the session
- 8. Brief presentation on the steps in co-ordination and networking:
  - Review of community vision and action plans
  - Collect and document stories of change
  - Encourage leaders of the various groups and institutions in the community to form a co-ordinating committee to oversee implementation of all PREVENT activities in the community
  - Encourage co-ordinating committee to engage all such groups and institutions for community-wide assessment of results, learning and sharing to promote wider sense of ownership and achievement.
  - Encourage the Co-ordinating committee to establish forums for dialogue with external stakeholders for continued support after closure of PREVENT.
- 9. Group work to practice and internalize the steps for facilitating intra community co-ordination and networking.

### **SESSION 2**

10. Presentation of outcome of group work
11. Discussions of issues arising from activities and presentations
12. Syntheses (facilitator collates ideas into factual coherence on how to facilitate inter community co-ordination and networking for HIV prevention, stigma and care)
13. Conclusions
14. Facilitator's notes: Box 1 (a brief about how to facilitate inter community co-ordination and networking For HIV prevention, stigma and care)
15. Blank sheet(s) for relevant issues

Blank sheet(s) for relevant issues