



**AIDS Community**



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## **Solution Exchange for the AIDS Community** **The Constellation for AIDS Competence** **Consolidated Reply**

*Query: Report on AIDS Competence Process - Experiences*

Compiled by [E. Mohammed Rafique](#), Resource Person and [Rituu B. Nanda](#), Research Associate

Issue Date: 3 May 2008

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**From Shyamala Nataraj, South India AIDS Action programme (SIAAP), Chennai**

**Posted 7 April 2008**

I am Shyamala Nataraj, associated with the South India AIDS Action programme, (Siaap) since 1989. Siaap's first community-based HIV interventions were with truckers in 1991. We started with the Targeted Intervention (TI) approach, namely, health education, condoms, and STI referrals. Soon we realised that this approach had failed to build the capacity of vulnerable communities to prevent HIV or cope with illness. We therefore, started working with individuals on specific needs and aspirations in the context of their own livelihoods as well as being part of larger geographic communities. Thus, we addressed issues such as insurance for truckers, violence against women, care of children, linkages with government welfare schemes, issue of voter-id cards, MSM, blind people, and PLHIV, supporting development of sangams or CBOs and promoting thrift and credit cooperatives, in addition to conventional HIV prevention elements.

In this process, we supported the development of thirty CBOs, of Women selling sex, MSM, blind people and PLHIV in Tamil Nadu. We believe that this approach has been the main factor that has seen no new infections reported by the sangams in the last five years. The sangams run, largely self sufficient, HIV preventive and care programs among their members.

One way to facilitate and stimulate the Community Response to HIV, and ownership of the issue is the AIDS Competence Process (ACP). The global non-profit organization promoting ACP or the Community Response to HIV is the Constellation. See details at [www.aidscompetence.org](http://www.aidscompetence.org). Presently, with funding from ADB, the Constellation is building the capacity of NGOs in six

countries including India to develop the competencies of communities responding to HIV. In the AIDS Community's visioning workshop in September 2006, there was a presentation on the potential of working with geographical communities, as an effective response to the HIV epidemic. In the brainstorming session that followed, what emerged was the lack of relevant documentation of these local Community responses to HIV.

The Consolidated reply to a query on this topic in the Solution Exchange AIDS Community, is available on:

<http://www.solutionexchange-un.net.in/aids/cr/cr-se-aids-20120601.doc> Subsequently, an action group selected two programmes, namely that of Samraksha in North Karnataka and Salvation Army's Community Health Action Network in Aizawl, as sites for the visit. After that, the complete Action Group Report of the Community Response to HIV was sent to all our members in February 2008. Please find it at: <http://www.solutionexchange-un.net.in/aids/resource/res-01-270208-01.pdf>

I would like to hear of experiences from India, especially those that have saturated the key populations at higher risk. Herein, the Constellation and other groups can identify opportunities for taking the interventions into the geographical or general community. Towards this the Constellation and Indian NGOs already working in ACP in India plan to hold a meeting in June 2008, to showcase the Indian ACP experience. In order to better prepare for that visit I would like to hear from others on this list:

- How well known is the "AIDS Competence approach" in India and elsewhere? Apart from those mentioned in the Action Group Report what other Community responses to HIV have you come across?
- Has anybody applied the AIDS Competence Process in his or her organization or environment as part of the National AIDS Control Program?
- I would be interested to learn if you have had experiences similar to mine with the AIDS Competence approach. If yes, how did you learn about the approach? What were the results you had with processes or approaches other than AIDS Competence?
- I would also be interested in hearing the lessons learnt from your experience with AIDS Competence Process.

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### **Responses were received, with thanks, from**

1. Laurence Gilliot, The Constellation for AIDS Competence, Belgium ([Response 1](#); [Response 2](#); [Response 3](#))
2. E. Mohamed Rafique, UNAIDS India Office, Delhi ([Response 1](#); [Response 2](#); [Response 3](#); [Response 4](#))
3. [Upahar Pramanik](#), UNAIDS India Office, Delhi
4. [Ravishwar Sinha](#), Consultant, New Delhi
5. [Paul Ponniah](#), Jeevan Sagar Trust, Bangalore
6. [Surya Prakash](#), Humana People to People India (HPPI), Alwar
7. Marlou de Rouw, The Constellation for AIDS Competence, France ([Response 1](#); [Response 2](#))
8. Avnish Jolly, Consultant, Chandigarh ([Response 1](#); [Response 2](#))
9. [Bobby Ramakant](#), Health and Development Network, Lucknow
10. [Dinesh Agarwal](#), UNFPA, New Delhi
11. [Mayank Agrawal](#), NACO, New Delhi
12. [Rituu B. Nanda](#), UNAIDS India Office, Delhi
13. [Gaston Schmitz](#), The Constellation for AIDS Competence, Thailand
14. [R. Meera](#), Women's Initiatives (WINS), Tirupati
15. [Joe Ngamkhuchung](#), North Eastern Drug/HIV Training Centre (NEDHIV), Dimapur

16. [Ian Douglas Campbell](#), The Constellation for AIDS Competence, U.K.
17. [Geoff Parcell](#), The Constellation for AIDS Competence, U.K.
18. [Nabeel M. K.](#), Kannur Medical College, Kannur
19. [Rajaratnam Abel](#), Consultant, Chennai
20. [Jean Louis Lamboray](#), The Constellation for AIDS Competence, Belgium
21. [Bobby Zachariah](#), Salvation Army, Ahmednagar
22. [Steve Glovinsky](#), Solution Exchange, New Delhi
23. [Amrik Singh Kapoor](#), Consultant, New Delhi
24. [Zoengpari](#), Independent Consultant, Aizawl
25. [Koen Van Rompay](#), Sahaya International & University of California, USA
26. [Sukumar David](#), Consultant, Hyderabad
27. [Lawrence Singh](#), Agnes Kunze Society, Dehradun
28. [Pranay Dutta](#), Sonata Foundation, Kolkata
29. [M. L. Prabakar](#), South India Aids Action Programme, Chennai
30. [Gideon Philip](#), North West Scientific, Papua New Guinea
31. [Jayakar Kotte](#), Share an Opportunity (SAO), Secunderabad
32. [Alison Campbell](#), The Constellation for AIDS Competence, U. K.
33. [Lawan Vejapikul](#), The Constellation for AIDS Competence, Thailand
34. [A. Prabakaran](#), Public Action, New Delhi
35. [S. Murugesan](#), Village Community Welfare Society (VCWS), Annavasal
36. [Chirume Mendo](#), UNAIDS, Democratic Republic of Congo
37. [Meble V. Birengo](#), Nairobi, Kenya
38. [Savitri Singh](#), International Co-op Alliance - Asia and Pacific, New Delhi

*Further contributions are welcome!*

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## Summary of Responses

The discussion on AIDS Competence Process (ACP) brought forth that sharing and collaboration can get things done more effectively than individual effort. Discussants shared their national and international experiences in ACP and found it the most exciting and powerful strategy, which seeks and solicits the support from the community in a geographical area.

From the rights-based perspective, communities have the right to information and the right to evolve their own responses to HIV. From the developmental aspect, communities need to own both the problem and the response for effective results. From the sociological view, behaviours of risk taking as well as stigmatizing and discriminating behavior can change at the individual level. However, community norms need to change to sustain the change in individual behavior.

The Community in a geographical area draws on community resources to influence community behaviour towards HIV, respondents explained. The process is bottoms-up with community animators facilitating community leaders and volunteers to take the initiative for the community's response to HIV. ACP appreciates people strengths with the belief that people have the capacity to solve their own problems. The community is empowered to become self-reliant to counter this

problem. The global non-profit organization promoting ACP called the Constellation has used Knowledge Management (KM) tools in the approach but over time, it realized that the essence of ACP is not the tools but the way to use them.

Subscribers informed that in India people have limited information on ACP. As the discussion progressed, they stated that their understanding of ACP got better. India has adopted the Targeted Intervention (TI) model driven by NGOs, which 'targets' populations at high risk, members noted. Unlike TIs, ACP adopts a comprehensive and holistic approach to respond to HIV, like in [Phayao](#) where HIV prevalence dropped from about 20% in 1991 to less than 1% by 2005 end.

ACP has been a very successful approach to HIV in Africa and Thailand and is steadily gaining ground in India. Respondents analysed the reasons why ACP has worked so well. The organizations involved as well as the participant's efforts play a key role. [SIAAP's](#) experience paved the way to the concept of "working with" the Sex workers and MSM communities through establishing partnerships with communities, instead of the "working for" concept. Facilitators access communities in their "settings," they can question, than being recipients of messages and programmes. Communities are competent when they learn from local responses to HIV, apply knowledge, measure their own progress, and share their knowledge.

Subsequently, the **motivation** levels to accomplish the decisions are highest. Furthermore, all communities exhibit not only high levels of **volunteering**, but also high levels of **decentralized planning** and delegation. **Flexibility of response** is the hallmark of ACP making it prepared at all times. Another appealing feature of ACP is the **sustainable** model that evolves from its adherence. We could compute the value of all the volunteering inputs of community members in terms of actual money, members said. However, one can do the measurement when the transfer mapping, Participatory Action Research (PAR), community counselling are in place and foundations for proper measurement are established.

While members accepted the cost-effectiveness of the ACP strategy, they wondered how they could transfer it to the NGO driven TI of the NACP-III. ACP is very relevant in the light of the shift of NACO approach about phasing out of NGOs from the Targeted Intervention programme. If the Government understands the concept and sees the power of communities in taking up their own issues, only then can ACP blossom in India, respondents emphasised. Power of local responses convinced three city mayors to allocate money to implement the ACP in generalized populations in their cities in [Indonesia](#). Some participants questioned the viability of the approach in low prevalence areas and among general communities. Here, the facilitation can be more challenging in the beginning, but by building a community's dream, the issue of HIV often arises as seen in the low prevalence communities of [DR-Congo](#).

Discussants felt that more preparation on this front is required, as it will generate mixed responses from the NGO community. While NGOs might feel left out, the community might miss the support from the NGO. Another concern of shifting from NGO is the quality of the implementation by the CBO. Some NGOs could feel that they are not getting acknowledgement for the good work they had been doing in their TI projects. Adding to the obstacles in this progress will be the organizational frictions creeping into some of the positive networks. Other two important impediments could be getting the community together and keeping their attention span, members stated. The Constellation for AIDS Competence is implementing the ACP approach in India with twelve NGOs but the participating NGOs are not finding firm support to implement it. However, the NGOs have a key role to play in helping these partnerships happen. Salvation Army helps the communities use PAR as a tool to track and measure the progress made by them.

As it is the experience of many organisations, one can transfer the principles of this approach to deal with other issues of community concern as in trauma and stress created due to the tsunami, or in malaria, diabetes, and disability. However, some West-African countries, find malaria is a larger problem and use [Malaria Competence](#) successfully.

To sum up, all participants affirmed that ACP is an effective, humane way, to respond to the HIV epidemic. When communities assume responsibility for their health, they far surpass the efforts of health services and institutions in combating HIV. This concept of AIDS Competence Building provides greater opportunities of learning from the experiences of different communities and enables to harness core strengths of certain communities for the benefit of others.

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## Comparative Experiences

### Nagaland

**ACP Response, Dimapur** (from [Joe Ngamkhuchung](#), North Eastern Drug/HIV Training Centre (NEDHIV), Dimapur)

In 2007, NEDHIV conducted ACP orientation of the staff with SALT visits in three sub-centers. There is an enthusiasm about ACP as a tool for HIV response as it is in tandem with the tribal spirit of community work, community thinking and community approach to everything affecting the village. ACP builds on the community strength and its prospects are long term. During 2008-2009, NEDHIV is incorporating ACP into Targeted Intervention Projects in 24 rural villages including those which address 360 PLHIV. The new concept will take time especially with the diversity of dialects in the State.

### Karnataka

**Self-Assessment by communities, Bellary** (from [Upahar Pramanik](#), UNAIDS India Office, Delhi)

In 2006, UNAIDS study group visited four communities in Bellary. The community members found self-assessment as an exhaustive exercise. The facilitator had to go through nearly 50 parameters from the self-assessment framework. To keep the attention of community over a long period was a challenge. Although the process captured different dimensions of AIDS Competence in a comprehensive manner, some of the parameters were not relevant for the communities. The facilitation team analyzed the findings especially the score on competency scale and presented the summaries at the end of the exercise.

### Maharashtra

**Community response and transfer of experiences, Ahmednagar** (from [Bobby Zachariah](#), Salvation Army, Ahmednagar)

Evangeline Booth Hospital team did follow-up visits to PLHIV in their homes in 1990s to provide and stimulate care, promote reconciliation and provoke discussions in the neighbourhood on HIV. The evolved neighbourhood-based teams care for the sick and discuss behavioral issues resulting in an increased awareness about HIV, change in attitudes and reduction in risky sexual behaviour. One such team opened a 'Counselling centre' in their church and was invited to open one in a nearby private hospital. The experiences influenced Nityaseva hospital in Shevgaon to incorporate home based care as a part of its response.

### Mizoram

**Community Ownership and Action, Dintnar** (from [Dr. Zoengpari](#), *Independent Consultant, Aizawl*)

CHAN has been working with Dintnar community since 1997. In 1998, the community set up a counselling board, as part of the Joint Action Committee consisting of church leaders, and village leaders. The Board reaches out to IDUs, PLHIV and sex workers in the community and their families, and tries to change their behavior. In 2005, based mostly on community contributions, with some help from the Government the Community set up a halfway home to provide counseling and rehabilitation services. In addition, the Community pays the counselor and the running costs of the home.

**Andhra Pradesh**

**ACP by Share An Opportunity India (SAO India)** (from [Jayaka Kotte](#), *Share An Opportunity India (SAO India) Hyderabad*)

The staff of SAO India applied the ACP approach and conducted SALT visits in its project areas – Guntur, Prakasam, Narsaraopet, Nalgonda and Ranga Reddy Districts. SAO works with women savings groups who because of prevailing stigma had earlier no PLHIV in their groups. However, ACP approach motivated these groups to get some PLHIV in their fold. Some new groups of women with positive people also came up. Another result was that the community took up the ownership of the issue and decided to provide transportation costs and meals to sick PLHIV in the community without any help from SAO.

**Tamil Nadu**

**Working with rather than working for communities** (from [M. L. Prabakar](#), *South India Aids Action Programme, Chennai*)

In a workshop seven years ago, SIAAP found that while HIV was the main agenda for it but for the community violence and welfare of children were the priority issues. Through their experiences, the community, however, realised that these key factors influenced their vulnerability to HIV. This paved the way to the concept of “working with” the communities through establishing partnerships. Recently, in a self-assessment process among the next generation of the same community, the experienced leaders ranked themselves at lesser levels than the new ones. With deeper understanding on HIV, they felt that the current level of response was inadequate.

**India**

**Indian leg of ADB-NGO Programme 2007-2009** (from [Rituu B. Nanda](#), *UNAIDS India Office, Delhi*)

NGO participants have been enthusiastic about the process and have come to believe in the power of the ACP tools. However, when they go back to their organisations they do not get the firm support to implement it. Their organisations see it as a voluntary thing they learnt and added to their knowledge. Moreover, the other staff does not see its feasibility and compatibility with the Targeted Interventions. With virtually little organizational support and no funding allocated for AIDS competence, it is not getting enough impetus. In addition, people often question the viability of the approach in low prevalence areas and among general communities

**Thailand**

From [Bobby Ramakant](#), *Health and Development Network, Lucknow*

**Role of youth, Ban Pang Lao community**

Youth began organizing themselves to respond to HIV in 1994. They formed a working group, held discussions among themselves and with adults, had access to information, and used participatory approaches in advocacy events on HIV and risky behaviour that makes youth vulnerable to HIV. Youth use participatory theatre, music, and traditional folk dance performances on themes around HIV prevention, care and support to raise awareness and understanding of key issues in the community. They write their own 'proposals' to raise financial resources at provincial level to meet the costs of the performances or advocacy events which ensures sustainability of local responses.

### **Holistic approach, Phayao**

HIV prevalence dropped from about 20% in 1991 to less than 1% by 2005 end in Phayao. The community adopted a comprehensive, integrated, and holistic approach to a healthy life to respond effectively to HIV. Suwat, a researcher, produces a report with HIV prevalence data every six months using military conscripts classified as per indicators like the district, pregnant women, age, society, sexual behaviours, number of sexual encounter, and other indicators. These studies changed the policy and an active awareness campaign targeted at 'understand yourself, then you will be able to understand others'.

*From [Gaston Schmitz](#), *The Constellation for AIDS Competence, Thailand**

## **Indonesia**

### **UNFPA and local governments, West Kalimantan and Papua**

In December 2006, the Constellation team demonstrated the AIDS Competence approach through SALT visits in the cities of Pontianak, Merauke and Singkawan and discussed the opportunities for collaboration with the local government. In Jakarta, the team briefed the NACP and UN Theme group on the AIDS Competence approach and explored opportunities for further spreading of AIDS Competence in the country. After experiencing the SALT visits in their own communities, three city mayors have allocated money to implement the ACP in generalized populations in their cities.

## **Africa**

### **Malaria Competence, Multiple countries in Africa**

Since June 2005, the Constellation facilitates the Mombassa Group, a network with members in 12 countries to develop Malaria Competent societies, where vulnerable groups take the lead in fighting the disease. Facilitators help local communities to assess and use their own strengths to roll back malaria and to connect with other communities. Participating communities are making a greater use of bed nets and malaria medicines. As a result, the Constellation has joined the Roll Back Malaria Task Force in 2006 and integrated the Malaria Competence Approach into Roll Back Malaria's toolkit and general policy.

## **DR-Congo**

**RDC Competence approach, Kinshasa** (from [Dr. Jean Louis Lamboray](#), *The Constellation for AIDS Competence, Belgium* and [Gaston Schmitz](#), *The Constellation for AIDS Competence, Thailand*)

RDC Competence was born as an organisation in 2007 with 30 members who stimulate local responses. The approach spreads on top and at the grassroots of society. In one year, screening for HIV jumped from ten to forty percent of population. Every month about fifty people take a HIV test, compared with one or two people in the past. Twice as many people come to the health center where ARV is free. Various communities get together, share, and learn from each other. Positive People are accepted, and integrated into the community life. Integrated Police Unit chief

takes up the HIV issue during the parades. 540 policemen out of 1000 did their test after the first SALT visit.

## Zambia

### **Communities become AIDS competent** (from [Rituu B. Nanda](#), Research Associate)

In late 1980s with high HIV rate, hospital care was no longer an option in Zambia. The Salvation Army started consultations with the communities around Chikankata Hospital. The approach built on the strengths of communities encouraging them to take their own decisions about how best to respond to HIV. Communities that developed this competence also transferred their learning. The success of the facilitation process included community gardens to provide food, demand from community members for voluntary counseling and testing, more people reached in home-care programmes, and increased the number of communities that respond to HIV and change in risky behaviour.

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## Related Resources

### *Recommended Documentation*

#### **Facilitating Human Capacity Development– a Pathway for Local Community and Organizational Response to HIV/AIDS by the Salvation Army**

By Ian D. Campbell and Alison Rader Campbell

Available at

[http://www.salvationarmy.org/ihq/www\\_sa.nsf/766d2187c97e6bf180256cf4005d2284/fdb5578e5e1a3c9280256f0e004aed0e/\\$FILE/facilitating\\_human\\_capacity\\_development.pdf](http://www.salvationarmy.org/ihq/www_sa.nsf/766d2187c97e6bf180256cf4005d2284/fdb5578e5e1a3c9280256f0e004aed0e/$FILE/facilitating_human_capacity_development.pdf) (Size: 325 KB)

*Details of Salvation Army facilitating HIV approaches through stimulation of local response in 39 countries based on development of human capacity*

#### **Community, Care, Change, and Hope: Local Responses to HIV in Zambia**

By Sue Lucas; The Synergy Project; July 2004

[http://www.synergyaids.com/documents/ComCareChangeHope\\_Zambia.pdf](http://www.synergyaids.com/documents/ComCareChangeHope_Zambia.pdf) (Size: 445 KB)

*Documents a successful model that builds on local strengths and resources, stimulating community people for facilitating a strong community response to HIV*

#### **AIDS Competence Process** (from [Dr. Avnish Jolly](#), Consultant, Chandigarh [response 1](#))

Uganda AIDS Commission

Available at:

[http://www.aidsuganda.org/AIDS%20Competence/ACProcess%20Op%20Principles\\_09.06.05\\_.pdf](http://www.aidsuganda.org/AIDS%20Competence/ACProcess%20Op%20Principles_09.06.05_.pdf) (Size: 80 KB)

*Combines learning from local responses to HIV with the knowledge management expertise and the experience of human capacity development*

#### **Evaluation of the UNAIDS/UNITAR AIDS Competence Programme** (from [Dr. Avnish Jolly](#), Consultant, Chandigarh [response 1](#) and [Amrik Singh Kapoor](#), Consultant, New Delhi)

UNAIDS and UNITAR; June 2005

Available at Source (website [http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR\\_en.pdf](http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR_en.pdf)) (Size: 2.2 MB)

*Measures the effectiveness and efficiency of the ACP's process and states that ACP introduces new methodology of community facilitation rather than a new programme*

From [Bobby Ramakant](#), Health and Development Network, Lucknow

### **Learning from youth groups in Ban Pang Lao on AIDS response**

By Bobby Ramakant; HealthDev.Net; 2008

Available at <http://www.healthdev.net/site/post.php?s=471>

*Youth organized at the community level, held dialogue, and used participatory approaches in advocacy, to check the spread of HIV in Ban Pang Lao*

### **Use 'both sides of the brain' to respond to AIDS**

By Bobby Ramakant; HealthDev.Net; 2008

Available at <http://www.healthdev.net/site/post.php?s=472>

*A comprehensive, integrated and holistic approach to HIV which looks at related issues like social, economic and cultural contexts has helped bring down HIV spread in Phayao*

### **Learning to Fly: Practical Knowledge Management from Leading and Learning Organizations (Paperback)** (from [Steve Glovinsky](#), *Solution Exchange*, New Delhi)

By Chris Collison and Geoff Parcell ; Capstone Publishing Limited; West Sussex, U. K.; 2004;

Available for purchase for £ 13.99 at :

[http://www.amazon.co.uk/exec/obidos/ASIN/1841125091/qid=1102067152/sr=1-1/ref=sr\\_1\\_10\\_1/202-8311431-7021408](http://www.amazon.co.uk/exec/obidos/ASIN/1841125091/qid=1102067152/sr=1-1/ref=sr_1_10_1/202-8311431-7021408) (File format File size)

*Demonstrates participatory approach to put knowledge management theory into practice with tools, experience and insights from leading practitioners in the field*

From [Amrik Singh Kapoor](#), Consultant, New Delhi

### **The HIV/AIDS District Response Initiative Action Research in Uganda** (from Name, Organization, Location)

PowerPoint presentation by Department of Social Work and Social Administration, Makerere University

Available at [http://www.aidsuganda.org/pdf/Presentation\\_METHODODOLOGY.pdf](http://www.aidsuganda.org/pdf/Presentation_METHODODOLOGY.pdf) (Size: 1 MB)

*Describes methodology of community level participation with a multi-sectoral approach and establishment of the AIDS Commission in Uganda to harmonize national response*

### **HIV/AIDS Learning Workshop for Senior Staff of UN Agencies – Toward AIDS Competency**

Workshop report; UNAIDS; June 2004

Available at [http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR\\_en.pdf](http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR_en.pdf) (Size: 2.11 MB)

*In the workshop the participants from various UN organisations assessed ACP, provided their suggestions and framed their work plan as result of the discussions*

### **Sharing Knowledge at the AIDS Competence Programme** (from Dr. Avnish Jolly, Consultant, Chandigarh, [response 2](#))

Case Study by Seth Kahan; MAQ Paper; 2004

Available at [http://www.sethkahan.com/Kahan\\_UNAIDS\\_UNITAR\\_AIDS\\_Competence.pdf](http://www.sethkahan.com/Kahan_UNAIDS_UNITAR_AIDS_Competence.pdf) (Size: 128 KB)

*Demonstrates through the activities of AIDS competence Process how Knowledge Management has contributed to ACP's success in developing human capacity*

From [Sukumar David](#), Consultant, Hyderabad

### **AIDS competence: saving lives with KM**

By Geoff Parcell; Knowledge Management Review; Jan/Feb 2005

Available at [http://findarticles.com/p/articles/mi\\_qa5362/is\\_200501/ai\\_n21371140](http://findarticles.com/p/articles/mi_qa5362/is_200501/ai_n21371140)

*Describes evolvement of ACP to respond to HIV globally through collaboration with Knowledge Management tools of facilitation, self-assessment, and peer assist*

### **Adapting our Response**

Video by Dr. Jean-Louis Lamboray

Available at:

[http://www.blinkx.com/video/DailyMotion/Adapting\\_our\\_Response~vEKfY2S7iF73W0qAtF3Ez5Q](http://www.blinkx.com/video/DailyMotion/Adapting_our_Response~vEKfY2S7iF73W0qAtF3Ez5Q)

*It gives description of the practice of 'Adapting our Response' used in the Self Assessment framework of AIDS Competence*

### **eHealth in development: Policy meets Practice**

Report of joint Norad-NST Workshop, TTeC Tromsø, Norway; 15 June 2006

Available at

[http://telemmed.custompublish.com/getfile.php/306115.357.twebvwcffu/Joint+Norad\\_NST\\_worksh\\_op\\_ttec\\_15June2006\\_report\\_040706.doc](http://telemmed.custompublish.com/getfile.php/306115.357.twebvwcffu/Joint+Norad_NST_worksh_op_ttec_15June2006_report_040706.doc)

*Constellation and Norwegian Centre for Telemedicine have designed a blended learning program combining local training with online tools for learning and collaborating*

### **Some Impressions from the SALT Visits to Northern Thailand in December 2007 (from [Rituu B. Nanda](#), Research Associate)**

By Dr. E. Mohammed Rafique; Healthdev.net

Available at <http://www.healthdev.net/site/post.php?s=1802>

*Captures the essence of the ACP, its advantages because of higher motivation, responsibility and sustainability, as well as its synergy with religion, tradition and culture*

### ***Recommended Contacts and Experts***

From [Rituu B. Nanda](#), Research Associate

#### **Ms. Marlou de Rouw, The Constellation for AIDS Competence, France**

[www.aidscompetence.org](http://www.aidscompetence.org)

*Marlou de Rouw is the Manager of the Constellation and can be contacted for information on AIDS Competence Process*

#### **Mr. Gaston Schmitz, The Constellation for AIDS Competence, Thailand**

[www.aidscompetence.org](http://www.aidscompetence.org)

*Gaston Schmitz is the facilitator, transfer in the Constellation*

### ***Recommended Organizations and Programmes***

#### **North Eastern Drug, HIV Training Centre (NEDHIV), Dimapur (from [Joe Ngamkhuchung](#), Dimapur)**

Post Box 174, Bank Colony, Dimapur; Tel: 03862 233238

*Engaged in HIV programmes in the field of care, support, training, awareness, counseling, self-help groups and has initiated the ACP approach in a few sites*

#### **South India AIDS Action Program, Chennai (from [M. L. Prabakar](#), Chennai)**

No. 8/11, Jeevanatham Street, Lakshmipuram, Thiruvannamiyur, Chennai; Tel: +91-44-5539 8050 / 2452 2285 / 2452 3301; [siaap@eth.net](mailto:siaap@eth.net); [siaap@satyam.net.in](mailto:siaap@satyam.net.in); <http://www.siaapindia.org/>

*Committed to communities creating their own agendas and has developed models of empowerment to suit the requirements of each community in HIV programmes*

**Share an Opportunity (SAO) India, Secunderabad** (from [Jayakar Kotte](#), Secunderabad)

Plot No. 12, P & T colony, Vikram Puri, Karkana, Secunderabad; Tel: 040 27892485

*Engaged in HIV awareness, education and supports WAD events among other activities like child care, empowering women and Community Capacity Building*

**Salvation Army India, Ahmednagar** (from [Bobby Zachariah](#), Ahmednagar)

Flat 103, Aashirwad Complex, D-1, Green Park, New Delhi; Tel: 91-11 651 2394;

[intmail@INT.salvationarmy.org](mailto:intmail@INT.salvationarmy.org); [http://www1.salvationarmy.org/ind/www\\_ind.nsf/vw-dynamic-index/80256E520050A2E280256C09004DF41D?openDocument](http://www1.salvationarmy.org/ind/www_ind.nsf/vw-dynamic-index/80256E520050A2E280256C09004DF41D?openDocument)

*One of the leading organisations in India that has adopted the approach of building human capacity in the communities to effectively and efficiently respond to HIV*

From [Rituu B. Nanda](#), Research Associate

**Samraksha, Bangalore**

No 11, Sree Nivasam, Bull Temple Road A cross, Chamrajpet, Bangalore; Tel: 085 36268214;

[samraksha@samraksha.org](mailto:samraksha@samraksha.org); [http://samuha.gn.apc.org/html/hiv\\_aids2.html](http://samuha.gn.apc.org/html/hiv_aids2.html)

*The NGO uses geographical community approach to HIV with focus on key issues of care and support, counseling, education and awareness*

**International HIV/AIDS Alliance, UK**

Queensberry House, 104-106 Queens Road, Brighton BN1 3XF, United Kingdom; Tel: +44

(0)1273 718900; <http://www.aidsalliance.org/sw1280.asp>

*Believes in the principle that most successful responses to HIV and other development challenges are built upon local leadership, commitment and responsibility*

***Recommended Portals and Information Bases***

**The Constellation for AIDS Competence** (from Laurence Gilliot, Belgium, [response 1](#) and Marlou de Rouw, The Constellation for AIDS Competence, France, [response 1](#))

<http://www.aidscompetence.org/>

*This website provides comprehensive information on what is the AIDS competence Process, its tools and its application in various countries in the world*

***Recommended Upcoming Events***

**ADB NGO Competence International Knowledge Fair, Chiang Mai, Thailand, Dec 10 – 12, 2008** (from Marlou de Rouw, The Constellation for AIDS Competence, France, [response 1](#))

Organised by The Constellation on AIDS Competence with ADB funding, Thailand. Information available at <http://www.aidscompetence.org/index.htm>

*NGO-facilitators with participating coaches will share and learn from each other their experiences on working with communities in HIV and develop draft knowledge assets*

***Related Consolidated Replies***

**Local Community Response to HIV, from Sanghamitra Iyengar, Samraksha, Bangalore (Experiences). AIDS Community**

Issued 20 November 2006. Available at <http://www.solutionexchange-un.net.in/aids/cr-public/cr-se-aids-20110601-public.pdf>

*Approach, which helps communities to recognize and build capacity to respond to HIV by sharing knowledge that helps reduce vulnerability and risks, to live to the full potential*

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## Responses in Full

**Laurence Gilliot, Constellation for AIDS Competence, Belgium** (*response 1*)

Thanks a lot for this document! We had been talking about capturing results in India before. I'm so happy to see that the India AIDS Community has found time to do this documentation.

I found the conclusion extremely powerful: *"The Geographical Community Competence Building Approach is both a belief and a strategy. From the rights-based perspective, communities have the right to information, which helps them build a perspective on the various aspects of HIV. They also have a right to evolve their own responses to the issue in ways, which they find best for them. They have the right to self-determination and can deal with this crisis as they have dealt with others in their lifetime. From the developmental perspective, communities need to own both the problem and the response for effective results and sustainable impact. From the sociological perspective, HIV is the problem of individuals that is embedded in a social context. Behaviours of risk taking for self and others, and stigmatizing and discriminating behavior can change at the individual level but community norms, pressures and sanctions also need to change to reinforce and sustain the change in individual behavior."*

Thanks to all the people who collaborated on this documentation.

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**Dr. E. Mohamed Rafique, UNAIDS India Office, New Delhi** (*response 1*)

**SALT** is an acronym for a way of thinking and relating ourselves to a situation. S is for Support and Stimulate. A is for Appreciate, Analyze and Act. L is for Listen, Learn and Link while T is for Transfer and Team. Team members Stimulate further action through their appreciative questions, Support each other in the Appreciation of individual and community strengths, exchange their perspectives about what they have Learned from each visit, and prepare to Transfer lessons learned to their own context. Accepting the invitation from the Constellation of the AIDS Competence process (ACP) to learn this Knowledge Management technique, I joined the SALT visits in Northern Thailand. Appended is what I picked up.

### **Some Impressions from the SALT Visits to Northern Thailand in December 2007**

#### **The start of the Journey**

'First impression is the best impression', I felt as Laurence introduced us, a team of eager beavers, to the nuances of the AIDS Competence Process (ACP). She had asked us a very introspective question that was both best, as well as impressive by its central and profound nature correspondingly. That query, which took us on an exploration of our innate nature was, 'Are we human?'

I replied instinctively and truthfully, 'At times, we are human!' Jean Louis beside me burst into peals of laughter, pushing us on with, 'What are the times we are not?'

'Well. We do slip up; After all we are all human!' I muttered slowly to him, setting him into another bout of amusement.

Soon we had a list of the inhuman traits: Selfishness, anger, power, cruelty and so on. Similar was the assumptions that we have more experience, know more, and are better than people in communities are. Other such traits include, not caring or sharing, as well as operating

automatically and not consciously. The group's contributions were fast filling up spaces on a chart.

On the other hand, being aware that everyone else is an equal human being was a display of the least iota of human behaviour that we have. Communicating appreciation, support, care and the like were humane. We share our fears, reflecting on what we do, looking into ourselves. We also consciously try to connect with others, look beyond ourselves, and see despite the differences our similarities and respect them. Therefore, it was for us to constantly rediscover, recognize, resolve and remind ourselves that we must vigorously exhibit such humanitarian qualities to our fellow men. So essential was this requirement as it was elementary. The perfect logic of its simple and natural spirit had won me. This was the starting point of the journey, on the road of ACP.

'We are sexual, we are human', stated members from the group, much after this session. Animals are sexual too. However, exhibiting our sexuality and strengthening it through love and bonding are its human qualities.

### **On the Road**

Once we accept human equality, the next and the rest of the logic follow its due course. We then see the people of the community through a humane lens. This lens focuses on us learning from their experiential knowledge, rather than teaching them our pre-defined solutions.

If we, the visitors found the community members confronted with an issue our contribution to solution seeking of the community members, could be by posing challenging questions. These questions dare people to further action. Here again, as the responses to the queries posed were sought and found by the community members, they would be most active in testing and implementing them, than it were had we imposed the same solutions on the community members.

### **Counselling a Community**

I remember as a child, I would rebel against orders. The same activity I would willingly complete if it came in as a request. Probably this could be because a request respects the requested one's decision. Conversely, an order belittles it. Moreover, the counsellors amongst us will remember that in order to make a client pursue a decision, we help the client to make the decision by providing the complete range of options. In addition, based on experiences we provide an awareness of the consequences of following each of the options. Subsequently, we leave it to the client to decide or choose from among these options. Clearly, decision-making is the client's responsibility. Similarly, ACP extrapolates this logic from an individual level to that of a community's. After all, the community is only a collection of individuals.

### **Effect of Decision-making on Motivation, Enthusiasm and Implementing**

As in counselling where we see clients practicing only the decisions they made, so also in ACP it became increasingly clear to me that communities execute those decisions that they made. Subsequently, the enthusiasm and motivation levels to accomplish the decisions are highest. This is because if an individual gives his word to his own community that he or she would undertake an activity for their own, then their integrity, and the community's trust and confidence in their ability to implement it, is in question until they have completed it. Furthermore, all communities visited by us exhibited not only high levels of volunteering, but also high levels of decentralized planning and delegation of practice.

### **Other spin-offs**

We could compute the value of all the volunteering inputs of community members in terms of actual money. Then if we compare it as a ratio with the funds spent from donors during the same period, we would be able to develop tested index of sustainability

### **Awareness and Behaviour Change**

Sensitized Health Care Workers do realize that behaviour change is the key solution against the epidemic. The model of providing awareness and leading it to behaviour changes in only the sexual act, is fraught with failure. For awareness alone does not necessarily enforce behaviour change in decision-making or risk-taking. Currently, we know that the battle against HIV is won or lost, in the bedrooms by the millions of decisions made by people. Here, in their intimate moments, only their own determination to change behaviour is with them. If these resolutions are part of the collective declaration of a community, it has more chances of standing up to the test. Therefore, realization by a community is the easiest way to a stronger and en masse behaviour change.

### **Religion, Culture and Traditions**

Many communities are rooted in their religion and culture. We must sift through available data to find out whether following culture and traditions is leading to a remarkable reduction of HIV prevalence in some of these communities. Phayao has shown the world a reduction in prevalence from 18 to less than one. Suat of Phayao is placed best to analyze surveillance data that he as an epidemiologist has collected over the years. His depth in academic analysis is matched by an equal strength of his devotion as a Buddhist. Selflessness helped him to build three temples in his village, where he is called, 'Professor'. None can dispute his philosophy that one must see People Living with HIV (PLHIV) holistically. For, PLHIV were part of a family, and the family a part of the community.

### **Flexibility of response**

This is the hallmark of ACP making it prepared at all times. Thereby the community responds best to emerging issues or changing environment than the one it had planned for earlier.

### **Sustainability**

The most appealing feature of ACP is the sustainable CBO model that evolves from its adherence. Ms. Pimjai stating that for the last two years their Community Health project did not have to access any Government or donor funding is ample proof of having attained sustainability.

### **Reflections on Pimjai's challenge:**

Pimjai practiced selflessness. She had devolved responsibilities, developed peers to leaders, and a system, that made her dispensable. As for the reality of HIV in her life, she saw it as a immense opportunity to employ the human qualities. Her meditations on death, while sitting alone in the pre-dawn darkness in the Buddhist crematorium, were to focus on her very mortality. For being mortal is again a basic human trait. The remembrance of death before we begin life every day is the best way to be human, that Pimjai has taught me. Preparing for death humbles one with a remembrance of the stark fact that in death the great leveler, all human beings are equal. Her statements that she was ready to pass away made her my epitome. Her plea that the best service we could do to her was to transfer the concepts that we had learnt from her organization or life.

If we ought to be the change first, that we want to see in others, then we must measure how much ready we are now to pass away. Therefore, I must bury my selfishness that makes me cling to this material world. How I do it without betraying anyone is the challenge that I could solve by devolving my responsibilities. Over time, everything is possible. If the key is selflessness and if in death, I go away taking not anything from the world, then I must begin to give everything. How fast I do it, the better human being I will soon be.

## **Working in India**

A billion people, with a vast majority living in rural communities provide opportunities galore! Convincing the funding agencies to support a National Facilitation Team that coach detected champions, to start this bottoms-up response, is one way of scaling up the success tasted in the states of Karnataka and Mizoram.

Decentralization is the mantra of the current National AIDS Control Program (NACP). Therefore, mainstreaming community response to HIV is a prime area. In addition, the United Nations Country Team's (UNCT) current support to transferring and transforming knowledge to action and implementation, gives ample scope within its ambit, for supporting community responses not only to HIV but also to most of the other themes in the Millennium Development Goals (MDG).

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### **Upahar Pramanik, UNAIDS India Office, New Delhi**

I had an opportunity to accompany a core team from the Constellation to field test the "self assessment framework" in India. The tool was field tested in 4 select communities in Bellary district, Karnataka in October 2006. The key feature of this tool is - it emphasizes on determining and building "human capacity" through a participatory process. However, one has to be selective while using this tool in a particular socio-cultural context. I like to share following observations about the process, when this was tried among a group of community members:

- The community members found this as exhaustive exercise. The facilitator had to go through nearly 50 parameters from the self-assessment framework. To keep the attention of community members over a long period was a practical challenge.
- Although the process captured different dimensions of AIDS Competence in a comprehensive manner, some of the parameters were not relevant for those four communities.
- The analysis of the finding especially the score on competency scale was very well summarized and presented at the end of the exercise. But, I feel the process of analysis is little sophisticated and de-links the community members to be part of it. Nevertheless they are given feedback on the findings and analysis.

The tool was purposely tried in a community where HIV prevalence was low. It generated good amount of discussion within the community around issues of vulnerability to HIV. Perhaps this is more effective where prevalence is high or has significant number of key populations and PLHIV.

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### **Laurence Gilliot, Constellation for AIDS Competence, Belgium *(response 2)***

Thanks a lot for your very interesting email. We really appreciate to keep on learning and improving our way of working and our tools!

I would like to react on the points you have made and share a bit of my experience. It can be quite a challenge to go through the whole self-assessment framework and to keep the attention of the community. That is why sometimes we use an "empty" framework with only the 10 practices and the 5 levels. We use a generic explanation for the levels that can be used for all practices, instead of using the text in the boxes like in:

- Level 1: We are aware of this practice, we have the basic information,
- Level 2: we have the info to act but we don't,
- Level 3: we act sometimes,
- Level 4: we act systematically; but it is still tough, and
- Level 5: this practice is part of our life-style; it is natural for us.

What is also possible is to make the self-assessment more fun is to divide the room into 5 spaces representing the 5 levels and ask people to physically place themselves where they think the community is.

**Relevant parameters:** In Belgium, we had the same experience. Some of the parameters are less relevant. So feel free not to do all of them but keep in mind that if several communities do the same self-assessment, they can share more easily because they used the same framework.

**Low or high prevalence context:** I have experienced the self-assessment in Belgium and in the Philippines, two low prevalence countries. It is sometimes a challenge to get people to talk about an issue that does not seem to be a priority for them. However, as soon as the discussion is launched, it works! The self-assessment is a way for the community to measure how immunized it is to HIV, because AIDS Competence is like a social vaccine...

Again, thanks a lot for your email. Please send us some suggestions on how to improve what we are doing and how to address the challenges you mentioned!

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**Dr. Ravishwar Sinha, Consultant, New Delhi**

Thank you for your informative and thought provoking views.

The need for such a self-assessment is very much there for the practical purposes, for planning lessons learnt, incorporation and improvement. Two important impediments or challenges that come to my mind as a program person are:

1. Getting the community to come together for the exercise
2. Keeping their attention span

1. For this it is very necessary to have a congenial and friendly atmosphere where the community feels comfortable and reasonably sure of getting something like knowledge or practice, out of the exercise. Communities that are in the grip of HIV and AIDS or threatened by it are more likely to respond. Communities that do not perceive themselves to be of threat are less likely, though this is unfortunate. Perhaps this is the challenge also. If the community that is of the second category shows good response, it can be taken to mean that the HIV and AIDS messages has been well received. The converse is also true. If the response is poor, it is a reasonable expectation that the community competencies are in need of improvement and requires strategic assessment, analysis and action.

2. Keeping attention and getting fruitful participation is a difficult task at best of times. However, my experience is that if the activity is planned where the atmosphere is that of happy people, then there is a tendency to be more participatory. Long winding questionnaires are generally a turn off. The response design could in the form of plays or competition or a frank question answer with some notional prizes for recognition. This keeps people engaged. Good training of the investigators and rationalizing capacities are necessary.

Lastly, I congratulate my friends for taking the lead. It is an evolving process.

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**Paul Ponniah, Jeevan Sagar Trust, Bangalore**

From the report put up, I get to understand that that Community Response or AIDS Competence approach has the following strengths:

- Local ownership, as communities start feeling ownership and responsibility
- Local planning and action - based on communities starting their own planning and action instead of "only" waiting for outside help
- Scaling up success - the approach has helped communities find other communities to learn from similar experiences. It was easier to match success with learners,
- Service providers support - instead of "only" intervening, the service providers started to support and strengthen the local action.

Since the community is holistically briefed on HIV care and stay at homes is correctly expressed, it answers many of the aspirations of the support NGO. I understand that participation and monitoring the care of the suffering Individuals, is taken as an indicator in the assessment. Moreover, better involvement of the community means better and quicker reach of those at home, and employment for some of the members of the community. Reaching everyone, in turn will mean that families will be better honoured and respected.

Finally, I must say that it is a very encouraging report.

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**Surya Prakash, Humana People to People India (HPPI), Alwar**

I have had an opportunity to be a part of the HIV prevention programme in Alwar District. During the previous three years, we have been conducting the Targeted Intervention programme. This query is very relevant when seen in the light of the recent shift or approach of NACO about the CBO in some districts and phasing out of NGOs from the Targeted Intervention programme. It seems there needs to be more preparation at this front before embarking on such an issue, as it will generate mixed responses from the NGO community. The NGO feel left out in such situations. Moreover, the fledgling CBO badly misses the technical and capacity support from the NGO.

One of the concerns of shifting totally from NGO to CBO is upon the quality of the implementation by the CBO. The capacity building exercises for the CBO must be well formulated and adherence levels must be very high for the desired impact. Are there more differences in programmes implemented by CBO and NGO?

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**Marlou de Rouw, The Constellation for AIDS Competence, France (*response 1*)**

I am reading the exchange in this group with great interest, and am grateful for the initiative.

The Constellation for AIDS Competence is implementing the AIDS Competence approach in India together with twelve NGO's, in the context of the ADB-NGO Competence programme. Those who are interested in getting to know more about our ways of thinking and our ways of working are welcome to join us on any of our national or international events. The next one is coming up in June, at Mumbai.

Thailand, Indonesia, PNG, Cambodia and the Philippines are also engaged in this ADB-NGO Competence programme. In December 2008, participants from these six countries are coming together in Chiang Mai, Thailand, for a Knowledge Fair: a joyful event where participants exchange lessons learned from local responses to HIV and build knowledge assets for sharing with others.

If you like to know more about these programmes, you can contact Bobby Zachariah, the Constellations Country Connector for India or Sirinate Piyajitpirat the Coordinator of the ADB-

NGO programme. You can also visit our website [www.aidscompetence.org](http://www.aidscompetence.org) to read about AIDS Competence Activities elsewhere in the world and download tools for self-assessment and the like.

Looking forward to reading further exchange on experiences with the approach on this platform.

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**Dr. Avnish Jolly, Consultant, Chandigarh** (*response 1*)

We are learning daily, that always motivates us to serve and helps us to reach the un-reached. If we look a little into the past on our evolution of the response to HIV, we see that, “Non-interfering, non-judgmental” identification, mobilization and association into organisations of “high-risk” persons to receive selected services termed “comprehensive” were seeded and nurtured through NACP-I & II. Targeted Intervention remains the focus in NACP-III also.

We know the aim of NACP-III is to cover one million “Commercial Sex-Workers” (CSW) and their clients; contact 1.5 million “Men-Having-Sex-With-Men” (MSM) and 0.19 million “Intravenous Drug-Users” (IDU). The financial break-up of this TI approach further reveals that while 1260 TI—to cover 0.60 million CSW, contact 0.90 million MSM and 0.14 million IDU—will be through Government Budgetary Support, another 840 TI—to cover 0.40 million CSW and their clients, contact 0.60 million MSM and 0.05 million IDU—are to be organized and implemented at national level.

Personally, I felt that the gender sensibility with reference to HIV requires special attention and we are implementing projects in isolation. I also felt for effective implementation the morale of comrades require a boost, while the program needs strengthening in the following areas:

- Mainstreaming of Targeted Group for Holistic and Sustainable Development (Community Development Approach)
- IEC Activities according to needs of the community in local language
- Consistent and effective Condom promotion and development of new reachable outlets for condom promotion/ intervention
- Regular Support and Monitoring of all the components
- Regular orientation and capacity building of the staff with special reference to ITPA
- Legal literacy to HRG and implementers
- Developing SHG of Vulnerable Sections for Sustainable development for mainstreaming
- Development of IEC material of different State or Centre Schemes concerning PLHIV and Target Groups
- Advocacy of Publication and Action Research
- Networking with different concerned institutions
- Experience Sharing of gained knowledge and experiences of all levels is required
- Regular meeting and orientation of Programme Partners
- Overcome Isolation in preview of Holistic development through Social Work.
- Linkages and capacity building of PLHIV require great attention

The following notes and Resources from various sources could be of help:

Combining learning from local responses to HIV with the knowledge management expertise and the experience of human capacity development, the AIDS Competence Process (ACP) has been designed for various groups and organisations to build on their existing strengths to respond. Lessons, information, Principals and strategic orientations can influence HIV interventions at any point, provided they are action-oriented. We must understand AIDS COMPETENCE PROCESS first: [http://www.aidsuganda.org/AIDS%20Competence/ACProcess%20Op%20Principles\\_09.06.05\\_.pdf](http://www.aidsuganda.org/AIDS%20Competence/ACProcess%20Op%20Principles_09.06.05_.pdf)

“Cost Effective” Strategies is badly needed - Fortunately, at this juncture we have the gift of hindsight. The Thai-experience reveals “pragmatic” “cost-effective”

“rapid-blanket-saturation-TI-methodologies” are at very best a temporary reprieve carrying expensive end-tags, most particularly for future generations. As with environment-issues, tampered inner-environments—of which sexuality is an intrinsic core-element—carry individual/social costs, most severe to the poor, gender and inter-generational interests.

Evaluation of the UNAIDS/UNITAR AIDS Competence Programme  
[http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR\\_en.pdf](http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR_en.pdf)

A report comprised of UNAIDS Learning Strategy case studies from sixteen countries that include Botswana, Brazil, Burkina Faso, Cape Verde, India, Indonesia, is at:  
[http://data.unaids.org/pub/SpeechEXD/2007/jc1311-un-learning-strat07\\_en.pdf](http://data.unaids.org/pub/SpeechEXD/2007/jc1311-un-learning-strat07_en.pdf)

The people who are working as service providers their experience and expertise do not synchronize their activities due to many factors that is the area which needs special consideration. Hope to understand this issue from fellow friends.

**Dr. E. Mohamed Rafique, UNAIDS India Office, New Delhi** *(response 2)*

After this query went out, there has been many who are asking the moderating team the difference between Targeted Interventions and the AIDS Competence Process (ACP). Therefore, in this response, I am attempting to make a distinction between them. Accordingly, I provide a section of the draft that went into making the report at <http://www.solutionexchange-un.net.in/aids/resource/res-01-270208-01.pdf> on the AIDS Competence Process written for our Action Group last year: **The Geographic approach or Community response compared to Targeted Interventions (TI):**

The Community response to HIV makes an interesting study when viewed in comparison with the Targeted Intervention approach

No.	Targeted Interventions	<b>Geographic Approach or Community Response to HIV or AIDS Competence Process (ACP)</b>
1.	HIV Prevention and treatment Interventions are targeted at High Risk Behaviour (HRB) Groups and People Living with HIV (PLHIV).	The Community in a geographical area draws on community resources to influence community behaviour towards HIV prevention and treatment, helping to “normalize” and better manage the epidemic.
2.	TI applied so far amongst HRB groups mostly in urban setting with relatively the highest HIV prevalence.	In India ACP practiced among general population in rural areas with the lower risks and prevalence. The Geographical approach is being explored in urban and high prevalent situations.
3.	Approach is top-down with National Policies breeding State Level Plans according to which Implementing Agencies execute pre-	Process is bottoms-up with Community Animators facilitating and motivating community leaders and volunteers who take

	determined activities to achieve targets set in their plans.	responsibility to accomplish certain components of the Community's response to HIV.
4.	Mobilizes the target group from without collectivizing them and demarcating the high risk groups or PLHIV thus losing confidentiality and singling them out for stigma and discrimination	No heterogeneity introduced in the Community, confidentiality remains intact longer and at the most is only shared, and therefore members with high risk behaviour are not prone for stigma and discrimination
5.	Collectivizing for advocacy and policy leads to introduction of new structures and cultures in the community	Uses existing structures and cultures in the Community.
6.	Implementing Agencies fix the Targets without consulting the target groups.	Community Volunteers and Leaders are under no compulsion to fix targets. If they do they fix their own targets in discussion with their peers.
7.	Revisions of targets or course correction in project strategies and activities have to be decided and approved by those higher in the hierarchy, often causing delays.	The Community members and volunteers carrying out the activities themselves report and decide in the Community's meeting.
8.	Pressure to achieve targets felt by implementing agencies	Targets that are set and revised by own volition cannot exert pressure
9.	Project Performance depends on completion of activities and achievement of Targets detailed in the GNATT chart	The Community does not consciously gauge its own response, but sets out to solve or address problems and issues faced by it.
10.	Interventions are heavily dependent on financial and technical support from funding and capacity building agencies.	Uses as far as possible their own resources, with a binding resolve to be fiercely independent.
11.	Financial inputs are high	Almost negligible
12.	The numbers covered, treated, or addressed per rupee spent is low. Often National policy development and administration costs and those of the State offices are not accounted in the cost-coverage analysis	Almost everyone in the community is covered while the cost involved is that of the facilitator only. Hence, per rupee coverage is high.

If there are any comments on this, I am most open to correction and would like to learn.

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**Bobby Ramakant, Health and Development Network, Lucknow**

The discussion on AIDS Competence process is indeed going so well, and rich with sharing of experiences and learning! I am sending two articles that I wrote for HealthDev.net, when we were in northern Thailand:

The one at <http://www.healthdev.net/site/post.php?s=471> is titled, 'Learning from youth groups in Ban Pang Lao on AIDS response'. A quote from this article that provides evidence that ACP works is:

'Sustained local responses strengthened by the needed services and supportive policies brought down the HIV prevalence in Thailand from 18% in 1991 to 1.4% by end of 2005 (Source: UNAIDS Report on the global AIDS epidemic 2006). However in this community of Ban Pang Lao, the HIV prevalence remained low even when the country was hard-hit by AIDS in a generalized manner. The credit goes to the local responses undoubtedly.'

<http://www.healthdev.net/site/post.php?s=472> gives us the second article called, "Use 'both sides of the brain' to respond to AIDS". A quote from this is:

'Some diseases don't have a social impact like diabetes, hypertension, but some like alcohol, AIDS and drugs have a profound social impact. So when one person is impacted by alcohol, drugs or AIDS, whole family or affected community should be considered to be 'sick' or 'ill' because all of them have to face the consequences. Therefore they all need to understand how to manage and respond to the 'illness' effectively" explains Suwat.'

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**Dr. Dinesh Agarwal, UNFPA, New Delhi**

Thanks Dr. Rafique for clarifying this. However one is not yet clear as how this gels with transition from NGO driven TIs to CBOs or key community driven comprehensive TIs as reflected in the NACP-III. Should we assume that ACP in essence will be focused on key communities and not in general population. I am not sure about this. Grateful if you can enlighten us about this also.

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**Mayank Agrawal, NACO, New Delhi**

It is interesting to know about AIDS Competence Process. In India, we have adopted the TI model driven by NGOs. A major NACP-III objective is to build up the capacity of communities so that the CBOs may take up prevention activities themselves. After going through different queries posted in this mail, I am still not clear about how ACP works. Is it for targeted population or can be extended to general but vulnerable populations such as youth? The Thailand example is good, but the social and cultural norms are very different in India. If there are any experiences relating to ACP in India, I would like to know about them and visit the sites.

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**Dr. E. Mohamed Rafique, UNAIDS India Office, New Delhi (response 3)**

I appreciate your interest in the AIDS Competence Process (ACP). To answer, '*how this gels with transition from NGO driven TIs to CBOs or key community driven comprehensive TIs as reflected in the NACP-III*', I will have to delve into the experiences we had during our visits we made to Aizawl last year for documenting the AIDS Competence Process for our Action Group. Also for your next query: '*Should we assume that ACP in essence will be focused on key communities and not in general population*'; I will try my level best to inform and share, from my observations, hoping that those in the field like Bobby Zachariah and Sanghamitra Iyengar will correct me.

In Aizawl, we learnt that the Community Health Action Network (CHAN), which has a TI program of Salvation Army, in the field of Substance Abuse, HIV prevention, AIDS Care and support, and with women in sex work, has demonstrated scaling up into most districts of Mizoram using ACP, both in the key communities and in the general population. The TI programme of CHAN is for groups at high risk, especially women in sex work and IDUs. The Family Counselling Centre provides counseling services in multiple areas and, includes HIV pre-test and post-test counseling.

ACP is a belief in people's capacity to solve their own problems: Given that the General Population in Mizoram is structured around communities, it was easy for CHAN to support both the TI program and the ACP one. Moreover, Salvation Army as a church was well placed to use its infrastructure to enter its own community, and other groups through affiliated organizations like Young Men's Association and Young Women's Association, which are present all over Mizoram with lakhs of members.

CHAN set up a Vocation Training Centre that provides training for clients to help interested community members become self-employed and self-sufficient as part of the change process to ACP. The Home and Neighborhood Care programme provides counseling, education, care and training to the members of the families affected by HIV and their neighbors, in order to improve the functioning of existing community support groups.

CHAN has recently been re-organizing itself, to take on a more facilitative role in ACP, whereby it can guide other NGOs to nurture more community-based approaches. A conscious choice has been made to move away from direct Targeted Interventions; CHAN now operates through the Territorial Facilitation Team, which plays a facilitative role in helping the local communities identify and deal with the problem. The Territorial Facilitation Team has been further decentralized to District Facilitation Teams, which handle the facilitation processes in their respective areas. The approach is to build a relationship, discuss the community concerns, encourage them to identify their strengths, find appropriate solutions for their problems, helping them implement their solutions, evaluate their action and outcomes, and come up with new action.

During our visit, we went to Chatlang and Dinthar. At Dinthar, it was impressive to see that the Community or general population in the area has taken over the whole program including its financing. Moreover, many nearby general population groups and communities have started transferring this ACP model with fair degrees of success.

Hope others can add in where, I have not been comprehensive.

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**Rituu B. Nanda, UNAIDS India Office, Delhi**

The Asian Development Bank (ADB) and the Constellation started a programme for building the capacity of NGO's in six countries to develop AIDS Competence with the communities they work with in 2007. Interested NGOs practice the various elements of the AIDS Competence process jointly with Constellation coaches. Eventually, the representatives of these NGOs will form a National NGO Facilitation Team. I have attended two modules of the programme as an observer.

I would like to share my experiences with the AIDS community. The participants have been very enthusiastic about the process and have come to believe in the power of the ACP tools. However, when they go back to their organisations they do not get the firm support to implement it. Their organisations see it as a voluntary thing they learnt and added to their knowledge. Moreover, the other staff does not see its feasibility and compatibility with the Targeted Interventions they are engaged in. With virtually little organizational support and no funding allocated for AIDS competence, it is not picking up. In addition, people often question the viability of the approach in low prevalence areas and among general communities.

We need to identify common aspects in ACP and activities happening in the field, which will encourage the leaders to give it a shot and connect the concept of ACP with the goal of the organisation. Most importantly, if the Government understands the concept and sees the power of communities in taking up their own issues, only then can ACP blossom in India.

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**Gaston Schmitz, The Constellation for AIDS Competence, Thailand**

Thanks for the very interesting exchange so far. Rituu B. Nanda is touching on some very relevant issues for the Constellation at the moment.

*'However, when they go back to their organisations they do not get the firm support to implement it'.* What determines a successful transfer of the ACP after several workshops and experiences? We applied the ACP on Malaria together with Roll Back Malaria in ten African countries. We started with a kick-off workshop in Kenya with one participant per country. Afterwards some of the participants transferred the approach organization-wide (e.g. World Vision in Sierra Leone or UNICEF in Guinea Bisau). No additional funding was made available for this as it complements current programs. The organization implements the same programs, but in a different way. The ACP complements service delivery and increases its effectiveness as it is driven by local responses. However, other participants had less success in transferring the approach. We observe the same with the ADB program. Both the organization involved as well as the participant's efforts and skills to transfer certainly play a role in this. Funding is certainly encouraging, but not a prerequisite for success.

*'If the Government understands the concept and sees the power of communities in taking up their own issues, only then can ACP blossom in India.'* The Constellation highly recommends government involvement, though it is not always easy. In the ADB program, our primary focus is NGOs, but government representatives are invited and encouraged to participate. The Constellation believes that you change policy when the policy maker is changed. We have seen policy makers that attend our community (SALT) visits in Northern Thailand, Rwanda or Indonesia and experience the power of local responses. They are convinced by experience, not by expert opinions. With our partner UNFPA in Indonesia, we have seen a great commitment of three city mayors to allocate money to implement the ACP in generalized populations in their cities. This happened after they experienced SALT visits in their own communities. For a good illustration, read the story of Novi from the Pontianak city AIDS Commission [http://www.aidscompetence.org/content/news/news\\_february\\_2008/novi.htm](http://www.aidscompetence.org/content/news/news_february_2008/novi.htm)

*'In addition, people often question the viability of the approach in low prevalence areas and among general communities.'* Our experience in low prevalence countries and communities in DR-Congo, Mali and even Belgium show the strength of the approach. The facilitation can be more challenging in the beginning, but by building a community's dream, the issue of HIV very often arises. However, in some West-African countries, Malaria was indicated to be a larger problem and Malaria Competence is used widely. In DR-Congo, the ACP is about to be implemented countrywide under generalized populations with the support of the national AIDS Commission. The process is driven by a strong and diverse local facilitation team. [http://www.aidscompetence.org/content/news/news\\_november/rdc\\_november.html](http://www.aidscompetence.org/content/news/news_november/rdc_november.html)

These are some experiences the Constellation had in other countries. I do agree with Rituu B. Nanda that we should identify common aspects. We should appreciate and learn from the great efforts that are being done in India so far.

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## **R. Meera, Women's Initiatives (WINS), Tirupati**

Person working the field of HIV is struck by the complexities of issues the epidemic poses and there is an immense need to deal with these issues as they have to handle the entire gamut of life be it love, sex, birth or death.

Most often women have been perceived as "recipient" of information be it for HIV prevention, or care and continuum programmes. However, this option leaves them with less or no choice to critically analyze the contents and be argumentative of the processes, which is thrust upon them. Women still have not got used to question gender and sexuality related questions either in private or in the public sphere.

In TI programs, the staffs are trained to speak and approach the members of the community on the issues, which often offend middle class morality. Say for instance Condom demonstration. Nevertheless, when we work in the villages, there are instances where they come up with one-liners, folklores, mythological stories that help them to carry a conversation about males and females provided the person has time to listen. This is a critical and crucial link for the workers.

HIV Project staffs are mostly recruited from the "educated" sections of the society. They are armed with double standards, loaded questions, and are fond of catch phrases. While they set out to work with the vulnerable groups (read as TIs) they have not questioned various things be it religion, and the conventions or social mores in their lifetime. Whatever belief they hold, they air them without bringing about a "consensus".

When we compare this, with the approach of geographical community, they are accessed in their "settings" and the best bet and the benefit is that they are allowed to question and then they get involved into this processes as secular and democratic persons, than simply being targeted with the messages and programmes and handing them over in a straight jacket. This I found to be the most exciting and powerful strategy which seeks and solicits the support of the majority of persons from the geographical community.

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**Joe Ngamkhuchung, North Eastern Drug/HIV Training Centre (NEDHIV), Dimapur**

### **The Nagaland ACP Response**

It was in 2007 through internet that I came across the invitation for ACP. I attended the first ACP training at Bangalore on July 2007, followed by the second in Mumbai in November 2007. I missed the third held in Chennai as the dates coincided with our State Assembly Elections in March 2008.

Nagaland a Christian State with a small population of 19, 88, 636 with sixty-four percent literacy and eighty percent HIV awareness, is the sixth HIV prevalent state in the country. Eighty percent of the people are agri-based population in rural areas. ACP woke me up to the idea of community AIDS competency. I was fascinated by the ACP concept. Villages have not only problems but enormous resources in manpower, financial resources, infrastructure and the very traditional and cultural background of community work, community sense, could be turned into a dynamic response for HIV/AIDS problem.

Following my exposure to ACP, I conducted orientation of my staff to ACP concept and initiated ACP in three sub-centers of our work. I made SALT visits to the centers. There is a general enthusiasm about the new concept as a tool for HIV response. ACP is new to Nagaland State. The new concept takes time to become a regular habit. Added to that is the diversity of dialects in the State. While English is the State language, the villagers speak mostly their own dialects.

ACP has begun to make a difference in community response. It has given a new dimension into collective strength and collective effort as a possible solution to a village problem. The concept suits the tribal mentality of "community work" "community thinking" and "community decision making" and community approach to everything affecting the village.

What I have learnt as a project leader with regard to ACP is the importance of tapping community strength and community ownership. While external projects are time bound and continuity is not guaranteed, community is sustainable. "Strength in the pact" is a collective

approach which is effective and ownership driven. ACP builds on the community strength and its prospects are long term.

The prospect of State level implementation is bright as the village have similar social and traditional structures and set ups. **During 2008- 2009 ACP is being incorporated into our Targeted Intervention Projects in 24 rural villages.** ACP also will address the core PLHA community in Dimapur. We have over 360 PLHIV.

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**Dr. E. Mohamed Rafique, UNAIDS India Office, New Delhi** *(response 4)*

I am glad to see that you are interested in ACP. Your enthusiasm to learn about the ACP sites in India and visit them does encourage us. I am sure you will support ACP after you attend the June 2008 meeting.

Apart from the two Indian ACP sites documented in <http://www.solutionexchange-un.net.in/aids/resource/res-01-270208-01.pdf>. You will meet others from India and a few members of the Constellation during the June meeting. I hope that you can learn more than this discussion on what the action group recorded in India. Also during the June meeting, I have proposed that a few skeptics of ACP must also be invited. As the supporters of ACP are few in number presently, their apprehension of this suggestion is comprehensible. I remember in the Visioning Workshop when the, 'Community Response to HIV', was presented there were only skeptics. So much so, it forced me to stay back in the break away session on, 'Community Response to HIV', just to see whether I would have to intervene and balance the discussion, though I was not a convert to ACP then! Yet, I did not spend time in the other two break away sessions namely those on Stigma and Universal Access.

Our maiden attempt at documenting ACP in India is only qualitative. As suggested by other Constellation members, we are presenting this to UNAIDS India and asking them to fund a quantitative study that could be done by a third party, selected by UNAIDS. Off hand, I can think of organizations like Futures Group. Open to suggestions.

Always willing to pick up from what ACP has seen from other parts of the globe, following the Competence path in the light that the Constellation guides.

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**Marlou de Rouw, The Constellation for AIDS Competence, France** *(response 2)*

Many thanks, the plans for a quantitative ACP study is welcome!

MACEPA (Path) is currently carrying out an evaluation of the Malaria Competence Approach. There is probably advantage in learning from, or with them in the plans for the quantitative study in India. Our contact person is based in Thailand; his research will focus on three countries in Africa.

It was nice to cross-post your message for the India AIDS Community at the AIDS Competence group on eWorkspaces. If there are some interested to join and not registered to the AIDS Competence eWorkspace, let me know, I'll invite you immediately.

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**Dr. Ian Douglas Campbell, The Constellation for AIDS Competence, UK**

May I suggest some thoughts?

Perhaps it is right to delay conclusions just yet. Keep the idea of 'measurement' going but consider the fact that a human capacity for response or AIDS Competence vision and approach cannot be adequately evaluated externally and quantitatively. It needs a qualitative and semi-quantitative approach from the beginning that is shared with communities and driven by them. It must be shared in terms of implementation, planning, and understanding. It must be owned by the communities and NGOs. It must not happen before actual sustained work and outcomes are happening in terms of both local response expansion -a core indicator - and organizational adaptation . It must recognize that the communities are not the subjects only but the Constellation, UNAIDS, the NGO's are the subjects. It needs time and consultation to do this well. The primary goal now must not be to prove anything to skeptics-that may come but it is later. It is unlikely that human quality can really be 'proven ' anyway. For now the skeptics must occasionally be inspired to see that they need to support where they can for at least a time. The National Facilitation Team (NFT) by the way, as it emerges may be a helpful process to build into the measurement process but that is something that will and should emerge from the AIDS Competence approach of the NGO's communities and support people and organisations . It is delicate process in terms of emergence and in itself is a process that needs evaluating in time, and it will be a vehicle for ongoing measurement

So the complex subject of measurement must not be developed prematurely at the expense of success of the people, who are trying to succeed and who need to be maximally encouraged right now by multiple connections face to face. Then, the wonderfully exciting possibility of community-to-community transfer can actually be seen. Subsequently transfer mapping, PAR, community counselling are in place and the foundations to proper measurement are established. This is the priority for money expenditure right now. Then an outside group can take their place not before.

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**Geoff Parcell, The Constellation for AIDS Competence, U.K.**

Thanks for these profound thoughts Ian, especially the reminder about we being the subjects, it does seem that money is found easier for measurement than for collaborative capacity building.

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**Dr. Nabeel M. K., Kannur Medical College, Kannur**

As the discussion is progressing, my understanding of ACP is getting better. In fact, it is much broader and deeper in perspective than what I had understood before. Thanks to Shyamala for the query, and others who responded, especially the ACP enthusiasts that include the moderating team themselves.

Maybe because of my error in perception, I was feeling a bit uneasy somehow in the course of discussion when it sounded like it was either, or between TI and ACP. Now I feel much better as the discussion is thinking seriously about how to incorporate ACP in TIs. The comparative analysis with TI was of course useful in understanding ACP better. However, once we incorporate ACP in our TIs, then such differences should become less and less. In other words, ACP as we understand now should positively influence the entire gamut of response to HIV, which includes TIs as well.

Though not labeled and publicized as ACP, in Kerala we witnessed it, when there was a shift in focus from NGOs to CBOs in running TI projects. "Community ownership" was one buzzword heard in this context. At least some project managers were not happy with this shift, as they felt that a large-scale roll out of this "ownership transfer" was premature at that stage. Some of them would have also felt that the good work they had been doing in their TI projects is not properly

acknowledged by this move. On the other hand, such apprehensions were countered by alleging that these people -mostly NGOs- are really worried about losing the control over funds associated with traditional TI approach and the usual phrases like "there are more people living on HIV than those living with HIV", made the rounds. I fully acknowledge that the issue in question cannot be dissected out into black and white as we have many shades of gray in between. Without explaining further, I hope you all would appreciate the importance of "change management" in such scenarios. Adding to the obstacles in this progress will be the organizational frictions creeping into some of the positive networks. ACPs results could be enhanced further if issues like these are adequately addressed as we move ahead.

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### **Rajaratnam Abel, Consultant, Chennai**

I am happy to note the experience shared by Shyamala that their initial TI effort was not successful. This is always the case whether it is growth monitoring for malnutrition or Vitamin A solution, or iron and folic acid. Without concomitant behavior change at the community level these interventions good in themselves will not have desired impact on the problem. I would like to share two different experiences.

The first one relates to RUHSA's work in K. V. Kuppam Block of Vellore District in Tamil Nadu. Since we did not agree fully with the TI we did not receive any funds. That forced us to educate and empower the community. Our data shows we had very few cases and ANC HIV prevalence was rapidly declining. Someone else needs to validate this claim and learn if any lessons are available.

The other experience relates to the work of CARE or VTRC in Madurai area. Almost right from the beginning their care and support was community and home based. There has been phenomenal change among the community including the outlook of PLHIV. I would like to call it the beginning of the Post ART Era in Tamil Nadu.

Recently Lancet published an article entitled "Reduced mortality with home-based HIV treatment in Uganda". A comment was made on that article which can be accessed in the following site. It may require a password. The substance of the comment is that home and community based care and support is an empowering process which is beginning to see changes in Tamil Nadu.

<http://www.thelancet.com/journals/lancet/article/PIIS0140673608603207/comments?action=view&totalComments=2#1540>

Based on this observation I had raised a query in the SE AIDS. While there were a few responses, some critical, there was one response from Nagaland, which echoed the same thought. Something is happening at the community level, which has not been adequately captured.

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### **Dr. Jean Louis Lamboray, The Constellation for AIDS Competence, Belgium**

A few documents from [http://www.aidscompetence.org/content/7\\_downloads.htm](http://www.aidscompetence.org/content/7_downloads.htm) that is the download page of the AIDS Competence website will help this lively discussion on ACP. It has a full section on AIDS Competence Process Tools.

<http://www.aidscompetence.org/content/documents/Final%20editorial%201dec2007.doc> gives a brief write up, about a page, titled, "AIDS: let us learn from those who progress", which served as an editorial for the World AIDS Day 2007.

[http://www.aidscompetence.org/content/documents/article\\_jean\\_legastelois\\_english.doc](http://www.aidscompetence.org/content/documents/article_jean_legastelois_english.doc) is an article by Jean Legastelois titled, "HIV/AIDS In Democratic Republic of Congo - Local communities meet the challenge"

At the BTC <http://www.btcctb.org/showpage.asp?iPageID=2948&slangcode=NL> is a video clip titled, 'Competences in the fight against AIDS'

<http://www.aidscompetence.org/content/documents/080222presentation.ppt> has a power point on ACP entitled, "HIV/AIDS - There is another way!", which incidentally is also the title of my autobiography. I quote its first page:

'Yes, there is a better way! The battle against AIDS can be won, this I know, not because of any sudden personal revelation, but because of impressive, little-known successes among communities and countries in Africa and Asia that I have worked with who have been able to cope with the epidemic of HIV and hold it at bay.

When people, when communities assume personal responsibility for their health, they far surpass the efforts of health services and international institutions in combating an urgent health problem. Thirty years of experience in public health service in Africa and Asia have taught me that there is an actual "social vaccine" that grows out of these successful campaigns of the people against an epidemic like HIV. I have been able to witness these successes first hand, thanks to my work in Zaire, other African countries, and my extraordinary experiences with my friends in Thailand and in conjunction with my work with the United Nations.

So, I invite you to come along with me and share these many extraordinary encounters as well as the harsh realities of my experiences. In this way, you will, I hope, come to share my conviction that there is a better, more effective, more humane way, to respond to the HIV epidemic.'

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### **Bobby Zachariah, Salvation Army, Ahmednagar**

It is exciting to experience what the communities affected by HIV can do, when they are facilitated to respond to their concerns, based on their strengths. The community's strategies to combat the issues which concerns them is often community specific even though common principles can be derived based on analysis of experiences of different programs. Often the collective experiences of the community in the past play a strong role in their initiatives. This can be seen from the experiences of communities in different parts of India, which though have different cultures, and languages show the common themes of love and concern towards their co-community members, a belief and interest to make change happen, and hope generating through leadership to face their own future.

For an organization which is interested in helping the community address HIV, based on community initiated strategies, the way of thinking or working in dealing with the communities are based on the belief that communities can act from their strengths. Volunteer community action teams are often formed because of the discussions. The organisations thus facilitate the community to think and come up with their solutions through ongoing discussions and reflections in the neighborhood. Systematic home visits and use of participatory methods are tools to help this happen. To ensure ongoing learning happen, the organization also needs to help the community analyze the process, actions and help learn lessons.

Whilst human resources like time, willingness and interest of community members, are acknowledged as the most important one, they also develop capacity to access resources like from the relevant government departments, private donors, services from Testing Centers,

hospitals where they can access treatment and the like. The NGO's can play an important role in helping these partnerships happen.

We have been helping the communities use Participatory Action Research as a tool to track and measure the progress made by them. One summary report is at <http://www.solutionexchange-un.net.in/aids/resource/res-01-190408-01.doc>

As it is the experience of many organisations, the basic principles of this approach can be transferred to deal with other issues of community concern as in trauma and stress created due to the tsunami, malaria, diabetes, disability and so on.

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### **Steve Glovinsky, Solution Exchange, New Delhi**

One of the joys of being the Adviser for Solution Exchange, and reading these messages, is that I get to learn of your inspirational experiences and watch them evolve into something that has the potential to really impact the people you are all aspiring to help. While I am not active on the AIDS Community, maybe I can help bring another perspective to this conversation, which is the perspective I am currently engaged in, and which Solution Exchange is but one manifestation of: how sharing and collaboration can get things done so much more effectively than individual effort. Solution Exchange has proven to be an effective way of knowledge sharing among practitioner Communities. Geoff Parcell, mentioned below, has contributed a concept that I understand is used by the ACP - the "River of Life", which has proven to be an effective way of knowledge sharing among "geographical" communities. It is described in the book he wrote with Chris Collison, "Learning to Fly" which is a great source for many practical applications of learning by sharing. It is very simple - ten parameters each with five levels of competence. When many communities do the assessment, matching communities can take place, bringing together communities with the most competence in one parameter with communities having the least. Geoff tells a story of a team from Niamey, Niger visiting Lyon, France as a real example of how such widely different communities can learn from each other.

When I monitored the Action Group session last year and heard Sanghamitra Iyengar speak of how Samraksha was working with 800 geographical communities, I was reminded of the 'River of Life' concept, and saw an opportunity to bring it into the tool box of AIDS mitigation approaches. Perhaps it can be an outcome of this exchange...

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### **Amrik Singh Kapoor, Consultant, New Delhi**

I have read with interest many good experiences that have come out from numerous stakeholders. I have very little to say since I do not have much India-related experience in AIDS Competency Process. Whatever little experience I have about regional or community oriented approaches in HIV relates to African countries, which bore the first brunt of the pandemic and despite many gains through long-term battle with this problem, and are still grappling with its continued onslaught.

With whatever name one may call it, ACP approaches have abounded with a view to enabling communities and build their capacities to handle some HIV activities at their own level. Strengthening the fighting spirits and skills of the community has always assumed greatest priority everywhere, in every programme worth its name. Some of the African countries like Zimbabwe and Uganda that I had a chance to observe and Zambia where I was involved in the field, community ownership and competence got top priority. In these countries, exemplary

community programmes were in operation whose efficiency was studied by many. In the areas mentioned above community capacity building was achieved through numerous approaches. To bring about community self reliance in fighting HIV and to create socio-economic resources for the same, vocational trainings for community based income generation activities were introduced where small scale agriculture, sowing and selling of vegetables, piggery, poultry farming and at places credit and thrift societies became operational. These community-operated activities were for the benefit of the community affected and impacted by HIV.

At the face of it, this may look a petty or a small effort, but it is not as easy as it appears and should not be taken lightly. First, it is important to identify local, committed leaders who can give their time and energy to the programme. Suitable training and orientation in handling HIV activities, especially home based care and harnessing community volunteers ready to man the activities need always to be given due importance. All said and done, we may overcome 'denials' and 'stigmas' but a dogged perusal is a must.

I am not very much aware about any qualitative assessment of this competence process and at many places it is not known as ACP but rather community based programmes and community initiatives. However, such processes did mitigate quite some sufferings and narrowed the chasm between organized or official programmes and hard operational realities in the field.

Just a word about difference in Targeted Interventions and ACP. Apart from what my learned friends have striven to ably explain the distinction, may I submit that the Targeted Intervention is mostly from without, from the implementing agency, which may be a project, an NGO or even a public body. It is targeted at specific Behavior Groups with several commonalities. Say in HIV context it can be any high risk or most vulnerable groups having common problems. Whereas ACP is sought to be handled in such a manner that after due training and orientation, it emanates from within the community to take HIV issues in community's own hands. The community is empowered to become self supporting or self reliant and competent to counter this problem. Need Assessment is paramount in both the cases.

Lastly, some resources that is not so recent, and so gives ideas of how ACP began in Africa: [http://www.aidsuganda.org/pdf/Presentation\\_METHODODOLOGY.pdf](http://www.aidsuganda.org/pdf/Presentation_METHODODOLOGY.pdf) has a PowerPoint presentation on the methodology used in Uganda to reduce their HIV prevalence. Uganda experienced a sero prevalence peak of about 30% in 1992 in some sentinel sites. Since then there has been a progressive decline in prevalence to an average of 6.5% among pregnant women (Surveillance Report June 2002).

[http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR\\_en.pdf](http://data.unaids.org/publications/irc-pub06/JC1144-Evaluation-UNITAR_en.pdf) is about the Evaluation of the UNAIDS UNITAR AIDS Competence Programme

<http://eritrea.unaids.org/Publications/hivaidslearningworkshopforuniorstaffmay2004-wkpreport.doc> is a report on the HIV and AIDS Learning Workshop for Senior Staff of UN Agencies – Toward AIDS Competency.

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### **Dr. Zoengari, Independent Consultant, Aizawl**

I would like to share my experiences with the Salvation Army, Community Health Action Network (CHAN), Aizawl, working in various capacities, and presently as consultant.

CHAN has been working since 1991, in the field of Substance Abuse, HIV and Female sex workers. The foundational belief has been that caring for drug dependents, alcohol dependent persons, sex workers, distressed women and people living with HIV, will provoke expanding

circles of change in their lives. CHAN ran a focused targeted intervention programme for groups at high risk, especially women in sex work and IDUs. The Family Counselling Centre provided counseling services in multiple areas and, includes HIV pre-test and post-test counseling. A Vocation Training Centre provided training for clients to help them become self-employed and self-sufficient. The Home and Neighborhood Care programme provided counseling, education, care and training to the members of the families affected by HIV and their neighbors, in order to improve the functioning of existing community support groups. The activities focused on IEC, care and counseling. The basic objective was that of preventing the spread of HIV infection among the groups with high-risk behavior.

CHAN has re-organized to take on a more facilitative role, whereby it can guide other NGOs to nurture more community based approaches. A conscious choice has been made to move away from direct or targeted interventions; CHAN now operates through the Territorial Facilitation Team, which plays a facilitative role in helping the local communities identify and deal with the problem. The Territorial Facilitation Team has been further decentralized to District Facilitation Teams, which handle the facilitation processes in their respective areas. The approach is to build a relationship, discuss the community concerns, encourage them to identify their strengths, find appropriate solutions for their problems, helping them implement their solutions, evaluate their action and outcomes, and come up with new action.

CHAN's work with communities has evolved from earlier experiences with marginalized groups, like providing shelter for women in sex work, or pastoral care for people addicted to substances. The approach itself is significantly related to other experiences of the Salvation Army International Teams as well the AIDS Competence Process, promoted by the Constellation for AIDS Competence. Different tools and techniques from the AIDS Competence processes are used within the programmes. As a faith based organization, CHAN has also been significantly influenced by the church and its teachings. It has also been able to utilize its own relationship to a church, and the centrality of the church to life in Mizoram, to facilitate its engagement in the community. This is manifest in different ways in the activities, both at a practical and a philosophical level. At a practical level, it is this link with the church, and its different groups like local corps, Salvation Army youth groups and so on, which facilitates CHAN's engagement with the communities. At a philosophical level, concepts like love, compassion and caring, are largely articulated using the language of Christian discourses.

CHAN uses the methods of participatory group exercises, developed by the Salvation Army, in the facilitative process. The different tools and techniques used are community counselling, development planning framework, self assessment framework, facilitating the formation of support groups in the community for PLHIV and facilitating the linkage of community, family and neighborhood. The SALT process of Stimulation, Appreciation, Learning and Transfer guides much of these methodologies.

CHAN is currently involved in conducting electoral visits to different areas and facilitating community and organizational response based on the principles of Human Capacity Development. CHAN is now working with the vision of building motivated local teams in the communities. Involving people in the homes and neighborhood including different community institutions and leaders in the activities, community to community transfer of learning, synthesizing the lessons learnt, and networking and advocacy with other government and non-government agencies, are some of the ways of making the processes deeper and more sustainable.

An example of Community Ownership and Action: CHAN has been working with Dinthar community since 1997. In 1998, the community decided to set up a counselling board, as part of the Joint Action Committee. This board consists of church leaders, and other opinion leaders in the village. The Counselling Board reaches out to the people addicted to alcohol or other

substances, people living with HIV and sex workers in the community and their families, and tries to make them change their behavior. A special counselor is appointed for the purpose and paid a salary, from community contributions. In 2005, the Dinthar community, based mostly on community contributions, with some minimum help from the Mizoram Government set up a half-way home to provide counseling and rehabilitation services. The home is run by the counselor, and the pay of the counselor and the running costs of the home are met by community contributions.

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### **Koen Van Rompay, Sahaya International & University of California, USA**

I am learning a lot from many of you about the AIDS competence process, for which my big thanks. I think that a peer education program that we started a few years ago shares some common themes with it. We just published the manuscript that describes the program, and I am pasting the abstract below. The full manuscript can be downloaded from this link:

<http://www.human-resources-health.com/content/6/1/6>

### **Empowering the People: Development of an HIV Peer Education Model for Low-Literacy Rural Communities in India**

#### **ABSTRACT**

**Background:** Despite ample evidence that HIV has entered the general population, most HIV awareness programs in India continue to neglect rural areas. Low HIV awareness and high stigma, fueled by low literacy, seasonal migration, gender inequity, spatial dispersion, and cultural taboos pose extra challenges to implement much-needed HIV education programs in rural areas. This paper describes a peer education model developed to educate and empower low-literacy communities in the rural district of Perambalur (Tamil Nadu, India).

**Methods:** From January to December 2005, 6 non-governmental organizations (NGO's) with good community rapport collaborated to build and pilot-test an HIV peer education model for rural communities. The program used participatory methods to train 20 NGO field staff (Outreach Workers), 102 women's self-help group (SHG) leaders, and 52 barbers to become peer educators. Cartoon-based educational materials were developed for low-literacy populations to convey simple, comprehensive messages on HIV transmission, prevention, support and care. In addition, street theater cultural programs highlighted issues related to HIV and stigma in the community.

**Results:** The program is estimated to have reached over 30,000 villagers in the district through 2,051 interactive HIV awareness programs and one-on-one communication. Outreach workers and peer educators distributed approximately 62,000 educational materials and 69,000 condoms, and also referred approximately 2,844 people for services including voluntary counseling and testing (VCT), care and support for HIV, and diagnosis and treatment of sexually-transmitted infections (STI). At least 118 individuals were newly diagnosed as persons living with HIV (PLHIV); 129 PLHIV were referred to the Government Hospital for Thoracic Medicine (in Tambaram) for extra medical support. Focus group discussions indicate that the program was well received in the communities, led to improved health awareness, and also provided the peer educators with increased social status.

**Conclusions:** Using established networks (such as community-based organizations already working on empowerment of women) and training women's SHG leaders and barbers as peer educators is an effective and culturally appropriate way to disseminate comprehensive information on HIV/AIDS to low-literacy communities. Similar models for reaching and empowering vulnerable populations should be expanded to other rural areas.

Dr. Avnish Jolly, Consultant, Chandigarh (response 2)

To understand AIDS Competence Process it is important to understand Competence first. Our Solution Exchange Adviser has guided us well in the direction of understanding AIDS Competence and Knowledge sharing and in the same note, I would like to recommend a "CASE STUDY By Seth Kahan: Sharing Knowledge at the AIDS Competence Programme". This four page document gives how Geoff Parcell and Jean Louis Lamboray evolved the AIDS Competence Process. The link is

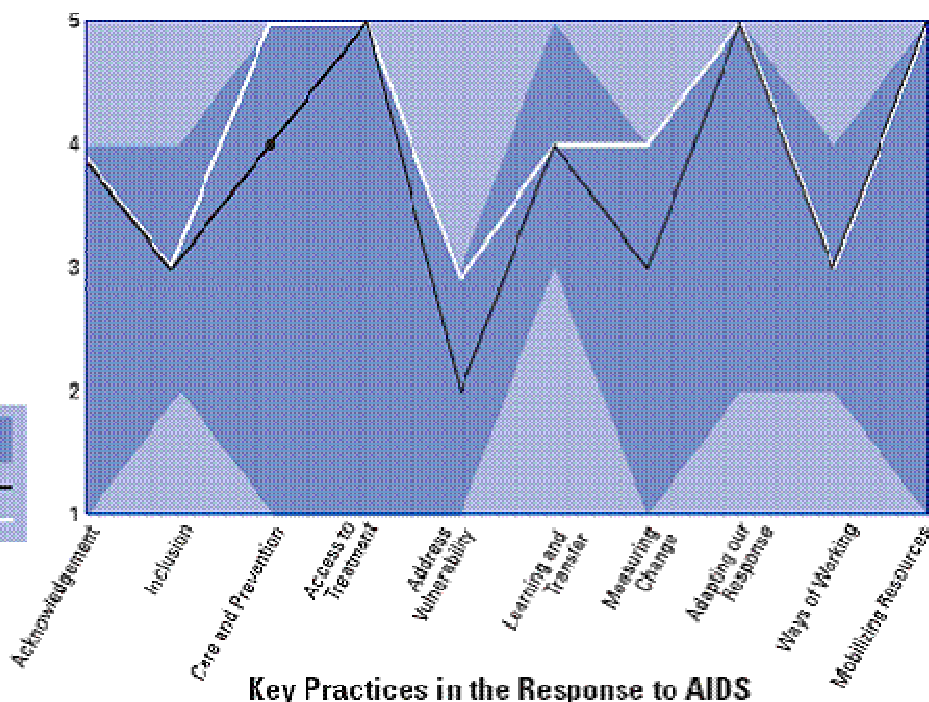
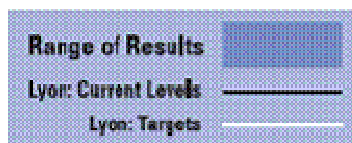
[http://www.sethkahan.com/Kahan\\_UNAIDS\\_UNITAR\\_AIDS\\_Competence.pdf](http://www.sethkahan.com/Kahan_UNAIDS_UNITAR_AIDS_Competence.pdf)

I provide from that brief study the, 'River of Life' diagram and how we can derive this 'river' reflecting the range of self-assessment results from the, 'Self-Assessment Table' given below it.

**Figure 3.**

**The River of Life**

Range of self-assessment results from teams attending the 2003 Knowledge Sharing Workshop on City Responses to HIV/AIDS, with current levels and targets for the city of Lyon.



Source: ACP, 2003, Annex 7 (1)

**TABLE 1: SELF-ASSESSMENT FRAMEWORK FOR AIDS COMPETENCE**

Key Practices	Competence level				
	1 (BASIC)	2	3	4	5 (HIGH)
<b>Acknowledgement</b>	We know the basic facts about HIV/AIDS, how it spreads and its effects.	We recognize that HIV/AIDS is more than a health problem alone.	We recognize that HIV/AIDS is affecting us as a group/community,	We acknowledge openly our concerns and challenges of	We go for testing consciously. We recognize our own

<b>&amp; Recognition</b>			and we discuss it amongst ourselves. Some of us get tested.	HIV/AIDS. We seek others for mutual support and learning.	strength to deal with the challenges and anticipate a better future.
<b>Inclusion</b>	We don't involve those affected by the problem.	We cooperate with some people who are useful to resolve common issues.	We in our separate groups meet to resolve common issues (e.g., PLWA, youth, women).	Separate groups share common goals and define each member's contribution.	Because we work together on HIV/AIDS, we can address and resolve other challenges facing us.
<b>Care and Prevention</b>	We relay externally provided messages about care and prevention.	We look after those unable to care for themselves (sick, orphans, elderly).  We discuss the need to change behaviors.	We take action because we need to, and we have a process to care for others long-term.	As a community we initiate care and prevention activities and work in partnership with external services.	Through care we see changes in behavior which improve the quality of life for all.
<b>Access to Treatment</b>	Other than existing medicines, treatment is not available to us.	Some of us get access to treatment.	We can get treatment for infections but not ARVs.	We know how and where to access ARVs.	ARV drugs are available to all who need them and are successfully procured and effectively used.
<b>Identify and address Vulnerability</b>	We are aware of the general factors of vulnerability and the risks affecting us.	We have identified our areas of vulnerability and risk (e.g., using mapping as a tool).	We have a clear approach to address vulnerability and risk, and we have assessed the impact of the approach.	We implement our approach using accessible resources and capacities.	We are addressing vulnerability in other aspects of the life of our group.
<b>Learning</b>	We learn from our actions.	We share learning from our successes	We are willing to try out and adapt what	We learn, share and apply what we	We continuously learn how we can

<p><b>and</b></p> <p><b>Transfer</b></p>		<p>but not our mistakes. We adopt</p> <p>good practices from outside.</p>	<p>works elsewhere. We share</p> <p>willingly with those who ask.</p>	<p>learn regularly, and seek</p> <p>people with relevant experience to help us.</p>	<p>respond better to HIV/AIDS and share our learning with those we think will benefit.</p>
<p><b>Measuring</b></p> <p><b>Change</b></p>	<p>We are changing because we believe it is the right thing to do, but do not measure the impact.</p>	<p>We begin consciously to self-measure.</p>	<p>We occasionally measure our own group's change and set targets for improvement.</p>	<p>We measure our change continuously and can demonstrate measurable improvement.</p>	<p>We invite others' ideas about how to measure change and share learning and results.</p>
<p><b>Adapting</b></p> <p><b>our</b></p> <p><b>Response</b></p>	<p>We see no need to adapt, because we are doing something useful.</p>	<p>We are changing our response as a result of external influences and groups.</p>	<p>We are aware of the change around us, and we take the decision to adapt because we need to.</p>	<p>We recognize that we continually need to adapt.</p>	<p>We see implications for the future and adapt to meet them.</p>
<p><b>Ways</b></p> <p><b>of</b></p> <p><b>Working</b></p>	<p>We wait for others to tell us what to do and provide the resources to do so.</p>	<p>We work as individuals, attempting to control the situation, even when we feel helpless.</p>	<p>We work as teams to solve problems as we recognize them. If someone needs help, we share what we can.</p>	<p>We find our own solutions and access help from others where we can.</p>	<p>We believe in our own and others' capacity to succeed. We share ways of working that help others succeed.</p>
<p><b>Mobilizing</b></p> <p><b>Resources</b></p>	<p>We know what we want to achieve but don't have the means to do it.</p>	<p>We can demonstrate some progress by our own resources.</p>	<p>We have prepared project proposals and identified sources of support.</p>	<p>We access resources to address the problems of our community, because others want</p>	<p>We use our own resources, access other resources to achieve more, and have planned</p>

			to support us.	for the future.
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Hope these key tools of ACP helps us to understand and apply the competence process not only in HIV better, but also in other diseases.

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**Sukumar David, Consultant, Hyderabad**

Greetings from Hyderabad. I am Sukumar David. You were the first person to talk about HIV in AP, and we all took the lead, it is wonderful to hear from you. I think you will already be knowing about the following resources:

[http://findarticles.com/p/articles/mi\\_qa5362/is\\_200501/ai\\_n21371140](http://findarticles.com/p/articles/mi_qa5362/is_200501/ai_n21371140) Geoff Parcell's article on ACP and KM.

[http://www.blinkx.com/video/DailyMotion/Adapting\\_our\\_Response~vEKfY2S7iF73W0qAtF3Ez5Q](http://www.blinkx.com/video/DailyMotion/Adapting_our_Response~vEKfY2S7iF73W0qAtF3Ez5Q)

This is a Video by Dr. Jean-Louis Lamboray. It gives his description of the practice of 'Adapting our Response' used in the Self Assessment framework of AIDS Competence. There are many other ACP related Videos on this page by Alison Campbell, Dr. Wongwat Lewiat and Joan Didier of the AIDS Action Foundation.

[http://telemmed.custompublish.com/getfile.php/306115.357.twebvwcffu/Joint+Norad\\_NST\\_workshop\\_ttec\\_15June2006\\_report\\_040706.doc](http://telemmed.custompublish.com/getfile.php/306115.357.twebvwcffu/Joint+Norad_NST_workshop_ttec_15June2006_report_040706.doc) ACP training through e-modules by Dr. Jean-Louis Lamboray for the Norad.

Please let me know how best I can contribute to your ideas.

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**Lawrence Singh, Agnes Kunze Society, Dehradun**

Greetings and good wishes for the coming days. Many thanks for support of the HIV awareness programmes in Dehradun, especially in the slum areas. We are looking forward for any kind of partnership in the field of HIV and AIDS. So friends if you know someone who can guide our society with the kind of help to help the slum communities like I have been reading here in the forum, will be very good. Please do keep us in your mind, when you have the next programme on AIDS Competence Process.

One thing in our own experience is that the stigma and discrimination of HIV will never be removed until we have a one to one interaction with the community. As for doing awareness through T.V. and newspapers and so on, we should always keep in mind whether this is reaching the target groups. if given a chance for partnership we will do our best to learn AIDS Competence Process and over come this problem. Many times the real partnership goes to the society, which only works on paper. We also request UNAIDS India office to visit our society and the 'Hope project' in Dehradun and advise us on how we can take it further through ACP. Hope we can work together for this hill state.

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**Pranay Dutta, Sonata Foundation, Kolkata**

Thanks for your information. We are interested in this Competence Process in Cities like Kolkata. Hence, we found the discussion about Self Assessment Process in Cities at [http://www.cifalatlanta.org/city\\_aids/06202005/session1a.html](http://www.cifalatlanta.org/city_aids/06202005/session1a.html) very interesting and would like to transplant it here.

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**M. L. Prabakar, South India Aids Action Programme, Chennai**

I would like to share my experience of applying the ACP concepts in working with Sex workers and MSM communities. This concept had been practiced by Siaap in working with different communities with special focus on women in sex work and MSM. Building on the concept of the Human Capacity to Respond (HCR) has been the core of our work. The workshops we are attending in India, through the Constellation has reinforced certain core believes which had been our guiding principles all these years. I wish to site an experience that happened some time ago and compare it with what had happened recently.

Seven years ago, we had a workshop where we wanted to understand the priorities of community members. It gave us a clear understanding that it is just we (NGO) which had HIV as the main agenda but the community perceives it to be third or fourth, priority in their list. Reducing violence, advocating for rights and welfare of their children were their top priority. Through their experiences, they had seen these key factors directly and indirectly influencing their vulnerability to HIV. Our preparedness to learn about the key concerns of women and men and a conscious effort to keep our agenda secondary and the focusing on the need to address their concerns helped us to modify the course of our work and make it more relevant. This experience paved the way to the concept of "working with" the communities through establishing workable partnerships with communities instead of "working for" which always sounds as the big brother relationship or the provider and the receiver relationship.

Recently, we met with a team of members who have succeeded the earlier group that enriched our understanding seven years ago. Over the years, these core components in the agenda had been passed to the leaders from one generation to another. The team at Siaap facilitated a self-assessment process among these leaders. The self assessment tool has ten domains related to responding to HIV and also has five levels ranging from, responses like being aware, that HIV is an issue to, I or We, have made this response a part of our day to day life, meaning I , We have internalized and responding to it at personal and community levels. To our amusement the most experienced leaders from the community ranked themselves at lesser levels than the new ones. We learnt that their understanding on the context of HIV is much deeper and they feel that the current level of response is not adequate. For example, any group would be happy about the numbers of members identified, educated and great number of condoms distributed. These leaders though they have achieved significantly in all these aspects they acknowledged that their focus and role in the reduction of violence and forced sex is very less since it posed greater threat to Sex workers and MSM who have absolutely no possibilities in preventing infections in those situations.

This concept of AIDS Competence Building or development provides greater opportunities of learning from the experiences of different communities and enables to harness core strengths of certain communities for the benefit of others. In the current context of HIV it is inadequate if we just have informed communities or empowered community members we need to have effective community leaderships, sustainable partnerships and continuous interactions with different stake holders, right from the representative of the local governance body at village level to the policy makers, in order to handle the situation effectively.

In my experience of working with different communities, I strongly feel it is high time for the general population to learn from the experiences and responses of certain groups of Sex workers, MSM, PLHIV, and some rural communities. This is because these groups understanding of HIV, risk perception levels, negotiation skills, and responding to the needs of PLHIV are outstanding and can be very useful for general community. Let us not focus only on saturation of the core

populations but also focus on sharing between different communities and effective assimilation of prevention and treatment experiences. The AIDS Competence Building Process provides effective tools that help in implementing this process. Moreover, the Constellation provides contacts to reach, and provide the care continuum at all levels from community to policy makers.

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### **Gideon Philip, North West Scientific, Papua New Guinea**

As a new comer to AIDS Community and AIDS Competence mailing list, I am honored to be part of this important organization that is creating waves across the globe, preaching the concept of empowering communities and individuals. I am just starting to understand the abbreviation such as ACP, TI and so on. In Papua New Guinea from what I read the Salvation Army is doing an excellent job and I'd like to commend them of empowering individuals and communities around Papua New Guinea.

I am in point of care testing businesses, which include supply of HIV rapid test kit. I had my experience in empowering students at the University of Papua New Guinea, those doing Medical Laboratory Science program. Students experience very empowering, which I am sharing with the rest of the readers: "To know the unknown – a real life experience with HIV Test Kit"

The dilemma associated to HIV Test is a rather heart stopping experience any one can encounter in life. Even if it is done in the remotest settings in the rural area where there is no road links or in the city lights of Port Moresby city. The test for HIV is a highly emotional stigma oriented experience that one must momentarily scrutinize and over come in the presence of a Doctor, Nurse or Health Worker in the Hospital. However, besides the normal trend of standard testing in Hospitals the other side of the story is a rather interesting phenomena individual must stringently maneuver to tackle at the best of his or her own conscience. The experts in the Medical Field describe this side of the coin as the urge of "Empowering Individuals" in the drive to maneuver consistently to contain the HIV Virus in our own back yards better. In addition, perhaps the most consistent thing is that before the Health Worker can eventually go out and test other people they must first test them selves. After all they are just as human like you and I.

This is an extract from an essay written by a 2nd year Bachelor of Medical Laboratory Science Student, Ms Phyllis Ivarato of the UPNG School of Medicine & Health Science at the Taurama Campus.

#### **Title: To know the unknown- HIV Rapid Test Kit**

Imagine if you were about to test yourself for the first time in your life for HIV. Its rather scary. Disgusting indeed if you know you had always behaved right. But then, the big question is – Are you obviously sure of your self? Apparently my mind was set for the test. I was fully dressed in my laboratory gears complete with Coat, Boot and rubber cloves. But the huge doubt in my mind slowly forced the adrenalin level in my blood to over flow my mind.

My mind drifted past third dimension in to the galaxies of nature and wondered off to an unknown destination forcing my blood level to rise even higher. Silently I prayed in my heart. Oh! God Help me. My mind silently recouped the lecturer last remarks "How would you like to test your own blood for HIV". So deeply sealed in my own little world, I soon realized my lecturer Mr. Gideon Philip striding through the door with a plastic bag full of the HIV Rapid Test Kit. The atmosphere was tense. Every individual in the laboratory was perhaps cruising along the same wave lengths because of the chain reaction expressed on every ones face.

At first, I was very excited to do the HIV test myself and to prove my personal status. But when the actual moment of truth arrived I was very doubtful. It was different. After listening to the pre-test counseling a sudden flood of doubtful thoughts waged through my mind. What if the virus had somehow infiltrated my blood vessels through some form of accident? Perhaps by accidentally coming in contact with some infected fresh blood from other people during my course of duty. It cannot be that. It just cannot be that because I was a very strictly cautious person in dealing with matters aligned to my duties. After all I was only in my 2nd year at Medical School.

I was definitely sure; I'd get a negative result on the slide. The HIV Rapid Test Kit are rather unique, they come complete with every thing needed in a conventional laboratory. There is an assay diluent tube (buffer), capillary pipette, lancet, alcohol swab and a test device. The kit is packed in a self contained pack with silica gel to inhibit moisture and it has a temperature variation of 1c – 32 c Centigrade. Grooming to become a medical laboratory science expert in future, I was determined to tackle the challenge head on and face the destiny. Step by step, I followed all the procedures through.

As the assay diluent was dropped onto my blood sample on the test device, my heart pounded harder on my chest as I watched the solution rushing through the test band. A few minutes later, I observed a color band evolving at the exact location where the test results were designated to appear. Fear. Fear was my worse enemy. As I waited, I could feel my heartbeat. My heart pumped harder. I felt what I thought others in the class felt in such a situation where we were about to discover the unknown part of our lives. What, what did that result indicate? A silent trickle of an invisible tear of joy overwhelmed my heart when I finally read the indicator. It was NEGATIVE.

I yelled that magic moment of joy in my mind as I stood up from the stool and bent lower on the bench to take a closer look at the result in the test device. I was indeed overwhelmed, my eyes sparkled to signal the joy in my heart. Yes I knew it. I knew it from the very first instance that it would be negative. Thank you Lord, for your protection over my innocent life" I whispered in my mind with a jubilant smile on my face as my best friend reflected back the joy in my smile.

"Man? I thought. What could have it been like, if the result was an unexpected one? What if the test result read positive? My God, How would I live to face the future with such a low status of life? Thank God. Now I am fully geared to tackle the challenges of the 21st century in my chosen field of Medical Laboratory Science. Moreover, of course, now that I've physically tested and empowered myself with my personal status of life I can be able to go out and test other people.

Amazing Indeed, my mind just strayed of track as I thought of the old tales of our people in the rural area who had to wait for weeks to get their blood sample results from the nearest Aid Post in those days. Now I was stationed in a Medical Laboratory where modern technology had invented a Rapid Test Kit that significantly produced results within 5-20 minutes. As an aspiring Medical Laboratory Science Student, I would whole heartedly recommend this Rapid Test Kit to be used in all public health facilities as a general HIV/AIDS awareness drive to empower the 85% rural population in the country.

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**Laurence Gilliot, Constellation for AIDS Competence, Belgium** *(response 3)*

Thanks a lot for sharing all your exciting experiences with ACP! I am amazed by India's strengths! I just wanted to share some more thoughts.

The Constellation and the ACP has evolved a lot over the last two years. In the beginning, the tools like the self assessment, river and stairs diagram, knowledge assets and so on, were central. Tools are fascinating! We still use these tools, with some update here and there, based

on experience. However, over time we realized that the essence of ACP is not the tools but the "mindset", the way to use the tools. A screwdriver can drive screws but it can also kill! Therefore, the way we use tools is vital.

We discovered that SALT is our DNA. The idea is to appreciate people's strengths and to believe that people have the capacity to solve their own problems.

In addition, people need information about HIV to make choices for their own life. Peer education is an efficient way to give information to people. Nevertheless, information is not enough. People need to recognize HIV like an issue that concerns them in their own life. The ACP stimulates people and communities to take ownership of the HIV issue and to look for the information that is relevant to them.

[http://www.aidscompetence.org/content/news/news\\_february\\_2008/butembo.htm](http://www.aidscompetence.org/content/news/news_february_2008/butembo.htm) gives an example from Burundi, where the Constellation works with HealthNetTPO.

Nzotsi Paluku, working for HNTPO in DR-Congo, explains: "*Before, every day we would give the same information on HIV and AIDS to the people. People got bored. Now, the communities assess their own AIDS Competence and decide what they want to know about HIV. The demand comes from them! And this makes a big difference.*"

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### **Jayakar Kotte, Share an Opportunity (SAO), Secunderabad**

I would like to share my experience on AIDS Competence Process. It has widely spread, and has tremendous impact in the communities. The Community people have developed the skills to support each other independently. The individuality of the community people have been awakened by the AIDS Competence Process.

Individuals of communities and CBOs are competent when they are learning from local responses to HIV, and applying such knowledge in their response to HIV, when they are able to measure their own progress in fighting the epidemic, set improvement targets and share their knowledge.

The staff of SAO India has applied the SALT approach, found it better to get good result; staff applied the SA Tool learnt about ACP Tools. SAO India, Project areas are in Guntur, Prakasam, Narsaraopet, Nalgonda and Ranga Reddy District of Andhra Pradesh. In these districts SALT and ACP has been applied. The community learnt to help and trust each other as they have no financial support and moral support earlier. The community came forward and decided to stand up to any occasion.

I would like to share what we learn from our Communities:

- Learnt about the community's confidence; community is farther ahead than expected
- Community loved the dreaming and visioning parts
- ACP provides an opportunity for the community to think
- They adapt the Self Assessment according to the local needs
- AIDS competence is development and not building
- The tools help the community to take charge
- Facilitation from community strengths is not easy
- We helped the community identify the gaps themselves.

With the Introduction of SA Tool and its levels in our community, the people have decided to help each other. It developed good interactions and healthy relations among them.

As for as my experience is concerned this ACP has greater impact in the communities. However, due to limited resources and the activities already possessed by the organization, the rest of the communities are not getting the privilege of having this kind of process. HIV is a serious epidemic that deserves to be eradicated, or at the least prevented on war-footing scale.

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**Alison Campbell, The Constellation for AIDS Competence, U. K.**

I have been moved and encouraged by the responses people have made to this question about ACP.

Joe Ngamkhuchung wrote about work that is relevant in his own specific context of Nagaland, and at the same time this work shows common themes, or 'transferable concepts', which could be applied in different contexts. In fact, the same themes or concepts can be seen in what everyone else has shared.

Shyamala initiated the discussion with a description of learning from local experience, shifting from target-only, to include the surrounding relationships, which is geographic community. Maii from CHAN in Mizoram wrote about their shift of emphasis into facilitating others – looking for the strengths of others to be expressed, and changing role accordingly. Sanghamitra has described this experience as well, of learning from the local experience and adapting.

R. Meera so clearly expressed the strengths of the 'target' becoming human strengths to make everything work much better, and actually educate the 'educators'.

Local response is happening with or without us – whenever a family cares for its own family member, whenever a person is responsible with a partner, with children, whenever the neighbourhood supports – human response happens all the time. However, generally it is not very visible to organisations that are so busy doing their activities they may not have time to stop, look, listen and learn, and then encourage people to go further with every good thing.

Great strengths we have always found in India include the celebration of diversity with unity, the human responses of caring, and the belief in local people and local knowledge. All these are activated in a human capacity approach.

I hope, through ACP and Solution Exchange and other means, we can all keep demonstrating and sharing with confidence about what we know from experience, so that awareness and understanding of these concepts will increase.

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**Lawan Vejapikul, The Constellation for AIDS Competence, AIDS Education Program, University of Chiang Mai, Chiang Mai, Thailand**

Dear All,

It was good to see the enthusiastic response from the participants during the last SALT Visit Programme in Northern Thailand. Having made all the arrangements, it helped me to learn from the participants, first hand their experiences from other countries. I have always found that there are some areas, we could transfer learning to our communities in our home country.

What brings to me a special joy is that every time there is no such thing as having completed the learning. There is always something new to learn in ACP. For always there is a participant sharing

something we have not come across before in other SALT visits. Therefore, I always look forward with this eager expectation to every SALT visit that I make.

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**Dr. A. Prabakaran, Public Action, New Delhi**

Dear Ms. Shyamala,

Different stakeholders to arrest the spread of HIV have adopted different methods. AIDS Competence Process is very significant. Social stigma towards sex is the major blockade towards the reduction of HIV cases. In Goa, some of the fisher folk have removed this problem and minimized HIV risks. In Namakkal district of Tamil Nadu by following proactive approach towards lorry drivers who are staying away from home during their work, HIV is decreasing. Unless and until the criminalizing of sex is stopped, there is less scope for the elimination of HIV from India.

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**S. Murugesan, Village Community Welfare Society (VCWS), Annavasal, Pudukkottai District, Tamil Nadu**

Dear Mr. Koen Van Rompay

Greetings from VCWS,

We take this opportunity of referring to your e-mail of 19 April 2008. You are already aware of us by the HIV programme conference at Chennai about three years ago. As we are working with People Living with HIV in our areas for the last ten years we are much keen to undertake further activities in our region we shall be kindly grateful if you will please render your valuable assistance and guidance and enable us to involve ourselves in this much needed campaign.

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**Chirume Mendo, UNAIDS, Democratic Republic of Congo**

On my side, I have experienced that people have to acquire minimal or basic information on HIV before they can begin assessing their community performance. I have seen it in Bas Congo and other places. Could anyone else have experienced the same?

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**Meble V. Birengo, Nairobi, Kenya**

I have the impression that the last salt visit in Thailand was extremely successful and rich with exchanges. Another time? Thanks for the updates and the new developments within the constellation!

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**Savitri Singh, International Co-op Alliance - Asia and Pacific, New Delhi**

Dear AIDS Community Members,

I do not know if we can use ACP in our co-operatives. I leave it to the more experienced members to guide us. At best, I can describe our initiative to utilise cooperative potential to outreach rural and urban people in India, which is an unique experience and worth sharing with you.

There are more than **5,40,000 co-operatives in India** with more than **230 million individuals as co-op members**, both men and women in different age groups. The Indian co-operative movement is said to be the largest in the world. Development of various sectors of co-operatives, such as agriculture, fertilizer, consumer, banking, health and youth and women have been adopted as one of the most important component of strategy for socio economic development of poor and marginalized. Co-operatives are enterprises that operated under the value of solidarity and social responsibility-they care about their members and their communities. The co-operative demonstrated on daily basis their concern for people whether it be addressing health issues, environment or strengthening the capacities of their communities to better cater for economic, social or cultural needs. Co-operatives have a special responsibility to ensure the well being of their individual members as well as the community.

However, most of the members of co-operatives are small agricultural farmers and land less farm workers, fishermen, construction labourers, floating population of factory workers who are facing several problems such as lack of information about the disease, absence of resources, inadequate supply of preventive measures i.e. awareness and condoms. Also populations in remote areas who are out of reach of health extension workers.

Co-operatives can offer an integrated approach to mobilize communities for the prevention, mitigation and care of those affected by HIV. Co-operatives can provide the following services:

- Behaviour change and life skills education
- Provide preventive information and promote and distribute condoms
- Train community health workers
- Support for women affected by HIV
- Provide home based care for individuals and families living with HIV

The International Co-operative Alliance, Asia Pacific has taken initiative to address the HIV awareness and prevention needs of Co-operative members in India. In 2004 first National Workshop for sensitization of co-operative leaders, policymakers, directors and trainers to generate awareness for prevention of spread of HIV among co-operative members in India was organized. The workshop had been the part of this bigger project planned to be implemented by ICA in several Indian States for the co-operative members and the community.

During the year 2006-2007, a series of awareness and capacity building programmes have been organized for co-operatives in four states, Uttar Pradesh, Bihar, Gujarat and Andhra Pradesh, targeting right from leaders to members including targeting special vulnerable groups such as women and youth, with an aim to mobilize the community in fighting against HIV.

**The activities completed from April 2006- March 2007**

	<b>Activities</b>	<b>Out-put</b>	<b>Achievements</b>
1.	4 Joint consultation of ICA and representatives of co-operatives of 4 target states and the support agency	Strategy for conducting HIV awareness programmes	The National policies on HIV/AIDS prevention and cure recognizes the significance of the role of community service/extension services

2.	four Sensitization Workshops for co-operative leaders and policy makers, one in each target State Duration 1.5 days	Orientation of 200 cooperative leaders about the issue.  Framework for action plan to implement the above referred strategy.	Pronounced commitment from co-operative leadership and managers of all co-operatives to bring out required facilities for spread of preventive education to reduce risk of HIV/AIDS among the co-operators.
3.	Eight Training of Trainers Programme, two in each state 1 for men and 1 for women covering 30 trainers each. 5 days class room and 1 day field visit	Capacity building and skill development of 220 Co-operative trainers to facilitate co-operative members. Creating network of trained people.	Created a pool of about 60 trainers in each state, total about 220 cooperative trainers from ICMs, Junior Training Centers and Projects.
4.	Four Refresher trainings	Feed back from the trainers after field testing of knowledge acquired	220 master trainers trained. Based on the feed back, curriculum revised and 3 days need based training conducted in each state.
5.	The HIV/AIDS training Integrated in the training System.	All the cooperative training institutions and trainers have been imparting information and knowledge about HIV/AIDS	Within 4 months of attending the TOT, the trainers in all the 4 states have conducted about 1000 regular cooperative related trainings/meetings or seminars in which more than 17187 cooperative members, potential members, leaders and staff participated. The trainers spoke about HIV/AIDS in all these trainings/meetings.

***Many thanks to all who contributed to this query!***

*If you have further information to share on this topic, please send it to Solution Exchange for the Aids Community in India at [aids-se@solutionexchange-un.net.in](mailto:aids-se@solutionexchange-un.net.in) with the subject heading "Re: [aids-se] Query: Report on AIDS Competence Process - Experiences. Additional Reply."*

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