field work: building local response

A cultural approach to HIV/AIDS prevention and care
Since the mid-eighties, the fight against HIV/AIDS has gradually mobilized governments, international agencies and non-governmental organizations. However, it became evident that despite massive action to inform the public about the risks, behavioral changes were not occurring as expected. The infection continued to expand rapidly and serious questions began to emerge as to the efficiency of the efforts undertaken in combating the illness. Experience has demonstrated that the HIV/AIDS epidemic is a complex, multifaceted issue that requires close cooperation and therefore multidimensional strategies.

The establishment of the Joint United Nations Program on HIV/AIDS (UNAIDS) in 1994 initiated a new approach to the prevention and care of this disease. The first requirement stressed was the need for increased co-ordination between institutions. An emphasis was also made on the need to work on both prevention and treatment while considering the significant social factors involved. As a result UNAIDS was involved in several studies focusing on developing new methodological strategies with which to tackle the issue.

Following a proposal made by UNESCO’s Culture Sector to the UNAIDS Program, on taking a cultural approach to HIV/AIDS prevention and treatment for sustainable development, a joint project “A Cultural Approach to HIV/AIDS: Prevention and Care” was launched in May 1998. The goals were to stimulate thinking and discussion and reconsider existing tools.

Taking a cultural approach means considering a population’s characteristics – including lifestyles and beliefs – as essential references to the creation of action plans. This is indispensable if behavior patterns are to be changed on a long term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

In the first phase of the project (1998–1999) nine country assessments were carried out in three regions: Sub-Saharan Africa (Angola, Malawi, South Africa, Uganda, Zimbabwe), Asia and the Pacific (Thailand and bordering countries) and the Caribbean (Cuba, Dominican Republic, Jamaica). The findings of these studies were discussed in three sub-regional workshops held in Cuba, Zimbabwe and Thailand, between April and June 1999.

The second phase of the project (2000-2001), concentrated on several activities. One was the Inter-regional conference on “A Cultural Approach to HIV/AIDS Prevention and Care”, held on 2 - 4 October 2000 in Nairobi, Kenya. In addition two sub-regional training workshops were organized in Uganda (Kampala, 8-12 May, 2000) and Egypt (Cairo, 20-24 May, 2000). Also, the first local version of the Handbook for culturally appropriate project design was prepared for India. Finally, the first phase in the implementation of a Pilot Project (Kampala, Kawempe Division), was completed. Based on the lessons learnt from the different country reports, four Handbooks were drawn up for target audiences involved directly in policy building, project design, field work and communication.

The nine country reports and the proceedings of the workshops have been published within the Special Series of Studies and Reports of the Culture and Development Unit. The handbooks are being published within the present Methodological Handbooks Series of the Division of Cultural Policies.
A CULTURAL APPROACH TO HIV/AIDS PREVENTION AND CARE
UNESCO/UNAIDS RESEARCH PROJECT

FIELD WORK:
BUILDING LOCAL RESPONSE

Methodological Handbooks, Special Series, Issue No. 3
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The opinions expressed in this document are the responsibility of the authors and do not necessarily reflect the official position of UNESCO

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This handbook is one of a series of four methodological documents:

- Appropriate Information/Education/Communication
- A cultural approach to strategy and policy building
- Culturally sensitive project design and implementation
- Field work: building local response

Each specific handbook deals with two major topics:

- A general explanation of the cultural approach to HIV/AIDS in relation to risk itself, situations of vulnerability and appropriate prevention, support and impact reduction;
- Specific sections focus on the levels of action to be considered: strategy/policy, project design and field work. These are intended to assess the current situation and to propose innovative methods and tools.

The present handbook comprises two major divisions: assessing current field work and building appropriate response, and includes cross-references to the other three handbooks. Numerous UNAIDS documents were consulted during the elaboration of this work, footnotes reference those quoted directly.
The Joint UNESCO/UNAIDS Project “A Cultural Approach to HIV/AIDS Prevention and Care” was launched in mid-1998, in relation to the new approach to HIV/AIDS prevention and care inaugurated by UNAIDS. The UNAIDS strategy emphasizes the necessity of giving priority to the multi-dimensional configuration of the issue and to the diversity of its environment, in order to build comprehensive and adaptable strategies and policies.

In this sense, “A Cultural Approach to HIV/AIDS Prevention and Care”, represents a new contribution towards finding solutions to this apparently insuperable challenge. Its major methodological output aims at tailoring the content and pace of action to people’s mentalities, beliefs, value systems, capacity to mobilize and, as a consequence to accordingly modify international and national strategies and policies, project design and field work.

In this respect, this initiative clearly meets the principles and orientations of the Declaration of commitment on HIV/AIDS adopted by the Special Session of the United Nations General Assembly on HIV/AIDS (June 2001), that states the importance of *emphasizing the role of cultural, family, ethical and religious factors* in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms (paragraph 20).

This handbook is specifically devoted to presenting methods for field work and building local response. After recalling the key assumptions, objectives and methodological implications of the cultural approach, it defines the major challenges as identified by UNAIDS: risk, vulnerability, prevention, care, support and impact reduction.

This handbook defines the terms of reference for evaluation and review of current field work in relation to its understanding of local realities and its mobilization of populations for local response, summarizing general achievements and limitations.

Finally, this handbook describes methodological tools for building culturally appropriate local response, for field workers as well as for local communities. It also points to the main action priorities in this respect, with special emphasis on building partnerships between institutions and the field and culturally appropriate communication, preferably through pilot projects.
1- THE CULTURAL APPROACH: A REMINDER

1.1- ASSUMPTIONS

In the light of experience, it is increasingly being recognized that the HIV/AIDS epidemic is a problem which concerns not only the medical sector, but is above all, a multifaceted issue, which requires a multidimensional response. If the question is limited to medical considerations or to purely cognitive information, modern-type information, education and communication for safe practices, namely the promotion of condom use, the expected results will not be achieved. It is, indeed, a complex socio-economic, societal and cultural phenomenon to be considered in the perspective of sustainable human development. Thus, a cultural approach is necessary for the prevention and treatment of the epidemic in order to deal with all the aspects of the problem.

Generally speaking, a cultural approach to development must meet two conditions, derived from the UNESCO Mexico definition of culture, and which can be summarized as follows:

- **Grounding development** on mentalities, traditions, beliefs and value systems, for practical and ethical reasons, in so far as they may enhance needed changes, or hamper them, if they are not correctly identified, and will necessarily interfere in the action taken;
- **Mobilizing the cultural resources** of the given populations, in order to benefit from their support, when bringing about, through the joint identification of needs and action, the necessary changes in thinking and behaviour for endogenous sustainable human development.

These cultural references and resources are sometimes misinterpreted as monolithic systems, which cannot be modified, since they are supposed to represent an intangible asset, to be protected unconditionally. Observing real situations clearly shows that there is not necessarily a contradiction between culture and change, since all societies and cultures evolve over time:

- First, because of their intrinsic dynamic aspects;
- Secondly, because they interact with all kinds of external economic, social and cultural transformation processes.

These evolutions can result in destabilizing situations if these processes are not monitored and mastered. HIV/AIDS prevention and care policies and methods will be improved and made more efficient by making them culturally-appropriate (acceptable and relevant), fully understood and highly valued (culturally integrated) among given groups and persons, according to their priorities. This will enhance a new awareness of responsibility and motivate a subsequent willingness for mobilization against the expansion of the epidemic.
Over the last 15 years, many different approaches have been adopted in an attempt to curb the expansion of HIV and minimize its negative effects on individuals, families, and society. It is now clear that there is no simple formula that works for all countries. The most effective national responses are those designed to meet the specific needs of a country. They address the specific situations that make people vulnerable to HIV and its effects, and make use of the particular strengths of the country’s people and institutions. These practices are outlined in the UNAIDS Guide to the Strategic Planning Process for a National Response to HIV/AIDS (1998-1999) and the UNAIDS Methodological Review (1999).

The cultural approach is fully consistent with the policy and planning principles advocated in the UNAIDS documents. Its specific input consists of a detailed analysis of the specific and changing aspects of a given situation and population, and in proposing working methods derived from this detailed analysis.

1.2- OBJECTIVES AND IMPLICATIONS

This handbook is meant to facilitate the design of more efficient and relevant strategies and policies aimed at HIV/AIDS prevention and care, through improving the understanding of cultural references and resources and integrating them into building relevant responses at the national level.

In the light of these goals, this handbook proposes concepts, criteria and methodological tools in order to adopt a cultural approach in building, implementing and evaluating HIV/AIDS prevention and care strategies and policies. These strategies and policies will thus be better equipped to face risk and vulnerability situations and reduce the impact of the epidemic through building more efficient prevention and support systems, including the appropriate preventive education.

These proposals are derived from the analysis of the current conditions, the assessment of institutional action taken to date at all levels and an in-depth investigation of field situations. This analysis is meant to show the gap between the current approach and the scope of prevention and care systems in relation to the complexity of concrete situations. More detailed evaluation of these interactions is presented at length in the three other methodological handbooks. The present handbook focuses on proposing methods for identifying major orientations and priorities, ways and means, cooperation and partnerships in order to build local response through culturally appropriate field work.
2- FOUR MAJOR CHALLENGES

As emphasized by UNAIDS, building a response to HIV/AIDS at all levels requires a preliminary diagnosis in clear terms. Risk in itself, and vulnerability as its environment, are two major challenges to be faced in all their facets before attempting to find reliable solutions. Developing relevant prevention and support systems in order to alleviate the impact of the epidemic represents a key issue in strategy building, policy-making, project design and field work. This is why these different questions are identified as the four major challenges of HIV/AIDS.

These issues have to be analysed in detail, individually and in their context, with due consideration of their socio-economic and societal/cultural determinants and effects at all levels. They are reflected in the evaluation of the present situation concerning policies and the appropriate response to building, in terms of national strategies, regional initiatives and local response.

2.1- RISK

High-risk behaviour is directly associated with the physical proximity between infected and non-infected persons. This is a fact in all situations and regions. Nevertheless this behaviour differs significantly according to the various contexts.

- The main cause of infection is sexual relations, whether heterosexual, as in Africa and in other regions, and/or bi-sexual or homosexual, as recognized in the Caribbean, Latin America and South-East Asia. The risk is aggravated by certain sexual practices such as having multiple sexual partners, casual sexual relations, violent sexual intercourse and prostitution. It is also related to other STDs, past, co-existing or confused with HIV/AIDS.
- Mother-to-child transmission of HIV/AIDS appears as another major cause, either during pregnancy, at birth, or during breastfeeding. The latter represents half of this type of infection, especially for women who have numerous children and breastfeed. This practice is often maintained because safer alternatives, such as hygienically safe milk for babies, are not available to them.
- The growing use of intravenous drugs with infected needles and the simultaneous consumption of drugs and alcohol are also causes of infection, more specifically in eastern Europe and central Asia.
- The transfusion of contaminated blood is estimated to be the cause of 10% of the HIV/AIDS infections in sub-Saharan Africa. Contamination can also occur during sexual intercourse when the reproductive organs of one partner are bleeding. It can also occur through rituals of blood exchange in certain initiation ceremonies involving young men, unhygienic excision or circumcision operations, tattooing and skin piercing. However, recent research in certain African countries tends to show that male circumcision may entail a lower sexual contamination risk. Factual evidence corroborates that violent fighting can also result in contamination through bleeding wounds.
Despite this factual evidence, identifying these various high-risk situations raises two questions that go beyond the epidemiological approach, and are of an obviously more societal and cultural nature:

- Personal, family and community awareness of the risk and its consequences in matters of infection and, in optimal situations, the subsequent choice of protected contact or abstinence;
- Public acceptance and formal acknowledgement of the risk and its implication and/or the disclosure of the infection by the group, community, society or public authorities as opposed to silence and denial.

This in itself leads to issues of prevention and care, at the individual and collective level.

**2.2- VULNERABILITY**

Epidemiological research has made important contributions to the identification of the direct determinants of HIV infection. However, it tells little or nothing about the social, economic and cultural factors, which influence people’s behaviour in relation to the risk. Social and economic conditions and societal/cultural features have to be analysed in turn, first at the various levels, then as interwoven groups of causes and effects.

The first AIDS cases in sub-Saharan Africa were reported in scientific literature in 1983. These patients did not share the main risk factors associated with the disease in Europe and North America, i.e. principally homosexual intercourse and intravenous drug use. It soon emerged that epidemiological HIV/AIDS in Africa was quite different from that of high-income countries: heterosexual intercourse, blood transfusion and mother-to-child transmission being the predominant modes of transmission. While common risk behaviour such as intravenous drug use and unprotected homosexual intercourse can be targeted with interventions aimed at reducing the risk, it is much harder to design interventions for larger populations engaging in heterosexual intercourse.


**2.2.1- SOCIO-ECONOMIC CONDITIONS**

The analysis of these conditions should be carried out at two levels:

- Macro-level: economic crisis, globalization (and its impact on communication and transportation, internationalization of markets – including drugs and prostitution), environmental degradation, wars, population displacements, international migrations, mass tourism;
- Micro-level: poverty, unemployment, housing conditions, lack of access to health-care services and education, rural exodus, urban violence.
2.2.2- SOCIETAL AND CULTURAL REFERENCES AND THEIR EVOLUTION

A few examples can be given in this respect, bearing in mind the multifaceted character of many cultural features. Thus, certain aspects of local cultures are conducive to risk behaviour while others induce direct or indirect protection attitudes with respect to spiritual and ethical rules:

- Representations of health and disease, life and death, fate and human responsibility;
- Strong control on the part/behalf of society and the family;
- Prescription of attitudes and sexual norms through certain rituals, traditions and religious beliefs;
- Disruption or collapse of traditional norms and value systems;
- Inequitable gender relations and underestimation of women’s potential in daily life continuity or change;
- Young people’s status and situation in society;
- Linguistic and semantic habits for discussing sexuality.

2.2.3- SOCIAL/POLITICAL ENVIRONMENT: HISTORICAL AND PRESENT SITUATIONS

Even if not directly linked to the material and medical aspects of risk, the overall social and political conditions at national level have a strong impact on the scope and feasibility of prevention and care policies. More specific issues can be mentioned in this respect, for instance:

- Institutional weaknesses, including the chronic instability of public authorities and subsequent fragility of administrative structures;
- Lack of communication between public authorities and population;
- Imbalance in internal/external decision-making capacity;
- Weight of external debt and structural adjustment policies;
- Non-respect of fundamental human rights.

2.2.4- IDENTIFICATION OF VULNERABLE GROUPS

In general, the categorization of vulnerable groups should fully take into account people’s situation in the context of overall development: poverty, insecurity and fundamental human rights. In this respect, the poor, women, and youth, and more specifically, refugees and minorities, are at maximum risk exposure. Specialized target audiences have to be defined.

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2.3- PREVENTION AND SUPPORT

In response to the high risk and vulnerability situations described above, national strategies and policies have to be elaborated and implemented in the following fields:

- National health-care policy;
- Preventive education and communication care and support within relevant national policies;
- Medical, social and psychological follow-up for infected people;
- In the context of social welfare policies, special action in order to alleviate the social impact of the infection.

The range of these policies and the number of people being educated and assisted require a coordinated action, not only between national public authorities, but also among all types of stakeholders involved. More specifically:

- International cooperation institutions;
- International and national NGOs.

In this respect, however, no public or institutional policy will reach a significant stage if it is not complemented by the input of civil society in all of its aspects. The various categories of economic, social and cultural actors (sports and cultural movements, business associations, trade unions, political parties, religious communities, traditional community leaders, traditional healers, midwives) are important stakeholders in the joint mobilization against the epidemic.

Needless to say, medical and sanitary personnel at all levels are partners in the overall effort to provide testing facilities and care to infected people, especially pregnant women intending to breastfeed their infants.

Another category of professionals actively involved in preventive education can be found not only among school and out-of-school educators but also in the media (both in audiovisual media and the written press).

2.4- IMPACT REDUCTION

2.4.1- ECONOMIC IMPACT

The high mortality rate due to AIDS among the most active sector of the adult population can be expected to have a radical effect on every aspect of social and economic life. This is due to the fact that this sector of the population is typically at an age when they have already started to form their own families and have become economically productive. While it is difficult to measure the precise impact of HIV at national level in most hard-hit countries, a great deal of information exists about the disastrous impact, direct or indirect, of the epidemic on households as well as on the public and private sectors of the economy.\(^1\)

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However impact reduction policies should not focus exclusively on the economic disruptions caused by the epidemic, such as manpower shortage and decreased production. The education sector is also hard hit by the disease: teachers, already insufficient in number to face overcrowded school classes, and new generations of trained specialists in other sectors of national development are also decimated by the virus.

2.4.2- SOCIAL IMPACT

Reducing the social impact of the disease is another major challenge for national social development and welfare policies. Giving support to abandoned and widowed women, unable to provide the minimum care for their children, or developing solidarity systems for HIV/AIDS orphans, abandoned street children and youngsters places an additional burden on an already fragile national public budget.

2.4.3- SOCIETAL AND CULTURAL IMPACT

The societal and cultural impact of the infection and disease can result in a general collapse of energy and hope for fighting the virus. The taboo itself and the widely spread rule of silence are just a few of the disastrous cultural effects of the revelation of the disease by the infected person or his/her family. Stigmatization and rejection have been observed in many instances, especially in rural zones and among the poorest populations.

In some countries, at least in the first phase of the epidemic, numerous cases of hesitation or denial were recorded in respect to the recognition of the scope of the disease and the seriousness of the challenge it posed for the country.

The pressing character of this situation clearly requires urgent action, but different approaches. This has to be done with the necessary respect for the populations’ societal cultural norms and basic human rights, especially if breaking the silence is imperative. Moreover, there may be significant misunderstanding on the issue of sexuality arising from semantics and language. This may lead external prevention and care agents to erroneously consider that women are frequently ignorant of their physiological functions.

HIV/AIDS and the private sector

The impact of the HIV/AIDS epidemic on the private business sector has been growing steadily over the last years, and has become quite visible in some places. Still many business leaders need to be persuaded that AIDS prevention programmes for their employees are in their own rational self-interest. In economic terms, such prevention programmes can be marketed as “minimizing cost” or “profit-loss prevention” and protection of valuable fixed investment in “human capital”. The advantage of developing new partnerships with private business is that they have substantial resources available. At the same time, workplaces provide an excellent opportunity to reach the labour force in large numbers and with high impact.

Dominican Republic:
Linguistic hiatus, silence and disclosure regarding HIV/AIDS

In most cases, couples with HIV inform friends, families and neighbours of their condition when one member of the couple has the disease. When the husband is ill, men’s groups tend to hide the infection from the families of their wives and the majority of their neighbours. The family and friends of the wife will only be notified of the infection when the husband is tested positive. In other cases, mothers of HIV positive patients revealed the condition of their sons to their friends and neighbours, and subsequently received the solidarity and support of many of them, in spite of the general poverty. Women do the housework and attend to the ill, while men work and help to move the ill from one place to another.

Men and women tend to react differently when they discover their diagnosis: resignation among men, panic and depression in the case of women. There is evidence of apathy, family rejection and stigmatization, as well as other reactions, which seem to motivate secrecy.

Recent developments in prevention, care and support field work have demonstrated the need for more specific both pedagogical and practical guidelines, and for a revision of the field worker’s role in relation to populations, external institutions and large NGOs. Three major conclusions can be inferred from the analysis of the current situation concerning: 1) community participation, 2) feedback from the field, 3) field worker’s role in the overall process.

It is obvious that prevention and care field activities cannot be unilateral and limited to medical and health services, in so far as medical staff and facilities are not readily available, especially in suburban areas, remote rural zones and refugee camps. This is why it is pragmatic to develop collaboration with local populations.

Moreover, in providing extra-human resources in medical and health care, it gradually became apparent that it was impossible to rely exclusively on external intervention to promote and strengthen behaviour change regarding risk prevention and care to infected and sick people. Fundamentally, the expected change could not take place without effective participation and mobilization of local communities.

### 3.1 FIELD WORK: GENERAL OBSERVATIONS

The term “participation” has been increasingly used since the 1970s to designate a process of development now advocated by international institutions. But this simple term covers many different realities, depending on the level of the planning process at which the principle is applied. Participation can go from mere lip service to effective partnership and even shift responsibility from external agents to the local community itself, through a more or less limited consultation process. In all field work and local response projects, it is a major component in the cultural approach.

In this respect UNAIDS research has provided a crucial and innovative contribution to the debate on participation. As expressed in the UNAIDS Community Mobilization and AIDS Technical Update (April 1997):

“Community level action – much of it initiated by persons infected or affected by HIV – has always played a major role in the global response to HIV/AIDS. In many countries, community response came before the official national response. It has proved essential to many components of a successful national response – most notably awareness, prevention, policy and legal changes, impact alleviation, advocacy, and family or community care and support.”

### 3.1.1 WHAT IS A COMMUNITY?

Community mobilization has usually meant initiatives at the neighbourhood, village or local district level. In rural areas, the village is of sufficiently relevant dimension for implanting community prevention and care projects. In urban areas, even if community structures tend to be weak, they can emerge at the district, societal or cultural level. Field work can be built on this
basis, in as much as it develops mutual understanding and group solidarity based on common societal and cultural references and resources.

However, UNAIDS has identified another type of community, where other cultural and societal references and resources can be mobilized in prevention and care. In this wider and more inclusive sense: a community is a group of people who may be bound by religion, beliefs, practices and will act together in their perceived common interest in relation to HIV/AIDS prevention, care and support.

**Different types of communities**

In addition to the purely geographical criteria, communities can also be identified according to other considerations such as:

- Communities of interest – groups of people with a common purpose, such as health professionals working together on HIV, who may improve their action by adopting a cultural approach;
- Communities of circumstance – people with different backgrounds, but who are bound together by a common health issue, for example people who have been infected through contaminated blood products;
- Structured communities – people with a common identity or history, whose shared common values or attitudes unite them and identify them as a distinctive community.

They may be church groups, trade unions, professional associations, sports clubs, sociocultural associations, youth, women and family organizations and, of course, associations of people living with HIV/AIDS. Each of these communities is associated with different resources, capacities and readiness to respond to HIV/AIDS. Notwithstanding these differences, the capacity of such communities, once mobilized around the issue of HIV/AIDS, must be emphasized.

Moreover, strategic prevention and care activities may be developed in the workplace, markets, sports grounds, bars and entertainment places.

3.1.2- WHAT IS PARTICIPATION?

Limited consultation

The focus on “community” participation in prevention and care projects often leads HIV/AIDS and health agencies to confuse participation with consultation, within tight substantive and time limits. In most cases, major decisions in preventive education or information campaigns are still frequently taken before any explicit or detailed discussion takes place with the affected population. Consultation with local representatives and other stakeholders may form part of the preliminary assessment stage, or be used to make minor modifications in prospective activities still based on the medical and cognitive approach. It is not frequent that people at the grass roots level are given the opportunity to present their concerns, needs, and views to find possible solutions. It is relatively impossible for them to redefine the aims and objectives of a given prevention and care programme, whose core is still considered to be purely scientific and rationalist.

**Incomplete participation or representation**

In any initiative, there is always a risk that community leaders or spokespersons – whether traditional or newly arisen – will not represent the whole community, but instead will focus on their own concerns or agendas. At the same time, certain groups within the larger community – whose participation can be highly important to HIV/AIDS Prevention or Care – may be marginalized or ignored.

Depending on local society, these groups may include ethnic minorities, people in stigmatized professions such as sex workers, or people excluded from power because they are too young, too old, or because they are women. Often they are reluctant to speak publicly for fear of discrimination reprisals, or have no experience in doing so.

*Source: UNAIDS, Community mobilization and AIDS, technical update, April 1997.*

Within these limits, consultation may enhance discussions among certain groups of the population. At the same time, it assumes that people are well informed and have structured means to represent their views effectively. This is hardly ever the case with the vulnerable groups that are most in need of prevention and care projects. Consequently, consultation often remains symbolic, in fact more designed to legitimize an intervention than to incorporate public opinion into the decision-making process.

**Participation in planning prevention and care**

Beyond limited consultation, institutions can also use participation as a basis for detailed research on community needs. The community could then be involved in the implementation of projects.

A certain degree of flexibility is considered as acceptable by external actors, provided it does not affect the aims and objectives of the planned actions. In this type of situation, participation remains relative and conditional and the project criteria and interests are determined externally in the last analysis. Sustainability will therefore not be secured, due to the absence of genuine responsibility in the definition, implementation and evaluation of needs and available local human and cultural resources.
Partnership

Participation in the form of partnerships at the local level already exists in an experimental form in various parts of the world. It represents a good balance of forces between the local community and external intervention. It requires a progressive shift from various forms of participation (more or less limited) to partnerships.

Building partnerships should be based on the following principles:

- Prevention, care and support activities should become an objective for the entire village community, incorporating the organization of the local societal and cultural systems. Thus, local beneficiaries, including infected people, will be motivated and get involved in the actions taken. The project should be based on local communal structures and experience of common management in previous initiatives, even in other fields;
- Conflicts and disputes will be arbitrated by competent local authorities;
- Any possible fee for medical services or the purchase of condoms should be compatible with local means.

When initiating prevention and care action, the community enters a process of change, which has been defined with the help of external support. In this process the codes and taboos of the communities involved should be taken into account, bearing in mind the ways in which community dynamics can give rise to new cultural practices, norms and values. This experience of potential change can be extended to similar issues in other places, where they can be conducted by other teams. In other less dynamic communities, extensive action should be handled with great care, since important components of the whole action will not be available.

3.1.3- WHAT IS FIELD WORK? WHO ARE FIELD WORKERS?

Any analysis of the role of field work and field workers in the prevention, care and support process should be based on the specificity of situations. In this respect, the main issue to be considered is the breach between institutions’ and populations’ perceptions of problems to be identified and responses to be built.

Despite the recent overall evolution linked to UNAIDS special programmes and activities, many specialized institutions and economic actors, at the international and national levels, both in the public and private sectors, are still not fully aware of the importance of non-medical, non-cognitive and non-economic factors and effects of HIV/AIDS on populations. This is particularly evident when assessing diagnosis and action programmes through the cultural approach.

Communities which are the intended beneficiaries of prevention, care and support actions, often have difficulty in understanding the rationality guiding agencies and institutions and the ways in which this may influence the attitudes and practices of their agents, thus distorting the effects of their actions.

The present contradiction has great impact on the conditions and content of field work and the field workers’ role.
What is field work?

Field work is the preparation, implementation and evaluation of a project at the local level, for and with a given population.

- Field workers should help populations to prioritize their problems, to identify those solutions they could put into practice themselves and those for which they need external assistance;
- Implementing activities at the local level requires information which only field workers can provide, following requests from the populations; this should lead to a joint and permanent evaluation of the progress achieved and problems encountered;
- Support given by field workers can be beneficial only if it is integrated into endogenous cultural processes of behaviour change.\(^2\)

In most field work these three conditions for valuable field work are far from being met due to institutional pressure prioritizing medical and cognitive activity and to lack of training/sensitizing of field workers on the cultural determinants and effects of their tasks. Thus, the result is, all too often, a breakdown in communication between the local populations, the field agents and the institutions to which they report on their activities and the real needs of the population.

Any new approach to prevention, care and support – such as the cultural approach proposed in this handbook – must pay particular attention to field workers, drawing upon their experience and their criticism of current work habits. After analysing the experience of those who work with local communities, and are thus best placed to understand and articulate their needs, improvements can be proposed to present action methods, planning and institutional structures, in order to make them more responsive and suitable to field situations, an indispensable condition for sustainable efficient, and culturally appropriate activities.

Who are field workers?

Field workers fall into two principal categories:

- Development agents: salaried or staff under service agreement working for major international and national institutions and for the larger NGOs, responsible for channelling funds to projects and for running operations, and chosen for their administrative and technical competence, and often for their familiarity with social sciences and communication methods;
- Field agents: working directly with the communities, as volunteers or permanent staff in local NGOs, they may have received intensive training or acquired skills and knowledge through extensive experience.

Field workers in both categories may either be local people or expatriates. As a rule, they do not work alone, but as part of a team, including other field workers and members of the local community and their representatives.

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In addition, they have to cooperate with local stakeholders, including locally-based civil servants, traditional cultural leaders, communicators and healers.

3.2- FIELD WORK: ACHIEVEMENTS AND LIMITS

Community mobilization against HIV/AIDS is being achieved with some success all over the world. The activities carried out in community projects are as diverse as the peoples and cultures that make up these communities. Some are entirely “home-grown” and self-sufficient, while others have benefited from external advice and funding. Some are based in religious centres, others in medical institutions, and still others in neighbourhood meeting places – including people’s kitchens. Many concentrate on public education, others on providing care, and yet others on prevention or other goals.

Unfortunately, data collection in this field is a challenge. Record keeping in community-level organizations is frequently rudimentary and inconsistent, quantitative data is partially or entirely unavailable, and sample sizes are too small or ill defined to give reliable results. Even when changes can be measured, it is often difficult to link them to the practice supposed to be evaluated.

However, it is possible to draw conclusions on the major reasons for which community or locally based projects reach significant progress in handling action in prevention, care and support. The first reason is geographical proximity between partners, populations involved and local stakeholders, which allows them to get better acquainted with each other. Besides, this proximity allows for further possibilities to clearly identify the issue, its environment and the available means for action. Thus, it becomes easier to mobilize all categories of actors, since they all belong to the community or are close to it. Finally, this can provide opportunities to draw up the overall situation, its shortcomings and the gradually more visible changes entailed by the action taken.

Despite its rewards, this type of initiative has its limits. The first limitation is the gradual loss of confidence and motivation in the project on the part of the local population. This weakness is particularly serious since any action concerning HIV/AIDS requires a long-term effort, given the time lapse between the initial infection and the development of the disease, as well as good estimate of its lack of “visibility”.

How do we know what is “best”? 

In community mobilization, we rarely know what is best – if by “best” we mean “most relevant, most effective, most efficient, most ethical, and most sustainable, all the time and in all places”. This is particularly true if the rigorous measures of quantitative analysis and the controls of research design are demanded.

On the other hand, we can often say with some confidence that a practice is “good” – certainly in a particular place – and possibly in many other places. Sometimes we can go as far as to judge that one practice is “better” than another, again, in a particular place and possibly in many other places.

Source: UNAIDS, Comfort and hope, six case studies on mobilizing family and community care for and by people with HIV/AIDS, June 1999.
The second serious limitation to a field project is its geographical scope. By definition, it is focused on a limited action area and cannot function efficiently beyond these limits. Thus, its possible expansion from a first-phase action zone to other neighbouring areas is subject to the provision of complementary resources and the assessment of the feasibility of this extension from the result of initial field experience. The replication of the results in a different environment, country, socio-economic context and above all societal and cultural context, raises complex issues, which require an in-depth preliminary analysis.

The last serious difficulty in field work and local response initiatives lies in the always present, but not easily mastered if not overwhelming, impact of the local effects of non-local, non-national and possibly international actors and strategies, one among multiple effects of the globalization process. In this situation, local action is impossible outside a global thinking process.
4.1- SYNOPSIS: FIELD WORK, THE CRUCIAL STAGE IN PREVENTION, CARE, SUPPORT AND IMPACT REDUCTION

The various country assessments carried out within the joint UNESCO/UNAIDS project have shown that national policies to-date have not induced significant changes in behaviour among populations in respect to prevention, care and support. Part of the reason for this difficulty lies in the breach between institutions and the field. The lessons learnt from such observations has led UNAIDS Geneva to develop a special programme entitled “Building Local Response”.

Thus, it has become widely accepted that the field is the “corner-stone” of the success or failure of HIV/AIDS prevention and care policies and projects. Consequently, it is the source of the most realistic and most relevant information, which can facilitate both the adaptation of future action for prevention, care, support and impact reduction at all levels, and the appropriate reassessment of institutional strategies, programmes and plans.

Many field workers, particularly those belonging to smaller NGOs, consider that effective participation and mobilization by the population are essential in prevention, care and support projects, and thus in significant behaviour change. Some of them judge that it would be more relevant to replace the notion of “participation” by “empowerment”. A reliable local response is thus achieved by building prevention, care and support strategies, which empower the local population, encouraging it to actively involve itself in the battle against HIV/AIDS.

4.2- BUILDING LOCAL RESPONSE

4.2.1- FIELD WORK

Field work needs to be assessed by field workers. This will enable them to initiate a more balanced dialogue with the populations and to shift from being the action leaders to being resource persons in the context of an active partnership with the local community for designing, implementing and evaluating relevant preventive IEC as well as care and support to affected people worldwide.

As a consequence, field work is not simply an instrumental link in the chain between the project and its results. It is the core of the fight against the epidemic, where institutional actors come face to face with the real life conditions and specific cultures of the victims of the disease, beneficiaries of medical and human care and support, and main actors in prevention, care, impact reduction through change in behaviour.

As such, field work can be seen as:

- The place where development action towards the specific target groups is concretely implemented;
• The place of **application** of principles and methods elaborated within the various institutions involved in the international mobilization against HIV/AIDS (international agencies, especially UNAIDS co-sponsors, national governments, NGOs);

• The source of **information**, which enables these institutions to adapt their actions to meet priority needs.

**4.2.2- FIELD WORKERS’ PROFILE**

In this perspective, field workers’ role is to act as a **liaison** between the local community and the institutions, while participating in the preparation, implementation and follow-up of local response and community initiatives projects. The relationship between institutions and field workers should be adapted to facilitate the performance of these tasks.

Therefore, the re-evaluation of field workers’ role from actor to **mediator** and **facilitator** will be crucial. In this perspective this role must be reinterpreted accordingly (societal/cultural references related to sexuality, personal, family or common responsibility, etc.).

There are many different conceptions of the role, which the field worker ought to play in relation to the community. This role can be described in various ways:

• A resource person addressing questions without putting forward other questions or offering solutions unrelated to the problems, as perceived by the community;

• A catalyst: helping the community to discover the true nature of the problems to be faced and the means available to solve them;

• A social activist: intervening more dynamically in the debate to raise issues and questions that might otherwise go unnoticed.

The roles he/she adopts may well be determined by the degree of economic, social and cultural destabilization already manifest with regards to the HIV/AIDS issue in the community he/she is working with.

The extreme diversity of situations in the field concerning the epidemic and its context naturally means that field workers must be flexible in their approach to opening a dialogue with populations, identifying the issues and seeking solutions:

• Field workers should not have preconceived ideas as to what would be the most logical, the most efficient, or the most cost-effective response in terms of human and material resources to be mobilized. However he/she must be aware that his/her own culture will interact in the communication process and he/she should be able to adjust accordingly;

• It is also necessary to accept that the community has its own rationality, which is valuable in its own right. Field workers must learn to understand the language and terminology of their partners in order to be able to evaluate the costs, benefits, aims and results of mobilization against HIV/AIDS from the point of view of the population.
The main responsibility of field workers is to see that any prevention, care and support project is firmly rooted in the local cultural and societal references and resources.

4.2.3- FIELD WORKERS’ TASKS

Foremost, field workers should ideally be able to live as observers in the community for a substantial period of time (five to six months). During this period, they should focus on the following activities:

- Establishing relationships of trust and friendship;
- Meeting the local opinion leaders;
- Learning the language(s) and semantic habits;
- Becoming familiar with the religion, local customs, norms, values, practices and issues.

By taking a genuine interest in the life of the community, field workers can gain the confidence of its members and of its key decision-makers. They will also learn to evaluate the distance between their own culture and that of the community, above all, differences in knowledge and in ways of interpreting ideas and events.

This period will also enable the field worker to identify those members of the community with specific knowledge or know-how that may be both of practical use, and provide an in-depth insight into forms of culturally-specific rationality, existing local resources and means of confronting unbalanced or traumatic local situations linked to HIV/AIDS.

However, in many cases, this period will not precede the development action, but will rather coincide with the early stages of the field worker’s active presence in the community.

Guidelines for building relationships

Forging successful relationships with the various members of the community is essential if field workers want to encourage a culturally sustainable prevention, care and support process. To this end, a number of simple principles should be followed:

- Personal visits to community and key opinion leaders will facilitate acceptance into the community;
- Asking questions without being biased (adopt a neutral attitude and try to confirm previous information);
- Creating bonds of real friendship (avoid keeping a “professional” distance);
- Enlarging and diversifying contacts (to avoid manipulation and isolation from the core of the group), and choosing representatives from different, classes, age groups and sexes;
- Participating in major events in the life of the community (celebrations, ceremonies, social gatherings, cultural and sporting events), and using them as an opportunity to meet new people and discuss new subjects.
Field workers also need to ensure that the whole community is well informed about the background of the planned project and its positive effects.

In order to reach this result, they must be well informed about the community’s communication networks – how, when and where information circulates.

**Building an “objective” picture**

The impressions the field worker creates through first-hand experience of the local culture are a unique and indispensable resource for his/her future work. They are however subjective. The field worker needs to be able to trust his/her vision of the society he/she lives in, and to present it coherently to those institutions to which they belong, which do not share his/her direct experience.

Various techniques can be used to render the knowledge acquired during this period both more useful (more “culturally-acceptable” to institutions), and more reliable as a guide to further action for the field worker.

**Informing people**

Just as field workers must ensure that they understand the community’s action, they must also make certain that all messages they send to the community are simple and clear.

To do this, two major mistakes should be avoided:

- **Over-information**
  Information should not be given to the community as a mass of unsorted general data about problems regarding health, education, housing, employment, etc. In order to be effective, information should always be given in response to a specific question or need expressed by the community itself.

- **Rushed decisions**
  If a response to information is expected and if a decision is to be made the community should be allowed time to assimilate and discuss the data. This may take more time than the field worker’s own culture may lead him to expect. Observing and analysing how problems are discussed and resolved in the community is therefore an important preliminary, which will help the field worker propose appropriate timetables for planning.

**Keeping informed**

Gathering information is not simply a prerequisite it is a continuous process during the field worker’s presence in the community. As a development action begins to take shape, discussion and exchange should continue in parallel, allowing the success of the action, in terms of appropriation by the community, to be continuously evaluated.

The main points, which field workers should take into consideration, are:

- Identification of the differences between conventional needs (legitimized by the institutions) and real needs (validated by the population);
• Resources and capacities within the community (knowledge, know-how, methods for solving problems and conflicts, open-mindedness to innovation, will to change);
• Conflicts, either within or outside the group, and the corresponding possibilities for establishing consensus;
• Nature of available “points of leverage” and scope for external influence, potential benefits and dangers of using this influence.

**Communication is the indispensable instrument of participation**

Good exchange of information between field workers and communities is essential. Field workers should also ensure that the communication is good within the community, even in conflictuous situations – which may arise on subjects like HIV/AIDS.

The less culturally homogenous the community, the more vital it is to encourage its different groups to communicate freely amongst themselves.

There are several preconditions for establishing successful communication networks within the community as a whole:

Field workers must understand how the community perceives their presence.

• Are they expecting to gain something from them? And if so, what? (Financial assistance, distribution of products, material help, verbal advice, prestige by association?);
• What is the gap between the real and perceived benefits of the operation from their point of view?;
• Field workers must understand who their interlocutors are: their status within the community (traditional leaders, local administrators, representatives of civil groups, independent individuals…), their background and beliefs, the interests they may represent and the strategies that lie behind their replies.

Only when they are aware of the possible pitfalls that their relationship with the representatives of the partner group may conceal, can field workers be sure that their actions will promote successful communication within the community as a whole.

This will make it easier to develop technological communication, through local or urban radio programmes for instance.

Therefore, the population should be asked preliminary questions, in order to build the cultural foundations of the project. These can be seen as initial cultural indicators, or “situation” indicators, which have to be used to launch a truly people-centred process of change.

**4.2.4- BEYOND PARTICIPATION: POPULATIONS’ EMPOWERMENT**

Too often participation has been reduced to a rapid and superficial process, in which contact is established only with the most accessible members of the community, both materially and intellectually.
This form of participation is an administrative obligation, and as such it is often viewed by participants as a mere waste of time.

In some cases the gap between theory and practice have brought out such negative experience that some local NGOs reject the very idea of participation. In doing so, they have also rejected the intervention of external institutions and donors, and denied the relevance of prescriptive messages such as condom use and sexual abstinence considered as the exclusive tools of preventive education, independent of its societal and cultural environment.

For these local NGOs, field work is completely self-reliant. Thus, the only roles open to outsiders are:

- Integration into the daily life of the people they work with;
- When possible, helping the community to identify the means available to it to resolve its problems;
- Helping the community promote its own values to combat segregation and social trauma entailing vulnerability and promoting solidarity towards infected and sick people.

Thus effective participation should be a continuous two-way process of communication between field workers and the populations involved, aimed at building partnerships for people-centred prevention, care and support field projects. This process will be put into practice in the following stages.

**Highlighting cultural references and resources for behaviour change**

Existing culture is not a fossilized code, it responds to new challenges. It changes according to material, environmental and external circumstances as well as evolves according to its own internal logic. In terms of HIV/AIDS, this response will have to question ways of life, traditions and beliefs, value systems, basic human rights. In other words, these various cultural references and resources will have to be reconsidered: encouraged, modified, reinvented or dropped. This choice belongs to the community, not to the development worker. It should take place as a process of self-evaluation.

Under no circumstances should field workers attempt to change the culture of a community by depriving it of its greatest asset – its sense of autonomy. Field workers can, however, enhance invention, creativity and criticism from certain groups within a culture, who can help their community in seeing its weaknesses and its potential, so as to be able to build a genuinely local response.

**Supporting the behaviour change process**

It is also important to rethink which role field workers will play once the community accepts the idea of behaviour change. In this process, more than leaders of the debate, field workers are resource persons whom the community members can draw upon when identifying cultural and societal conditions for change in behaviour.
As a general rule, field workers’ support should never interfere with the community’s prerogative in the behaviour change process, including the solidarity movement to be launched or reactivated.

In this perspective, three areas can be distinguished in which field workers can usefully intervene:

- Stimulating debate;
- Mediating conflicts;
- Defining activities.

These should be implemented through various methods.

**Cultural motivations and concrete interests**

One of the major issues concerning HIV/AIDS prevention and care is frequently people’s lack of motivation to become involved in the battle against HIV/AIDS, which for many is a low priority among what they consider to be their most pressing issues and needs. Their life patterns, spiritual and ethical beliefs, relationship to their past and value systems are more likely to be oriented towards preserving their identity, developing daily survival strategies in extreme poverty and facing all kinds of deadly threats, including diseases they and their close family or community are permanently exposed to. This is why they do not see their day-to-day interest in giving HIV/AIDS prevention and care a high priority. Thus any rethinking process and subsequent attitudes towards behaviour change should emphasize concrete reasons for this shift in their priority systems, in order to preserve or regain their identity, improve their daily life conditions and encourage the respect of human life and basic human rights.

Generally speaking, in daily life experience, a culture’s constituent features remain tacit, or unsaid even in extremely extravert cultures. Thus, certain references or resources become apparent only in certain specific circumstances, such as the challenges brought about by HIV/AIDS.

**In the field**, the starting points are actual local practices (including those of decision-makers), scales of values, and ways of ranking (actors’ preferences) items in terms of lifestyle, education, traditions and beliefs. Such elements can only emerge through the interactions at work in given situations. These practical observations can then be used in the social negotiation process (between health or social field workers and population) to support decisions concerning initiating, continuing, extending, modifying or stopping local projects for appropriate prevention and care.

In this respect, a fundamental distinction should be made between the concepts of need and **interest**. Need is a vague and ambiguous concept, whatever the community, the economic, social or political context may be. Subjects with concrete implications, which can be made clear and discussed among community members are: explaining the necessity of prevention; the differences or similarities between vulnerability and risk taking; the rules which should be observed after infection or at the final stage of the disease; and why silence and stigmatization can be dangerous for infected people and the whole community. However, in the quest for technical efficiency, field workers may be tempted to substitute their own list of legitimized needs for that of the community’s.

Ultimately, cultural references and resources may be taken into account in identifying prevention and care choices at the local level by three different approaches:
• Identifying cultural values, translated into questions about relevance or interest, based on the community's reactions to HIV/AIDS;
• Identifying the societal or cultural relevance of possible alternatives (thus substituting the reductionist cost/benefit approach);
• Implementing a process of negotiation between external intervention and local community.

Expected changes

It is important to recognize that the expected results of the action undertaken cannot be identified as quickly and precisely as institutions would hope for, except, to some extent, in a few countries like Thailand and Uganda. It may be counter-productive to try to predict the results of the action for three major reasons:

• The apparent “disorder” (when compared with administrative models of “order”) of the behaviour change process (i.e. condom use, stable relations and sexual abstinence) which has been fully integrated into the culture of community, does not mean that the action has been totally unsuccessful;
• “Invisible” changes (in mentalities and behaviour underlying rationality) may be more valuable to the community than the more visible results repeatedly advocated by institutions (infection decrease, statistical data in general, etc.);
• It should be kept in mind that, especially when considering the HIV/AIDS issue, the process of change may require much more time than could be initially predicted (the time needed for the cultural integration of prevention and care action is essentially unquantifiable: interactive consensus, collective will and responsibility, etc.).

At the same time, it may be necessary to explain to the community the possible unforeseen effects of the action undertaken, so that they may assess it in their own terms.

Participatory evaluation

In the last decade of the campaign against the epidemic, the most frequent practice has been to have prevention and care projects evaluated by specialized officers from institutions or by external experts not directly linked to the local authorities. This second type of evaluation was meant to guarantee a neutral analysis of achievements and failures in projects, which had received institutional support.

Over the recent years, however, it is gradually being recognized that the involvement of institutions in the evaluation process is not sufficient to guarantee that the results of a given project are effectively sustainable, especially when assessing the role of local initiators or stakeholders. Participation is thus increasingly seen as an indispensable condition for successful evaluation, since the local actors are and will be responsible for the follow-up activities when institutional support comes to an end.

Participatory evaluation cannot, of course, be put into practice afterwards, if participation has not been at the core of the project right from the initial stage of discussion. From the outset, it must be part of a continuous process in discussions between external and local actors.
4.2.5- MOBILIZED COMMUNITIES

According to UNAIDS, the major characteristics of a mobilized community are as shown below:

The prevention and care potential of a mobilized community

- Awareness of their individual and collective vulnerability to HIV;
- Motivation to address their vulnerability;
- Knowledge of the options that they can take to reduce such vulnerability;
- The time, skills, and other resources that they are prepared to invest.


Community participation: motivations and skills

While materials and funds are undoubtedly required to implement activities, it is even more crucial to have motivated and skilled human resources. The participation of the concerned communities at the relevant stage of the planning process is as important as government leadership in the planning process. It represents the single most important resource for a country’s response. Individually and collectively – be they members of affected populations, associations of PWAs, HIV/AIDS service providers, national or international NGOs, small local organizations, research institutions, epidemiologists or behavioural scientists – they make valuable contributions to the national response, and even more so when involved in the planning process.

Local counterpart: material contribution

The community's ability to find within itself the financial and material means necessary to implement any prevention and care action is not only a sign of its pre-existing wealth, but a good indicator of its degree of commitment in sustaining the project in the longer-term. Material support can take many forms, from money to volunteer work, demonstrating the willingness of the population to cooperate in the action.

Local technology and know-how

It should not be taken for granted that the appropriate technology and relevant action method is in principle the medical approach and cognitive information/education. It can be highly advantageous to draw upon traditional knowledge and know-how, which are often highly sensitive to the local environment and its resources. Traditional herbal medicines, midwives’ expertise and the psychotherapeutic value of certain magical rituals, especially shaman practices, are now more widely respected and used in combination with modern-type medical intervention. Traditional healers are the most frequently mentioned type of experts in local know-how and oral communications.


Time and energy expected from community members

There are very few examples of spontaneous mobilization against HIV/AIDS and they depend heavily on the participation of unpaid volunteers who have many other priorities, and who have to be recruited, trained and motivated. These volunteers are often peasants or labourers who must balance the time they spend volunteering with the time they need to spend in working in order to feed themselves and their families. Sometimes volunteers are unemployed persons whose first priority is to find a job.

Paid facilitators sometimes do not understand the priorities and needs of their volunteers. This often leads to unrealistic expectations about what volunteers will do with no other incentive than their awareness of the problem.

Motivation cannot be taken for granted, even with a serious threat like the AIDS pandemic. Most community initiatives, at some time or another, are forced to find new ways of keeping volunteers’ enthusiasm high and helping them continue to identify the problem.

But HIV/AIDS initiatives have an additional vulnerability: it is especially hard to maintain motivation when highly valued colleagues who are infected with the virus eventually succumb to it.

Traditional healers: opportunities and limits

- Traditional healers often outnumber doctors by 100 to 1 or more in most African countries. They provide a large accessible, available, and affordable trained human resource pool.
- Traditional healers possess many effective treatment methods.
- Traditional healers provide client-centred, personalized health care, which is culturally appropriate, holistic, and tailored to meet the needs and expectations of the patient. Traditional healers are culturally close to clients, which facilitates communication about disease and related social issues. This is especially important in the case of STDs.
- Traditional healers often see their patients in the presence of the other family members, this gives insight on the traditional healers’ role in promoting social stability and family counselling.
- When traditional healers engage in harmful practices, there is a public health responsibility to try to change these practices, which is only possible with dialogue and cooperation. Research has shown that traditional healers abstain from dangerous practices when educated about the risk.
- Traditional healers are generally respected health care providers and opinion leaders in their communities, and thus treat large numbers of people through dialogue and cooperation. Healers have greater credibility than village health workers (who are often their counterparts in village settings), especially with respect to social and spiritual matters.
- Since traditional healers occupy a crucial role in African societies, they are not likely to disappear soon. They survived even strict colonial legislation forbidding their practice. Even with the rapid sociocultural changes occurring in many African societies, traditional healers continue to play a crucial role in addressing a variety of psychosocial problems that arise from conflicting expectations of a changing society.
- Numerous studies document traditional healers’ enthusiasm for collaborating with biomedical health providers and show that their activities are sustainable as they generate their own source of income.
- Since the 1980s, healers have been organizing themselves into traditional healers’ associations, which make it easier to establish collaborative programmes.
- Collaboration seems to improve health delivery in number of ways: increased knowledge and skills of traditional healers, increased confidence in their practice, increased openness towards the community within their work, earlier referral to hospital or health centre.

However, points against, or weaknesses of collaboration include:
- The training and licensing of healers is not institutionalized, which makes it difficult to reach and train them regularly in a standardized manner.
- Quality control of healers is difficult in the absence of officially recognized licensing procedures.
- There is no general monitoring of healers’ activities or claims.
- Traditional healers lack detailed anatomical and physiological knowledge.
- Traditional healers may engage in some harmful practice or cause delays in referral to biomedical facilities.
- Promotion and improvement of traditional methods may undermine efforts to increase access to biomedicine.
- Official recognition of traditional medicine gives legitimacy to traditional healers though their treatments and methods are still largely untested.
- Collaboration with traditional healers raises their expectations of greater recognition from government, which they may not be able to give.
4.2.6- MANAGING FIELD WORKERS’ RELATIONS WITH INSTITUTIONS

The criteria for prevention, care and support are significantly different between field workers and institutions. The field worker acts as the “go-between” of the community to convey its views to institutions. But he/she is also the representative of the institutions, transmitting their message to the community. In his/her work, these two functions must go hand in hand.

The main characteristic of the present situation is the insufficient communication between the major institutions and the field. This deficiency results in increased difficulties for these institutions to establish a cultural approach in combatting the epidemic.

This cultural breach is particularly visible when it comes to establishing criteria for the evaluation of actions. The communities and agencies often use very different criteria to evaluate the results of the project’s implementation.

Institutions must report to their financial authorities or donors on the money and time they have spent. For them, the lessons learnt from their experience are often limited to the efficiency of the action undertaken in terms of their own internal methods of management and timeframe and respect of budgetary limits.

On the other hand, communities and local organizations may reject the use of “stable” and/or “clearly-defined” success criteria. Their evaluation is likely to be phrased in much more concrete terms: Has the situation improved? What should they do next, even if it takes more time than the criteria used in planning?

Field workers should work with the community and the agencies in order to try and make these two sets of criteria compatible. This means both encouraging the community to reflect on the objective conditions underlying their subjective perception of the situation, and persuading the agencies to find ways to take into account the societal and cultural dimension of the needs expressed by the community. Their activities in monitoring and assessing the project, on the one hand, and reporting and transmitting feedback on the other hand, must be seen in this perspective.

Field workers: extending their role

Until now, most of the responsibility for improving communications between the field and institutions has been in the hands of the institutions themselves. There are, however, two ways open to field workers, which can allow them to introduce their own initiative in order to encourage more culturally appropriate prevention, care, support and impact reduction activities.

Readjusting institutional strategies and policy choices through critical review of information

Appropriate strategies and policies developed by agencies depend on the information they receive from the field. Detailed, concrete and critically reviewed information will therefore enable agencies to adapt these strategies and policies to the reality of the field. The following are guidelines, which may improve the nature of the information being passed on:
• Include careful description of situations in official action reports (for example under the heading “country situation” in UNDP reports);
• Supplement official reports with informal notes and oral briefings, which will allow more varied information to be put forward;
• Do not limit reports to sectoral and technical information, but include trans-sectoral and general information, especially details about the way the community reacts to the projects they are involved in;
• Never omit the difficulties or even failures of certain projects, and suggest possible reasons.

Forging a wider network

The limitations resulting from isolated field action and a narrow sectoral approach are major obstacles to broadening prevention, care and supportive field action. Field workers can already begin to modify this situation in the field, by creating opportunities for formal and informal cooperation between agents representing different institutions (IGOs, local NGOs, universities, national research centres, etc.). This exchange of information may bring about the elaboration of joint activities and harmonize action for complex projects.

Experience gained in the field has gradually led UNAIDS and certain co-sponsoring institutions to adopt participatory methods in planning prevention and care strategies and programmes. In this respect, field workers could make a unique contribution by providing decision-makers with accurate first-hand information on the real needs and situations of populations in respect to risk, vulnerability, prevention, care, support and impact reduction.

Institutions should in turn rely more on field workers and grant them more autonomy to launch or encourage local response potential. Field workers should also be more involved, not only in implementing, but also in preparing and evaluating large projects and programmes and even strategies and policies building.

4.3- MAIN ACTION PRIORITIES

4.3.1- BUILDING COMMUNITY-BASED RESPONSE

Involving people in the campaign against the epidemic is of prime importance. In other words, building an appropriate and sustainable response to HIV/AIDS means that people have to be involved personally: at home, in their neighbourhood and at their work place. Each individual, family and community can become “AIDS-competent” by assessing how AIDS affects various aspects of their life and by taking concrete measures to minimize its impact at the local level.

In order to change their behaviour, people need a supportive environment. Developing partnerships at a local level can improve the effectiveness of their responses. Thus, a well-backed up mobilization process should result in numerous local initiatives. Sustained behaviour change comes as a result of a shared social reaction and a clear perception that disease and death are the direct consequence of HIV/AIDS for oneself and the families.

4. Barrière Constantin, Luc (UNAIDS) Key concepts of the local response agenda. Presentation at the Kampala subregional workshop on “Cultural Approach to HIV/AIDS Prevention and Care”. 
As a consequence, it should be emphasized that interventions proposed by experts and planners have to be appropriated and implemented by people and communities. In this process, sociocultural determinants may greatly influence the assessment and reaction of the community in respect to HIV/AIDS issues. Thus, it is indispensable to learn and understand how the various actors at the local level have handled the assessment and response process. Experts and planners have to change their way of thinking and modalities of action accordingly, and adopt an influencing attitude rather than the usual control of the whole action process.

4.3.2- BUILDING PARTNERSHIPS BETWEEN INSTITUTIONS AND THE FIELD

Community-based prevention and care projects can only be designed, carried out and evaluated successfully through a continuous exchange process with the target populations, whether non-infected, HIV-positive or sick. This is necessary in order to fully understand their concerns, priorities, and enable the full use of their cultural resources and power of mobilization to build effective partnerships between the institutions, networks and the society.

4.3.3- CULTURALLY-APPROPRIATE COMMUNICATION FOR BEHAVIOUR CHANGE5

Elaborating culturally appropriate behaviour change communication is of crucial importance for building sustainable and appropriate responses to the challenges of risk and vulnerability with respect to HIV/AIDS.

Enhancing a better understanding of the challenge in culturally appropriate terms should result in a high priority for HIV/AIDS related issues. This in turn will develop a sense of communal responsibility and focus community energy towards mobilization.

As explained above, communication is a two-way system of information, in which the field worker plays the role of mediator between two different systems of rationality and significance.

Consequently, the role of the field worker is to encourage the community to:

• Express its concern regarding HIV/AIDS prevention and care with respect to risk, vulnerability, preventive education, care, support and impact reduction;
• Formulate its basic priorities;
• Identify culturally-appropriate responses within their reach and the need for external support;
• Implement the agreed upon activities.

At this stage, the field worker’s role will be to provide the best possible assistance (material, technical, financial, etc.), where and when it is necessary, in order to empower the community and enable it to mobilize itself within the framework of its societal and cultural values.

As explained above, the communication process between the field worker and the community depends upon a number of conditions, which need to be described in more detail.

5. A detailed description of methods for cultural appropriate communication for behaviour change is given in the handbook specifically devoted to this question within the same series.
Field work begins with self-assessment

All development workers are rooted in their own culture, as are the people they work with. Development workers will necessarily include their own values and assumptions in a project. Projects themselves often reflect the culture of the sponsoring institution or donor. However, field workers are more aware of real situations and are more open to the concerns of the populations they are working with.

The first step towards mutual understanding must be taken by field workers, whether on their own initiative or as an integrated part of their training. Their capacity for constructive self-evaluation will ultimately serve as a model and encourage the community to engage in a similar process.

Self-evaluation questionnaire

In order to identify their potential unconscious bias, field workers can begin by asking themselves the following questions:

- Why are they involved in this project?
- Where do they come from?
- Who are the other actors involved?
- What is at stake for field workers and their employers?
- What is the time frame imposed on field workers by their institutions?
- Do their institutions have their own internal reasons for carrying out the project? If so, what are they?
- What sort of approach have they been taught to adopt? Is their basic attitude to development problems professional, intellectual (rationalist/functionalist), humanitarian, political, ethical or religious?

This process of self-evaluation can begin before field workers join their projects. Part of this process can successfully begin in their countries of origin, in the case of expatriate agents. In any case, it should not stop when the “real” work begins, but continue throughout and beyond the duration of the project. In this way, field workers can track their own personal development and steer away from possible distortion, which may arise in the course of their work.

Taking time to get to know the local culture

Beyond preparatory information and documentation, field workers should be ready to enter a field learning process that will continue as long as they are with the community.

Collecting information does not come to an end when the field worker joins the community. Previous information should be complemented and reinterpreted through direct contact with reality.
Field workers need to get acquainted with the culture of the community – their traditional practices, and their needs, not only in material terms, but also in terms of meaning. They should also be aware of and interested in such sources as myths and legends, religious rituals and texts, popular art forms, oral traditions in their various forms. Moreover, they should carefully listen to people’s opinions, knowledge and judgments – and also note what they do not feel and do not know. Appreciation of these sources can add a great deal to the understanding of the people they are working with.

Field workers should always see that they distinguish between what is genuine and spontaneous expression and what is superficial repetition of official information without real appropriation of its content and implications especially as regards HIV/AIDS formal education or general media information programmes.

At a more general level, the field worker’s community experience can serve as a basis for elaborating and delivering culturally appropriate information, education, and communication. In this respect the following activities should be carried out:

- **Methodological research to:**
  - Evaluate the cultural relevance of the current IEC practices;
  - Understand people’s cultural references and resources;
  - Identify the societal/cultural conditions for people’s sensitization and mobilization.

- **Identification of the specific demands and needs of the vulnerable groups**, with respect to HIV/AIDS, their socio-economic situation, specific risk behaviour and their relationship to society at large.

- **Developing proposals for a cultural approach to relevant IEC materials and processes for prevention and care**, based on an interactive elaboration/delivery of relevant messages.

### 4.3.4- RENEWED PREVENTIVE EDUCATION (RISK AND SOLIDARITY)

**Preventive education for all adapted to a specific cultural context**

UNESCO believes that understanding depends not only on the factual soundness of the message, but also on the social, gender, educational, economic and religious factors, and cultural frame of references of the targeted population. This is crucial for the mobilization of local resources to promote understanding of the risk of AIDS and of the need to care for those affected.


After a first phase of action based on the epidemiological approach, focusing on health and medical care, education (and to some extent media information) has become the second major instrument used to prevent risk and to implement the practical protection measures it implies.
However, its limited results have raised growing concern as to the real efficiency of preventive education campaigns. It has become increasingly clear that even when preventive education messages are well received and intellectually assimilated, their content is not appropriated by populations, especially children and adolescents, and does not result in behaviour changes and solidarity towards the infected and sick people.

The reasons for this insufficient impact are probably linked to the confusion between preventive education and school instruction. In addition, school instruction is too often limited to a one-way transmission of purely cognitive information. Thus, in spite of the unique and indispensable capacities of the school system, it remains that by definition, it does not reach children and adolescents who cannot attend school (up to 80% in certain countries). Moreover, illiteracy rates among young people and adults above the age of fifteen, especially girls and women, are still very high in many countries (over 75% in some cases).

For these reasons, preventive education must be diffused through all possible channels, including non-school educators such as social workers, NGOs, business people and entrepreneurs, associations and movements, sports groups, ethical, religious and traditional community educators.

From another point of view, educational material should not be “pre-cooked”, but should emerge gradually from the educational process itself, through empathic dialogue and on the basis of people’s societal and cultural values, behaviour norms and understanding capacities.

To this effect, preventive education will have to be remodelled, in order to adapt to the diversity in people’s representations, lifestyles and daily life conditions. Only this approach will allow people to accept a reassessment of their practices and motivations, thus giving genuine attention to new ways of considering their personal and collective priorities for the future and to change their behaviour accordingly.

4.3.5- TRAINING/SENSITIZING/ CAPACITY-BUILDING

Training/sensitizing decision-makers in culturally appropriate HIV/AIDS prevention and care strategies and policies means not only developing techniques, skills and know-how, but also changing attitudes and understanding capacities. This will allow self-evaluation sessions on the compatibilities and discrepancies between institutional cultures and local cultural habits and ways of thinking.

This requires the elaboration of training/sensitizing programmes aimed, in a research-development perspective, at helping decision-makers, project planners and managers to integrate cultural references into strategies, programme and project design and

### Capacity-building

Like many other externally driven actions, the strategic planning approach has no chance of surviving in the long term unless national and local planners internalize this method. Hence, capacity-building of local staff is critical in order for the process to gain the necessary momentum to affect the national, regional and global response to HIV/AIDS. As stated above, the regional networks of technical support will be used for that purpose, but the best way of learning is active involvement in real-life exercise.

*Source: UNAIDS Guide to the strategic planning process for a national response to HIV/AIDS.*
implementation. As a general rule, this should be a two-way participatory learning process and exchange of experience between decision-makers and practitioners. Moreover, capacity building in the field of local agents and stakeholders should be another priority.

**Who should be trained/sensitized?**

*High- and medium-level decision-makers*

Planners, scientific and technical experts, medical and health programme leaders, in national and international institutions:

- Theme groups;
- National health and HIV/AIDS planning and administrative committees;
- Educational and media specialists (see above).

*Field-level actors*

- Field workers;
- Local stakeholders: religious, spiritual, political (for example traditional chiefs) should be given appropriate information with a view to optimize their action potential.

**Culturally-appropriate training methods**

*Category 3: Field workers*

- **Pre-service training**
  Information on people’s traditions, habits, practices, social codes and taboos, specific to the populations, in order to avoid the most obvious errors.

- **In-job training**
  In-depth and responsible knowledge and attitudes can be acquired only through working and living within the given society or community for long periods (staff transfers should take this fact into consideration).

- **Ongoing training**
  It should combine theoretical knowledge with apprenticeship through action. This could be achieved through:
  - Participatory observation;
  - Real or simulated exercises in taking responsibility (role games);
  - Project design and implementation in real situations (projects combining research, action and training).

All these training programmes combine instruction on theoretical and methodological issues with more experimental methods (action-research, participatory research). Both elements are clearly essential to any cultural approach in training field workers.

However, training field workers requires not just formal teaching, but also a wider process of raising awareness on problems to be encountered and on skills required for understanding situations from the outset. In addition to knowledge and practical skills, field workers must be prepared to analyse, evaluate and change the ways their perception both of their culture and that of the communities involved.
This implies that field workers must set out with an open mind. They must be receptive to other people and to other cultures. These are qualities, which cannot be acquired only through cognitive training. They must be or become part of their personality. This will enable them to work in an equal footing with local stakeholders and actors.

It is not enough to be aware of cultural differences and of the specific problems of inter-cultural relations. It is necessary to be able to recognize them in real life situations and to draw practical conclusions from this recognition, without falling into the trap of value-relativism. Thus field workers should be prepared to question their own culture – national, academic or professional – and their own assumptions. Not only is curiosity required, but an open-mindedness to accept that others may be right to think as they do, even in those areas in which one considers oneself an expert, and even regarding principles and values one has been brought up to think of as immutable.

4.3.6- PILOT PROJECTS

General prerequisites

Possible pilot projects may provide opportunities for concrete applications of the methodological research results on the cultural approach to the above-described HIV/AIDS prevention, care and support.

The overall objective of such projects is to better inform and mobilize populations, in order to bring about changes in their sexual and non-sexual behaviour and practices concerning the infection and the dissemination of the virus, giving HIV/AIDS prevention a high priority among their vital choices, and developing more supportive attitudes in taking care of the infected and sick people, as an expression of family, group or community solidarity.

An important aspect of these projects is the emphasis put on local cultural references, with respect to traditions, religious beliefs, representations of health and disease, life and death, sexual norms and behaviour. Special attention will be given to cultural aspects linked to value systems, knowledge and know-how, which are – or could be – used as resources to motivate people to question their sexual and non-sexual behaviour in connection with HIV/AIDS prevention and care. The evaluation of risk behaviour, which results in catching and transmitting the virus, may subsequently lead to changes in practices and behaviour.

Methodological conditions

This review of current practices and ways of thinking and identifying new behaviour norms and representations will be part of the information-education-communication process. In order to avoid the shortcomings of unilateral transmission of medical and sanitary data, often phrased in rationalistic, medical and sexological language, appropriate IEC should incorporate an interactive process of exchange and dialogue, in which informants and informed people will be on both sides (participatory data collection and interpretation, discussion through action, peer education, information to local stakeholders).
Another innovative aspect of the project is the combination of three major components: research, action and training in a transdisciplinary perspective.

Participation and collective involvement in the project will be at the core of the whole project and provide/reactivate its momentum. Thus, institutional and professional stakeholders, representatives of national institutions, teaching personnel, medical and nursing staff, social field workers from IGOs and NGOs, will work in a common interactive process with local authorities: elders, traditional chiefs, religious and spiritual leaders, traditional healers, or representatives of the civil society such as associations, social movements, sports groups, trade unions, business and trade associations, parents and family associations and groupings.

The choice of the participatory approach aims at fostering general mobilization against the disease: at the inter-institutional level, as well as from the international, national to the local level, in full cooperation with the institutional system and the population.

Institutional dysfunction is often associated with lack of cooperation, overlap and competition between various institutions, as well as lack of communication between top decision-centres and the field. An even more serious issue is that the specific concerns, priorities and potential capacities of the population to involve itself in the campaign against the disease are not well documented and frequently underestimated. Thus emphasis must be laid on a better understanding of the people’s culture and capacity for initiative.

The site of the project is also an important aspect: the value systems and behaviour norms, which still exist in rural areas, are increasingly destabilized and disintegrated by the migration flows to big cities, where young people are brutally faced with the challenge of surviving in a hostile and economically destructive, though apparently permissive environment. Thus, HIV/AIDS has to be understood in the context of dramatic and rapid change from rural, traditional, and relatively stabilized societal systems to modern urban, competitive and destabilizing life conditions. Migration figures and urban population growth give an indication of the current fundamental upheaval in the organization of non-Western societies.

Therefore the cultural approach proposes a way to better understand people’s reality, their ways of thinking, lifestyles, behaviour norms and motivations in the context of rapid economic and social change. Based on this, the priority given to HIV/AIDS, the content and modalities of preventive action, as well as medical and human care, will facilitate a more effective change process.

Moreover, pilot projects provide opportunities to improve the present situation in the selected countries and to open new possibilities of meeting the challenge with reasonable hope of building lasting solutions, well-adapted to the size and diversity of situations in their respective regions.
4.4- SUMMARY

As in strategy and policy building and project design, implementation and evaluation, field work must respond to the major HIV/AIDS-related challenges: risk, vulnerability, prevention, care, support and impact reduction through the cultural approach. In this respect the current action modalities show serious deficiencies: geographic, medical and socio-economic limitations, combined with insufficient consideration of people’s societal and cultural references and resources. Another serious shortcoming is the lack of communication and the incomplete involvement of stakeholders, and beyond the public sector: NGOs, societies and communities.

Culturally appropriate response in terms of field work should first consider its crucial role in identifying methods for discussion and action, through a better understanding of current realities concerning community participation, field work and field workers. Preliminary evaluation is essential in order to evaluate the achievements and limitations of actions taken to-date, and more specifically in order to identify the local determinants and effects of the current situations and their possible outcomes. Field investigation is not possible without in-depth discussion in order to fully understand the complexity of daily life difficulties. The field worker’s task in this respect is to focus on developing a two-way communication process, in order to clarify the concerns, value systems and mobilization capacity of the local population, in prevention, care and support.

Building local response is then discussed more in-depth in terms of field work, field workers’ profile and tasks. The core of the whole process is empowerment, which is indispensable for mobilizing communities in prevention, care, and support and impact reduction. Special emphasis is put on ways and means to improve the field worker’s relations with large institutions, at the national and international level.

On this basis the main action priorities for field work and building local response can be listed by order of relevance:

- Building community-based response;
- Building partnerships between institutions and the field;
- Culturally-appropriate communication for behaviour change;
- Adapted preventive education;
- Training/sensitizing/capacity building;
- Pilot projects.
As stated in previous documents of the project, field work is the indispensable task for relevant information meant to build appropriate response to local situations as regards risk, vulnerability as well as prevention, care and support to endangered populations. It is also the framework for mobilizing population’s resources and the touchstone for the validity of action taken.

In the present booklet, three major issues have to be considered:

- General observations on the meaning and content of key concepts such as community, participation, field work and field workers;
- Assessment of achievements and limits in the present field work ways and means;
- Building culturally-appropriate field work through strengthening local response and subsequent action priorities in terms of population’s references and resources enhancing solidarity among communities and grounding human resources development for local capacity-building.

N.B.: As mentioned in the Foreword of this booklet three other methodological handbooks are respectively devoted to: project design, strategy and policy building and appropriate-communication for behaviour change.
List of Publications elaborated within the Project:

**A Cultural Approach to HIV/AIDS Prevention and Care**
**UNESCO/UNAIDS Research Project**

Studies and Reports, Special Series -

No. 1 Country Report: Uganda’s Experience (English, French), 1999
No. 2 Country Report: Zimbabwe’s Experience (English), 1999
No. 3 Country Report: South Africa’s Experience (English), 1999
No. 4 Country Report: Angola’s Experience (English), 1999
No. 5 Country Report: Malawi’s Experience (English), 1999
No. 6 Country Report: Thailand’s Experience (English), 1999
No. 7 Country Report: Dominican Republic’s Experience (English, Spanish), 1999
No. 8 Country Report: Jamaica’s Experience (English), 1999
No. 9 Country Report: Cuba’s Experience (English, Spanish), 2000
No. 10 Summary of Country Assessments and Project Design Handbook (English, French), 2000
No. 11 Proceedings of the Kampala Regional Workshop (English), 2001
No. 12 Proceedings of the Nairobi International Conference (English), 2001

Methodological Handbooks-

No. 1 Handbook for appropriate communication for behavior change (English, French), 2001
No. 2 Handbook for strategy and policy building (English, French), 2001
No. 3 Handbook for field work: building local response (English, French), 2001
No. 4 Handbook for project design, implementation and evaluation (English, French), 2001

All of these documents are available for consultation on Internet at:

http://www.unesco.org/culture/aids/