



SOCIAL DEVELOPMENT NOTES

COMMUNITY DRIVEN DEVELOPMENT

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Scaling-up a Community-Driven HIV/AIDS Program in Malawi

This note is part of a series that examines factors that facilitate the scaling up of Community Driven Development (CDD) programs. The note describes the factors that enabled and constrained the scaling up of a community based HIV/AIDS intervention in Malawi - Scaling-up HIV/AIDS Interventions Through Expanded Partnerships (STEPs). The STEP's initiative assists local HIV/AIDS committees with community mobilization and capacity building so that communities become empowered to act collectively to address their own problems.

Background

In Malawi, HIV/AIDS accounts for 70 percent of all hospital admissions, and for the recent drop in life expectancy of parents and other adults from 43 to 39 years. As the crisis worsened, and with the growing number of AIDS orphans (projected to reach 20 to 25 million children throughout Sub-Saharan Africa by 2010¹), the Government began to focus on creating an enabling environment in which a wide spectrum of public, private, civil, and faith-community actors could participate in addressing the problem. Since 1999, these actors have been operating within a strategic framework that emphasizes: (i) local action through district, community, and village-level AIDS committees (established by the National AIDS Committee and UNICEF in 1994); and (ii) facilitated community-driven programs that promote behavior change, care and support activities, effective mitigation plans, and community and home-based services. Most of these programs have been small in scope, and experiences with scaling up have been limited. The STEP's program is the notable exception. By end of its second phase (1997-2002), STEP's had scaled up to more than 300 communities in four districts, covering

What Is Community-Driven Development?

Community-driven development is an approach to development that supports and empowers participatory decision making, local capacity building, and community control of resources. The five key pillars of this approach are community empowerment, local government empowerment, decentralization, accountability and transparency, and learning by doing. With these pillars in place, CDD approaches can create sustainable and wide-ranging impacts by mobilizing communities, and giving them the tools to become agents of their own development.

What Is Scaling Up?

Scaling up is a multi-dimensional process through which the impact of a community-driven programs is broadened and deepened. Dimensions of scaling up that have been identified include quantitative (physical replication); programmatic (new activities and programs); social (increasing the capacity of the community to engage in development activities, and mobilization of increasing numbers of local residents, including the vulnerable and marginalized); organizational (increasingly effective internal management and financial viability); and political (incorporation of the CDD approach by higher levels of government, and the direct entry of grassroots organizations into politics).

12 percent of the population. The program now aims to expand to six districts and reach 75 percent of the population, directly and through partnerships, by 2005.

The STEPs Program: Evolution of the community mobilization model

STEPs began in 1995 as a two-year pilot in three communities in Malawi, carried out by Save the Children U.S.A. and supported by a half-million dollar grant from USAID's Displaced Children and Orphan's Fund. The pilot had a difficult beginning. Designed as a program of input-intensive, multisectoral interventions, it was unable to scale up, even locally, beyond its primary focus of identifying orphans and providing them with psychosocial and material support. Two reasons for this difficulty were identified: (i) the extremely high cost per beneficiary (estimated at US\$162); and (ii) uncertainty as to whether community volunteers would continue the activities once the program staff withdrew, which was a disincentive for other organizations to become involved.

Phase I: From implementer to agent for change

Based on this evaluation, the second year of the pilot – here called Phase I of STEPSⁱⁱ – adopted a dramatically different approach. It changed its focus from an implementer to that of an outside *change agent: assisting communities* with community mobilization and capacity building so that communities become empowered to act collectively to address their own problems. The program worked through the decentralized AIDS committee structures of the National AIDS Committee (NAC) to accomplish this goal. Instead of acting as implementer of the program. The new goal was to empower the AIDS committees, and the communities they served, to: (i) identify problems resulting from the AIDS crisis; (ii) develop action plans to address the problem; (iii) mobilize internal resources; (iv) implement activities; (v) advocate on their own behalf; and (vi) establish linkages with government offices, NGOs, donors, and other organizations. In addition, the program facilitated the formation of partnerships between the National AIDS Committee and organizations that could provide necessary resources.

This approach infused new life into the AIDS committees, which had been languishing due to a top-

down approach, lack of support, and insufficient resources to fulfill their mandate of identifying problems and developing responses to problems faced by AIDS-affected families in their areas. With program support, NAC mobilized 16 village AIDS committees with 229 active members; and then mobilized another eight villages after the program withdrew. (Subsequently, committee staff working on the pilot left to form their own community-based organization.^{iii,iv})

A post-evaluation of STEPs Phase I found that while participating villages had become more committed to thinking about the impact of HIV/AIDS on orphans and other vulnerable groups and more aware that caring for the vulnerable is a community, not just a family, responsibility; the mobilization effort should have further developed community capacity, knowledge, and networking capability; and that the program phase-out should have taken place gradually and included a one-year follow-up period to monitor community performance and help in solving ongoing problems.

Phase II: Refining the approach to community mobilization and scaling up

Based on these lessons, STEPs refined its approach to community mobilization and fully consolidated its role as a change agent during Phase II. Working in four districts, and guided by the underlying principles of communication, respect for culture, and involvement of persons living with HIV/AIDS, the program redoubled its efforts to build the capacity of the AIDS committees and their technical subcommittees (Home-Based Care, Youth, High-Risk Group, and Orphans).

The STEPs community mobilization model is a *six-part community action cycle*:

- Prepare community leaders for mobilization
- Organize the community for action
- Explore HIV/AIDS issues, focusing and setting priorities for action
- Plan in collaboration with community and STEPs-Malawi staff
- Implement community action plans
- Collaboratively evaluate the program's impact on the community's ability to prevent and respond to HIV/AIDS-related problems .

The main role of the district STEPs staff can be summarized as facilitators for development of networking, resource mobilization and leadership skills at district, community, and village levels.

The *District AIDS committee (DAC)* included district health, education, agriculture, social welfare, and youth officers; assembly members; business, religious, and political leaders; NGOs; and people living with HIV/AIDS. *Their responsibilities* included coordinating and monitoring the quality of HIV/AIDS activities in the district; building the capacity of villages to address their HIV/AIDS needs; facilitating community and village-level access to financial, technical, and other resources; and helping village committees to identify and address their problems.

The *Community AIDS committee (CAC)* included community health, education, agriculture, social welfare, and youth officers; traditional leaders; religious and political leaders; village AIDS committee representatives; business leaders; CBOs; and people living with HIV/AIDS. *Their responsibilities* included monitoring the quality and reach of activities at the community and village levels; facilitating village-level access to financial, technical, and other resources through funding proposals or community-based fundraising; advocating for the needs of the village committees to the district committee; and facilitating the exchange of lessons learned among the different community and village committees.

The *Village AIDS committee (VAC)* included people and families affected by HIV/AIDS; traditional leaders; representatives of village organizations; traditional healers, initiators, and birth attendants; youth. These committees were responsible for developing village-level action plans and delivering services directly to the vulnerable. Services addressed a wide variety of needs, from cultivating communal plots to feed HIV/AIDS affected persons, to establishing village-based childcare centers for needy children, to behavior change campaigns, to providing home-based care and medication, to psychosocial assistance.

Findings from STEPS Phase II

Although the program was unable to scale up to two additional districts due to the ongoing food crisis, the

results in the four districts were promising. By the end of Phase II, 38 community committees and 700 village committees had been mobilized (4 and 49 of which had formed spontaneously). A series of assessments also found that the community mobilization and capacity building effort had a considerable impact on the ability of communities to organize themselves to address HIV/AIDS and other problems. While the outcome in terms of AIDS prevention and mitigation has not yet been demonstrated, the initiative reduced the stigma attached to HIV/AIDS, and increased communities' willingness to provide care and support to those affected by the disease. In addition, the STEPs programs helped build social capital in these communities, which in turn enabled VACs to resolve their governance problems; mobilize funds and resource people and expand their care giving activities.

Factors in Scaling Up

STEPS was designed, from its inception, to address the HIV/AIDS crisis over the long term. It was this long-term vision that enabled the program to switch from its unsustainable, input-intensive approach to the more dynamic and sustainable role of outside change agent, which in turn enabled it to expand to more districts. The program used a multi-pronged approach to scaling up collective action. In addition to engaging communities through the AIDS committee structure, STEPs actively participated in shaping national HIV/AIDS policies and strategies; and intensified its strategic partnerships with civil society to reach national scale. Further, the program's development over the years was informed by regular reviews of the factors affecting successful implementation and replication. The most important of these were:

- ***The creation of and response to community demand.*** Initial discussions with community members revealed that they felt helpless and ineffective as the scourge of HIV/AIDS progressed. Many were coping with the problem in a disjointed fashion, but as they witnessed the more coordinated effort of STEPs-mobilized community and village AIDS committees, they began to demand STEPs' services to strengthen their own AIDS committees.
- ***A flexible, multisectoral, and proactive approach.*** The first phase of the pilot was

primarily an orphan support program, but food insecurity was found to be a major barrier to placing the orphans with new families. Therefore, food security and other income-generating activities were incorporated into subsequent phases. The program also came to recognize home-based care as a way to prolong parents' lives and support children before they became orphans. STEPs is now planning to initiate systems to protect children from violence and abuse – a key element of the program's evolving rights-based approach.

- **Intensification and expansion of partnerships.** In its initial stages, the program did not envision the intensification of partnerships, but focused on its own internal development as late as 2001. At that point, informed by assessments and discussions with the National AIDS Committee, the program decided to focus on partnerships with NGOs, including prominent international NGOs, as a way to build the capacity of local structures (district, community, and village AIDS committees, and district assemblies) to absorb funds and scale up responses.
- **Replication.** Over the past few years, the program has trained a number of NGOs and CBOs in the STEPs approach, to enable these organizations to carry out similar interventions in their own districts. In response to the growing demand for replication of the STEPs model, a national implementing partnership was initiated in September 2001, with the aim of achieving national coverage of community-based HVI/AIDS programs by 2005. To date, 15 organizations have joined this partnership.

Conclusions

The STEPs experience shows that scaling up multisectoral, community-driven responses to HIV/AIDS is possible, even in resource-poor settings. Some key success factors for scaling up include a well trained and motivated staff, adoption of a community mobilization model through capacity building of the district, community and village AIDS committees, its commitment to document and disseminate lessons learnt; and reaching more affected populations through partnerships. Contextual factors critical for scaling-up include an enabling policy environment with a strong

commitment of the current government to a multi-sectoral approach of combating HIV/AIDS. However, important challenges still remain. Lack of adequate funding, the magnitude of the epidemic, the ongoing food crisis, and the overall context of poverty and underdevelopment are factors that are undermining the scaling up potential of STEPs.

This Note is based on the study, *Scaling-Up HIV/AIDS interventions through expanded partnerships (STEPS) in Malawi*, by Suneetha Kadiyala, produced by the International Food Policy Research Institute for the Social Development Family of the World Bank. Additional copies can also be requested via e-mail: socialdev@worldbank.org

ⁱ UNAID/UNICEF/UNAIDS (2002). *Children on the brink 2002: a joint report on orphan estimates and program strategies*. Washington DC.

ⁱⁱ The pilot and second phases were originally called COPE I and COPE II, respectively. For convenience, this report refers to the pilot as Stage I and the following stage as Stage II of STEPs.

ⁱⁱⁱ J. Williamson and J. Donahue (1998). *Community mobilization to address the impacts of AIDS: a review of the STEPS II program in Malawi*. Washington DC: Displaced Children and Orphans Fund/War Victims Fund, USAID.

^{iv} S. Phiri, G. Foster, and M. Nzima (2001). *Expanding and strengthening community action: A study of ways to scale up community mobilization interventions to mitigate the effect of HIV/AIDS on children and families*. Washington DC: U.S. Agency for International Development.