Partnership work:
the health service–community
interface for the prevention,
care and treatment of HIV/AIDS
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Geneva, 5–6 December 2002

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Better collaborative interaction between the health services and the communities could help to address the challenge of scaling up HIV/AIDS services at the community level.

A consultation on Enhancement of the Health Services/Community Interface for HIV/AIDS Prevention, Care and Treatment was held from 5 to 6 December 2002 at the headquarters of the World Health Organization (WHO) in Geneva, Switzerland. The consultation was convened by the HIV department of the Family and Community Health Cluster of WHO. The participants at the meeting included partners from United Nations and other international organizations, experts and activists from nongovernmental organizations (NGOs) working with HIV/AIDS, HIV/AIDS researchers, advisers on HIV/AIDS from the WHO regional offices and staff from other departments at WHO headquarters undertaking related work or having relevant expertise.

The aim of the Consultation was to identify roles for WHO in enhancing the interface between the health services and the communities. This aim was expressed through the following specific objectives:

1. to review the previous and current work by the United Nations that is relevant to the health services–community interface;
2. to identify the opportunities and constraints of the health services–community interface relevant to HIV/AIDS; and
3. to identify the roles that WHO should play to enhance the health services–community interface for HIV/AIDS.

This report comprises three main sections. The first section addresses the challenges and opportunities for collaborative interaction and partnerships between health services and communities. This section includes chapters of the original background paper from the meeting and of the presentations made during the meeting. These include a review of previous relevant work, highlighting the practical and operational underpinnings of collaborative efforts, and a discussion of the potential challenges as well as of the successes that might be expected when fostering partnership development for addressing HIV/AIDS.

The second section presents and analyses six “on-the-ground” case-studies presented by the participants at the meeting. They describe partnership efforts for the prevention, care and treatment of HIV/AIDS and represent a range of collaborative initiatives from different countries and continents as well as global endeavours. They reflect various issues pertinent to the stated aim of the consultation, such as interaction between health services and communities, collaboration, synergy and the need for innovative models for service delivery.

The third section presents the outcomes of the meeting. The participants identified three categories of strategy. These categories were:

1. strengthening the capacity of the health care system to interact with communities;
2. strengthening the capacity of communities to interact with health services; and
3. strengthening the processes and methodologies for change.

Within these categories several mechanisms that could enhance the interface between health services and communities were identified. The participants identified clear and crucial roles for WHO in putting the strategies into action and recommended some concrete steps to be taken by WHO to move the interaction between health services and communities forward.
Glossary

The definitions given below apply to the terms used in this report. They may have different meanings in other contexts.

**AIDS-competent community:** one whereby people are able to assess accurately the factors that may put them or their communities at risk of infection, and act so as to reduce those risks (UNAIDS, 1997; Lamboray & Skevington, 2001).

**Collaboration, partnership and joint-working** are used interchangeably to refer to collective actions by individuals or their organizations for a more shared communal benefit than each could accomplish as an individual player (El Ansari et al., 2001).

**Community:** a group of people living in close proximity to one another who have formed relationships through several overlapping and interacting social networks and through a shared sense of needs and local common good (adapted from Eng & Blanchard, 1991).

**Community capacity in health:** the characteristics of communities that affect their ability to identify, mobilize for, and address social and public health problems (McLeroy, 1996).

**Community empowerment:** a social action process that promotes participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life and social justice (Wallerstein, 1992).

**Community involvement:** a deliberate strategy that systematically promotes the participation of the community in its own health development in order to benefit from increased local self-reliance and social control over the infrastructure and technology of health care (adapted from Kahsay & Oakley, 1999 and Fonoroff, 1983).

**Community structures:** a wide range of organizations, formal and informal groups and networks within the defined community.

**Competent community:** one whose members can collaborate effectively in identifying problems, can reach consensus on goals and strategies, and can cooperate in the actions necessary to acquire resources to solve those problems (Cottrell, 1983).

**District health system:** a self-contained segment of the national health system consisting of a well-defined population living within a clearly delineated administrative and geographical area, whether urban or rural (WHO, 1995).

**Health service structures:** those structures within the local health system that provide promotive, preventive, curative and palliative services by formal (professional and para-professional) health workers.

**Interaction:** reciprocal action or influence.

**Interface:** the point where interaction occurs between the health service structures and community structures.

**Synergy:** increased effectiveness or achievement produced by combined action or cooperation.
REFERENCES


In recent years tremendous progress has been made in the treatment of HIV infections. This has led to a reconsideration of how the HIV epidemic should be dealt with and to increased political will and commitment to tackle the epidemic in a comprehensive and scaled-up manner. This is expressed most clearly in the Declaration of Commitment issued by the United Nations General Assembly Special Session on AIDS (UNGASS) in July 2001. The commitment invested in fighting HIV/AIDS has also raised a number of old questions such as:

- How can more people benefit from better treatment and more effective prevention?
- How can HIV/AIDS services be made accessible where they are most needed, given the serious constraints on resources?
- How can the benefits from the many examples of small-scale success be increased to a global scale?

Considerable knowledge has been gained about what technical interventions are necessary to address HIV/AIDS. The most pressing question now is how the available interventions can be brought into practice in the many countries and communities that urgently require them. Given the scarce resources and overstretched health care personnel in countries with a high burden of HIV/AIDS, the provision of conventional health services seems unrealistic and unlikely to meet the needs of the steadily increasing number of people requiring HIV/AIDS services. WHO is exploring alternative approaches to service provision to increase access to HIV/AIDS services and to enable the health service to become a strong partner in the prevention of HIV. The answers to the problem of scaling up services could lie in an enhanced framework for better collaborative interactions between health services and communities. Therefore, the concept of the interface between health services and communities needs to be appropriately explored.

The following trends and global strategies provide strong indications of the need for such work.

In recent years, HIV/AIDS has been transformed from an uncontrolable disease into a manageable chronic condition for those who have access to antiretroviral therapies. Next to prevention, care, support and treatment are now recognized as the elements essential for the control of the epidemic. This knowledge has created opportunities for the development of new comprehensive approaches in response to HIV/AIDS. As a consequence of the advances in antiretroviral therapy, a new stage of the epidemic has been reached, with the focus moving towards the integration of care and treatment with prevention. However, to date, most people who need HIV/AIDS services still do not benefit from this progress and HIV prevention programmes have not been strong enough to reverse the tide of the epidemic.

The Declaration of Commitment issued by the UNGASS calls for the strengthening of the health systems for implementing comprehensive strategies in the expanded global response to HIV/AIDS (UNGASS, para 55). The Declaration also supports actions to strengthen family and community-based care and to support the individuals, households, families and communities affected by HIV/AIDS (UNGASS, para 56).

The impressive record of civil society groups in responding to HIV/AIDS has consolidated the recognition that their full involvement and participation are crucial. The global community therefore assigns key roles to the communities, civil society actors, families, young people and people living with HIV/AIDS in the comprehensive approach to addressing HIV/AIDS prevention, care and support (UNGASS, paras 31 & 33).

It is recognized that the lessons learnt during 20 years of effort in response to the HIV/AIDS epidemic have presented "an important opportunity not only to provide better care for people living with HIV/AIDS, but also to improve health systems and the provision of health care for all" (WHO, 2002).

The health service–community interaction refers to the relationships between the health service structures (such as health centres) and the community organizations and groups. The potential of the interface has been discussed in depth in previous WHO work on community involvement in health. The attention given to the interface for HIV/AIDS is based on the realization that all available resources need to be mobilized and harmonized in order to address the challenges presented by the HIV/AIDS epidemic, not least the problem of providing access to antiretroviral therapy for all those who need it.
Interface: relevance and problem statement

The relevance of the interface is based on the notion that collaborative interactions between different actors may lead to synergistic results. To mount an effective response to the huge HIV/AIDS epidemic, maximum synergy obtained through strategic linkages and relationships between the various actors is critical. Much has been said about the need for collaboration with the relevant sectors and with all segments of society. The lessons learnt suggest that broad national partnerships can generate successful responses to HIV/AIDS.

We argue that an integral element of such broad partnerships is founded on the interactions between the health services and the communities that are served. This is a particularly important facet that warrants more attention for three main reasons.

Firstly, experience suggests that the responses from health service provision structures and those from communities may complement, hinder or strengthen one another. The intention is to move beyond complementary results and foster synergy.

Secondly, an important determinant of community capacity is the community’s ability to form links with the outside world in general and with institutions and health services in particular. A partnership between the local community organizations, agencies and consortia and the health service structures will inevitably strengthen the community capacity for addressing HIV/AIDS and for health development in general.

Thirdly, now that programmes for care and treatment have been established, good relationships and regular contact between the health care workers and the people and families living with HIV/AIDS are becoming increasingly important. Similarly, the successful implementation of the more technical preventive interventions, such as prevention of mother-to-child transmission using antiretroviral drugs, requires optimal contact and connections between health workers and clients. The quality of the interactions between the health services and the communities affects the relationships between health workers and clients. This is especially true for societies with a collective culture, where the formal and informal social and traditional organizations and their leaders exert a strong influence on the individual’s health perception and health-related behaviour. In addition, given the chronic nature of the disease, a continuum of care from homes to facilities needs to be assured.

However, there is evidence to suggest that collaborative interactions between the health services and the communities are often not realized. It is therefore opportune and essential to review previous work in the area of the interface, to identify both the prospects and constraints for such an approach, and to suggest potential roles for WHO.

References


Section 1
Structural and operational underpinnings of partnership work

AN INTRODUCTION TO THE STRUCTURAL AND OPERATIONAL UNDERPINNINGS OF PARTNERSHIP WORK
Dr Walid El Ansari

The devastating magnitude of the HIV/AIDS epidemic necessitates a systematic and harmonized fight against the disease aimed at prevention, care and support. Building on effective partnerships at all levels appears to be the best way forward. The potential benefits inherent in collaborations between the formal health systems with their trained personnel, facilities and knowledge on the one hand, and the communities with their structures, capacities, wisdom and promise on the other, are enormous.

However, partnering for health is an art, and collaboration is a growing science. Marginalized communities who are struggling for their day-to-day survival and health workers who are overstretched in their struggle against HIV/AIDS should not be functioning unguided among the maze of factors and literature that relate to partnership work. To facilitate the building and maintenance of partnerships and to provide broad overviews of what collaborative work entails, this section addresses the structural and operational underpinnings of partnership work.

There are distinct sets of essential ingredients for successful partnering and well defined clusters of critical dimensions that are necessary for collaboration. There is also a body of work and literature by the United Nations that addresses a range of factors, aspects and challenges relevant to the interface between health services and communities. Because collaborative interaction between the health services and the communities is being increasingly considered as a potentially helpful mechanism for responding to the growing needs of both the communities and the services, stakeholders are required to be increasingly well informed about such partnerships.

When confronted with the tremendous challenge of responding to the HIV/AIDS pandemic, community members, health workers and agencies from other sectors will need to be increasingly aware of other partnership experiences, of initiatives being taken elsewhere, other collaborative work and efforts, other literature that describes successes and challenges, and other factors that represent constraints and opportunities for the health services–community interaction. All of these merit serious consideration by those working in partnership-based programmes at the district, municipal, national and international levels.

DISTRICT HEALTH SYSTEMS AND PARTNERSHIPS FOR HIV/AIDS PREVENTION, CARE AND SUPPORT
Dr Prosper Tumusiime

The advent of the HIV/AIDS epidemic in Africa in the 1980s gave rise to various myths and an association with specific groups of the population, namely sex workers and long-distance truck drivers (Bwayo et al, 1994; Godfrey-Faussett et al, 1994). At that time it was a new disease whose origin and characteristics were not known. Although little could be done about the people who were affected, the situation was not perceived to be of great health importance because the cases were few, isolated and limited to those regarded as “careless and immoral”. At that time, HIV/AIDS was more a subject for research than for health interventions aimed at prevention, care and support. By the end of the 1980s, however, it emerged that the situation was of serious health concern in terms both of morbidity and mortality and of socioeconomic impact (UNAIDS, 1999; Booysen et al, 2002). The health service delivery systems started to experience an increasing burden of AIDS cases that threatened to take over most of the available beds, health personnel time and health facility resources. Unfortunately, this coincided with the
The increased number of persons infected with HIV/AIDS and the diversity of the groups at risk called for a different response from the health system to address the issues of prevention, care and support. As more and more people suffering from the terminal stages of AIDS were taken to their villages before they died, their families and communities also had to grapple with the new situation of caring for relatives who were terminally ill with AIDS.

This chapter will address the following four questions:

- What adjustments, if any, did the health systems make to cope with the HIV/AIDS epidemic?
- What are the requirements for addressing the HIV/AIDS epidemic in terms of prevention, care and support, especially at district and sub-district level?
- Who should be involved and how?
- Given the present circumstances, what can best be done at community level to fight and contain this epidemic?

**Health systems coping with the HIV/AIDS epidemic**

Initially, before the HIV/AIDS epidemic blew out of proportion, the health system responded to the needs of patients by providing treatment and care for the various symptoms they presented (mostly diarrhoea, meningococcal meningitis, skin disease, Kaposi sarcoma and tuberculosis (TB)). Because of the long hospital stays needed and the increase in the number of new TB cases associated with HIV/AIDS, the health facilities were increasingly occupied by patients with HIV/AIDS-related diseases or infections. HIV/AIDS, therefore, competed with common diseases such as malaria and respiratory tract infections, and stretched the capacity of the health facilities trying to respond to the high demand. Often, the number of health personnel available was less than the minimum required to provide basic health care and the additional demands of caring for patients with HIV/AIDS meant that the health personnel tended to be overworked and prone to burnout.

One significant coping mechanism was to shift the burden of caring for the HIV/AIDS patients to their relatives in their homes. This strategy has since been extended in some areas to supervised home-based care which includes training of family home care givers and community volunteers and supervision by health staff (UNAIDS, 1999). Home care programmes, however, are still generally pilot schemes rather than being institutionalized in the general health delivery system. In some cases, the organization of home care has been left to NGOs or faith-based organizations. Some countries in Africa have also started using institutionalized palliative care systems, albeit on a small scale.

Initially, prevention activities mostly involved provision of information, education and communication (IEC) using print and electronic media; these were later augmented by dance and drama, peer education, voluntary counselling and testing, blood screening, treatment of sexually transmitted infections (STIs) and promotion of safer sex (using condoms). Where these preventive measures have been used effectively, there has been a significant decrease in transmission rates. However, such successful prevention programmes are more the exception than the rule. Services such as voluntary counselling and testing, condom supply and distribution and blood screening need to be scaled up to reach the target population (Contact Group on Accelerating Access to HIV/AIDS-related Care, 2001). In addition, services such as antiretroviral therapy that are required following a positive diagnosis, need to be catered for if these measures are to be useful. For example, for the distribution of condoms to be effective, it is necessary to have in place an appropriate distribution system.
Structural and operational underpinnings of partnership work

Partnerships at district and sub-district level

With the decentralization policy in force in most African countries, the district or equivalent local authority is the centre stage for the implementation of the programmes of the health services or of other sectors. This is the level at which all sectors converge and are coordinated at their implementation stage. The coordination may be mainly administrative, but in addressing issues related to HIV/AIDS there have been attempts to form a coordination committee or body to try to bring the efforts of the various sectors together (UNDP, 2001). In addition to the specific HIV/AIDS coordination mechanism, there is usually a development committee at district level that coordinates the plans of all the government departments. In addition to the government departments, a number of NGOs operate at district and sub-district level. Whereas some of these NGOs operate individually, in other instances, bodies have been established to coordinate NGO activities at district level in NGO forums. Sometimes the NGOs are incorporated into the planning and management structures of the district, in which case their programmes will be integrated into the district plans. However, this arrangement is not fully institutionalized in most countries although NGOs and community-based organizations (CBOs) are involved in many HIV prevention, care and support activities, especially at community level.

Most government structures, especially the administrative and political ones, go as far as the community level. These government structures have long been known and used by other programmes for planning and budgeting and as centres for extension workers (i.e. the programme agents who reach out into the communities; examples in the agriculture sector are well known). In addition to these structures, the health sector has management boards and committees for the health facilities, which include community representation. All these structures provide opportunities for mobilizing community involvement in the various health programmes, including those relevant to HIV/AIDS.

In the first instance planning in the health sector has mostly involved the health teams at the district level and there has been little involvement of the lower structures (i.e. the health facilities or the communities). Sometimes when planning takes place at the lower levels, it is not in concert with the overall planning process and implementation may be disjointed. The capacity for planning, even at district level, is inadequate and the situation is worse at the lower levels. It is also true that in the health system the capacity for participatory planning is even more lacking, especially for the health structures that form the links with the communities. Inevitably, the lack of such skills for participatory planning will hamper the development of community capacity, community mobilization and community involvement. In some cases, it is the NGOs that have some knowledge and skills in participatory planning methods (Guijt, 1996). But unless an opportunity is created for such capacity to benefit those who lack it, the impact of the NGOs' capacity will remain unnoticed. It is now necessary to strengthen the partnerships between governments, NGOs, CBOs and the communities, and for institutionalized mechanisms be put into place to allow maximum benefit to be gained from the various efforts being undertaken for HIV/AIDS prevention, care and support.

Full partnership with the communities, however, can be achieved only when the communities in question are well informed, have the capacity to assess the problem and are able to identify what they can do to solve it. Communities do have the requisite potential; they only need to be facilitated to use it.
Enhancing community-level action for HIV/AIDS prevention, care and support

There is an increasing burden on the communities to cope with HIV/AIDS prevention, care and support (Russell & Schneider, 2000) in areas with weak health systems and increasing poverty. The need to provide support to these communities is now greater than ever. Some attempts to support the communities have met with success; however, these attempts have been largely ad hoc and not conducted in a synchronized and institutionalized manner.

The existing planning and administrative structures together with those for health service delivery should be strengthened and harmonized to enable them to support bottom-up planning for HIV/AIDS prevention, care and support. Planning for HIV-related activities should also be integrated into, and become part of, the overall health planning of the country. This will avoid duplication of effort, minimize wastage of resources and lessen the strain on the already overstretched health staff. Because HIV/AIDS prevention, care and support require a multi-sectoral effort, the sectors concerned must be involved at all stages of planning to ensure consistent and effective implementation.

It will not be possible to implement a successful HIV/AIDS programme if the health system itself is unable to deliver even the basic health services. A strong component of the HIV/AIDS prevention and control programme aimed at strengthening the health system must be core to the programme. For example, even if antiretroviral drugs are affordable, their use requires a robust system to ensure appropriate distribution, use, monitoring and quality assurance. Condoms are a well-known and effective preventive measure, but they must be readily available to people when they need them.

Information is a very powerful tool for promoting behavioural change. However, this information needs to reach the appropriate targets and be in a form that will be understood. The methods commonly adopted for disseminating information, and for education and communication, tend to favour people in urban areas, the well-to-do and those who are literate. The high rates of poverty and illiteracy in the countries of Africa mean that members of rural communities need specially tailored IEC methods. Information on HIV/AIDS is best disseminated through the local community structures in forms appropriate to their cultures.

Challenges

The HIV/AIDS epidemic, especially in sub-Saharan Africa, is continuing to grow and to devastate the population and to damage the socioeconomic development of the affected nations. It is an emergency that cannot wait. Given the weak health systems currently in place, and while attempts are being made to revamp the health systems, a deliberate move is required to address the suffering caused by HIV/AIDS, sometimes through parallel systems. These should be seen as temporary measures and an attempt to reintegrate the parallel systems into the normal health systems should be made as soon as possible.

The health service delivery systems should be able to support the communities in building their capacity to participate fully in the interventions necessary for HIV/AIDS prevention, care and support. However, the health service delivery systems are hampered by inadequate financial resources, a fragmented infrastructure, poorly motivated and inadequate health personnel, and poor or nonexistent procurement and distribution systems. This makes it difficult for them to provide effective support for programmes for the prevention and control of HIV/AIDS.

The efforts at building community capacity have been made mainly through NGOs and CBOs, which are usually under the direct supervision and control of their donors or parent organizations. Unless these organizations are coordinated at the district level, integrated into the district
development planning process and monitored by the appropriate local authority, there will continue to be a wastage of resources and a lack of harmony in the fight against HIV/AIDS (see Box 2).

**Box 2: Recommendations: time to institutionalize**

While the HIV/AIDS epidemic still calls for an emergency-like response, it is time to start to institutionalize the programmes for HIV/AIDS prevention, care and support and to integrate them into the existing health systems and other development programmes. For this to happen we need to re-orient health service structures and health care personnel and to increase their capacity to handle the programme and to support other lower structures. A deliberate effort is required to build the capacity of the communities and to enable them to be fully involved in all processes, from problem identification to participation in the formulation and implementation of suitable solutions. Appropriate mechanisms to foster partnerships between government, NGOs and the community need to be identified and these, as far as possible, should utilize existing structures.

The magnitude of the HIV/AIDS epidemic is so great and so devastating that there must be a more systematic and harmonized way of fighting the disease. The best strategy seems to be one aimed at prevention, care and support, building on effective partnerships at all levels and particularly at district level (i.e. the level of implementation). While the ad hoc interventions are in place to deal with the emergency, the move towards institutionalization should be initiated, capacity should be built at all levels and coordination and partnerships should be strengthened, especially at district level. A deliberate effort should be made to empower the communities by building their capacity to participate fully in HIV/AIDS prevention, care and support activities.

**References**


THE INTERFACE BETWEEN THE HEALTH SERVICES AND THE COMMUNITIES: SUMMARY OF A REVIEW OF RELATED WORK BY THE UNITED NATIONS

Dr Hedwig Goede

Background of the review
The health sector has been confronted with the tremendous challenge of responding to the HIV/AIDS pandemic with its ever-increasing number of people in need of services (UNAIDS/WHO, 2002; WHO, 2002). The collaborative interaction between the health services and the communities is being increasingly considered as a promising potential mechanism for responding to the growing need for health services.

United Nations agencies as well numerous NGOs and donor organizations are making great efforts in promoting and providing technical and financial support to countries in the area of the interaction between the health services and the communities, i.e. community involvement in health in general, and community mobilization and partnership-building in response to the HIV epidemic in particular.

To obtain useful pointers for the identification of appropriate roles for WHO in improving the interaction between the health services and the communities, previous and current schemes developed by the United Nations that demonstrate the significance and value of a collaborative interaction between the health services and the communities were reviewed. The objectives of this review were to determine what work had already been undertaken in the domain of HIV/AIDS and in the domain of district and community health in general. This was a necessary prerequisite to identifying previous and existing work and to identifying gaps in the work that might require and benefit from supplementary action. This chapter summarizes the findings of the review.

Findings
A variety of United Nations agencies are involved in activities related to the interface for HIV/AIDS. Some examples are:

- work by the UNDP on participatory tools for strengthening community responses to HIV/AIDS (UNDP, 2000);
- work by the International Labour Organization (ILO) on human capital for HIV/AIDS (Cohen, 2002);
- guidelines produced by WHO’s regional offices such as Building blocks (PAHO, 2000) and Planning and implementing HIV/AIDS care programmes: a step-by-step approach (Narain et al, 1998);
- work by the World Bank on involving NGOs in HIV/AIDS programmes and on mobilizing rural workers (Schapink et al, 2001; World Bank–ActAfrica, 2002); and

In addition, other work relevant to the interface, but not specific to HIV/AIDS, was identified. This included:

- work by WHO on district health systems (WHO, 1995), community involvement (WHO, 1991), health promotion (WHO, 1998) and on building community capacity to address various health problems;
- work by the World Bank on services for low-income countries and the poor (www.worldbank.org/hmp/lssd) and on the provision of services by civil society organizations (CSOs) (McLeod & Tovo, 2001); and
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The UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) which includes work on participatory training for health workers to improve their interactions with clients and families (Haaland & Vlassoff, 2001) and community-directed treatment of diseases (WHO, 2000).

Although all the above-mentioned efforts are valuable, the most relevant and comprehensive work relating to the health services–community interaction is WHO’s work on district health systems and on community involvement in health and the work by UNAIDS on local responses. This work is briefly discussed below.

1. District health systems: providing a framework and structures for the interface

Since the 1980s, the work undertaken by WHO on structures and programmes for local health systems has been mostly within the framework of district health systems (WHO, 2001a). During this period, HIV/AIDS was emerging as a pandemic and work was therefore instigated on supporting the affected countries with the establishment of national AIDS programmes (WHO, 1988).

The district health system, globally the most widely available sub-national health system, provides the mechanisms (and structures) necessary for the realization of the plans and interventions of the national AIDS programmes. More importantly for the subject of this review, it offers a potential platform for the overall arrangements for the interface between the health services and the communities. WHO regional offices already have specific programmes in place to support countries in the development of their district health systems.

The district health system recognizes both the health services and facilities and the community structures as integral components (Kahssay & Baum, 1996). By definition, a district health system encompasses all the players and structures in health development and health service delivery (for any given district). This includes the formal health workers, health centres and posts, families, traditional health providers, and a variety of CBOs such as women’s groups, youth assemblies and faith organizations. The district health system therefore offers opportunities for building an enabling environment for the interface between health workers and community organizations. In addition it offers opportunities for attention to be given to issues related to the interface such as the community financing scheme that has been introduced as the Bamako Initiative in west and central Africa (UNICEF, 1995) and stewardship roles for the health system that reflect the role of the local government in health (WHO, 2001b).

The local government serves as the interface between communities and government. Experience has suggested that local government has the potential to facilitate the involvement of communities in health and health services (WHO, 2001b). The influence of local governments in health services is far-reaching: it is the local government, not the ministry of health, that “hires and fires” local health staff. The review undertaken for this WHO Consultation suggested that local government, given its influence on local health decisions, deserves more attention as a stakeholder in health generally, and in HIV/AIDS in particular.

Within the framework of the district health system, the service structure at the interface between the health services and the local communities is the health centre, defined as all front-line facilities for the provision of a variety of health services (WHO, 1997). It is the health centre with its front-line workers that is able to maintain both an ongoing dialogue and functional partnerships with the communities. Table 1 outlines the three components of a district health system.

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1 The district health system is defined as a self-contained segment of the national health system comprising a well-defined population living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private or traditional. It has the following three components: health management, health facilities and community groups and organizations, previously named health development structures (WHO, Global Programme Committee, 1986).
Community health workers (CHWs), who originate from within the community, do not necessarily belong to the formal health services, but are briefly trained and are supported in their activities by the formal health structures. CHWs have the critical role of bridging between the community and the formal health services. They exist in various forms in many countries, have increased the coverage of primary health care services, and are the foundation of community-based actions of many vertical programmes (Kahssay et al, 1998).

2. Community involvement in health: a basic principle for health development
Considerable efforts in conceptualizing and promoting community participation have been made since the 1980s (Oakley, 1989) and the concepts and practices have been reviewed by Kahssay & Oakley (1999). The work on health promotion, with its focus on the wider determinants of health, is an area that has strongly encouraged multisectoral collaboration and partnerships between health services and communities. World Health Assembly resolution WHA 51 on health promotion urges all Member States to consolidate and expand partnerships for health, to increase community capacity and to empower the individual in matters of health (WHO, 1998). Community involvement as a principle is based on community ownership of the health services. It is about developing “people’s services”. A WHO Study Group on Community Involvement in Health stated that, to be able to meet the target of health for all, it is necessary that: “...radically different forms of health care are put into practice, permitting the development of health services that are people’s services...” (WHO, 1991).

Although much work has been done on fostering community participation in addressing various health problems and implementing health programmes, this review suggested that limited efforts have as yet been directed towards building the capacities of the health providers. A shift in focus is therefore required (see Box 3).

Box 3: Shifting the focus
After many years of experience with community involvement in health (CIH), experts recognized that:

«Any major advance in the implementation of CIH as a principle of health development could come about only when health services fully understood the value of CIH and were prepared to meet its challenge.»

An expert committee meeting on community involvement in health recommended that the focus be shifted from «encouraging communities to participate in health» towards “preparing health services for community involvement in health”. Efforts to build the capacity of health providers to work with communities should be emphasized. (Source: WHO, 1991)

3. Local responses for HIV/AIDS: providing a participatory process for building community capacity
In the mid-1990s UNAIDS and WHO instigated the District Response Initiative in six countries, with support from the German organization, the Deutsche Gesellschaft für technische Zusammenarbeit (GTZ) (UNAIDS, WHO & GTZ, 1997). This initiative aimed to strengthen the capacity of the districts and was taken beyond the strict health sector. The initiative focused on multisectoral collaboration to assess the situation within the communities and the planning of appropriate responses. This initiative

| Table 1. The three components of a district health system |
|----------------|----------------|----------------|
| Health services management | Health service facilities | Health development structures |
| District medical officers Heads of health centres and posts, etc. | District hospitals Health centres Health posts | Farmers’ associations, women’s groups, village organizations, faith-based organizations, etc. District councils, district health committees |
was developed further into the Local Response Initiative led by UNAIDS, which contributes substantially to building and enhancing the community capacity for addressing HIV/AIDS in many countries in Africa in which controlling HIV/AIDS is a priority (UNAIDS & TANESA, 2000).

A local response to HIV/AIDS is defined as “the involvement of people where they live — in their homes, their neighbourhoods and their workplaces” (UNAIDS, undated). Such a response can be viewed as a strategy for developing a process that involves people in building partnerships and an enabling environment with the aim of increasing local competence to respond to HIV/AIDS. It builds on theories of action learning and participatory methods (KIT/UNAIDS, 2002). Local partnerships are viewed as being critical for effective local responses. Figure 1 illustrates the three groups of key players in the local response, namely, the communities and key social groups, the service providers and the facilitators.

People living with or affected by HIV/AIDS (PLWA) and their NGOs have made significant contributions to community capacity building and are recognized as critical partners in the local responses. A special programme, Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA), has been established by UNAIDS, and aims at promoting the involvement of PLWA in community action as well as in planning and policy development (UNAIDS, 1999b). The involvement of PLWA in services enables important links to be built between the communities and the services. This can be most readily accomplished if there is concurrent development of capacity among PLWA to enhance their communication with, and influence on, other parts of the local community. Thus the work on building the capacity of PLWA for interacting with health providers and with other community groups is a critical component of building community capacity for the interface and for responding to HIV/AIDS in general. UNAIDS has documented many cases worldwide of community processes and action led by or involving PLWA (UNAIDS 1999c, 1999d, 2000). Such positive experiences in local response for HIV/AIDS could be documented, and adapted to different contexts (see Box 4).

![Figure 1. Stakeholders in local partnerships](source: KIT/UNAIDS (2002). Turning local experiences into global learning: from tool to application. Inception report. Amsterdam, KIT (Royal Tropical Institute) (unpublished document).)
Work to build upon
The health service structures and delivery models that are related to the interface derive from the primary health care approach, and have been described in previous work on the framework of district health systems. The work on the processes for the interface is grounded in the efforts on community participation and brought into more practical detail in the initiatives on health promotion. What is evident from the many expert meetings and documents on the subject is that the interface between the health services and the local communities has been a principal concern in previous work.

The local response initiative is a remarkable scheme that focuses specifically on HIV/AIDS prevention and care; it offers many experiences and strategies for linking a variety of service providers (among them the health service providers) and communities specifically to address the problems of HIV/AIDS. On the basis of transformation theory and participatory methodologies, the local response initiative provides the processes and methodologies needed for the local interface (collaboration, partnerships and joint working). An important feature is that it acknowledges the difficulties in getting local stakeholders to interact with each other and therefore makes use of facilitators in the process. The local response initiative has been implemented over the past few years in many countries where controlling HIV/AIDS is a priority and has been useful in building capacity in local communities.

Gaps in the work
From the review of the relevant literature, three important gaps in the work were identified.

The first was that within the local response initiative, no specific attention has been paid to the interface between health services and communities. Health workers are just one group in the category of service providers. Although it is legitimate to regard the various service providers (social, legal, education etc.) as important stakeholders in HIV/AIDS, it may be equally justifiable to suggest that health service providers are in need of special attention. This is because health service providers differ from all other service providers in that, historically, they have dominated the health agenda. Joint work on health, collaboration and sharing responsibility with communities is now urgently required from health service providers to enable them to respond appropriately to HIV/AIDS. Such a relationship of shared responsibility and joint work between...
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Health services and communities is completely different from the traditional one in which decision-making is unilateral. Moreover, health service providers differ from all other service providers in terms of the range and frequency of their interactions with the communities and clients on health issues. The efforts to improve access to preventive services, to care and to antiretroviral treatment are expected to increase the interaction with PLWA, their families and communities.

The second gap that has been identified is that little work has yet been undertaken on enhancing the capacity and expertise needed by health workers for interacting with the communities. The emphasis so far has been on augmenting the capacities of the communities and families for disease prevention and care. Relatively little effort has been directed towards enabling formal front-line workers to work jointly with the communities.

The third gap is that the work undertaken by WHO that is relevant to local health systems and partnerships, and the experience gathered in this area by many other health programmes, has not yet been systematically reviewed. Such a review is necessary to explore past experiences and to decide whether they can reveal opportunities for improving and expanding the community care of HIV/AIDS patients. Similarly, the many case-studies on HIV/AIDS reported in the UNAIDS Best Practice Series have not been reviewed from a health system viewpoint to identify health service – community partnerships and the factors that are conducive to building such partnerships.

Advancing the work

For health generally, wide experience with the interface has been gained worldwide. However, our review suggests that the following actions may be needed to fill the gaps in the present body of work, and could contribute to advancing the efforts undertaken to date.

- A detailed analysis of the lessons learned by the local health systems that are pertinent to the interface between the health service and the community could prove useful for application to HIV/AIDS. Likewise, a comprehensive analysis of the many cases described in the UNAIDS Best Practice Series with a specific focus on identifying health service–community partnerships, and the critical factors that contribute to such partnerships, could be useful for reorienting the health services towards collaborative interaction.

- Additional and focused attention on the health service providers, together with the recognition of the broad range of other service providers as stakeholders in the local response, could enhance the support from the United Nations for the local response initiatives.

- Development of an overall strategy and actions aimed at re-orienting health care systems to encourage community partnerships, as well as the building of capacity for partnership and joint work at local community level with mainstream health service providers, is desirable. Such changes in the health care system could advance not only the work on HIV/AIDS, but also that in other areas of health. The lessons learned from HIV/AIDS have created opportunities for changes in health service provision.

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HUMAN CAPACITY DEVELOPMENT: A PARTNERSHIP RESPONSE TO HIV/AIDS

Ms Sue Lucas

Human capacity development (HCD) is an innovative approach to addressing HIV/AIDS that goes beyond technical solutions and service provision and builds on the existing strengths of both people and communities. It does not replace service provision, which will always be an essential part of any response to the epidemic, but it enables service provision to be both appropriate to and complementary to the responses made by communities. It is community-led rather than commodity-led. The aim of HCD is to create “HIV/AIDS competent” communities and organizations (Campbell, 2001) that are able to acknowledge the existence and impact of HIV care for those who are affected or infected, to change in order to address the epidemic and to measure the changes taking place.

The key elements of a human capacity development (HCD) approach are a working culture of facilitation (Campbell et al, 1998) and the building of a shared vision. Rather than imposing external solutions, HCD is based on community responses to HIV/AIDS. Facilitation teams enable a continuous process of learning from local action and responses, reflection, action, learning and further reflection. The process of learning together validates and encourages community responses. Through participation in facilitation teams and in shared learning with communities, organizations find out how the way in which they work can be adapted to complement and enable community responses, rather than, as is sometimes the case with expertise-led interventions, hindering and undervaluing them.

Facilitation teams (Rader et al, 2002) stimulate local ownership of both the problems that HIV creates for communities and of the solutions to these problems. Solutions are therefore not externally imposed by any party. Facilitation teams create and share knowledge of effective responses, and draw community members and service providers into the process. Teams are not static, but rather are dynamic in nature. They can function in a variety of environments from the international level to the local level. Members are self-selecting, and participate as individuals, not as representatives of organizations. One of the limitations of the current technological approaches to HIV is that scaling up of service provision has proved to be very difficult. An HCD approach builds on community capacity by facilitating transfer of learning and action from community to community. This “horizontal learning” occurs between communities in the absence of external stimulation (Salvation Army Africa Regional Programme Facilitation Team, 2002), but not fast enough to match the speed of the spread of HIV. Facilitation teams stimulate assessment, design, process analysis and evaluation of patterns of response locally and elsewhere. A key way of working is through learning from and valuing local strengths. This strategy is a means to a more effective process and outcome. Links can be made in all directions, so that for example policy-makers, who may be from government or international institutions, can share learning (Lucas et al, 2002) with communities to improve the ways in which relationships function and services are provided.

A satellite meeting at the International AIDS Conference in Barcelona (UNAIDS/TND, 2002) agreed on a framework to show how HCD can bring together communities, individuals and families (these three groups having being identified as “spheres of action”) to learn with service providers and policy-makers. Although each of these groups has a key role in the overall response to the epidemic, there
has so far been little collaborative interaction between them. Enabling shared learning that focuses on the community sphere, in which the transmission and the impact of HIV are seen, increases understanding in all spheres, of the role and strengths of the others, and enables a more holistic and integrated response.

The challenge to organizations is to change their way of working from one of expertise-based interventions to one of facilitation and community leadership. The shift in perspective is illustrated in Box 5 below. An HCD approach would also require a shift towards equal partnerships, working with rather than for communities, clients and “target groups”, as well as addressing several spheres of action (see Figure 2).

**Box 5: A shift in perspective**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>We believe in our own expertise</td>
<td>We believe in people’s strength to respond</td>
</tr>
<tr>
<td>We control a disease</td>
<td>We facilitate responses</td>
</tr>
<tr>
<td>Responding to need</td>
<td>Revealing strength</td>
</tr>
<tr>
<td>You have a problem</td>
<td>Together, we can find the solutions</td>
</tr>
<tr>
<td>Provision of services</td>
<td>Partnerships that foster community ownership, multisectoral service provision, and a supportive environment</td>
</tr>
<tr>
<td>Mobilizing external expertise</td>
<td>Supporting in-country networking and community responses</td>
</tr>
<tr>
<td>We instruct and advise</td>
<td>We learn and share</td>
</tr>
</tbody>
</table>

Figure 2. Spheres of action

The Salvation Army has been working using this approach since the mid-nineteen-eighties. They started with the home care programme in Chikangata, Zambia, in 1987. This was the first home care programme for people with HIV in Africa that built on the capacities of families and communities to care. The programme, developed from Chikangata Hospital, established community teams to support families caring for the sick. Competent communities were soon discovered, and the care/prevention linkage was a source of energy and hope.

During 2002, the Salvation Army and UNAIDS/Technical Network Development have been working in partnership to establish HCD approaches. Other institutions and international donor agencies, including the World Bank, the United States Agency for International Development (USAID) and the Department of International Development of the United Kingdom (DFID) have been involved in discussions and several international meetings have been held, including the meeting in Barcelona in 2002 and a donor workshop in London in 2002. The key points learned from the experience of working with an HCD approach in practice are that effective responses to
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HIV are people-driven not commodity-driven, that technology, money and information lend support to, but cannot be a substitute for people-driven responses, and that to create a country-wide response, an approach of facilitation that builds on strengths and engages people within their own communities is required.

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COLLABORATIVE INTERACTION WITH THE COMMUNITIES: CONSTRAINTS AND OPPORTUNITIES FOR THE HEALTH SERVICES

Dr Hedwig Goede

Collaborative interaction between health services and communities has long been a concern of the health sector. Since the 1980s, the concept of community involvement has been generally accepted as an important component of health practice. Many valuable experiences have been gathered that demonstrate that a radical reorientation of health service practice is required for the institutionalization of community involvement. However, it was noted that after a decade of experience the necessary radical reorientation was still being underestimated (Oakley, 1989; WHO, 1991).

HIV/AIDS has led to numerous new experiences being gained in community health action based on partnerships and joint working (UNAIDS, 1999, 2000; UNGASS, 2001) and is calling more strongly than ever for a radical reorientation of health care delivery so that treatment can be brought within reach of the millions of people who need it (WHO, 2003a). Despite the considerable progress that has been made to date, some constraints on the interaction between the health services and the communities still need to be addressed if collaboration between communities and health services is to become normal practice. This chapter discusses these potential constraints and presents some promising examples of the health service–community interaction, that have been reported in the literature.

Constraints: health care model and capacity of the health services

Over the past two decades health care models and various local structures that facilitate community involvement and support the functional linkages between health service structures (district health systems and health centres) and community organizations (community health workers) have been promoted (WHO, 1991, 1994, 1995, 1997; Kahssay, 1998; Kahssay et al, 1998; Kahssay & Oakley, 1999). However, the following factors within the health care system restrict the ability of these structures to perform effectively in collaborative interactions with communities.
The biomedical orientation of the health care system. The medical model, which tends to overvalue biomedical care, is still the prevalent model in health care. Community involvement has been recognized as a challenge to traditional health service practice (WHO, 1991) and the health sector has not been able to move as far as other development sectors in the institutionalization of community involvement at the national policy level (Kahssay & Oakley, 1999). The biomedical orientation of health care also leads to an overemphasis on acute, episodic care. Chronic conditions, including HIV/AIDS, require different management that necessitates a long-term, trustful and partnership-based interaction between the health professionals, the clients and their communities. A new innovative chronic care model has identified three entities each with distinctive roles in care that need to be firmly connected: the health care organization, the patient and the community (WHO, 2002).

The strong hierarchical structure and non-participatory culture of the health care system. Local health workers have reported feeling frustrated about their lack of opportunity for input into decision-making about policies affecting their work (Vlassoff & Fonn, 2001). Health workers are generally unaccustomed to dialogue and partnership approaches at the workplace and remain reluctant to involve the communities in decision-making or to recognize them as full partners in the services.

Gender-based policies and approaches emphasize the importance of involving individuals, both men and women, in health services and promote interaction with diverse societal groups (WHO, FCH/RHR, 2001, WHO, 2003b). Therefore, gender-based approaches can be viewed as important tools to enhance participation of communities in the health care system. There is additional justification for gender sensitivity in the interaction between health services and communities dealing with HIV/AIDS. This is because of the gender-based power differentials in sexual relationships that may influence the vulnerability of women. However, the importance of gender as a factor in health and services has not yet been fully taken into account.

Attitudes and practices of health workers towards communities. Health professionals, by virtue of their position in health organizations, have considerable power to determine the health agenda (Robertson & Minkler, 1994). Mutual recognition of capacities and worth is a key requirement for collaborative efforts; however, there is evidence to suggest that professionals significantly undervalue the expertise of communities (El Ansari et al, 2002) and are often not even aware of the existence of community organizations and their health activities (Kahssay & Baum, 1996). Formal HIV/AIDS programmes sometimes operate without any feedback from the villages they serve and without establishing any links between the formal health services and the community home care system (Singhenetra-Renard et al, 2001). This unilateral determination of the health problem and its prevention or treatment is recognized as deeply embedded in the culture of modern medicine (Lopez Acuña et al, 2000). Studies of various programmes have reported that formal health workers initially resist the involvement of community members in care and treatment (TDR, 2000; Kironde & Nasolo, 2002). Furthermore, there is evidence that attitudes and practice of formal health workers showing a lack of respect for the community’s role in care create serious barriers to the performance of community members trained as “community caregivers” for PLWA (Uys, 2002). Conversely, in community-based HIV/AIDS programmes, transferring nursing skills to the families and communities, rather than requiring nurses to perform all the necessary tasks, has been recognized as an approach that contributes to the extension and sustainability of HIV/AIDS community care (UNAIDS & SANNAM, 2003). Poor-quality interactions present major barriers to the use of health services. Clients have reported being treated without respect by health staff, which they feel originates from the staff adopting a superior position as professionals (Onyango-Ouma et al, 2001). When social distance is considerable, as with poor and marginalized people, the lack of respect and the feeling of being badly treated by workers in social institutions is profound (Narayan et al, 2000; WHO, World Bank, 2002). Being a patient with HIV/AIDS exacerbates these problems. The enormous stigma attached to HIV/AIDS is accompanied by large-scale discrimination against PLWA in health facilities and by society in general (UNGASS, 2001; UNAIDS, 2002).

Lack of resources and incentives for local community level structures. The roles of the district health system and its peripheral structures are constantly emphasized in the public health literature. The Commission on Macroeconomics and Health identified the “close-to-client” services as the priority level for tackling HIV/AIDS and other important diseases affecting the poor (WHO, 2001). However, primary health care activities such as working in and with communities lack recognition. For example, the performance of nurses in South Africa is measured primarily on indicators of biomedical care (Petersen, 2002). Moreover,
there are strong suggestions of a serious misfit between the burden of work and the resources available to the health centres at district level (WHO, 1999). Therefore, community services have inadequate resources not only in absolute terms (because of the limited resources available in a country), but also because relatively more resources are directed to the secondary and tertiary levels of care.

**Gap in professional training.** A considerable gap needs to be bridged between the demand for new roles to be taken on by health workers and formal training (Guldan, 1996). The core concepts of the curriculum that provide health professionals in primary health care with skills for partnerships are the strategies of networking, negotiating, sharing power, and critiquing partnerships (MacIntosh & McCormack, 2001). The changes required for taking on the new roles involve the re-socialization or re-professionalization of professionals (Stewart, 1990). Addressing the problems of HIV/AIDS has exerted great pressure on training needs, because it requires health workers to go beyond their routine approaches (van Praag et al, 1997). In addition to training in new skills, institutional factors need to be tackled by means of strong leadership to encourage and enable health workers to make a real change in their practice and behaviour (Woodward, 2000).

**Constraints: community capacity**

The concepts of community capacity, empowerment, competence and readiness share some characteristics, but differ in others (Goodman et al, 1998). Community empowerment, viewed in its wider definition as a social-action process aiming towards increased individual and community control (Wallerstein, 1992), places emphasis on a collaborative interaction between health services and communities and challenges the conventional relationship between communities and professionals (Wallerstein, 2002). It is therefore an important concept in the discussion of the interface. UNAIDS defines an AIDS-competent community as “one whereby people are able to assess accurately the factors that may put them or their communities at risk of infection, and act so as to reduce those risks” (UNAIDS, 1997; Lamboray & Skevington, 2001). An AIDS-competent community will be empowered and have some general capacity to address community problems as well as specific capacity to address HIV/AIDS.

**General capacity and community empowerment.** Communities sometimes lack the level of empowerment and capacity that would enable them to collaborate as equal partners with health services. Leadership, inter-organizational networking and negotiation skills, as well as expertise in community organization and resource mobilization, are examples of the range of dimensions and competencies identified as being determinants of community capacity (Goodman et al, 1998). There is a need for those communities with little experience in community-based action and frail organizations to build and enhance their general capacity. This is particularly relevant for the marginalized populations and vulnerable groups at a high risk for contracting HIV/AIDS. The HIV/AIDS prevention movement has been successful in tailoring programmes to communities that are defined on their risk for HIV (Freudenberg & Zimmerman, 1995). In addition, the gay community has played a leading role in providing both prevention and care services. In the first years of the epidemic, in particular, the available HIV services were owned and managed by gay communities. However, at-risk populations and vulnerable groups may lack the type of social interaction and sense of community that could lead to community action. Experiences from Thailand suggest that creating a sense of community through social and political activism as with the western gay community may be more difficult in Asian countries (Scott & Rosko, 1999). In Madras, India, experience of working with the community of sex workers has shown that in some societies, vulnerable communities may be too powerless, isolated and marginalized even to act as a community. Hence, comprehensive structural changes are required to address the lack of empowerment before sex workers are able to act individually or collectively to prevent HIV/AIDS (Asthana & Oostvogels, 1996). In South Africa, experiences with sex workers confirm the influence of conditions such as poverty and sexual inequality on bringing community participation into practice in marginalized populations (Campbell & Mzaidume, 2001).

**Specific HIV/AIDS capacity.** There is evidence of a wide gap in some communities between the knowledge and skills available at the community or home level and the daily tasks that need to be performed in caring for someone with HIV/AIDS in homes and families. At the start of the epidemic, the AIDS activists from the western gay community were the best informed, educating not only the community members but also the professionally trained health workers (Cain, 1993). They had considerable capacity and impact. However, in other settings, insufficient capacity at community and home-care level was being associated with lack of support and supervision from formal health workers. For example, family members caring for AIDS patients often have little or no knowledge or experience of the skills...
needed to provide care, how to manage symptoms such as diarrhoea, dehydration and pain or how to take precautions against transmission. They are sometimes even unaware of the diagnosis of their ill relatives (Ndaba-Mbata & Seloilwe, 2000). Gaps in knowledge have also been identified as regards mother-to-child transmission and the available preventive interventions (Nyblade & Field-Nguer, 2001). A further constraint is the focus on individual knowledge and behaviour change without building the capacity at the level of society. For instance, in the past, changing individual behaviour to prevent HIV has received more attention and support than changing societal factors (O’Reilly & Piot, 1996). Changes in individual behaviour are difficult to sustain when the societal factors that influence the behaviour are not simultaneously tackled. This is because the individual, societal and institutional levels of capacity are mutually dependent and are therefore of equal importance (Fukuda-Parr et al, 2002).

**Constraints: processes and methodologies for linkages**

A body of literature is available on the processes that promote the building of partnerships based on community involvement and participation, and on processes for enhancement of community capacity for health. In addition, numerous manuals and guidelines that focus on developing various HIV/AIDS competencies are available, most of which have been produced by NGOs, and by various United Nations agencies. However, several factors restrict the gains that might be predicted.

**Application of participatory methods in the training of health professionals.** The application of participatory methods in the training of health workers for partnership fostering, such as the use of role-modelling of partner skills in nurse education (Petersen & Swartz, 2002), and improving health workers’ gender sensitivity and relations with clients and communities, have been effective in bringing about the desired changes and increasing job satisfaction (Onyango-Ouma et al, 2001). Relevant methods are based on the principle of joint learning where all participants, community members as well as the “educator”, “facilitator” or “health worker”, learn together. These techniques address the entrenched belief in professional dominance and lay the foundations for partnership building and work. However, these participatory approaches are not fully institutionalized in professional education and training although they have been applied to a limited extent in professional education and training. It is likely to be difficult for health workers to learn to use participatory methods when working with communities if they have not experienced these methods during their professional training.

**Frameworks for tools and methods.** Frameworks by which the numerous tools and models necessary for the participatory methodologies, joint working and partnerships for addressing HIV/AIDS can be arranged, categorized and catalogued are lacking. These tools and models are therefore dispersed and difficult to access. There are many success stories of local partnership processes for addressing HIV/AIDS, but there has been little effort to critically review and document the features of the different methods applied in such local partnerships, or to measure community participation and institutional changes that are conducive to partnership work. Transferring the experiences from local responses to other settings has proved difficult; deliberate efforts and specific tools are required to support this process (KIT/UNAIDS, 2002). Institutionalizing the application of methods used to create effective partnerships on a larger scale is still complex and the scaling up of efforts to combat HIV/AIDS is a difficult task for the individual NGOs leading the local processes. One way in which some countries have been able to scale up has been the adoption by governments of NGO methodologies for building community capacity and generating community action for HIV/AIDS (De Jong, 2001).

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The health service–community interaction: opportunities

A variety of experiences related to the interface between health services and communities in HIV/AIDS prevention and care suggest important opportunities for enhancing the interactions. The Consultation identified the potentials of such interactions for several key areas relevant to the problems of HIV/AIDS.

Key areas for the interface

Partnerships and collaborative efforts between different stakeholders have proved effective in responding to a broad range of aspects of HIV/AIDS. However, within this broad range, some areas (for example blood safety) seem to be less amenable to collaboration between health service structures and community organizations than others. The following areas are particularly sensitive to the health services–community interaction and are therefore key fields when considering the interface.

Voluntary counselling and testing. Increasing access to voluntary counselling and testing (VCT) is an important area that requires good collaboration between the health services and communities. The management and delivery of VCT services can either be jointly planned and implemented by the formal health workers and PLWA or may be implemented by one partner and supported by the other. Such collaboration enables both the coverage and the quality of VCT services to be increased.

Community and home care. Family, friends and community members provide most of the care to PLWA in the home. The carers need support from the formal health services, and links between facility-based, home-based and community-based services are required to maintain a continuum of care. Support, advice and supervision from health service structures for carers in the community and in homes is an important area of the interface.

Antiretroviral treatment and adherence. Community organizations may take action to increase local access to antiretroviral treatment. Family members and community volunteers play a critical role in supporting individuals with several aspects of treatment. Families and community members may play a role in helping patients to meet nutritional requirements and to adhere to their antiretroviral drugs. The risk of viral resistance when antiretrovirals are not properly used and the chronic character of the treatment are reasons why assistance in adherence can be considered as a critical contribution to effective treatment. Communities need to build specific capacity, knowledge and expertise for implementing and supporting antiretroviral treatment. Close collaboration between the health services and communities, family and friends is a prerequisite for the success of antiretroviral treatment.

Human rights — reducing stigma and discrimination. Human rights approaches to HIV/AIDS prevention and care provide the foundation for addressing the issues of stigma and discrimination. Furthermore, human rights approaches may provide a sound basis for gender-based action by recognizing gender differentials in power and rights as related to risks, prevention and access to care for HIV/AIDS. Health services and communities are mutually dependent in reducing stigma. Particular individuals who “wear two hats”, such as a nurse who discloses that he or she is seropositive, are in a unique position to play a critical role in reducing discrimination at the level of services as well as at the community level.

Responsiveness of and demand for services. The range of services available to individuals is often not fully utilized. The creation of an informed demand for the services and raising the responsiveness of such services are as important as the services themselves. Communities, especially PLWA organizations, can influence the quality and priority of services through dialogue and partnerships with the health services.

Social support, networking and intersectoral action. The interface with the communities offers the health services increased access to other sectors. This is because communities frequently have a variety of concerns that extend beyond health and therefore their organizations are often already involved in collaborative efforts with different sectors. The communities and the health services could derive mutual benefit from one another’s networks and linkages to help address a variety of issues ranging from prevention and treatment of HIV/AIDS to nutrition and care of orphans.
Lessons learned

Some useful lessons have been learned from the experiences in managing HIV/AIDS as well as from other health conditions. The lessons learned cover:

- health structures and programmes;
- approaches to building partnering capacity; and
- key actors for bridging between the health services and the communities.

Health structures and programmes

Health centres and community health workers. Health centres and community health workers have demonstrated their ability to reduce barriers to access and to increase access to care generally. Community health workers have succeeded in reaching people at community level with their services and have influenced the acceptability of the existing services. As a result, they have increased the utilization of these services (Kahssay, 1998; Swider, 2002). The employment of community health workers has also been successfully applied in community care for patients with tuberculosis (Hadley and Maher, 2000; WHO, 2003c) and in home care for patients with HIV/AIDS (Uys, 2002).

District hospitals. District hospitals have demonstrated their ability to organize outreach services for HIV/AIDS and to build community capacity through partnerships. The Chikankata hospital in Zambia pioneered the work in this area and provides one of the classic examples of what can be accomplished through working in collaboration with the communities (Malama, 2001). This hospital has served as a model for a range of other community care programmes in Southern Africa (UNAIDS & SANNAM, 2003).

Tuberculosis community care. Tuberculosis community care programmes have demonstrated that volunteers from the community are able to supervise treatment in an appropriate manner if there is a close interaction with the national tuberculosis programme and with the general local health services (WHO, 2003c).

Home care programmes. Home care programmes for patients with HIV/AIDS perform well when supported and supervised by professional health workers. It has been demonstrated that community members can be trained to assist families with care at home within a period as short as 3 months, but supervision and support by professionals are of the utmost importance (Uys, 2002). Effective partnerships between the government health facilities and the home care programmes of NGOs and missionaries have been identified as a way of expanding successful home care programmes (Nsutebu et al, 2001).

Responsive health services. Responsive health services have an empowering effect on people and on community capacity. Personal services directed towards individuals can be empowering to individuals and communities if delivered in an empathic and supportive way (Labonte, 1994) or as a right to people (Pilisuk & Minkler, 1986). Similarly, access to health services is essential in maintaining the supportive capacity of families, networks and communities (Pilisuk & Minkler, 1986). Access to essential services (including health services) has also been proved to enable women to engage in other empowering activities (Kar et al, 1999). In the case of HIV/AIDS, responsive and knowledgeable health providers have an empowering effect on patients and are identified as being critical components of the infrastructure required for care and treatment of PLWA (ICASO, 2002).

Approaches

Academic institutions — the use of participatory action research. Academic institutions have been effective in facilitating local partnerships and in building community capacity as well as capacity for partner roles between health workers and non-professionals. Schools of public health are increasingly engaging in partnerships with the health services and communities and are able to facilitate collaborative action (Schensul, 1999; Galea et al, 2001; Lantz et al, 2001). Nurse researchers have also successfully employed PAR to build community capacity for action and change in health generally (Lindsay & McGuinness, 1998) as well as specifically for HIV/AIDS (Lindsay et al, 1999). Similarly, community-oriented medical schools with innovative programmes have reduced the social distance between health services and communities (Blumenthal & Boelen, 2000).

Participatory and learner-centred approaches. Participatory and learner-centred approaches to the education and training of health professionals have been shown to be effective for teaching a range of non-clinical skills that are required at community level. Various methods that differ from those used in conventional training have been used,
Structural and operational underpinnings of partnership work

including supportive supervision (Wishik & Bertrand, 1990; Butcher et al, 2000), role-modelling of partnership skills (McIntosh, 2001), creative team-building (Butcher et al, 2000) and methods that use transformation theory and adult education (Haaland & Vlassoff, 2001).

**Gender-based interventions.** Gender-based interventions initiated by health services, often in association with women’s groups, provide opportunities to address a range of factors that determine vulnerability to HIV infection. Examples of such interventions include the development of skills for negotiating safe sex and the use of the female condom (Raphan et al, 2001; Pulerwitz et al, 2002).

**Key actors**

**Capacity, skills and knowledge of PLWA.** The capacity, skills and knowledge of PLWA can be raised to high levels. Peer education supported by NGO efforts has been found to lead to a good understanding of the disease and its care, including a significant level of knowledge among lay people. The building of capacity, skills and knowledge is not restricted to individuals in developed countries with high-level education, but has also been reported in less well educated individuals (ICASO, 2002).

**Committed nurses can play vital roles.** Committed nurses can play an important role in care of patients with HIV/AIDS in the community and in the home. Such a role involves empowering PLWA and their communities and challenging the attitudes to the stigma attached to HIV/AIDS among nurses and within communities. Individual nurses in southern Africa who have taken the initiative to work with communities on care and support for patients with HIV/AIDS have managed to set up community and home care programmes while under considerable stress from working on low salaries, lacking the most basic needs and being surrounded by professional peers who were sceptical about the efforts that they were making (UNAIDS and SANNAM, 2003).

**Civil society organizations.** Civil society organizations (CSOs) play a critical role in addressing the problems of HIV/AIDS and are key to the fostering and implementation of change. They have challenged the control of health professionals over health programmes and have taken on roles that were conventionally performed only by professionals. For example, grass-roots groups have organized community-based drug testing trials and have taken on roles that were normally reserved for trained academic researchers (Indyk & Rier, 1993). In addition to providing a variety of services themselves, CSOs have influenced the existing mainstream health services and the global and national policies (UNRISD, 2000).

**A final word: the interface — complex but feasible**

Some promising opportunities for HIV/AIDS prevention and care lie in the interface between health services and communities. However, the dynamics of the interface are complex and the nature of the interface is affected by various factors.

The constraints identified are strongly interrelated. Addressing the lack of partnership skills in health workers without addressing their attitudes towards communities will not lead to improvements. Changes in attitude are difficult to bring about without changes in the culture of the health institutions. Once changed, the attitudes and the related practices are difficult to sustain unless there is an enabling environment. If the gap in professional education is not addressed, academic institutions will continue to produce health workers who are ill-equipped for working at the interface with communities. If community capacity does not include individual as well as collective empowerment, structural barriers in HIV/AIDS will not be addressed and the success of the HIV/AIDS programmes will be limited. If the potential achievements of enhanced community capacity are not made evident and strengthened where necessary, the conventional attitudes towards communities are reinforced and the difficulties related to the attitudes of health workers will be difficult to overcome.

Despite the complexity of the interface there has been a wealth of experience and important lessons learnt over the past two decades demonstrating the feasibility and effectiveness of positive and effective interactions between health services and communities.

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Structural and operational underpinnings of partnership work


Structural and operational underpinnings of partnership work


Section 2
Partnerships for HIV/AIDS: case presentations

BRIDGING THE GAP BETWEEN THE COMMUNITIES AND THE SERVICE PROVIDERS BY WAY OF LOCAL RESPONSES: THE DISTRICT RESPONSE INITIATIVE IN UGANDA

Dr Cyril Pervilhac

From district health systems to communities: local responses
The district has been at the centre of health interventions within the district health systems over the past two decades. In many countries, national AIDS programmes (NAPs) have been able to develop planning tools and to invest in human resources to this effect; for example, HIV/AIDS focal points in the district health teams.

At the local level, primary health care (PHC) approaches in the 1970s and 1980s had already bridged a substantial gap between the health services and the communities. However, in the 1990s, concomitant with the escalation of the HIV/AIDS epidemic, there was less emphasis on the PHC agenda. This situation created a vacuum in the HIV/AIDS responses in the districts. District programme managers often lack the approaches necessary to enable them to translate the priorities of national programmes, often outlined under national HIV/AIDS strategic plans, into district HIV/AIDS plans, based on community needs and priorities. This highlights the importance of local responses (LRs), which aim to place the communities and individuals in the districts, together with their various partners and stakeholders, as centre actors in the expansion of the responses to HIV/AIDS. In epidemics, LRs are particularly relevant at the community level.

Various options relevant to expanding the responses to HIV/AIDS justify LRs (UNAIDS, 1998). These might include expanding the geographical coverage of participation or interventions and focusing the actions to include the most vulnerable groups. These options also embrace the expansion of joint working and partnership efforts in the design, implementation and evaluation of HIV/AIDS policies and programmes. The aim is to involve all the relevant sectors and not only the health sector, hence increasing the resources that can be mobilized in support of HIV/AIDS prevention and care. But the logistics of implementing such an agenda at the local level remain a challenge. The experience of the Kabarole District in Uganda, is an innovative example of an LR approach for bridging the gap between the communities and the health systems in addressing the HIV/AIDS epidemic (Pervilhac, 1997).

Improving local responses: multi-country studies
Between 1996 and 1997, UNAIDS, WHO and GTZ launched a multi-country study under an initiative called the District Expanded Response Initiative (DRI). Five countries in the African region were selected. These were Burkina Faso, Ghana, Uganda, United Republic of Tanzania and Zambia. The aim was to learn how to strengthen local responses. A situation analysis for each country was the starting point for a 2–3-year case-study documenting changes over time. Box 6 lists the objectives of the situation analysis.

Box 6. Objectives of the situation analysis for LR initiatives

- Actions, stakeholders and networking: who is doing what and where at the local level (communities, districts and the link between the two)?
- Expertise and direction: how to take stock of the present skills and vision of the key players and partners at the local level, i.e. communities, non-governmental organizations, faith-based organizations, and local private and public sector agencies.
- Experiences and lessons: are we taking the best advantage of what we know does or does not work with the communities?
- Value and effectiveness: overall, is the local response initiative a worthwhile endeavour?
- Tools: which tools can be used at the local level to expand the local response in the districts? Which tools already exist, or can be adapted to answer these needs?
Local responses: application in Uganda

The Kabarole District in Uganda, which has a population of 860,000, reported a 17% rate of HIV infection in 1997, and had benefited over the years from a comprehensive range of prevention and care activities.

Methods

In situation analysis, the units of analysis are organizations. These were grouped into three categories: the public sector, the private sector and those organizations centred around the communities. A three-pronged approach was utilized.

◗ A community-level study with community leaders, youth representatives and lay people. This was undertaken in four different communities, using adapted participatory rapid appraisal (PRA) methods, mapping, Venn diagrams, focus group discussions and interviews.

◗ An institutional/organizational district level study. This employed group discussions and interviews with representatives of the public and private sectors as well as of NGOs and CBOs.

◗ A coordinating mechanisms study. This took the form of group discussions with various local councils and interviews with representatives from the public and private sectors.

Tools

The tools that were employed (Pervilhac, 2000; KIT, 2002) included WHO indicators to assess the capacity for performance of services, community participation assessment and qualitative methods, political mapping for political analysis and policy advocacy, and organizational analysis.

Findings

Coverage. Rural areas were not sufficiently covered, knowledge of HIV/AIDS in urban and semi-urban settings was much greater than in rural settings. Home-based care was lacking in many rural communities.

Entry points. Entry into the villages and communities with local responses was gained through the parishes and the local councils of the sub-counties instead of directly into villages from the district. This takes advantage of the decentralization policy which has enabled sub-counties to be the basis for successful programmes and for increased local independence (e.g. raising local taxes and budgeting). By using well rooted and powerful local structures that group several villages and communities, it also enables a unifying, catalysing, and multiplying (scaling-up) effect starting with the parishes and their communities within the district (Pervilhac, 1998). However, this requires at least one active CBO per sub-county and well-documented processes and outputs for the HIV/AIDS activities of that sub-county. Figure 3 depicts the coordinating mechanisms for the district response initiative in the Kabarole District of Uganda.

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**Figure 3. Local responses: the coordinating mechanisms for the district response initiative in Kabarole District, Uganda**

<table>
<thead>
<tr>
<th>COORDINATION COMMITTEES</th>
<th>LINKS</th>
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<tbody>
<tr>
<td>NATIONAL</td>
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<tr>
<td>DISTRICT</td>
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<tr>
<td>Local Council 5</td>
<td>Present Links</td>
</tr>
<tr>
<td>7 COUNTIES</td>
<td></td>
</tr>
<tr>
<td>35 SUB-COUNTIES</td>
<td>Recommended Links</td>
</tr>
<tr>
<td>Local Council 3</td>
<td></td>
</tr>
<tr>
<td>177 PARISHES</td>
<td></td>
</tr>
<tr>
<td>VILLAGES/COMMUNITIES</td>
<td></td>
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<tr>
<td>Local Council 1</td>
<td></td>
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</tbody>
</table>

Some of the coordination committees involved included district management committee, district technical committee, district population committee, hospital management committee and health unit management committees.
Recognition. The accomplishments of the departments of health should be recognized. However, their top-down approach has decreased community participation and the chances of sustainability. This is because communities may consider such programmes and activities as being external interventions over which they have no control. Once the funding stops, communities have been unable and unwilling to sustain efforts. Communities would like health to be considered as a development issue, and community planning and interventions should facilitate the integration of HIV/AIDS activities into the activities of the community.

Tailoring. Young girls were not targeted sufficiently by programmes for HIV prevention, and HIV testing was not actively promoted outside the District capital. Traditional birth attendants, midwives from the private sector and health centre staff should have been included in counseling programmes. The findings suggest that HIV/AIDS is still taboo in the health centres. Patients treated for TB and STI at health centres received education about the risks of HIV/AIDS if seen by the senior staff, but not if they were seen by the junior staff who were often in charge, and had not received any appropriate training.

Gatekeepers. Gatekeepers, i.e. community leaders, lack skills or a mandate (often resting with the health authorities) on how to handle HIV activities productively.

Sustainability. Trained community counsellors, such as trained traditional birth attendants, have a high turnover because their “volunteer” status is not accompanied by compensation from the health system or the communities.

### Box 7. Local responses: summary of overall accomplishments

- The local response focuses on the communities, and brings consensus and common vision to the partners in the public and private sectors to feed into local planning activities.
- The local response uses existing tools applied in different contexts and with different partners. As it triangulates information collected through various channels and means, this adds value to the approach.
- The tools that have been developed can be used or adapted to suit the situation in a particular country.
- The same mistakes are being made in working with communities as those that caused PHC to fail 20 years ago (e.g. top-down planning, lack of ownership in the communities, lack of supervision and motivation schemes).
- Local response is a worthwhile investment for a district wishing to focus, accelerate and expand the activities of partners sharing a common vision. The costs of the local response can be reduced by focusing only on the interface between the health systems and communities.

In conclusion, LR can be instrumental in its early stages as a participatory diagnosis method serving to bridge the gap between the communities and the health services by determining roles and stimulating partnerships, using or adapting some relatively simple existing tools (Salla, 1998; M’Pele, 2000; UNAIDS, 2000; Rwomushana, 2002). On the basis of this positive experience there is a need for a better definition of WHO’s role in contributing to the local responses agenda and its documented benefits, and WHO should take the lead in relation to the “service providers” component.
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References


HEALTH SERVICES–COMMUNITY INTERFACE FOR HIV/AIDS: INITIATIVES IN CAMBODIA, CHINA AND VIET NAM

Dr Bernard Fabre-Teste and Dr Masami Fujita

Background
The pattern of HIV/AIDS in the Western Pacific region has been characterized by epidemics concentrated in populations with high-risk behaviours, notably among injecting drug users and sex workers, in countries such as China, Malaysia and Viet Nam. The region also has one country, Cambodia, where there is already a generalized epidemic with an estimated HIV prevalence rate in its adult population of 2.7%.

As the epidemic grows, the number of patients with AIDS increases. There is thus a growing need for more efforts to be directed towards caring for patients with HIV/AIDS. By the end of 2001, the WHO Regional Office for the Western Pacific (WPRO) estimated that almost 1.2 million people in the Region were living with HIV/AIDS. The number of AIDS cases is now increasing by an estimated 55 000 new cases per year and the number is projected to reach 120 000 by 2005.

In the priority countries in the region, discussions are currently taking place on developing models for the care of patients with HIV/AIDS. The WHO Regional Office is assisting these countries to develop national frameworks and guidelines, to initiate model development projects and to facilitate the exchange of experiences.
The situation of HIV/AIDS care in countries in the region

The care of patients with HIV/AIDS in countries in the Western Pacific Region is modulated by the following constraints and strengths.

Constraints

- Countries have very limited experience and low coverage of care that is specific to HIV/AIDS (e.g. VCT, treatment for opportunistic infections, antiretroviral therapy, palliative care and home-based care).
- The medical services are user charge-oriented (except in Papua New Guinea) and there are no incentives for hospitals (or medical services) to provide any form of educational or psychosocial support.
- There is considerable discrimination against PLWA in the health facilities and in society in general. The individual PLWA and their families have limited opportunities to meet and interact with others in the same position and to support one another.
- There is a lack of functional links between the health facilities, homes and the community. For example, home-visit services are not utilized for early detection of TB cases, or for involvement of the community in care. Neither household nor community members are involved in supporting adherence to prophylaxis against opportunistic infections or to antiretroviral therapy. Limited collaboration and communication takes place between the health services and camps for the rehabilitation of injecting drug users and sex workers.

Strengths and opportunities

- The governments of the countries of the Western Pacific Region have shown their commitment to care of patients with HIV/AIDS. This has been supported with considerable funding including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).
- Technical institutions, academic bodies, bilateral agencies, NGOs and WHO are strongly committed to the care of people with HIV/AIDS (e.g. with the International HIV Treatment Access Coalition).
- There are already a variety of peer support group activities and mechanisms to support them (see Box 8).

Box 8. Examples of peer support activities and potential mechanisms of support

Cambodia

- Regular meetings of people living with or affected by AIDS are organized in top referral hospitals that provide antiretroviral treatment.
- Marginalized women (abandoned by their families, victims of domestic violence, etc.), including those who are infected with HIV, have formed groups for peer support and occupational training/promotion supported by NGOs.
- Establishment of nationwide networks of people living with or affected by AIDS (24 groups, 4000 members) partly based on home-visit services to AIDS patients.

China

- Top referral hospitals have established care sites called “Home of Red Ribbon” and “Home of Loving Care” for providing various services. Similar sites are attached to health facilities at the local level. These could promote peer support activities.

Viet Nam

- «Friend-to-friend club»: officers in charge of HIV/AIDS at the local level have supported people living with or affected by AIDS in forming groups in Ho Chi Minh City and other provinces.
- Coffee shops for HIV/AIDS: a local government authority, with support from international NGOs, has established coffee shops for promoting HIV/AIDS prevention activities in an urban setting. These could also be used for group activities for people living with or affected by AIDS.
- An urban health centre supported by an international NGO has established a care centre for homeless people, including those infected with HIV, mobilizing peer support and education.
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Key lessons learned from other regions
The experiences in countries where major progress has been made (e.g., Brazil, Thailand and Uganda) suggest that PLWA can play various critical roles in HIV/AIDS prevention and care. These experiences, particularly those of northern Thailand (see Box 9), have pointed the countries in the Western Pacific Region in the direction of exploring and applying approaches and developing models of care that may facilitate the greater involvement of PLWA and reinforce the continuum of care in resource-poor settings.

Strategies in countries in the region
Based on the situation analysis in the priority countries of the Western Pacific Region and the lessons learned from other regions, the Western Pacific Region drafted the following strategies.

Core strategies
The strategies below could be applied to most areas of the region in which HIV is prevalent.

1. Creating a partnership mechanism between public health services, medical services and PLWA groups at the intermediate levels. This is the so-called “day-care centre” approach.
   - **Aim:** provision of care, management, capacity building and coordination. Linking of the medical and public health services with the community-based and home-based care. This requires an HIV care team and/or coordinator.
   - **Level:** to be identified on the basis of the number of PLWA in the area, the capacity of the health facilities and their physical accessibility to the PLWA.
   - **Format:** the experiences of the day-care centre are to be applied flexibly according to local context and should build on existing initiatives, e.g., Warm House, coffee shops, etc. NGOs and community organizations are also expected to play crucial roles.

2. Developing an essential care package, including antiretroviral therapy, and involving PLWA groups and other stakeholders.
   - **Aim:** ensuring that quality care is provided in an efficient and sustainable manner, and involving PLWA groups, other sectors and civil society in the provision of care.
   - **Mode:** gradual and incremental, stepwise development.
   - **Voluntary counselling and testing** should be offered as part of care.
   - **Collaboration:** the management of TB and HIV requires the systematic identification of common potential areas and themes for possible partnerships and team efforts.

3. Ensuring multisectoral political commitment to comprehensive care.
   This should include ministries and/or the agencies responsible for welfare, education, labour, women’s affairs,
public security, etc. Comprehensive care and support require services that address a broad range of needs. These cannot be provided by the health sector alone, and therefore a range of providers need to be committed to the collaborative, multisectoral efforts.

4. Promoting approaches for reducing discrimination and raising awareness about care. Such approaches include:

- establishing PLWA-friendly environments in the health facilities;
- formulating locally appropriate information suitable for the context in which it will be given and received, and developing education and communication packages employing a range of participatory approaches; and
- promoting constructive dialogues and discussions, for example, through community forums and other collective channels.

5. Generating responsiveness to a range of diverse and changing situations that may include:

- setting up relevant monitoring and evaluation systems; and
- promotion of mutual learning and action, for example, through a joint proposal-based funding mechanism.

Complementary strategies

Depending on the country or local context, stage of HIV epidemic, mode of HIV transmission, availability of existing services, progress of responses, etc., the following complementary strategies could be considered:

- prevention of mother-to-child transmission as a major entry point for care;
- extensive home-visit services;
- extensive involvement of community organizations (China and Viet Nam);
- expanding peer support at community level;
- link to rehabilitation camps for injecting drug users and sex workers (China and Viet Nam); and
- Expanding outreach activities to increase access for and utilization by marginalized PLWA.

Progress made

Cambodia, China and Viet Nam have drafted national frameworks or plans for HIV/AIDS care, with support from WHO/WPRO, incorporating most of the strategies listed above.

In order to test these national frameworks or plans, pilot projects are starting in all three countries. In Cambodia, for instance, day-care centres will be set up in the health centres at the operational district level in several provinces in parallel with the introduction of antiretroviral therapy in rural areas. In Viet Nam, similar schemes are being established in Ho Chi Minh City where the pilot projects are being conducted as part of the national project funded by GFATM.

Because the building of capacities and the fostering of partnerships between health workers, PLWA group members and NGOs are vital, a series of workshops and field-visits have been conducted. These have included visits to the day-care centres, followed by a planning workshop in Northern Thailand, which involved government officials at the central and local levels, representatives of PLWA groups and NGOs involved with the pilot projects in Cambodia, China and Viet Nam. These cross-regional learning experiences have contributed considerably to the development and implementation of national plans for care that incorporate strategies for collaborative interaction with support for PLWA.

THE ROLE OF THE COMMUNITY IN THE CONTROL OF TUBERCULOSIS

Dr Dermot Maher

Introduction

WHO has recently estimated the global burden of tuberculosis and reviewed its global trends and interactions with HIV (Corbett et al, 2003). The estimated global incidence of tuberculosis in 2000 was 8.2 million, with an incidence rate of 136/1 000 000. Ten percent of all new cases of tuberculosis recorded in adults aged between 15 and 49 years were attributable to HIV infection. There were 1.82 million deaths from tuberculosis in 2000, of which 226 000 (12%) were attributable to HIV. Table 2 shows the breakdown of these global estimates by WHO region.
Table 2. Summary of tuberculosis estimates by WHO Region

<table>
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<th>AFR</th>
<th>AMR</th>
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<tr>
<td>Number of cases (thousands)</td>
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<td>587</td>
<td>468</td>
<td>2986</td>
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<td>54</td>
<td>194</td>
<td>116</td>
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<td>Change in incidence rate 1997–2000 (%/year)</td>
<td>4.3</td>
<td>4.1</td>
<td>1.4</td>
<td>2.8</td>
<td>1.3</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>HIV-related tuberculosis</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevalence in new adult cases of tuberculosis (%)</td>
<td>38</td>
<td>5.9</td>
<td>1.8</td>
<td>2.8</td>
<td>3.2</td>
<td>1.3</td>
<td>11</td>
</tr>
<tr>
<td>Incidence rate of cases attributable to HIV (per 100 000)</td>
<td>65.8</td>
<td>1.4</td>
<td>1.1</td>
<td>0.9</td>
<td>3.5</td>
<td>0.8</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Deaths</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths from tuberculosis (per 100 000)</td>
<td>75</td>
<td>6.6</td>
<td>28</td>
<td>8.3</td>
<td>47</td>
<td>21</td>
<td>30</td>
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<tr>
<td>Tuberculosis deaths attributable to HIV (%)</td>
<td>39</td>
<td>6.5</td>
<td>2.0</td>
<td>2.1</td>
<td>3.7</td>
<td>1.5</td>
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</table>

Of all the regions in the world, sub-Saharan Africa carries the biggest burden of tuberculosis both in terms of the overall incidence and mortality rates, and in terms of the absolute numbers and rates of cases and deaths attributable to HIV. Sub-Saharan Africa has also seen the largest increase in incidence rate between 1997 and 2000 (6% per year). With the worst indicators of health and economic development of all regions of the world, sub-Saharan Africa is the least well-equipped to deal with the biggest burden of tuberculosis, and therefore deserves particular emphasis in mobilizing efforts for tuberculosis control.

Globally, the regional distribution of incidence of HIV infections shows wide variation; about 4 million incident infections were reported in 1999 in sub-Saharan Africa. This incidence was about four times that reported in southern and eastern Asia (estimated at less than 1 million new cases) and was more than the total number of incident HIV infections in the rest of the world.

In sub-Saharan Africa, national TB programmes (NTPs) need to ensure widespread access to effective tuberculosis care in the face of the mounting TB epidemic, which is increasingly fuelled by HIV infection. Widespread access requires collaboration between NTPs and a range of health service providers. These include government health facilities, NGOs, employer health services, private practitioners and the general community.

The main thrust of the efforts by WHO to promote community contribution to tuberculosis care has its geographical focus on sub-Saharan Africa. In the face of severe constraints on resources, NTPs are struggling to cope with the increasing numbers of TB cases related to infection with HIV. The internationally recommended strategy for TB control (DOTS) depends on TB case-finding and cure. NTPs need to improve case-holding if they are to obtain high rates of successful treatment. It is important to expand case-finding only where NTPs achieve high rates of successful treatment. Otherwise the result of NTP activities is to find TB cases without curing them, thus increasing the prevalence of drug-resistant TB.
Project implementation

The WHO-coordinated project, Community TB Care in Africa, is a collaborative initiative between six agencies: WHO, UNAIDS, CDC, USAID, IUATLD and the Royal Netherlands TB Association (KNCV). The collaborative project was started in 1995 by a WHO-led mission for the assessment of TB care in community care projects. Between 1998 and 2000, this initiative implemented eight district-based community projects for TB care in six countries with a high prevalence of HIV, namely, Botswana, Kenya, Malawi, South Africa, Uganda and Zambia. The goal of the project was to harness the community contribution to TB care and improve case-holding and treatment success. The additional expected benefits included improved equity (through extended access to TB care), mobilization of community resources against TB (which is a disease of the poor), and improved community oversight of health care provision.

Within the six countries, the project capitalized on different forms of already established community organizations and networks. Such networks included guardians and community workers, primary health care volunteers, community-based distributors of contraceptives, other NGOs working on HIV such as the AIDS Support Organization (TASO) in Uganda, faith-based NGOs, home care programmes for patients with HIV/AIDS, NGOs working on tuberculosis and traditional healers, as well as civic structures (such as the parish development committees in Uganda).

The projects aimed to establish and strengthen the links between the health services providers, the district medical and TB officers, and a range of community organizations. It was necessary to train the district level health workers, health centre workers, community project supervisors and volunteers. This required the development of a variety of training tools and educational materials. Figure 4 depicts a general model of integrated community TB care tested by the participating projects.

Figure 4. A model of integrated community care for TB

The examples of community responses to HIV provide an opportunity for collaboration with NTPs in detecting cases of TB and improving case-holding. The projects sought to answer the following question: “Can communities contribute to TB care in ways that are effective, affordable, cost-effective and acceptable?”
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Project results
Acceptability. The results of focus group discussions and questionnaires indicated positive attitudes towards community care for TB patients. However, the barriers to community acceptance of such an approach to TB care included fear of TB, poverty and HIV-related stigma.

Effectiveness. Figure 5 illustrates the performance of the district TB programme before and after the introduction of a decentralized/community approach between 1997 and 2000. The performance of district TB programmes that incorporated a decentralized/community approach was better than that of district TB programmes that used the traditional approach.

Cost-effectiveness. For new, smear-positive patients with pulmonary TB, Figure 6 shows the comparative cost-effectiveness (cost per patient successfully treated) for conventional and decentralized/community approaches between 1997 and 2000.
Conclusions

Communities can contribute effectively to TB care where the health services, the NTPs and the community organizations collaborate successfully to establish mechanisms for referral, logistics, training and patient education on TB care in the community.

The CBOs working on HIV/AIDS have a potential role in TB control. Such organizations have the following advantages:

- increasing awareness of the links between HIV and TB and therefore the willingness to contribute to TB care;
- the potential for providing means of access to at-risk and target groups; and
- the possibility of extending the treatment of common HIV-related diseases beyond health facilities, which could help to abolish the mystery and stigma surrounding HIV/AIDS.

Nevertheless, CBOs working with HIV/AIDS also have certain disadvantages.

- They are often small-scale organizations with limited population coverage.
- The stigma attached to HIV/AIDS may deter TB patients.
- The emphasis is often on care rather than treatment.

Recommendations

**Links.** Establishing links with NTPs and health service providers, and maintaining the motivation of community members involved in TB control are important. Connections between the community on the one hand and the health professionals and the formal health service providers on the other are essential for good-quality care.

**Community.** NTPs should harness community contributions to TB care where there is a need to improve the access to and quality of care. NTPs need to ensure the effectiveness of community members as supporters of TB treatment by identifying the right group(s), providing training in supporting TB treatment (including directly observing treatment) and ensuring sustainability.

Peripheral health units and community TB treatment supporters should record and report the outcomes of TB treatment.

**NTPs.** An effective NTP is necessary to handle the extra management responsibilities resulting from decentralizing the provision of TB care beyond the health facilities into the community. NTPs need to ensure an effective, secure and safe system of supplying drugs to TB patients and community treatment supporters. NTPs should monitor the community contribution to TB care using standard NTP performance indicators (i.e. percentage of patients choosing different DOT options, and quality-of-care indicators).

**Ministries.** Ministries of health need to ensure adequate financing to cover the new costs involved, while recognizing the cost-effectiveness of this approach.

**Sustainability and expansion.** Sustainability and expansion require the commitment of ministries of health, NTPs, donors and NGOs. Expansion involves developing costed plans and clear criteria for choosing those districts targeted for expansion.

References


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NURSE FACILITATORS WORKING TOGETHER WITH THE COMMUNITY IN HIV/AIDS PREVENTION AND CARE: EXPERIENCES FROM THAILAND

Dr Arphorn Chuaprapaisilp

Background
HIV/AIDS is a serious health problem in Thailand. There are no social boundaries for the disease, and it has affected people from all groups and social strata in Thai society. Currently, there are about one million people living with HIV/AIDS in Thailand. A range of programmes and projects have been formulated and implemented to help solve the problems that are being encountered, and to plan for the prevention of infection and the care of those already infected. This chapter describes the projects undertaken by the Faculty of Nursing at the Prince of Songkla University in Thailand. It addresses the issue and roles of nurse facilitators in HIV/AIDS prevention and care. The projects were implemented in southern Thailand between 1991 and 2001.

The starting point: nurse and participatory action research
The project is an illustration of the potential inherent in international collaboration in nursing. The collaboration described here was between Thailand (Faculty of Nursing, Prince of Songkla University) and Australia (School of Nursing, LaTrobe University). The two institutions worked jointly on a variety of issues including the research design, data collection, interim and final analysis of the data, as well as providing training for researchers and community workers on community assessment and development, epidemiology, social anthropology, action research methodology, nursing therapeutics and capacity building. The initial focus of the collaboration between the two institutions was a project that addressed a case study of the family-based nursing care programme. Its aim was to prepare communities to live with HIV/AIDS without stigmatizing the families and individuals affected. This project had four specific objectives:

- to enable family caregivers to develop family-based nursing skills for the management of infectious diseases including HIV/AIDS;
- to develop strategies to assist caregivers in treating and caring for people living with AIDS;
- to develop nursing kits and a Thai “train-the-trainer” manual to enable public health nurses to train caregivers in HIV/AIDS prevention and care; and
- to develop an HIV prevention programme.

From this initial partnership between the two institutions, an array of mutually beneficial programmes was generated. Over the following 10 years, this collaborative endeavour was expanded to include three further working projects and about 12 formal research programmes. Almost all of these projects were implemented on the basis of qualitative research methods and participatory action research principles, where nurses played a range of facilitating roles in community empowerment. For example, developing rapport and raising awareness, enhancing understanding through study visits to observe real-life situations and through group reflections, stimulating mutual participation in every step of the project and providing opportunities for self-development. Tactics were sought that would provide the resolution that was best fitted to the society and the culture of the individual communities. The nurse facilitators also undertook tasks that included training of trainers workshops for village health volunteers and public health nurses; training of housewives; training of researchers and community workers; study visits; friends-helping-friends project; campaigning; a slogan competition (and production of stickers carrying the winning slogan); a story-writing competition, and shadow-puppet theatre on AIDS prevention. All these activities are related to enhancing the interaction between health practitioners on the one hand and individuals, families and communities on the other, within the wider perspective of improving community and home care for people living with HIV/AIDS. Figure 7 illustrates the range of stakeholders involved in this international networking initiative for HIV/AIDS prevention and care and Box 10 outlines the progression and historical overview of 10 years of work in community and home care.
Figure 7. Mobilizing nurses: international networking for HIV/AIDS prevention and care

Australian nurses
Buddhist monks
Postgraduate students
Schools
NGOs
Factories
Funding agency
Government organizations
Muslim leaders
PLWA
Volunteers

University-Based Network of Nurses

Local communities (Family-Based Care)
Ministry of Public Health (MOPH) nurses
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**Box 10: Community and home care in Thailand: A 10-year overview**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>The design phase of a feasibility study addressing “Women and AIDS prevention” — a collaboration between World Vision Australia/Thailand, School of Nursing, LaTrobe University, Australia and the Faculty of Nursing, Prince of Songkla University, Thailand.</td>
</tr>
<tr>
<td>1993</td>
<td>Emergence of the south Thailand family-based nursing care projects: HIV/AIDS prevention and care, in collaboration with AusAID.</td>
</tr>
<tr>
<td>1994</td>
<td>HIV/AIDS prevention and care project in Muslim communities, in collaboration with United Nations Development Programme. This project was similar to the family-based nursing care projects: HIV/AIDS prevention and care, but with a focus on Muslim communities. Human caring project, with support from the Prince of Songkla University Fund. This project provided caring support for HIV/AIDS patients living in a Thai Buddhist temple, as well as training for volunteers in the temple and caregivers in the home.</td>
</tr>
<tr>
<td>1997</td>
<td>Self-care of people living with HIV/AIDS in a Thai cultural context at a Buddhist temple in south Thailand (supported by the Prince of Songkla University Fund).</td>
</tr>
<tr>
<td>1998</td>
<td>The “experiences of death and dying” of AIDS patients living in a Buddhist temple in south Thailand. This was a phenomenological study to describe and explain the perceptions of people living with AIDS regarding near-death experiences. AIDS prevention for teenagers in south Thailand: conducted in conjunction with the Thai Research Fund. This project aimed to develop a model for preventing HIV/AIDS in teenagers in southern Thailand, and to enable them to develop sustainable preventive activities.</td>
</tr>
<tr>
<td>1998</td>
<td>Development of networking model for HIV/AIDS prevention and care: utilizing a Buddhist as a network centre. White Bridge Project (PLWAs support group). This project established the first PLWAs’ support group in Songkla Province. It aimed to establish “friends-helping-friends” for PLWAs. White Bridge refers to the bridge for increasing true understanding, knowledge and caring skills, and reducing discrimination against and misunderstanding of PLWAs. Health perception and self-care of long-term surviving PLWAs. This project described and explained the experiences of PLWAs who had survived for more than 7 years. It described the phenomena of inability to adjust, seeking for survival, and self-care as a means of survival and harmonious life, at which stage informants became able to accept HIV/AIDS and death.</td>
</tr>
<tr>
<td>2000</td>
<td>Study of outcomes of the development of health care and continuum of care for PLWA in south Thailand. Study on perceptions of health and self-care in AIDS patients with TB. This study reflected the perception that TB is a double stigma for PLWAs.</td>
</tr>
<tr>
<td>2001</td>
<td>Qualitative study on AIDS patients and care as perceived by public health volunteers. This study described and explained the public health volunteers’ perceptions of care for PLWAs. The findings suggested that some informants were frightened and dared not get close to PLWAs and some even hated them. Empowering and networking for home and community care. This project aimed at developing innovative strategies to empower communities, health teams and PLWAs to provide holistic and continuous care. It commenced with social mobilization using local wisdom. Social mobilization led to mutual collaboration between PLWAs, their relatives, and the communities. The strategies included having an understanding of the community; strengthening the community-owned financing scheme to increase cooperation among members; involving the community in developing holistic health practices; working in collaboration with the existing AIDS networks; building up teams to sustain care; and, mobilizing resources for care and support.</td>
</tr>
</tbody>
</table>
Holistic approaches: mobilization, empowerment and networking

All the projects were based on key humanitarian principles. The respect and dignity of PLWA was a central and ongoing concern. A range of (traditional eastern spiritual) holistic approaches were employed by both the PLWA and the researchers. These approaches focused on the harmony of the triad of the body–mind–spirit and resulted in activities that addressed the spiritual, psychosocial, economic and physical needs of the PLWA. All the activities were rooted in the communities, and villagers learnt new skills from the process of implementing actions. They were then able to apply what they had learned to other activities, reflecting the sustainability of the projects. The actions involved in the prevention of HIV and the care for PLWA were all based on a true understanding of the local culture. Furthermore, the activities were completely integrated with traditional care, and multidisciplinary networks of volunteers to help and support PLWA built upon and worked in collaboration with existing AIDS networks. The result was the gradual development of a community–health services interaction model for mobilizing, empowering and networking. It was sustained through fundraising, seeking support, setting up a community-owned saving fund for health (Sud-Ja Aom-Suub), and mobilizing resources for care and support. The model simultaneously addressed a combination of holistic approaches, as well as the continuity of home and community care. Volunteers and villagers demonstrated the effectiveness of their knowledge of and skills in HIV/AIDS prevention and care.

Shelters and temples were available for PLWA to live in if they were rejected by their families. PLWA could gain confidence as well as an income by becoming counsellors and consultants for patients newly diagnosed with PLWA, and for governmental organizations and NGOs working in HIV/AIDS projects.

The centre for network development in HIV/AIDS prevention and care is based at the Prince of Songkla University, and works collaboratively with other organizations aiming at helping PLWA in developing AIDS networks in south Thailand; raising awareness on living in acceptance with PLWA, and providing materials, resources, medication and herbs for PLWA. The centre was developed in order to mobilize resources and support networks in the communities. Nursing kits were produced and volunteers were trained in the care of PLWA. However, professionally trained nurses were central to these projects. The activities of these nurses resulted in the development of networking among the health teams, PLWA, families and relatives, NGOs, villagers, religious leaders and traditional healers. Both the PLWA and the volunteers praised the effective knowledge, skills and expertise that the nurses brought to the projects. The key issues in developing home and community care are listed in Box 11.

Box 11: Key issues in developing home and community care

- Working together as friends with communities and PLWA
- Multidisciplinary networking
- Involvement of PLWA and traditional healers
- Understanding the local culture
- True community involvement

Lessons: difficulties to be addressed

- Collaborative work is very time-consuming and requires committed team members from both the community and the health services.
- Involving PLWA in participating in activities for HIV/AIDS prevention and care is not always feasible, because of health and income constraints.
- It is not necessarily easy to apply ideal, holistic approaches rather than ad hoc single interventions.
- A continuum of care between the hospital, family and community, needs to be established to meet the needs of both the communities and the PLWA.
- Networking between governmental organizations, NGOs and local communities can be difficult, and acceptance by the various organizations and communities of each other’s roles is not easy. Mutual understanding is crucial for networking.
- Communities prefer one-stop information centres. Local health care systems should therefore be
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strengthened to enable them to provide a variety of services and to integrate information and education on HIV/AIDS with existing services so that PLWA do not have to go to many different organizations for support or information.

• A consideration of the politics of the situation and continuous lobbying for the resources required to achieve success is involved in such work.

Key factors in success

The various projects that have been implemented over the past 10 years show that the following factors are key to success in assisting communities to empower themselves for HIV/AIDS prevention and care. A model for community empowerment for HIV/AIDS care is illustrated in Box 12.

• Focusing on the development of skills as regards community development, working with communities, participating in cultural activities, and in caring within a specific cultural context for patients with infectious diseases (including HIV/AIDS) benefits the whole community and is a successful strategy for home and community care.

• Providing space for truly participative/community involvement is a necessity.

• Working in collaboration with existing AIDS networks, and the availability of an information centre where guidelines and handbooks can be consulted, strengthens the impact of the projects.

• Flexibility in management and open-mindedness in team members are vital.

• Using the expertise and experiences of PLWA and volunteers (in the roles of counsellors, speakers and caregivers) contributes substantially to the success of the projects.

• Long-term survival of PLWA through self-care and harmonizing the balance between mind, body and spirit inspires others.

• An understanding of self, others and the nature of life contributes to self-care, self-healing and positive caregiving.

• Traditional healers, complementary therapies, and an understanding of the culture play major roles in developing appropriate interventions for home and community care.

• Working together as friends with community members and with PLWA, in a multidisciplinary network of volunteers, is a basis for success.

Box 12: A model for community empowerment for the care of patients with HIV/AIDS

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PARTNERSHIPS BETWEEN SEX WORKERS AND GOVERNMENT HEALTH SERVICES FOR HIV PREVENTION: MARGINALIZED WOMEN IN BANGLADESH

Dr Mausumi Amin

CARE Bangladesh initiated the work with brothel-based sex workers in Tangail in 1995. The overall goal of CARE was to develop and implement effective national strategies and programmes to fulfil its mission of reducing the spread of HIV/AIDS in Bangladesh. Since then, CARE has gradually expanded its work with vulnerable populations. Programmes have been implemented in different communities. Examples of these communities include the street-based sex workers, transgender sex workers, male-to-male sex workers, hotel-based sex workers, PLWA, injecting drug users, transport workers, people who frequently cross international borders, dock labourers, factory workers and tea gardeners. The geographical area of coverage now includes 27 districts of Bangladesh, out of a total of 64. To maximize the accessibility and availability of intervention activities the HIV programme is using the drop-in centre, peer-based model whereby clinical and outreach services are delivered through peers. This unique model is the basis for the practice in 94 drop-in centres throughout the country.

Programme approaches
The overall approaches employed for all the interventions in the HIV programme incorporated the following principles:

- a basic humane approach: working on restoring the respect and dignity of the marginalized community;
- creating an enabling environment for the effective implementation of intervention activities;
- involvement of the target communities in all the decision-making processes of the project (i.e. planning, implementation and monitoring of project activities); and
- empowering the vulnerable population.

Brothel-based interventions
In Tangail, two categories of brothel-based activities were in place to address the issues of vulnerability. These were:

- clinical and outreach service delivery; and
- social mobilization and capacity building.

The clinical services provided include treatment of sexually transmitted infections, promotion of condom use, education about HIV/AIDS, counselling, patient referral and follow-up.

The social mobilization and capacity building involves several aspects, namely:

- formation of self-help groups and organizations and strengthening their skills for building capacity;
- networking and alliance-building between self-help groups, the Government of Bangladesh, NGOs and other stakeholders;
- education and income-generating activities that facilitate empowerment;
- advocacy to create an enabling environment at the national level;
- building partnerships with NGOs, self-help groups and government departments;
- strengthening the community capacity for implementation of HIV programmes; and
- mainstreaming of the vulnerable population.

Programme approaches
The process employed for the brothel-based intervention comprised two stages, the preparatory stage and the action stage, both of which were based primarily on a peer approach.
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Preparatory stage. The preparatory stage started with assessing the social structure that operated within the brothel e.g. “Samaj” to gain an understanding of the context (in terms of values, beliefs, norms, customs and culture) so that the programme could be designed accordingly. Secondly, a set of enabling activities was initiated with the collaboration of the key actors and stakeholders. These activities included acts of advocacy and lobbying, building linkages and creating connections, and establishing the sharing of opinions. Thirdly, other activities, employed simultaneously, were directed to the sensitization of government officials, NGOs, local government and opinion-leaders to the various issues and concerns, with the aim of involving them in the various decision-making processes related to the project. The community capacity was also assessed and enhanced. The activities were undertaken side by side, reinforcing each other, because the issues were interconnected.

Action stage. After these three preparatory stages, the actions were implemented. Viable income-generating schemes were initiated to enhance the empowerment of the community. Initially, several slogans were coined to proclaim the sex workers’ demands and vision; for example, “right to wear shoes first, not condoms”, “living with dignity” and “recognition as humans”. Wearing shoes had an important symbolic meaning for the sex workers’ dignity and CARE needed to address this need first. Over time, the priorities expanded to “ensure safer sex by using condoms” and “access to STI treatment”.

Service users were involved in the management of the health services provided within the brothel with a view to ensuring the quality of care for patient’s with sexually transmitted infections and to exercising the user’s right in service delivery. The community selected individuals from within the community to become members of the Clinical Governance Committee and the members were involved in planning, implementation and all the decision-making processes relating to clinic management.

Actions to meet the health needs of the sex workers were linked to other existing services such as family planning, and the health centres were jointly operated by the government and the NGOs.

A need for partnership and collaboration
An important strategy was to build partnerships aimed at fostering collaboration between a wide range of government bodies and NGOs and institutions. This was undertaken for a number of reasons:

- to address a broad range of perceived needs of the community that could not be provided by a single agency;
- to contribute to and aid in sustainability;
- to maintain the activities in the future; and
- to widen the coverage and maximize the impact of the intervention.

The Nari Mukti Sangha
The Nari Mukti Sangha (NMS) is an officially registered sex workers organization based in the Kandapara Brothel, Tangail. NMS was formed in the hope of creating unity among sex workers, establishing their social and legal rights and implementing sustainable programmes aimed at combating HIV/AIDS, especially among vulnerable populations. For NMS, collaborative partnerships with a range of other stakeholders are considered to be both essential and important for the reasons given above. Through partnerships with other NGOs, the programme offered includes income-generation projects (e.g. sewing), adult literacy schemes and the sale and distribution of condoms.

Building the partnership with government health services
This section focuses on the partnership with the government health services. In building partnerships with government health services, the areas of interest of these health services were identified, and an assessment made of where CARE and NMS could contribute to and complement the government programmes that were already established. CARE/NMS became involved in the Extended Programme on Immunization (EPI), in the national immunization day and in the maternal and neonatal tetanus campaign. The government considered that CARE could contribute to their priority programmes by gaining access to the brothel, which is an area to which access for the government services is prevented by social constraints.
As a result of being involved in the national immunization day, the demand from the community (i.e. the sex workers) for immunizations for their children was raised. Because the brothel was situated within the municipal area, the local government needed to include it in their actions to obtain a wider immunization coverage. This was accomplished by establishing the immunization centre in the brothel. With a view to ensuring both maximum coverage and sustainability, the community members were involved in establishing the immunization centre and several of them were trained by government officials to enhance their technical capability of running the immunization centre.

As a part of the mainstreaming activities, the NMS was also involved in a variety of “activity days” where they made their voice heard, disseminated their messages, presented various organizational activities, explored the barriers to their work and the ways in which these could be overcome, and created space to articulate their views and rights. Gradually, the community members became more aware of the different services available and started bargaining with the numerous service providers to make those services more accessible to their members through partnerships with their organization.

Partnership activities were not confined to the location of the brothel, but also took place at the level of the government health facility. Sex workers visited the government health centres to receive training in administering immunizations and visited the Thana health complex for meetings with the family planning and health programme staff. Through NMS, the sex workers discussed with the government issues related to the improvement of the referral system from the brothel-based clinic to the government hospital. Together, the government and NGOs, with the support of WHO, organized meetings to sensitize the politically influential and religious leaders to the subject of HIV prevention and to reduce the stigma attached to sex working.

The partnership that was established had many other advantages. This was demonstrated when a large fire broke out and 46 homes in the brothel area were burnt down. An ad hoc disaster committee was formed with the participation of the community members and the NGOs. A disaster relief programme was also implemented by a consortium of the GO, local government, NGOs and allies of the sex workers’ network.

**Barriers and opportunities**

Various barriers were encountered. These included:

- the stigma attached to the vulnerable population;
- government limitations in recognizing the vulnerability of the sex workers to HIV/AIDS;
- social barriers (the reluctance of members of mainstream society to use the same hospital premises as the sex workers);
- condom promotion was seen as having a negative impact (i.e. to be encouraging premarital and extramarital sex); and
- low self-esteem among the sex workers affected their negotiation and decision-making skills.

However, several opportunities, strategies and activities contributed to overcoming these barriers. These included:

- working closely with the government health officials and identifying their interest in the work of the community members on the programme;
- organizing opportunities for social interaction between members of the vulnerable community and the mainstream society;
- making cross-visits to the government health centres;
- organizing sessions to sensitize and influence the civil societies, as well as different social and religious groups; and
- general advocacy to create enabling environments and to influence policy.

We recommend the reinforcement of the movement for the protection of the rights of vulnerable populations through advocacy at the national and international levels. For this, policies will need to be developed and their implementation in the field needs to be ensured. Various needs and priorities must be addressed (see Box 13).
CARE Bangladesh had a mission to fulfill through its HIV programme, namely, the reduction of the spread of HIV/AIDS in Bangladesh.

An innovative brothel-based intervention was employed to address the situation of the vulnerable sex workers; it consisted of two strands.

The first strand was clinical service delivery. This included treatment of sexually transmitted infections, promotion of condom use, education about HIV, referral and follow-up and a counselling service.

The second strand comprised social mobilization and capacity building by means of self-help groups, networking and advocacy, income generation and mainstreaming of the vulnerable population of sex workers.

However, in the preparatory stage of this innovative intervention, the concerns of the sex workers were not directly related to HIV/AIDS, but rather to a more basic need. They were forbidden to wear shoes, a measure taken to stigmatize them socially and to distinguish them from members of mainstream society. This discrimination had many repercussions. For example, sex workers were being charged more than other women for goods such as clothes and medicine. Wearing shoes had a symbolic meaning for the dignity and identity of these sex workers.

Hence they coined the slogan: “rights to wear shoes first, not condoms”.

When this basic need had been met, the sex workers turned their attention towards HIV interventions and gradually strengthened their partnerships with the government health services. Although there is still a long way to go, this partnership has already led to many opportunities for collaboration. This is an example of working on many fronts to the degree that the national sentinel surveillance is now being undertaken inside the brothel, in collaboration with the sex workers.

### Box 13: Addressing country needs and priorities: shoes for sex workers

<table>
<thead>
<tr>
<th>CARE Bangladesh had a mission to fulfill through its HIV programme, namely, the reduction of the spread of HIV/AIDS in Bangladesh.</th>
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</tbody>
</table>
COMMUNITY CAPACITY FOR TREATMENT:  
THE “SOLIDARITY IN TREATMENT” PROJECT  

*Mr Donald De Gagné*

**Background**

PLWA and their community groups play a crucial role in both the fight against AIDS and in AIDS care. Actions Traitements, an NGO based in France, has links with various community organizations and agencies in the southern hemisphere. It was recognized that within those organizations, the activists (who are HIV-positive themselves), who have considerable experience in addressing the problems of HIV/AIDS and have received extensive training, were dying because of a lack of access to treatment as a result of the limited resources available within their countries. We were facing the problem of losing human capital. Thus, three organizations in France, Solidarité Sida, L’UNALS and Actions Traitements, decided to initiate a new project for solidarity in therapy. The project is meant to help these community leaders and activists to continue to live, to have an acceptable quality of life and to continue to contribute to the work.

**The project: “solidarity in treatment”**

The project was implemented in partnership with two of the organizations involved in the struggle against AIDS in Burkina Faso (Associations REVS+ and Association African Solidarité (AAS)) and one organization in the Philippines (Positive Action Foundation Philippines Inc. (PAFPI)). These organizations were selected because they already had the level of capacity that was required for the care and treatment of patients with AIDS. Some of the three community organizations had already developed small-scale projects for treatment by collecting antiretroviral drugs from countries in the northern hemisphere to be used by members in the south. Similarly, these community agencies were already interacting with the community doctor(s) regarding treatment. One group had, among its activists, health workers living with HIV.

From each of these organizations, 16 persons started the treatment, most of whom were women. The patients to be treated were selected by these organizations using the following criteria:

- symptomatic and CD4 counts;
- involvement in a community-based organization (CBO);
- length of involvement in the CBO (including members who are ill and no longer capable of being present regularly); and
- whether a partner, child or close relative is living with the person already on the treatment protocol.

The treatment package consisted of:

- antiretroviral medicines;
- physical examinations and laboratory tests (including CD4 cell count four times per year);
- medicines for treating a range of opportunistic infections; and
- complementary nutrition.

Six months after starting the treatment, out of a total of 48 persons, three had died of gastroenteritis and one of TB, two had discontinued the treatment because of pulmonary infections and had later restarted the treatment, and three had developed hepatic intolerance and needed to change treatment. However, most of the persons are doing well on the medication. Dramatic visible improvements such as gaining weight, feeling better and being able to go back to work every day have given people hope and created a sense of solidarity. For instance, those people in the Philippines who are now able to work again and are earning money, want to pay at least part of the cost of their medication in order to create opportunities for the treatment of others who were not selected initially. The groups in Burkina Faso are having discussions with their government on the acceptance of generic drugs. These
developments are important as the project is not just about putting a few people on medication. The project is aimed at broadening the capacity in the groups in order to widen access to treatment. Other aims include learning skills that are useful in lobbying for treatment, and searching for and finding resources in the country for providing treatment. The goal is to have a broader and ongoing community impact.

Interactions between community groups and health care professionals
People living with AIDS and their community groups are unable to undertake all aspects of treatment on their own. They require technical support. The community groups involved in the treatment project have a trained health worker in a health institution to act as their partner and medical adviser. Good relationships and interactions between the community groups and patients receiving treatment on the one hand and the doctor on the other are of the utmost importance in avoiding treatment failure.

The community groups involved in the project select the doctor with whom they wish to work not only on the basis of his or her medical skills but, more importantly, on the commitment to the community movement that he or she shows. Doctors need to be willing to relate to, to interact with and to communicate with the community group as well. The doctors selected are open to the NGOs and to the work that they undertake, and, in many instances, they are already involved at the government level in making improvements in care.

The level of knowledge in community groups is surprisingly high. For instance, they may use the Internet to collect information on treatment side-effects and to follow the new developments in treatment. People have a desire for information and will approach different persons and institutions to collect the information that they and their organizations require. These patients need a doctor who does not feel threatened by a patient who already has considerable information and awareness and who, at times, may know more than the medically trained personnel.

It is also necessary for the doctor to have sufficient time for the patient. Often patients experience conflicting feelings about their treatment regime because of its side-effects. In such a case a doctor is needed who will take time and who has the consideration, patience and motivation to explain the benefits of the treatment; otherwise the patient might discontinue the treatment.

Positive interactions between the doctors and the communities are also necessary, because the doctors need the community groups as well. Doctors in developing countries are faced with an overwhelming burden of work and community groups undertake a great deal of work with families and communities. They play an important role in helping the patient with adherence, with nutrition and with checking the side-effects of the medication. Considerable capacity exists within the communities in both developed and developing countries. In every community organization that we work with someone collects and manages the data; for example to ensure that the CD4 cell counts are done. The members of the groups meet regularly to provide each other with emotional support. The low level of education in certain countries does not present a barrier. The people running the community programmes are well informed.

Community groups play a vital role in managing the treatment programme and in the follow-up, mobilization and support for people receiving treatment. A good relationship with health professionals who understand and accept this role of the community is crucial. In the absence of such a relationship between doctors and communities, there is a risk of treatment failure.
The presentation of the case-studies at the WHO Consultation on the Enhancement of the Health Services–Community Interface was an important way to share lessons of good practice. The case-studies represented a range of positive approaches to collaborative interactions between health services and communities. They also demonstrated a variety of ways of responding to the many challenges that arise. The important lessons to be learned from the case-studies are summarized below.

1. Any gaps between the communities and the service providers will require bridging. The experiences from the Local Response Initiative in Uganda suggested that partnerships between a variety of stakeholders result in wide coverage of, and targeted tailoring for, marginalized groups. The experience also highlighted the appropriate entry points into the villages and communities, as well as the importance of functional coordinating mechanisms and structures that link the districts to the local health committees to the hospitals and to the communities. However, for success to be achieved, the support of facilitators is needed to bridge the gap between communities and service providers.

2. Within the formal health care system, national frameworks and innovative models of care can be developed that facilitate partnerships aimed at increasing the involvement of PLWA in HIV/AIDS care. In the WHO Western Pacific Region, national frameworks and plans for HIV/AIDS care have been drafted, and several approaches aimed at constructive dialogues and discussions between the community and the health services are being promoted. However, there are certain prerequisites for success: namely, political commitment to comprehensive care and the provision of opportunities for the involvement of PLWA.

3. There are lessons for efforts in HIV/AIDS prevention and care to be learned from the TB programmes that are based on community contributions to treatment. Decentralized community approaches from sub-Saharan Africa and Asia are reported to be more cost-effective and to have a better rate of treatment success than the conventional TB programmes. However, there are certain prerequisites for success: good links between health professionals and the community members involved in TB treatment are essential for quality care.

4. Nursing institutions have the potential to facilitate partnerships between nursing institutions and other health service providers on the one hand and communities on the other hand. Experiences from Thailand suggest that family-based nursing care programmes for patients with HIV/AIDS are both feasible and effective when founded on a strong community base. It is possible to prepare communities to live with HIV/AIDS without stigmatizing families and individuals and to enable family caregivers to develop family-based skills for caring for patients with AIDS. However, there are certain prerequisites for success: projects must be based on respect for human dignity, use holistic approaches that address the spiritual, psychosocial, economic and physical needs of the PLWA, and be rooted in the communities through mobilization, empowerment and networking.

5. Collaboration between the mainstream government health services and marginalized groups is both achievable and necessary. Evidence from Bangladesh indicates that partnerships between government health workers and disadvantaged groups such as sex workers are both possible and functional. However, there are certain prerequisites for success: there must be a willingness to address the priorities of each group of stakeholders, unlimited by the boundaries of any single issue. Effective partnerships might need to go beyond HIV/AIDS or even beyond health to a broader focus on societal justice and development. The lessons from Bangladesh also show that non-professionals have the potential to run their own clinics and, after training, to be able to carry out various administrative and clinical tasks traditionally performed by professionals.

6. Community groups can implement their own HIV/AIDS care and treatment programmes in association with the health professionals. Experiences from Burkina Faso and the Philippines show that PLWA community groups are able to organize and implement comprehensive care and treatment programmes. However,
Partnerships for HIV/AIDS: case presentations

there are certain prerequisites for success: health workers who are open, encouraging and sympathetic to community-driven initiatives and committed to linking with and supporting the community movement are essential for effective treatment programmes. In communities where many people are affected by HIV/AIDS, community groups are an important source of support for the efforts of health workers who have heavy workloads and are constrained by limited resources.
Section 3
Conclusions and recommendations

OUTCOMES OF THE MEETING

The meeting was chaired by Mr Tesfamicael Ghebrehiwet, Nursing and Health Policy Consultant of the International Council of Nurses (ICN) and Mr Stuart Flavell, International Coordinator of the Global Network of People Living with HIV/AIDS (GNP+). Through the meeting’s plenary sessions and discussions, presentations and small-group work, the participants of the meeting were collectively able to formulate several outcomes. These outcomes were related to identifying strategies and mechanisms for the enhancement of the health services–community interface, identifying ways in which WHO could contribute to strengthening the collaboration between health services and communities, and providing suggestions of avenues that WHO could explore.

The meeting’s participants were in consensus regarding several issues:

- The potential of the concept of the interface offers a great opportunity to move forward with the prevention, care and treatment of HIV/AIDS.
- There were serious constraints on working in partnership with the communities. Most of these constraints were at the level of the health care system, and needed to be addressed.
- There were strategies (based on various successful experiences in the field) that could enhance the interaction between the health services and the community.
- There was a leading role for WHO in putting the strategies into action.
- The next important step is developing a plan of action.

STRATEGIES AND MECHANISMS

Strengthening the capacity of health care systems to interact with the communities

The participants at the Consultation identified several strategies for strengthening the capacity of the health systems to interact with the communities. They considered that further progress would require the triad of reducing the interpersonal barriers between the health workers and the community members, changing the attitudes of the health workers towards the communities, and building capacity to work in partnership with the communities and families. The participants presented several mechanisms that would contribute towards accomplishing these goals. The means of applying the proposed mechanisms would require the development of a true understanding of the community by health workers and application of the concept of “we” rather than “them and us”. Hence “people-centred” approaches will be needed to facilitate mutual and joint learning and to emphasize the necessity for listening to and learning from the local responses of communities and PLWA. The recruitment of PLWA with the necessary skills for all levels of service provision (planning, implementation and evaluation) is also necessary.

The participants also perceived a need for creating enabling environments in which the health services can interface with the communities. Such work would have to involve all the stakeholders and all the levels of the health system in the process of building an enabling environment and bringing about change (towards collective vision, shared values, respect, trust and dignity). The accomplishment of such goals would require a review of the existing human resource frameworks in health to explore how these relate to the interface and how they can provide a foundation for developing human resources for collaborative interaction.

Another direction would entail making effective use of the existing professional bodies and organizations to bring about changes in the practice of professionals in their interactions with communities. These mechanisms will also require improvements to the resources and integration of the local health services, while creating and employing incentive systems for increasing self-esteem, setting a higher value on work done and offering better remuneration to health workers.
Conclusions and recommendations

Strengthening the capacity of the community for interacting with the health services

The participants at the Consultation indicated that the application of a variety of approaches that collectively contribute to community empowerment would be necessary. The mechanisms for these approaches would need to focus on community strengths and assets rather than on weaknesses and deficiencies. They would also build on respect and trust between individuals, while mobilizing the communities and promoting community ownership of projects and programmes. A pertinent point raised was the creation of enabling environments for the community to interface with health services. Such mechanisms would need to alter the balance of power between the health workers and the community by recognizing the expertise and responses of the communities. There is also a necessity to support the work of effective activists, advocates, champions and “boundary-spanners” from the existing community structures. In addition to these mechanisms the creation and employment of incentive systems for increasing self-esteem, setting a higher value on work done, and providing opportunities to increase the financial remuneration for the community is needed. The working groups also called for strengthening of the HIV/AIDS-specific capacity and knowledge within communities where a good understanding of HIV/AIDS prevention, care and treatment issues is required.

Strengthening the processes and methodologies for change

The participants felt that it was essential to acknowledge and mainstream a range of participatory methodologies. The mechanisms for this goal could make use of, and give recognition to, the role and potential of participatory methodologies in the prevention, care and treatment of HIV/AIDS. They could also expose stakeholders at the central and global levels to experiences and lessons from community action initiatives with the aim of influencing policies. There is certainly a place for documenting and analysing the processes and methods that work effectively and produce good results. The working groups also noted that the promotion, exploration and use of participatory methods and tools is essential. Mechanisms to establish participatory methods were suggested such as providing opportunities for PLWA to take leading roles in the participatory processes, the use of bottom-up planning, and the inclusion of civil society members and PLWA. It was also suggested that policies that build on positive community experiences, and methods and channels to feed back knowledge and experiences to the communities should be developed.

WHO ROLES

In general, the role of WHO is seen as being in the area of supporting the institutionalization and replication of the small-scale successes that have been achieved in the health services–community interface. For this to happen, WHO should take a leading role in enhancing the collaborative interaction by reinforcing messages, facilitating the removal of barriers in the health care system and providing global visibility of the achievements possible at the local level.

The participants agreed that WHO should formulate, endorse and advocate a clear policy on the interface. WHO can bring about a process of change in the practice of local health service provision that will move towards collaborative interaction with communities. WHO should network and tap into the resources of a broad variety of organizations and sectors.

Normative role

The participants felt that the normative role of WHO should focus on the development of concepts and frameworks. This would include the development of a viable framework for the concept of the interface and advancement of the interface as a workable public health strategy. The normative role of WHO could also include the facilitation of the development of principles of good practice for the interface and guidelines for countries. Through such activities, WHO will be validating the participatory approaches and partnership building. A further point was the role of WHO in directing the change in policy to make it more conducive to interactions between communities and health services and in expanding the successful but small-scale experiences to a larger scale.

Advocacy role

The participants at the Consultation agreed on the role of WHO as regards advocacy. This would include promoting the concept of the interface and persuading governments to adopt approaches that have been shown to work and to allocate resources for enhancing the concept of the interface between the health services and the communities. WHO will have to advocate partnerships using the evidence on the benefits of partnerships in health, give recognition to the value of civil society and provide visibility of cases in which civil society has been successfully included in health planning and HIV/AIDS service provision.
Research role
The working groups considered the research role of WHO to be a multi-pronged one that embraces three aspects: the building of the evidence base, operational and action research, and monitoring and evaluation.

The evidence base. It was agreed that WHO will need to contribute to building the evidence for the necessity for the interface and local partnerships in health in order to develop evidence-based policies and to justify approaches.

Operational and action research. WHO could document and analyse methodologies that work for partnerships to enable identification of the critical factors that bring about change and lead to success. A further role identified was the demystification of research and the promotion of participatory research methods that will allow NGOs and communities to document the experiences themselves and will maximize the dissemination of lessons learned by the communities.

Monitoring and evaluation. WHO could promote and provide guidelines for the monitoring and evaluation of partnership processes and of the performance of local health services in partnerships with communities.

Capacity-building role
The participants suggested that WHO has a role in capacity building that embraces both the health services and the community. As regards the health services, WHO’s role was seen as facilitating the development of an enabling environment for building capacity and expertise in participatory methods and partnerships, and the development of appropriate guidelines and manuals. Participants considered that WHO will need to provide support to countries in building capacity, in resource allocation and formulation of incentives for forming partnerships with communities. The role would also include networking and making use of the existing professional organizations and training institutions in capacity building and supporting countries to develop strategies for the involvement of the next generation of health workers in partnership work.

In connection with community capacity, the working groups indicated that the role of WHO would be to recognize and build on existing community responses and actions, while networking with NGOs and CBOs that can help with community capacity building. It would also embrace the provision of support to community organizations in building the necessary capacity for the interface and for HIV/AIDS prevention, care and support and develop appropriate manuals.

Role in facilitating and supporting implementation
As regards role-modelling, the working groups felt that the WHO role would be to demonstrate its commitment to enhancing the interface. This would include a position statement or declaration about the interface and the value of partnerships, as well as the implementation of the necessary activities and the allocation of resources to this area of work. A further point was the bringing about of internal institutional changes within WHO that could contribute to the credibility of partnerships (e.g. WHO’s own relationship and partnership dialogue with NGOs, and the position on PLWA who are employed by WHO).

Suggestions to WHO for follow up
The participants made the following suggestions:

- That WHO Headquarters take a leading role in advocating the development and enhancement of the notions of the interface and partnerships. WHO will need to recommend ways of enhancing and promoting the collaborative interactions movement and of facilitating the global exchange of information on collaborative partnerships at the interface between the health services and the community. A centralized role will be required, as this work goes beyond the capacities of the regional offices.
- That WHO bring together an ad hoc group to carry forward the agenda and recommendations arising from this international meeting.
- That there be an exploration into whether donors with related agendas are willing to fund this WHO initiative.
- To pose the interface as a prominent feature of the International Treatment Access Coalition (ITAC).
- That WHO form links with other agencies with similar concerns and explore the possibilities for complementary roles.
Conclusions and recommendations

- That there be joint development with relevant partners of a framework for partnership between health services and communities. Such a framework will need to incorporate the principles of good practice learnt from experiences in various countries that have promising strategies for strengthening the capacity of health systems to interface with communities and, similarly, to strengthen the ability of communities to interact with health systems.

- Different parts/sections of WHO have different relationships with countries based on global, regional or country connections. Such relationships need to be utilized and could contribute to the playing of different and harmonizing roles in taking the agenda forward and making progress.
# Annex

## List of abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CBO(s)</td>
<td>Community based organization(s)</td>
</tr>
<tr>
<td>CHW</td>
<td>Community health workers</td>
</tr>
<tr>
<td>CSO(s)</td>
<td>Civil society organization(s)</td>
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<tr>
<td>DRI</td>
<td>District Expanded Response Initiative</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GIPA</td>
<td>Greater involvement of people living with HIV/AIDS</td>
</tr>
<tr>
<td>GTZ</td>
<td>Deutsche Gesellschaft für technische Zusammenarbeit (the German bilateral technical cooperation agency)</td>
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<tr>
<td>HBC</td>
<td>Home-based care</td>
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<td>HCD</td>
<td>Human capacity development</td>
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<tr>
<td>ICASO</td>
<td>International Council of AIDS Service Organizations</td>
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<tr>
<td>IEC</td>
<td>Information, education and communication</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>LC(s)</td>
<td>Local council(s)</td>
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<td>LR</td>
<td>Local response</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-child transmission</td>
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<tr>
<td>NAP(s)</td>
<td>National AIDS programme(s)</td>
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<tr>
<td>NGO(s)</td>
<td>Non governmental organization(s)</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>PAR</td>
<td>Participatory action research</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>PLWA</td>
<td>People living with or affected by HIV/AIDS</td>
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<tr>
<td>PRA</td>
<td>Participatory rapid appraisal</td>
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<tr>
<td>SEARO</td>
<td>South-East Asia Regional Office</td>
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<tr>
<td>STI(s)</td>
<td>Sexually transmitted infection(s)</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TDR</td>
<td>UNDP/World Bank/WHO Special Programme</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on AIDS</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<tr>
<td>WHA</td>
<td>World Health Assembly</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WPR</td>
<td>Western Pacific Region</td>
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*Note: TDR stands for Research and Training in Tropical Diseases.*
Recommended citation

In citing it is recommended to use the title and author name of the original article.

For example: