

5 key words:

Guatemala
Develop
Draft
Work Plan
Concurred

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CLM / LMS Trip Report Template

Process for completing trip report

1. This **trip report** must be completed by the traveler and distributed to the supervisor, relevant team leader, project manager and AdCo within 10 business days of the traveler's return to their home office.
2. The traveler will schedule a **debriefing** with their project manager and, if appropriate, the project team within 10 business days of their return to their home office. This meeting will highlight content for the trip report. If the traveler is a project manager, they will meet with the project team. Ideally, the debriefing will be scheduled prior to the traveler's departure. The appropriate Team Leader can serve as a resource to determine who else should be present at the debriefing.
3. Trip reports and addenda should be saved with the relevant TDY documents in sub-project eRoom.
4. Completion of the trip report and scheduling debriefings is the responsibility of the traveler.
5. In the event a trip report needs to be filed with USAID mission, the traveler must have the report **reviewed by the appropriate Team Leader first**, when possible, and project manager before sending the report to USAID mission.
6. When the entire template is completed, email the report along with all relevant documents to the relevant Program Manager, Team Leader, and AdCo. AdCo will determine if trip report and which documents should be sent to **Institutional Memory**.
7. Save this report using the following naming protocol: sub-project name_ traveler's name_ destination_program year_departure month (i.e. Global Fund-Stash- Pakistan -2006-6).

CLM / LMS Trip Report Template

1. Scope of Work: Training for VLDP facilitators in Peru

Destination and Client(s)/ Partner(s)	Destination: Guatemala City and Peten. Client: USAID/Guatemala Partners: The Alliance
Traveler(s) Name, Role	John D. Berman, Team Leader
Date of travel on Trip	June 17-31, 2009
Purpose of trip	The purpose of this trip was to develop a draft work plan for AIDSTAR-Two field support provided by USAID/Guatemala
Objectives/Activities/ Deliverables	The deliverable for this trip was a draft work plan.
Background/Context, if appropriate.	USAID has indicated its intent to provide field support to AIDSTAR-Two, and was eager to begin implementation of this work as soon as possible. Although no funding has been received to date, the activities are currently being forward funded with AIDSTAR-Two core resources.

2. Major Trip Accomplishments: Should include the major programmatic goals realized, relevant metrics, and stories of impact from the trip.

1. The team developed a work plan as required by USAID, and presented same to USAID/Guatemala in a debriefing meeting. The mission concurred with the design and structure of the program as presented to them.

3. Next steps: Key actions to continue and/or complete work from trip.

Description of task	Responsible staff	Due date
1. Revise work plan based on feedback from USAID/Guatemala.	John Berman, Ana Diaz, The Alliance (various)	asap
2. Assure that AdCo Lauren Bailey travels to Guatemala, as agreed with USAID/Guatemala, to begin project launch process (recruit staff, find office space at three locations etc.)	Lauren Bailey	asap
3. Revise budget for project as per feedback from USAID/Guatemala.	Curtis Feather	When we receive feedback from USAID/Guatemala on the budget.

4. Contacts: List key individuals contacted during your trip, including the contacts' organization, all contact information, and brief notes on interactions with the person.

Name	Contact info	Home organization	Notes
Fidel Arevalo	FArevalo@usaid.gov	USAID/Guatemala	Dr. Arevalo is the Activity Manager for AIDSTAR-Two field support activities.
Karen Nurick	knurick@usaid.gov	USAID/Washington	Karen is in the LAC Bureau at USAID/Washington, and was in Guatemala during the time of our trip. We met with her during the debriefing.
Raul Boyle	ONUSIDA GUATEMALA	UNAIDS	Dr. Boyle is the Country Representative for UNAIDS in

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CLM / LMS Trip Report Template

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5. Description of Relevant Documents / Addendums: Give the document's file name, a brief description of the relevant document's value to other CLM/LMS staff, as well as the document's location in eRooms or the MSH network. Examples could include finalized products and/or formal presentations, TraiNet Participant List, Participant Contact sheet, and Meeting/Workshop Participant Evaluation form are examples of relevant documents.

File name	Description of file	Location of file
AIDSTAR-Two Workplan for Guatemala version, Final July 31st draft	Draft Work Plan for AIDSTAR-Two field support activities	AIDSTAR-Two eroom

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USAID
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AIDS Support and Technical
Assistance Resources



AIDSTAR-Two
capacity for impact

AIDSTAR-Two/Guatemala Work Plan

Strengthening Community-Based Network Capacity to Reach Most-at-Risk Populations (MARPs) in the Petén and Izabal Departments

Submitted to

USAID/Guatemala

Health and Education Office (HEO)

Draft 2.0

September 8, 2009

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Acronym List

AIDSTAR	AIDS Support and Technical Assistance Resources
ART	Antiretroviral therapy
BCC	Behavior change communications
COCODES	Community Development Councils
CSO	Civil society organization
CSW	Commercial sex worker
FBO	Faith-based organization
FP	Family planning
IQC	Indefinite quantity contract
IR	Intermediate result
IHAA	International HIV/AIDS Alliance
LDP	Leadership Development Program
MARP	Most-at-risk population
MOH	Ministry of Health
MOST	Management and Organizational Sustainability Tool
MOU	Memorandum of understanding
MSM	Men who have sex with men
NGO	Nongovernmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	People living with HIV
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission
RH	Reproductive health
SOW	Scope of work
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

Executive Summary

AIDSTAR-Two will implement an 18-month intervention in the Petén and Izabal Departments of Guatemala which aims to build local organization capacity for a sustained response to HIV; enable local organizations to address social and structural factors that drive the epidemic; and map the continuum of HIV prevention, care, and support services. This program will be implemented in collaboration with the International HIV/AIDS Alliance (the Alliance), a core AIDSTAR-Two Consortium partner.

Activities to enhance local organizational capacity include working with NGO leadership to develop capacity-building plans, providing assistance both to individual organizations as well as nascent NGO networks (using best practices in capacity-building as identified by AIDSTAR-Two), and evaluate the progress of capacity-building efforts throughout the life of project.

Enabling local organizations to address the structural drivers of the epidemic will first assess cultural and social factors that drive risk for members of the MSM community, and assess the social, legal, and other factors that fuel sexual trafficking. AIDSTAR-Two partners will work with local network organizations to develop social mobilization interventions that address structural drivers of the epidemic, and provide assistance to them in the implementation of these programs.

In order to improve the continuum of preventive care services in the two target departments, AIDSTAR-Two partners will work with local partners/implementing agencies to prioritize investments in key services. Once these priorities have been established, AIDSTAR-Two's will provide sub-awards to local organizations, and monitoring of their progress executing these awards.

At the heart of this program is the transfer of skills to empower local organizations to support local initiatives, including the ability for Guatemalan organizations to build the capacity of local implementing partners to effectively advocate change in social, political, legal, and structural factors that drive the AIDS epidemic in Guatemala. Furthermore, protecting the rights of MSM, as well as victims of human trafficking (particularly those forced into sex work) will go far to decrease their vulnerability; in the long run, this will reduce HIV incidence in Guatemala, and improve care, support, and treatment for HIV positive populations.

The Alliance has established a well-tested model for identifying and empowering local organizations to conduct advocacy for social change while improving services to vulnerable populations. In the social mobilization component described here, the Alliance will invest in a local Guatemalan partner organization to play such a lead role in the MSM community. Combined with AIDSTAR-Two's investments in local partners who can address relevant aspects of human and sexual trafficking, we are confident that this initiative will launch a long-term, sustainable approach to HIV/AIDS prevention, care, and support in Guatemala.

Background

Most HIV/AIDS programs in Guatemala have focused on promoting risk reduction among people who are negative or unaware of their HIV status. However, to maximize the impact of HIV/AIDS program investments in Guatemala, it is imperative that implementers target populations most at risk for contracting HIV (e.g., sex workers, men who have sex with men) as well as people who are already infected.

According to a recent assessment conducted by AIDSTAR-One in five departments of Guatemala (Petén, Izabal, Zacapa, Quetzaltenango, and San Marcos), a variety of providers and institutions, both private and public, offer prevention, care, and treatment services to multiple target populations.

Local nongovernmental organizations (NGOs) carry out prevention interventions, in particular with youth and other most-at-risk populations (MARPs). Some departments have services and providers working with MARPs, although they lack sufficient human and financial resources to achieve significant public health impact. As noted in the AIDSTAR-One assessment, local organizations could be more effective if they improved their coordination.

In the departments of Petén and Izabal, there are multiple implementing agencies offering both prevention and care services to men who have sex with men (MSM) and/or female commercial sex workers (CSW). There is, however, a lack of interventions that address social and cultural factors—such as stigma and discrimination—that drive HIV transmission among MSM. Ethnographic information which allows for a disaggregation of MSM groups by social and behavioral risk factors is also required for more effective programming.

Finally, given Guatemala's significant migratory flows, it is imperative that future programming efforts untangle social and behavioral risk factors associated with mobile populations. These risk factors include commercial sex and human trafficking, which may fuel a significant portion of commercial sex activity.

Legislative Context

The Government of Guatemala has made recent legislative efforts against human trafficking, including the passage of a decree in April 2009 referred to as the “Law against Sexual Violence, Exploitation, and Trafficking of Persons, Decree 9-20091,” clarifying the statutory definition of trafficking in persons and increasing penalties for trafficking, trafficking related crimes, and other forms of sexual violence and exploitation². Article 202 is a principal component of the new legislation, prohibiting the “transport, transfer, retention, harboring, or reception of persons for the purposes of prostitution, sexual exploitation, forced labor or services, begging, slavery, illegal adoptions, or forced marriage, in addition to other prohibited purposes” (UNHCR, 2009). This new law also increased the severity of penalties for trafficking in persons, and made them commensurate with penalties for crimes such as rape.

Other recent legislative advances in Guatemala include the creation of a prosecutorial unit aimed at fighting human trafficking and illegal adoptions, the approval of a 10-year national action plan aimed at combating human trafficking, and the passage of Decree 22-2008, the “Law Against Femicide and Other Forms of Violence Against Women³.”

¹ <http://www.scribd.com/doc/17542534/Ley-contra-la-violencia-sexual-explotacion-y-trata-de-personas-Decreto-92009>

² UNHCR Trafficking in Persons Report, 2009. <http://www.unhcr.org/refworld/country....GTM.4562d94e2.4a4214b8c.0.html>.

³ Guatemala Human Rights Commission USA, http://www.ghrc-usa.org/Publications/Femicide_Law_ProgressAgainstImpunity.pdf

Although the Government of Guatemala has taken significant legislative action against human trafficking, these new laws have largely remained unenforced, and the country is currently on Tier 2 watch status by the UNHCR for “failing to show increasing efforts to combat human trafficking, particularly in terms of providing adequate assistance to victims and ensuring that trafficking offenders, including corrupt public officials, are appropriately prosecuted, convicted, and sentenced for their crimes” (UNHCR, 2009).

The Community Development Councils (COCODES) in the new Law of Urban Councils and Rural Development

The Guatemala Social and Economic Agreement established the need to “deepen the decentralization and devolution of powers, responsibilities, and resources concentrated in the central government in order to modernize and make effective and streamline public administration.” Decentralization should ensure the transfer of decision-making power and resources at appropriate levels (local, municipal, departmental, and regional) to efficiently meet the demands of economic development and promote close interaction between government bodies and the population. Decentralization should also promote reform so that deputy mayors are appointed by the municipal mayor, considering the recommendations of local residents in open council. Taking into account the crucial role the councils of urban and rural development play to promote and ensure public participation in identifying local priorities, the following measures were taken:

- Re-establish local development councils;
- Promote a reform of the Councils’ Act for Urban and Rural Development to expand the range of sectors participating in the departmental councils and Regional Development;
- Ensuring adequate funding for the council system.

On March 6, 1996 and during the first year of the new government the "Agreement on Economic and Agrarian Issues" was signed in the Federal District of Mexico City between the government of Alvaro Arzu and the Guatemalan National Revolutionary Unity-URNG. That agreement is now part of the Peace Accords. In the agreement, the government and the guerrillas agreed to re-create the local development councils as a mechanism of decentralization and access to financial resources by communities and municipalities; the operationalization of these councils was not agreed upon then. Another agreement made in March 1996 that is closely related to the definition of Community Councils is the “Agreement on Identity and Rights of Indigenous Peoples” by the existence of traditional community organizations in much of the country.

During this period of government (1996-1999), the development councils worked at the department level by managing the funds dedicated to infrastructure construction without really articulating the other socio-political initiatives in health and education sectors. The same issue occurred at the municipal and community level. In 2002 three laws were passed to correct this problem, resulting in the CODEDES, COMUDES and COCODES (Departmental, Municipal, and Community Councils): The Law of the Councils of Urban and Rural Development, Decree No. 11-2002, the City Code, Decree 12-2002, and the General Law on Decentralization, Decree 14-2002.

Goal, Objectives, and Intermediate Results

This scope of work (SOW) describes activities AIDSTAR-Two proposes to carry out with field support from USAID/Guatemala. The **goal** of this program is to reduce HIV incidence in Guatemala. The **objective**

of the program is to decrease HIV transmission among key MARPs. The specific **intermediate results (IRs)** follow:

- **IR1:** Enhanced local organizational capacity for sustainable HIV response
- **IR2:** Improved social environment for vulnerable populations accessing HIV services
- **IR3:** Improved continuum of preventive services in select geographical areas

During the first project year, AIDSTAR-Two will focus geographically on Petén and Izabal; at the close of year-one activities, we will evaluate the schedule for expansion to additional departments.

HIV/AIDS in Guatemala

The HIV/AIDS epidemic in Central America is concentrated in MARPs such as CSW and MSM, yet there is increasing evidence that HIV is spreading into the general population. HIV prevalence is highest among adults aged 20 to 39—people who are in their most productive years and most likely to travel and migrate—making the disease a threat to economic growth and regional stability. The relatively high prevalence among the people most likely to migrate from Central America to the US could also pose a health risk to US populations and among immigrant communities in the US.

The US Agency for International Development (USAID) implements the US President’s Emergency Plan for AIDS Relief (PEPFAR) efforts in Central America with a regional HIV strategy that focuses on prevention, improving the policy environment, and comprehensive care. USAID collaborates with governments, civil society, NGOs, and the private sector to implement this strategy in Central American countries including Guatemala. Major improvements have been made in the regional policy environment, including over 120 significant positive policy changes in the last decade. USAID, the only major donor concentrating its prevention efforts with MARPs, has scaled up prevention services and expects to make over 350,000 outreach contacts each year.

Guatemala accounts for nearly one-sixth of Central America’s HIV-infected population. The epidemic in Guatemala is considered concentrated because less than 1% of the general population is estimated to be HIV-positive. Since the first case of HIV was reported in Guatemala in 1984, infections have occurred primarily among MSM and sex workers. As of April 2007, Guatemala had 10,304⁴ officially reported cases of HIV/AIDS. UNAIDS (Joint United Nations Program on HIV/AIDS) estimates that 61,000 people are living with HIV and 2,700 deaths have occurred due to AIDS in Guatemala.

Guatemala’s HIV-infected population lives primarily in urban areas along major transportation routes. Available data indicate that HIV mainly has affected urban and Latino populations. However, preliminary data indicate that there could be increased HIV infection among Maya and Garífuna populations, but the data are insufficient to determine the extent of the epidemic. According to the 2007 National Epidemiological Center report, more than 77% of reported AIDS cases occurred in seven states: Suchitepéquez, Guatemala, Izabal, Escuintla, Retalhuleu, San Marcos, and Quetzaltenango. More than 80% of reported HIV cases have occurred among 15-to-49-year-olds, and 20-to-34-year-olds account for more than 52% of all cases.⁵ National HIV prevalence among CSWs is 3-4%; among groups of street-based CSWs, the prevalence is as high as 12%. National HIV prevalence among MSM is 10%, but in the capital, 5% of MSM were HIV-positive, according to data from a 2003 multi-site study.⁶ Other vulnerable

⁴ National AIDS Program, April 2007.

⁵ Ibid.

⁶ Ministry of Health. USAID/OASCA (Strengthening the Central American Response to HIV/AIDS Programs), et al. Guatemala Multisite Study, 2003.

populations include prison populations, youth, and street children. According to the Guatemalan Ministry of Health, no cases of infection have been reported among injection drug users or through blood or blood products.

Several risk factors contribute to Guatemala's HIV epidemic, including migration and proximity to the high-prevalence Caribbean region; proximity to Honduras, in particular, is likely an issue due to higher prevalence levels and illegal migrations across the border. Migrants often participate in high-risk sexual behavior, increasing their chances of becoming infected with HIV and other sexually transmitted infections (STIs). The effects of HIV/AIDS are exacerbated by high levels of poverty and limited access to health care. The rate of HIV co-infection with tuberculosis (TB) is growing in Guatemala—the 2006 Global Fund Project baseline survey found that HIV infection among TB patients was 12.9% and noted that TB is the most frequent opportunistic disease associated with HIV in Guatemala.

Program Description

Overview

AIDSTAR-Two will assist USAID/Guatemala in achieving its HIV/AIDS Bilateral Assistance Objectives for the five-year period, 2008-2013. These objectives include

- Increased use of prevention practices and services to combat HIV/AIDS;
- Improved policy environment to combat the HIV/AIDS epidemic;
- Expanded implementation of effective and efficient delivery of comprehensive care and treatment for people living with HIV (PLWH).

USAID/Guatemala will review and approve all key personnel and local implementing partners as part of the 18-month work plan which will be divided into two segments: July through September 2009, supported by currently available funding (about \$515,000), and October through September 2010 which will be funded with FY 2009 field support (estimated \$1.2 million). The 18-month work plan budget will total \$1.71 million, subject to the availability of funds.

MSH and the Alliance are the principal AIDSTAR-Two Consortium members participating in this program. As described below, MSH and the Alliance will coordinate their capacity-building efforts to assure local ownership and leadership of all activities, and the sustainability of these efforts beyond the end of project. Specifically, AIDSTAR-Two partners will work towards a sustainable consortium led by strong Guatemalan organizations that, in the future, could act as national partners of USAID and others for providing technical and financial support to MARP groups and will have principal coordination and capacity-building responsibilities for MARP organizations throughout the duration of the project. MSH will focus principally on institutional and organizational development of such lead organizations, empowering them to transfer these management skills and strategies to other Guatemalan organizations.

The Alliance will have principal responsibility for working with the lead organizations to build their capacity for the assessment of, and advocacy to transform social, political, and policy factors that drive vulnerability to HIV acquisition and limit access to services for MSM. The assessment involves leaders from a core group of organizations, and encourages them to work together from the start of the social mobilization strategy and to learn skills to conduct needs assessments before planning activities and projects. The needs assessment is instrumental in collecting the information that will be used for

planning the social mobilization strategy and will function as a social mobilization element, reaching the people who are most difficult to reach.

After the Chetumal Trafficking Conference described below, MSH will work to identify lead organizations that will tackle social, political, and policy factors which increase vulnerability to HIV among victims of human trafficking.

Activity Summary by Intermediate Result

IR 1: Enhanced Local Organization Capacity for Sustainable HIV

Activity 1.1: Identify potential network leaders in Petén and Izabal

Summary of site visits, partners identified

Based on reconnaissance visits to Izabal and Petén, and information recently provided by AIDSTAR-One,⁷ AIDSTAR-Two has identified networking initiatives involving key public and private sector institutions in both departments. However, these network structures are weak, and collaborative programming to date has been extremely limited. Investing in and building the capacity of these networks is an important opportunity to scale up and increase the effectiveness of advocacy and other programs that address the social, political, and policy environment for vulnerable populations (e.g., stigma and discrimination, human rights, and gender-based violence).

Table 1. Categories of Organizations Involved in the HIV/AIDS Response, Petén and Izabal

Organization Type	Example(s)
Works on issues related to health, education, development, and human rights, with component(s) on HIV/AIDS	Tanuxil, Petén Association of Women Junajil, Izabal
Does specific work on HIV/AIDS at the national level, implementing actions locally	PASMO, Nuevos Horizontes, Gente Nueva, Gente Positiva, Asecsa, National Alliance of People Living with HIV
Local organizations formed by groups of people infected or affected by HIV (PLWH, CSW, MSM, etc.)	Amistad Positiva, Petén; Alianza Liberal de Integración, Izabal; Asociación Vida Nueva, Izabal; Huellas Positivas, Izabal; Isaberi Ibagari (an association of Garífuna women affected and infected with HIV), Livingston
Government institutions that provide health, education, or human rights, or that are relevant to a multisectoral response to HIV at the local level	Health Center Izabal, Petén National Hospital, Japan-Guatemala Friendship Hospital, Procuraduría de Derechos Humanos
Local community town councils linked with government structures	COCODES, local level; COMUDE, municipality level; CODEDE, departmental level
Persons who provide private services related to HIV/AIDS and STIs	College of Physicians and Surgeons of Guatemala

⁷ AIDSTAR-One. "Complementary Evaluation of the Existing Activities on Community Care and Prevention in the Departments of Izabal, San Marcos, and Zacapa in Guatemala," April, 2009.

Overview of process for identifying additional leadership partners, and required qualifications

A variety of social development programs have been implemented in the departments of Petén and Izabal. Such activities have addressed health, education, democracy, land reform, gender, gender-based violence, sexual and reproductive health, and poverty alleviation. HIV/AIDS is generally considered to be a major issue in both departments, and is linked to other social issues including violence, stigma and discrimination, social injustice, human trafficking, and homophobia.

Existing networks involve stakeholders working on these social issues. As such, AIDSTAR-Two staff anticipate that a strengthened and cohesive network response would go far to reduce the vulnerability of MARPs. Network members include NGOs involved in health and social welfare programs, faith-based organizations (FBOs), the Community Development Councils (COCODES), municipal authorities, private sector medical providers, and many others.

Lead organizations

While there are many organizations involved in health related issues, AIDSTAR-Two partners will coordinate activities to identify two lead organizations: one lead champion for activities related to MSM, and a second to focus on victims of human and sexual trafficking. By the close of project, both organizations will have expanded their organizational and technical capacity and be able to effectively provide technical support and put strong systems in place to channel funds to other partners in joint strategies or larger projects. By working in this way, we provide key tools to help ensure that the project results in a level of community empowerment and sustainability.

Activity 1.2: Work with key public and civil society organization leaders to develop capacity development objectives and plans for their organizations or groups

Overview

AIDSTAR-Two capacity development staff based in Guatemala will work with leaders of civil society organizations (CSOs). Such groups include support groups for (and of) PLWH, NGOs implementing HIV/AIDS activities, and groups representing stigmatized and most-at-risk populations, particularly MSM).

AIDSTAR-Two will work with CSOs to help identify and address organizational factors (e.g., governance, financial management) which limit the quality and/or scope of the organizations' HIV-related interventions. The project will also help develop multisectoral, social mobilization responses to social/structural drivers of HIV infection among MARPs.

For this activity, the AIDSTAR-Two capacity-building team will facilitate **comprehensive self-assessments** with CSOs, public health care providers, and support groups identified as key HIV/AIDS service providers in Petén and Izabal. In-depth assessments will allow these participating organizations to review their current structures and systems and develop priorities for institutional strengthening.

Based on initial conversations with seven key HIV/AIDS providers in Petén and Izabal, AIDSTAR-Two staff expect that organizational priorities will include defining organization vision and strategic objectives, strengthening operational structures and processes, and securing appropriate legal status as nonprofit organizations. This highly participatory process will require the active engagement of leaders, frontline staff, and support group members to produce action plans that the organizations will execute in six months with coaching from our capacity-building team.

Descriptions of needs assessment tools and strategies

To increase the capacity of CSOs, support groups, and public sector HIV/AIDS providers, we propose to use the rapid Management and Organizational Sustainability Tool (MOST) to help them identify the specific management and leadership organizational gaps that are limiting their HIV/AIDS response. In every institution, staff and volunteers from all management levels will participate in determining the organizations' existing strategies, structure, and management systems. The results of this participatory ***self-analysis*** will be used to prioritize management systems that require strengthening and streamlining.

The MOST assessments ***will be carried out by the organization or group itself and not by an external evaluator***. The process is made possible by virtue of an experienced facilitator that guides the group through a structured and well-documented self-assessment process.

As a result of this facilitated self-assessment process, each organization will evaluate its own performance in 18 different essential management components. During this facilitated process, participants will be asked to share their perceptions regarding key management challenges, and reach consensus about priority changes that will improve their organizational performance. Through this consensus building process, the organization will establish its capacity-building priorities and develop a six-month action plan; the action plan will have concrete objectives and activities. To make sure that the plan is executed, each organization will choose an ***implementation team*** that will receive technical assistance from AIDSTAR-Two's capacity-building team.

Key Components of Capacity to Be Assessed

This version of the most will address a number of facets of capacity that are central to the success of this program. These include:

- The ability to conduct advocacy;
- The ability to analyze available information, and apply the results to priority issues;
- How to influence policy to bring positive change;
- The ability to monitor and document program activities;
- Sustainability—the ability to sustain an initiative, and the long-term viability of the organization generally.

Transfer of capacity building skills

Participation in the MOST self-assessment process is, furthermore, the first stage in the transfer of capacity-building skills. Designated leaders/staff participating in this self-assessment process will receive follow-up technical assistance from AS2 staff that will allow them to facilitate the MOST process with other Guatemalan organizations, thus assuring the sustainability and local ownership of these capacity-building efforts in Guatemala.

Through ongoing technical assistance, AIDSTAR-Two/Guatemala staff will transfer skills, knowledge, and tools to the implementation teams in the following areas: annual operational planning; human resources management; financial management and reporting; monitoring, evaluation, and reporting systems; and continuing education opportunities for staff with emphasis on developing leadership skills.

AIDSTAR-Two will help lay the foundation for strong leadership, governance, and management capacity of key HIV/AIDS provider organizations in Petén and Izabal by helping the provider organizations address key management issues and prepare to work collaboratively as part of a local intersectoral network.

AIDSTAR-Two will thoroughly discuss and review this section's proposed needs assessments and timeline with USAID/Guatemala and with participating providers. Adjustments in the proposed approaches and activities will be made if necessary and according to the discussions.

Roles and responsibilities

AIDSTAR-Two will hire two capacity-building specialists to coach CSOs in Petén and Izabal during the life of the project. These staff will be trained by one of MSH's organizational development specialists on the use of capacity-development tools and approaches.

Activity 1.3: Work with key network members to develop capacity-building plans for the network

Overview

Concurrent with civil society organizational development plans as described above, AIDSTAR-Two/Guatemala staff will develop strategies to strengthen existing NGO/implementing agency networks in both Petén and Izabal. Such networks have the potential to become engines of social change, and can serve as a platform for communication among disparate implementing partners. Networks are also critical in building a successful and sustainable HIV/AIDS response that addresses social (or "structural") drivers of the epidemic in Guatemala.

The principal objectives for strengthening provider networks include strengthened interagency coordination, improved oversight and transparency of individual organizations in their HIV/AIDS programming efforts, and the establishment of a platform for improving capacity in relevant technical areas.

Descriptions of tools and strategies

During initial interviews, key leaders have expressed an interest in becoming part of intersectoral HIV/AIDS networks; however they recognize that prior attempts to do so were unsuccessful because of poor coordination, lack of alignment, and a predisposition to compete for existing scarce resources.

In order to establish networks, our capacity-building teams will organize a series of meetings with key organizations that completed the MOST action plans and engage them in a thorough assessment of why past networks have failed. The assessment will take into account the challenges already identified and outlined in the AIDSTAR-One report "*Evaluacion complementaria de las actividades existentes de atencion comunitaria y de prevencion en los departamentos de Izabal, San Marcos y Zacapa en Guatemala.*" Some of these challenges include inadequate budgets for ongoing technical training and outreach activities; the alignment of each member organization's motivations with the overarching goals of its network(s); using each member organization's expertise to improve their network's outreach in that area (e.g., advocacy, prevention, treatment, social support of PLWH); being inclusive of MARP and PLWH organized groups; and network members' own misconceptions and stereotypes of vulnerable groups.

During the assessment, our capacity-building team will help members identify which of the following stage of network development they are in and would like to progressively move to:

- **Communication:** exchanging information between members
- **Coordination:** aligning efforts on a common activity, but not sharing funds
- **Collaboration:** explicitly planning and organizing activities together, using pooled or jointly budgeted funds for implementation

- **Formal partnership:** implementing planned activities using memoranda of understanding (MOUs) or contracts to define the terms of collaboration, content, and funding

In addition to the assessment, AIDSTAR-Two will bring key sector leaders together to review and assure the compatibility of their **social mobilization plans**, and to identify opportunities for collaboration. The objective of this phase is to assure that sector-level efforts will be harmonized, mutually reinforcing, and collaborative. The AIDSTAR-Two team will work with networks to define expected goals, management roles, and responsibilities, and to develop a common vision and mission.

Once the goals and objectives of the networks have been outlined, AIDSTAR-Two will also help member organizations evaluate their capacity to carry out their roles and responsibilities as part of formed committees. We will work with these committees to draft a simple **governance manual** detailing oversight roles, responsibilities, and mutual obligations of each member organization in their response to the epidemic. We will also help produce an **oversight plan** to be executed by a technical and financial oversight committee. The oversight plan and committee will continuously promote efforts for transparency, feedback, and collaboration among all members; efforts include monitoring progress towards objectives and documenting results.

As a result, each member organization will see clearly the advantages of being a network member but also acknowledge the potential loss of control and burden that network coordination can bring to their organization. By ensuring the voluntary commitment and motivation of each member organization to its network(s), these activities will provide a solid foundation for the networks' provision of services and social mobilization plans.

The intersectoral network will also be coached to accommodate key actors who may not have the capacity or inclination to be permanent members of a network. One alternative that will be proposed is to form informal and emergency multisectoral partnerships to address events such as World AIDS Day, and other specific community-wide activities. Independent private physicians, for example, may be willing to donate some of their time to specific activities.

Roles and responsibilities

The AIDSTAR-Two capacity-building team will facilitate the process and provide continuous coaching to the networks in order for members to establish membership, structure, and strategic direction. One of MSH's organizational development specialists will train the project's capacity builders on MSH's tools and approaches, and provide coaching as needed throughout the life of the project. Two administrative staff people, each located in one of the departments, will also support the local team.

Activity 1.4 Provide on-going capacity-building assistance in key organizational and technical areas to assure sustainability of capacity-building activities.

Key organizational and technical areas include

- Leadership
- Management
- Sexual diversity and identity
- Stigma and discrimination
- Best practices in HIV/AIDS prevention

Multisectoral networks require continuous work. AIDSTAR-Two will set up a process of communication manage network activities that are the responsibility of AIDSTAR-Two administrative staff; staff will work with capacity builders to plan and ensure that network establishment and training activities have been budgeted for and coordinated. Time and funding will be needed to plan meetings for all members, develop an intranet-like system or website for continuous communication and access to standard information, develop a common reporting framework, and continuously train member organizations in the specific technical areas mentioned above. Network members will help determine final training topics based on their order of priorities.

Training methodologies will be informed by the results of the study assessing the social and structural risk factors for MSM (i.e. behaviors and barriers to accessing services). As a key AIDSTAR-Two partner, the Alliance will lead trainings on sexual diversity, identity, stigma and discrimination, and best practices in HIV/AIDS prevention. The Alliance will adapt materials and methodologies to the needs and context of both Petén and Izabal and will leverage existing knowledge of network members, especially of MARPs and PLWH support groups working in these areas.

An additional tool to use in increasing the capacity of members in the area of leadership and management practices is the Leadership Development Program (LDP). The LDP works with organization teams to identify a challenge they are facing and coach them to apply leadership and management practices to address the challenge. AIDSTAR-Two proposes that participating teams be **network committees**, and that they choose an HIV/AIDS challenge affecting MARPs and that is aligned with the goals and objectives of the network. Committees will choose a service delivery result to reach by applying the leading and managing concepts and tools introduced in the LDP over the course of four to six months. In this LDP, network committees will meet for two-to-three day workshops during which they will learn core leading and managing practices and concepts and then meet on a biweekly or monthly basis to discuss strategies to address their challenges and achieve their measurable results. Regular coaching by AIDSTAR-Two capacity builders will be available to support the committees in implementing the tools of the LDP, and network members will be continuously updated and enlisted as resources to support these committees on a regular basis.

These tools will allow the network to define goals, approaches, and methodologies for action on their own while at the same time fulfilling their organizational missions and commitments with donors and other supporters.

Activity 1.5: Evaluate progress of capacity-building efforts with AIDSTAR-Two indicators

AIDSTAR II Global IQC, Task Order 1 (“AIDSTAR-Two”) includes a SOW for the identification of best practices in capacity-building, including indicators related to the measurement of success in capacity-building. Specifically, Subtask 1.1 states that MSH will “identify, assess, and analyze key capacity-building challenges and methods to address them and develop a knowledge base for capacity-building and its program implementation.”

IR 2: Improved Social Environment for Vulnerable Populations Accessing HIV Services

Activity 2.1: Assess social/structural factors that influence MSM in Petén and Izabal to behaviors that increase their risk of acquiring HIV

Background

Knowing the social and structural risk factors that facilitate or prevent the transmission of HIV among MARPs is key to better understanding what prevention and care activities people need. For example, to best serve MSM, one must recognize the different identities and behaviors that fall under the MSM label: men who identify as gay, men who identify as heterosexual, transgendered persons, men and transgendered people having sex for money or in prison, etc.

Social and cultural norms differ widely across countries and it is well-known that these norms play an important role in the quality of services available and provided to marginalized people, including many MARPs. In many countries, stigma and laws or policies against certain populations or behaviors (e.g., homosexual practices or sex work) drive people underground and make them very difficult to reach with vital services and support. These structural barriers must be overcome in order to serve MARPs and mitigate the impact of the HIV epidemic. AIDSTAR-Two will conduct a study of these factors to increase knowledge, support programmatic decisions, and advocate for structural changes in laws, policies, and health services. This is a necessary first step to a successful response.

Overview of current situation for MSM: programs, barriers to safe behaviors, priorities

Services to MSM populations in Guatemala include behavior change communications (BCC), the distribution of condoms and lubricants, treatment of HIV and other STIs, and voluntary counseling and testing (VCT). However, prevention programs are constrained by a lack of information about identity, sexual practices, and the influence of stigma and discrimination among MSM. The purpose of the study described below is to understand underlying social and cultural factors, and their influence on behaviors that put MSM at heightened risk of HIV infection.

Assessment methodology

Research methodologies involving the community in the design, implementation, and analysis of results have proven more effective for assessments focusing on communities affected by the HIV epidemic. The Alliance has developed a range of tools to carry out participatory community assessments, which can be adapted to different cultural, social, and geographic contexts, and to different populations. These methodologies include tools for mapping, rating services, analyzing needs, and identifying solutions; these tools can be supplemented with other ethnographic methodologies such as in-depth interviews and focus groups to obtain qualitative information. However, the main strength of the methodologies is the involvement of affected populations in the identification and analysis of *their* problems and *their* solutions.

Logistics and timing

The implementation process can be divided into the following steps:

- Define assessment objectives with a group of key people in the community, decision-makers, and advisors from academia;
- Develop a research protocol with the actors involved;
- Identify members of the MSM community who can help carry out the assessment;
- Train a group of MSM community members in Izabal and in Petén in community participatory assessment techniques;

- Collect information from MSM populations in field;
- Conduct a results analysis workshop;
- Develop a document that will summarize the findings;
- Disseminate the results among MSM populations, organizations, and institutions;
- Monitor the use of findings in services and other advocacy activities.

Key implementing partners: roles and responsibilities

The assessment team will be composed of International HIV/AIDS Alliance staff and/or consultants. The Alliance will provide overall technical direction and coordination for this study, and will use tools developed by the Alliance including methodologies for community participatory assessment. MSM organizations will provide guidance and participate in the design, implementation, analysis, and dissemination of results and in the process of identifying people in the community to be reached. A researcher from the University of San Carlos in Guatemala and an advisor to the AIDSTAR-Two Consortium will link the assessment process with the overall activities of AIDSTAR-Two.

Alliance staff based in Brighton will have overall technical responsibility for the execution of this assessment, and will utilize regional resources that have substantial experience in this area. Furthermore, it is important to note that in addition to producing the assessment report (to be delivered in December 2009), the Alliance will begin engaging local partners in the social mobilization process and identify the lead partner that will be a potential linking organization⁸ in the future.

Activity 2.2: Develop activities to address structural/other risk factors for victims of sexual trafficking

Background

Gender-based violence in Guatemala is linked with other vulnerability factors that put women at risk of acquiring HIV (poverty, mobility, gender inequity, child exploitation, etc.). Petén and Izabal are near one of the most important migratory routes connecting Central America with the United States. At various points along the route, it is possible to identify activities related to sex work (brothels and bars), but there is a difference between sex work exercised by adult women, human trafficking, and sexual exploitation. All three are broad issues that overlap but need to be addressed with different strategies. Implementation of anti-trafficking strategies often have had negative implications for the well-being of sex workers worldwide; thus sex worker involvement in activity planning should be considered. Police crackdowns have resulted in sex workers being blamed or mistreated.

Human trafficking is an illicit activity with a very violent history in Guatemala. It is beyond the scope of an HIV project to implement activities to stop trafficking. However, it is important to bring key stakeholders together to discuss the linkages between HIV and human trafficking, and to provide information on existing services to people potentially affected by HIV and human trafficking. Above all, it is vital that those who will be directly affected by policies related to trafficking have a voice in these spaces. As with MSM, the label “sex worker” encompasses different behaviors, circumstances, and levels of risk. Increased knowledge of these differences in Petén and Izabal will help identify unique

⁸ A “linking organization” is an organization that has been accredited by the Alliance to become a member organization. The process involves a rigorous capacity assessment and visits from peer organizations that are already members of the Alliance. It is a relationship-building process with all other linking organizations and the Secretariat, therefore the organization needs similar vision and values as the Alliance.

needs of and improve programs for adult CSW and their clients, but study results will also support services and advocacy for exploited minors who are victims of human trafficking.

Overview of current situation for victims of human trafficking: programs, barriers to safe behaviors, and priorities

Currently, programs that work with victims of human trafficking and sexual exploitation are carried out by organizations working on human rights and gender. However, barriers related to the illicit nature of these activities prevent the problem from being effectively analyzed and approached. Links to health services and other social programs have been particularly hard to implement and the underlying difficulties in hiding, violence, and lawlessness make this population even more vulnerable. Gathering additional information is a top priority; it will help implementers and policymakers better understand the forces involved in this social problem and the links with HIV and other STIs, human rights, and gender equity.

Chetumal Regional Conference on Human Trafficking and HIV

AIDSTAR-Two staff/consultants will participate in and facilitate the implementation of a regional conference to be held in Chetumal, Mexico, on human trafficking. This meeting represents an essential first step to pool knowledge of human trafficking in Guatemala and Central America in general. This conference, furthermore, will allow donors, implementing agencies, and academic institutions to build consensus regarding:

- The root causes or drivers of human trafficking;
- The relationship between human trafficking and HIV transmission in the region;
- Priority activities to prevent HIV transmission in a trafficking context;
- Provide assistance to victims of human trafficking that will empower them to reduce their vulnerability to HIV/AIDS and reclaim their basic human rights.

Next Steps: Relationship between Chetumal Conference and AIDSTAR-Two Interventions on Human and Sexual Trafficking

The AIDSTAR-Two program will build on the consensus and recommendations regarding HIV/AIDS and human trafficking that are established during the Chetumal Regional Conference on Human Trafficking. Immediately after the conference, the AIDSTAR-Two Chief of Party will work with local and regional experts to articulate a strategy for assessing the programmatic priorities related to human and sexual trafficking and HIV/AIDS, and identifying appropriate local partners who can participate both in additional follow-up assessments as required, and the execution of priority interventions designed to reduce vulnerability to HIV of current and potential victims of trafficking. A detailed plan for the assessment will be submitted within 30 days after the close of the Chetumal trafficking conference.

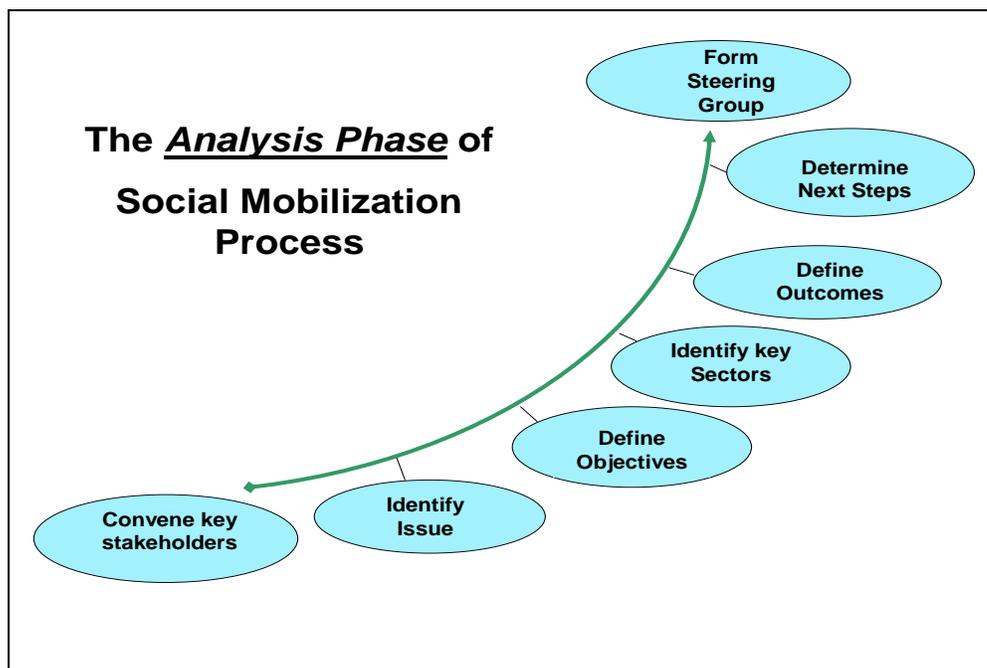
Activity 2.3: Build sustainable consortium network capacity to conduct social mobilization activities

During an assessment mission conducted by Alliance staff and regional consultants, a lead Guatemalan organization will be identified to ultimately manage a consortium of organizations or a network which will be the principal medium for social mobilization activities. Investments in this lead organization and the partners it coordinates/supports will focus on participatory identification of social, policy, or other

structural drivers of vulnerability; and social mobilization strategies as described in annexes E and F in this work plan.⁹);

Activity 2.4: Support sustainable consortium networks' efforts to build consensus among stakeholders regarding structural drivers of HIV-infection among MSM and victims of sexual trafficking

AIDSTAR-Two project team in Guatemala will support networks throughout the social mobilization process. This consensus building is a critical part of the social mobilization process, as various sectors of society cannot mobilize together until there is agreement regarding the nature of the problem, and probably solutions. Specifically, in the first phase of social mobilization, key stakeholders meet to decide how best to approach a given problem or set of problems.



AIDSTAR-Two/Guatemala will support phase one of this process by providing the resources to convene stakeholder meetings and by providing a facilitator *if and only if* the network leadership determines that such external facilitation would be useful. Per the graphic above, the outcomes from this stage of the process will be a clear identification of the social and structural issues (facilitated by MSM and trafficking studies described in IR3), statement of objectives, identification of key sectors to be engaged, projection of outcomes, outline of next steps, and formation of a network/social mobilization steering committee.

2.4.1 MSM Mobilization Efforts

The Alliance will support the lead organization to build consensus among stakeholders regarding structural drivers of HIV acquisition among MSM. This support will include working with the lead

⁹ In the previous section, the work plan notes that capacity-building for individual network member organizations will address the networking process. The introduction of material, through separate workshops, on social mobilization will reinforce the commitment of working together through strong networks; social mobilization could not be achieved otherwise.

organization to conduct investigations among relevant local organizations, ***and will be executed concurrently with the MSM assessment described above.***

2.4.2 Mobilization Related to Human/Sexual Trafficking

The AIDSTAR-Two Chief of Party (COP) and social mobilization staff will work with an organization identified during the Chetumal conference to build consensus among stakeholders (implementing organizations) regarding social, political, and other factors that drive HIV vulnerability for current and potential victims of sexual trafficking. As with the parallel effort on MSM vulnerability, the ultimate outcome of this stage of the mobilization process will be clarity about the specific problems that need to be addressed, and the organizations, institutions, and individuals that must be engaged to change current destructive practices, policies, and/or social norms.

Activity 2.5: Support sustainable consortium networks' coordination and implementation of mobilization campaigns to address structural drivers of HIV acquisition among MARPs

AIDSTAR-Two staff will provide financial, logistic, and human resources to support the social mobilization process. The key activities in this process are outlined below, while a detailed description of the social mobilization process is included in Annex F.

Principal components of mobilization process

Sector-level planning. After the initial sector-level engagement, representatives of the sector will be asked to decide on concrete steps that they and their members can take to advance the change of social norm(s) as proposed by the social mobilization program. There may be considerable variability between sectors and within sectors across geographic zones, suggesting specific actions that can be taken to support a social mobilization effort would not be useful.

Budgeting. The network, with support from AIDSTAR-Two, will consider what resources will be required for sector-level plans. To the extent possible, resources should be generated within the sector; doing so creates ownership and demonstrates commitment. However, where additional resources are required and appropriate, the sector leaders (coordinators) should be clear about the level of funding required, how those funds will be accounted for, and what the ultimate impact will be. AIDSTAR-Two will provide financial support as necessary.

Support plan. The networks will consider what types of logistic or other support will be required by various sectors. At the early stages of the sector-level mobilization, it may be unclear what types of support are needed or possible (over and above the resources needs described above). For the early stages, we recommend that sector leaders consider support (technical or other assistance) for

- Developing printed communications materials to be used in the sector specific outreach activities;
- Developing radio/video products to help disseminate messages and objectives, within the sector and to the general public;
- Coordinating with media to assure coverage of sector events;
- Training, logistics, and event coordination.

Activity 2.6: Develop and implement communications campaign to support mobilization efforts

AIDSTAR-Two will support the development of the amplification plan. The key document for the amplification plan will be a communications brief as used in traditional communications and social marketing programs. The fundamental difference of this amplification plan, however, is that the communications brief will be driven solely by the content of the sector-level plans. This brief should explain how the sector-level plans can be linked and how the “reach” of sector-level activities can be extended nationally.

The communications brief for the amplification plan will need to consider the following:

- Creation of visual (or other) linkages that unify the sector-level plans. Doing so will create a sense of unity and coordination and will help demonstrate the pervasiveness of the social mobilization movement.
- Development and placement of materials for radio and television.
- Utilization of visual media such as billboards, posters, pamphlets, and flyers.
- Development of “promotion” materials that can be used by each of the sectors can distribute to help them achieve their objectives. Such materials, as utilized in social marketing campaigns, might include pens, t-shirts, school supplies, key chains, drink coasters, aprons, or bumper stickers.
- Provision of pedagogical materials that will help actors within a given sector familiarize their members with social mobilization objectives and strategies.
- Facilitation of outreach to remote or hard-to-access populations.
- Budget

IR 3: Improved Continuum of Preventive Care Services in Select Geographical Areas

Activity 3.1: Facilitate development of network plan to prioritize investments in MARP services

AIDSTAR-Two staff will work with network leadership to prioritize investments in MARP-related services based on results from the GIS mapping exercise and the assessment of structural and contextual factors contributing to infections among MSM and victims of sexual trafficking (who are now engaged in commercial sex, or are otherwise at risk because of the sexual trafficking).

Types of services are likely to include VCT, legal services, psychological counseling, ART, palliative care, and prevention counseling. The prioritization will be made with respect to the need for services as established in survey/mapping exercises described above, and the degree to which current demand for services is being met in relevant geographic areas by existing providers.

We note, however, that programming related to structural drivers (e.g., stigma, sexual trafficking) will be addressed in activities under IR2.

Activity 3.2: Provide sub-awards/grants to network members for improvement of MARP services

Once the network has prioritized their investments for MARP services (over and above activities related to social mobilization), the program will make \$200,000 available through a grants program during the

first 18 months. We anticipate that individual awards will be up to \$20,000, for execution over a 12-month period. MSH has a well-established grants management infrastructure, documented in the AIDSTAR-Two contract (see "Grants under Contract"), and these procedures will be transferred to operations in Guatemala.

Activity 3.3: Monitor and evaluate execution of sub awards

During the first three months of program activity (July through September), MSH will field a monitoring and evaluation specialist to develop a performance monitoring plan (PMP). This plan will be the basis for monitoring and evaluation under the project, and will be modified as need be during the life of the project. An illustrative example is included here in Annex B.

Annex A: Results Framework

**IR 1:
Enhanced Local Organization
Capacity for Sustainable HIV
Response**

- Activity 1.1:** Identify potential network leaders in Peten and Izabal.
- Activity 1.2:** Work with network members to prepare capacity development objectives and plans.
- Activity 1.3:** Conduct capacity assessment of networks, develop plans for strengthening
- Activity 1.4:** Provide on-going capacity building assistance in key organizational and technical areas.
- Activity 1.5:** Evaluate progress of capacity building efforts with AS2 "gold standard" indicators.

**IR2:
Improved social environment
for vulnerable populations
accessing HIV services**

- Activity 2.1:** Assess social/structural factors that influence MSM in Petén and Izabal to behaviours that increase their risk of acquiring HIV .
- Activity 2.2:** organize regional conference on sexual/human trafficking to inform next steps for programmatic interventions.
- Activity 2.3.** Build sustainable consortium network capacity to conduct social mobilization activities.
- Activity 2.4.** Support sustainable consortium networks' efforts to build consensus among stakeholders regarding structural drivers of HIV acquisition among:
 - 2.4.1** MSM
 - 2.4.2** Victims of Human Trafficking
- Activity 2.5:** Support sustainable consortium networks' coordination and implementation of mobilization campaigns to address structural drivers of HIV acquisition among MARPS.
- Activity 2.6:** Develop and implement communications campaign to support mobilization efforts.

**IR 3:
Improved continuum of
preventive care services in
Peten and Izabal.**

- Activity 3.1:** Facilitate development of network plan to prioritize investments in MARP services.
- Activity 3.2:** Provide sub-awards to network members to improve MARP services.
- Activity 3.3** monitor and evaluate execution of sub-awards.

Shaded areas to be led by The Alliance

Annex B: Illustrative PMP

AIDSTAR-Two/Guatemala Project Performance Monitoring Plan (PMP)

January 1st -September 30th, 2010

IQC No. GHH-I-00-07-00068-00; Task Order No. GHH-I-01-64-70¹ (Global)

¹ This project is funded by the United States Agency for International Development (USAID), Bureau for Global Health (GH), Office of HIV/AIDS (OHA) under the HIV/AIDS Support and Technical Resources Sector TWO (AIDSTAR TWO) Indefinite Quantity Contract (IQC).

Background

Under the global HIV/AIDS Support and Technical Resources Sector II (AIDSTAR II) Indefinite Quantity Contract (IQC) Task Order One (AIDSTAR-Two), Management Sciences for Health (MSH) will increase the ability of U.S. Government (USG) country teams, local civil societies, and host governments to provide critical HIV/AIDS services under the President’s Emergency Plan for AIDS Relief (PEPFAR). A work plan has been proposed for USAID/Guatemala with the goal of reducing HIV incidence in Guatemala. The objective of the program is to decrease HIV transmission among key Most at Risk Populations (MARPs). The objective will be accomplished with three intermediate results: (1) enhanced local organizational capacity for sustainable HIV response, (2) an improved social environment for vulnerable populations accessing HIV services, and (3) an improved continuum of preventive services in select geographical areas.

Goals of the Performance Monitoring Plan (PMP)

This Performance Monitoring Plan (PMP) will be used to monitor and report on the overall performance of the AIDSTAR Two/Guatemala project in meeting its expected results and targets for each intermediate result (IR). The indicators detailed in the table below will help measure both output and outcome-level results according to the deliverables contained in the work plan. Indicators have been defined, along with data sources, estimated targets and frequency of measurement.

AIDSTAR-Two/Guatemala Performance Monitoring Plan Indicators

Indicators	Definitions	Data Source(s)	Target
IR 1: Enhanced local organizational capacity for sustainable HIV response			
# of organizational assessments conducted of NGOs supporting MARPs.	This refers to organizations whose functioning has been assessed under AIDSTAR-Two using organizational assessment tools.	Project Reports	
# of NGOs receiving direct grant support from AIDSTAR Two/USAID to enhance organizational capacity.	This will include any organization receiving a direct cash grant, regardless of the level of funding.	Grants Management Records	
# and % of NGOs who have improved their organizational functioning after receiving direct grant support through AIDSTAR Two	# of organizations who have improved their organizational functioning based upon application of assessment tools at the beginning of the capacity building process and six months afterwards as a proportion of the organizations that received direct grant support	Results of self-report tool application	

Indicators	Definitions	Data Source(s)	Target
# of workshops and # of participants of workshops held for NGOs supporting MARPs	MARPs include men-who-have-sex-with-men (MSM); transgender/transsexual; Garifuna; and commercial sex workers (CSWs).	Workshop reports	
# of NGOs/CBOs for which a MOST action plan is developed and the participating organization has made progress implementing the plan within 6-12 months following the workshop.	Progress is defined by participants. See the <i>Menu of Indicators on Management and Leadership Capacity Development</i> for definitions of indicators that MOST participants may track in their action plans.	Workshop reports	
Total # of facilitators trained for the Leadership Development Program (LDP) or Virtual Leadership Development Program (VLDP).	See the <i>Guide for Training Community Leaders to Improve Leadership and Management Practices</i> and the VLDP Guide.	Training Records	TBD
Total # of teams participating in the LDP or VLDP.	See the <i>Guide for Training Community Leaders to Improve Leadership and Management Practices</i> and the VLDP Guide.	Training Records	TBD
% of LDP or VLDP teams that have made progress in achieving their desired performance according to indicators in their action plans within six months of completing the program.	See the <i>Guide for Training Community Leaders to Improve Leadership and Management Practices</i> and the VLDP Guide.	Training Records	TBD
% of LDP or VLDP teams reporting improved integration, collaboration, and communication immediately following the program and after 6 months of completing the program.	See the <i>Guide for Training Community Leaders to Improve Leadership and Management Practices</i> and the VLDP Guide.	Training Records	TBD

Indicators	Definitions	Data Source(s)	Target
% of teams that experience an increase in Work Climate Assessment (WCA) scores at the conclusion of the LDP or VLDP.	<i>See the Guide for Training Community Leaders to Improve Leadership and Management Practices and the VLDP Guide.</i>	Training Records	TBD
% of LDP or VLDP teams that have made progress in achieving their desired performance according to indicators in their action plans within six months of completing the program.	<i>See the Guide for Training Community Leaders to Improve Leadership and Management Practices and the VLDP Guide.</i>	Training Records	TBD

Indicators	Definitions	Data Source(s)	Target
# of NGOs/CBOs provided with technical assistance for HIV-related institutional capacity building.	<p>A local organization is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.</p> <p>Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations including capacity to design, implement and evaluate HIV prevention, care, and treatment programs.</p> <p>TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies, including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.</p>	Project records.	TBD
# of NGO/CBO sub-grantees that address policy factors placing women and girls at greater risk for HIV infection.	This includes policies related to concurrent partners, male norms, gender-based violence and high-risk behaviors of male partners. The approach will take a comprehensive view of these factors and strive to address facilitators and barriers unique to the country context in order to decrease the risk of HIV infection among women and girls. (Adapted from PEPFAR Policy Area Description, p. 194)	Quarterly and annual reports from sub-grantees.	TBD
# of NGO/CBO sub-grantees that address policy and legal reforms related to gender-based violence.	This includes capacity-building of government ministries, institutions (education, health, legal, etc.), NGOs, and civil society to prevent and respond to gender-based violence. (Adapted from PEPFAR Policy Area Description, p. 194)	Quarterly and annual reports from sub-grantees.	TBD

Indicators	Definitions	Data Source(s)	Target
# of NGO/CBO sub-grantees that address policies that have a positive impact on the causes and consequences of HIV-related stigma.	This may include such programmatic approaches as incorporating Prevention with Positives programs into the training of healthcare workers and lay counselors, utilizing PLWHA as lay counselors and peer educators, and employing effective measurement and documentation of stigma in program plans. (Adapted from PEPFAR Policy Area Description, p. 195)	Quarterly and annual reports from sub-grantees.	TBD
# of workshops convened to address policies that broaden a multi-sectoral approach to HIV/AIDS.	This supports linkages of HIV/AIDS programs with other health programs, including maternal and child health, safe motherhood, malaria, and TB programs. Policies should also support linkage with other development efforts, for example food and nutrition, economic strengthening, and education. (Adapted from PEPFAR Policy Area Description, p. 196)	Quarterly and annual reports from sub-grantees.	TBD
# of assessments completed to address policies that broaden a multi-sectoral approach to HIV/AIDS.	This supports linkages of HIV/AIDS programs with other health programs, including maternal and child health, safe motherhood, malaria, and TB programs. Policies should also support linkage with other development efforts, for example food and nutrition, economic strengthening, and education. Linkages will be explored in each network assessment conducted by the Alliance. (Adapted from PEPFAR Policy Area Description, p. 196)	Assessment reports.	5
IR 2: Improved social environment for vulnerable populations accessing HIV services			
Problems analysis conducted to identify the underlying social and cultural factors that put MSM at heightened risk of HIV acquisition.	This problems analysis, although it will result in a single report, will likely involve a workshop as well as a number of meetings with key stakeholders and representatives of MARPs.	Synthesis report	
Problems analysis conducted to identify the root causes of sexual trafficking and the structural changes needed to prevent human trafficking and sexual exploitation.	This problems analysis, although it will result in a single report, will likely involve a workshop as well as a number of meetings with key stakeholders and representatives of MARPs.	Synthesis report	

Indicators	Definitions	Data Source(s)	Target
# of social mobilization plans that address norms/barriers to MARP programming	<p>The following are illustrative of the steps needed to develop Action Plans:</p> <ol style="list-style-type: none"> 1. Meet with VCT clinic staff to discuss MARP concerns/issues – including staff beliefs, practices. 2. Help VCT clinic staff understand needs, rights of MARPs. 3. Solicit their views on role of health professionals, and their need to serve all populations. 4. Secure commitment to action plan to improve services for MARPS. 	Action Plans	
# of NGOs receiving direct grant support from AIDSTAR Two/USAID for social/community mobilization activities.	This will include any organization receiving a direct cash grant, regardless of the level of funding.	Grants Management Records	
# of meetings held to build consensus among stakeholders regarding structural drivers of HIV acquisition among MSMs and sexual trafficking.	These meetings will provide an opportunity for representatives to meet, discuss their strategies, and propose join activities, wherever possible.	Meeting minutes	
IR 3: An improved continuum of preventive services in select geographical areas (see also IR 1 and IR2)			
# of grant awards made after a competitive process for improvement of MARP services	This will include any organization receiving a direct cash grant, regardless of the level of funding.	Grants Management System	
# and % of grant-supported NGOs whose quarterly report is reviewed and who have been given specific feedback on their quarterly report within 2 weeks of submission	This will include any organization receiving a direct cash grant, regardless of the level of funding.	Grants Management Records	

Indicators	Definitions	Data Source(s)	Target
# and % of grant-supported NGOs whose annual/end-of-project report is reviewed and who have been given specific feedback on their quarterly report within 4 weeks of submission	This will include any organization receiving a direct cash grant, regardless of the level of funding.	Grants Management Records	
# and % of grant-supported NGOs given specific technical assistance by type and duration of assistance	This will include any organization receiving a direct cash grant, regardless of the level of funding. Categories of assistance to be defined after problems analysis.	Grants Management Records	
# and % of grant supported NGOs developing a PMP	A PMP will consist of SMART indicators related to the SOW for each sub-grant.	Grants Management Records	
Document developed and disseminated to report the results of mapping the quality and availability of services for MARPS	During the first stage of the mapping process, we will gather data on the type of services provided by all CSOs, support groups and private physicians that have been identified as provided limited byt important HIV/AIDS services to the community. During the second stage, we will collect data on the quality of these services.	Document provided	

Annex C: Management Responsibilities of AIDSTAR-Two/Guatemala

Management Responsibilities of AIDSTAR-Two/Guatemala

Consortium Lead	Roles & Responsibilities
MSH – COP	<ul style="list-style-type: none"> Overall manager of the entire program in Guatemala Lead manager of IR1 & IR3 Responsible for the timely submission of all contractual deliverables Coordination & direct collaboration with the Alliance on IR2 Identification of and direct coordination with lead organization that will conduct human trafficking study Lead recruitment efforts in collaboration with MSH/SPO, including the Social Mobilization Advisor Line manager of Social Mobilization Advisor seconded to the Alliance Liaison with USAID/Guatemala along with MSH/SPO
MSH – SPO	<ul style="list-style-type: none"> Line manager of MSH/COP Day-to-day management support for the entire project Liaison with USAID/Guatemala along with MSH/COP Serve as back-up for PD's role on the project
MSH – PD	<ul style="list-style-type: none"> Submission of international travel authorizations for COTR's approval Engage COTR on programmatic activities, as needed
The Alliance – SPO	<ul style="list-style-type: none"> Overall manager of IR2 with the exemption of the trafficking study Direct communication with MSH's SPO, PD and COP prior to submitting documents or engaging in communications with USAID Submission of the Alliance's international travel requests to PD and SPO Provide technical direction to the Social Mobilization Advisor regarding IR2 activities Manager of all administrative and financial aspects of the contract on behalf of the Alliance
The Alliance – US Director and/or AS-Two SPO	<ul style="list-style-type: none"> Final approval of work plan, budget and programmatic changes
TBD	<ul style="list-style-type: none"> Lead the human trafficking and HIV/AIDS study

MSH:

- Eugenia Monterroso – Chief of Party (COP)
- Yadira Almodovar-Diaz – Senior Program Officer (SPO)
- John D. Berman – Project Director

The Alliance:

- Ruth Ayarza – Senior Program Officer (SPO)
- Natasha Sakolsky – US Director
- Kevin Orr – AIDSTAR-Two Senior Program Officer for the Alliance (AS-Two SPO)

Annex D: Budget

AIDSTAR-Two Guatemala

Title: Year One WP

Funder: USAID Guatemala

Technical Lead: John Berman

Proposed Dates of Work: April 1, 2009- September 30, 2010

Date Revised: September 8, 2009

Line Item	Rate	/unit	LOE/Units s 1st 6 Months April 1 - Sept. 30th	LOE/Units next 12 Months October 1 - Sept. 30th	Total: Months 1-6	Total: Months 7-18	18 Month Total
I. Salaries & Wages							
Guatemala City Office							
COP	487.00 /day		5.0	260.0	2,435	126,620	129,055
Finance Manager/Accountant/HR	100.00 /day		10.0	260.0	1,000	26,000	27,000
Accountant	50.00 /day		0.0	260.0	0	13,000	13,000
Social Mobilization Advisor	125.00 /day		10.0	260.0	1,250	32,500	33,750
M&E Officer	125.00 /day		0.0	260.0	0	32,500	32,500
Administrative/Logistics Officer	65.00 /day		0.0	260.0	0	16,900	16,900
Office Cleaning Staff	25.00 /day		0.0	260.0	0	6,500	6,500
Petén Office							
MARP Liaison/Office Director	125.00 /day		10.0	260.0	1,250	32,500	33,750
Capacity Building Advisor	75.00 /day		0.0	260.0	0	19,500	19,500
Accountant/Administrator	50.00 /day		0.0	260.0	0	13,000	13,000
Office Cleaning Staff	25.00 /day		0.0	260.0	0	6,500	6,500
Izabal Office							
MARP Liaison/Office Director	125.00 /day		10.0	260.0	1,250	32,500	33,750
Capacity Building Advisor	75.00 /day		0.0	260.0	0	19,500	19,500
Accountant/Administrator	50.00 /day		0.0	260.0	0	13,000	13,000
Office Cleaning Staff	25.00 /day		0.0	260.0	0	6,500	6,500
Headquarter Staff Support (includes Start Up)							
Project Director	604.00 /day		18.0	7.0	10,872	4,228	15,100
Dir: Finance & Administration	610.00 /day		4.0	0.0	2,440	0	2,440
Capacity Building Tech. Advisor	430.00 /day		0.0	7.0	0	3,010	3,010
Senior Program Officer	292.00 /day		15.0	52.0	4,380	15,184	19,564
Finance & Operations Officer	275.00 /day		0.0	7.0	0	1,925	1,925
Technical/ M&E	350.00 /day		5.0	7.0	1,750	2,450	4,200
Grants/Contracts/HR Blended	400.00 /day		15.0	10.0	6,000	4,000	10,000
Program Officer	200.00 /day		10.0	7.0	2,000	1,400	3,400
Administrative Coordinator	145.00 /day		20.0	7.0	2,900	1,015	3,915
HSV (only applied to HQ staff, pre-loaded in field rates)	17.5%		30342	33212	5,310	5,812	11,122
Subtotal Salaries & Wages					42,837	436,044	478,881
II. Overhead							
MSH HQ Personnel and STTA	81.0%		35,652	52,574	28,878	42,585	71,463
MSH Local Professional Staff and Consultants	42.0%		31,060	382,020	13,045	160,448	173,494
Subtotal Overhead					41,923	203,033	244,957
III. MSH STTA							
STTA #1: Network Capacity Planning	450 /day		0	10	0	4,500	4,500
STTA #2: M&E	350 /day		0	10	0	3,500	3,500
STTA #3: Org Dev.	370 /day		0	15	0	5,550	5,550
Subtotal MSH STTA					0	13,550	13,550
IV. Local/Regional/International Consultants							
Consultant: Acting COP, Conference Organizer	225 /day		40	0	9,000	0	9,000
Consultant: Trafficking (TBD)	225 /day		0	20	0	4,500	4,500
Consultant: Logistics Assistance	125 /day		60	0	7,500	0	7,500
Consultant: Legal Assistance	4,000 /contract		1	0	4,000	0	4,000
Consultant: M&E Data Collection/Analysis (TBD)	225 /day		15	0	3,375	0	3,375
Subtotal Local Consultants					23,875	4,500	28,375
V. Travel & Transportation							
	\$\$		Days/ Trips	Days/ Trips			
RT Flight: US-Guatemala	750 /RT		8	8	6,000	6,000	12,000
Per Diem: Guatemala City	227 /day		60	90	13,620	20,430	34,050
Per Diem: Boston/DC	201 /day		0	6	0	1,206	1,206
RT Flight: LAC-Guatemala	375 /RT		0	2	0	750	750
Per Diem: Soc. Mob. Sector Travel and TBD in Country	40 /day		0	25	0	1,000	1,000
Per Diem: Soc. Mob. Lodging and TBD in Country	75 /day		0	25	0	1,875	1,875
Travel to Honduras: program visit, flights	375 /RT		0	4	0	1,500	1,500
Travel to Honduras: program visit, per diem	150 /day		0	20	0	3,000	3,000

	TBD In country flights	200 /RT	4	10	800	2,000	2,800
	Trafficking Conference: Chetumal	10,000 /Event	1	0	10,000	0	10,000
	Airport Transfer	125 /RT	10	10	1,250	1,250	2,500
	Subtotal Travel & Transportation				31,670	39,011	70,681
VI.	Subcontracts						
	Alliance Sub-Award (MSM assessment, Soc Mob)	200,000 /total	0	1	0	200,000	200,000
	Trafficking Activities (TBD)	50,440 /total	0	1	0	50,440	50,440
	Grants to Network Partners (MARP Services/Activities)	15,000 /total	0	10	0	150,000	150,000
	Subtotal Subcontracts				0	400,440	400,440
VII.	Other Direct Costs						
	Office Rent/Utilities: Guatemala City	3,500 /mo	0	12	0	42,000	42,000
	Office Rent/Utilities: Petén	1,000 /mo	0	12	0	12,000	12,000
	Office Rent/Utilities: Izabal	1,000 /mo	0	12	0	12,000	12,000
					0	66,000	66,000
	Supplies and Misc. Expenses	500 /mo	1	12	500	6,000	6,500
					500	6,000	6,500
	Vehicle Fuel (Annual Vehicle Operating Costs)	7,109 /vehicle	0	3	0	21,328	21,328
					0	21,328	21,328
	Employee Benefits	100 /mo each	2.1	143.8	207	14,378	14,585
	13th and 14th Month Payment	66,272 payment	0	1	0	66,272	66,272
					207	80,650	80,857
	Soc Mob Communications: Trafficking	35,000 /unit	0	1	0	35,000	35,000
					0	35,000	35,000
	M&E Activities (See break out for M&E Activities)	15,000 /unit	1	1	15,000	15,000	30,000
					15,000	15,000	30,000
	Office Equipment/Computers	30,000 /unit	0	1	0	30,000	30,000
	Equipment: Vehicle Rental (3 X12 months)	14,000 /unit	0	3	0	42,000	42,000
	Office Furniture/Renovations	15,000 /unit	0	1	0	15,000	15,000
					0	87,000	87,000
	Subtotal Other Direct Costs				15,707	310,978	326,685
VIII.	Workshops and Training						
	MOST (adapted for Guatemala context)	3,500 /wkshp	0	10	0	35,000	35,000
	Quickstart Assessments	600 /assess.	10	0	6,000	0	6,000
	LDP Workshops and ToT	4,000 /wkshp	0	5	0	20,000	20,000
	Org Dev. TA to recipients	2,000 /org	0	7	0	14,000	14,000
	Convene MARPS/stakeholders (in Alliance subcontract)	1,500 /wkshp	0	0	0	0	0
	Engage Sectors- sector plans (in Alliance subcontract)	1,500 /wkshp	0	0	0	0	0
	Align Sector Plans (in Alliance subcontract)	1,500 /wkshp	0	0	0	0	0
	Grantee Start Up Training	2,500 /training	0	3	0	7,500	7,500
	Grantee Trainings	1,000 /training	0	5	0	5,000	5,000
	Subtotal Workshops and Training				6,000	81,500	87,500
	Subtotal				162,012	1,489,056	1,651,069
	Fee				8,101	50,831	58,931
	Total Costs plus fee				170,113	1,539,887	1,710,000

AIDSTAR-Two Guatemala Budget Breakdowns

Vehicle Operating Costs

Estimated Miles	35,000
MPG	16
Total Gallons	2,188
Cost/Gallon	3
Total Per Vehicle	7,109

M&E Activities Related to Evaluation of Social Norms/Attitudes about MSM

Sub-award (contract) for data collection to include following elements:

Pre-testing of instrument	3,500
Baseline Study: Hire enumerators to implement survey	4,000
Follow-up Study: Hire enumerators to implement survey	4,000
Review of data collected/data entry	2,000
Preparation of "top line" report	1,500
Total	15,000

Annex E: Social Mobilization Literature Review

Social Mobilization: Definitions, Practical Applications, and Evaluations

I. Introduction

This paper is based on a literature review conducted to explore the definitions and applications of social mobilization in the public health field and beyond. The paper will begin with a discussion of how the expression *social mobilization* was coined and will then provide an analysis of commonalities and differences among the various definitions. Each of these definitions has something to contribute to the understanding of social mobilization. Having covered the definitions, the paper will discuss agencies that are currently writing about social mobilization as a public health strategy, particularly in tackling HIV/AIDS. After providing a brief discussion of monitoring and evaluation strategies, the paper will provide an overview of where organizations have implemented programs employing social mobilization and will analyze the successes and obstacles of these programs.

II. Definitions

Karl Deutsch coined the term *social mobilization* in his paper entitled "Social Mobilization and Political Development" published in *The American Political Science Review* in 1961. Deutsch describes social mobilization as an overall process of change from traditional ways of life to modern ways of life:

It denotes a concept which brackets together a number of more specific processes of change, such as changes of residence or of occupation, of social settings, of face-to-face associates, of institutions, roles, and ways of acting, of experiences and expectations, and finally of personal memories, habits and needs, including the need for new patterns of group affiliation and new images of personal identity. (493)

Importantly, Deutsch argues, the process of change among the aforementioned elements is recurrent and identifiable among countries at various stages of economic development (493). That is, a long-term process of modernization is always accompanied by social mobilization, a shift to non-traditional practices and modes being made by large segments of the population (493). Social mobilization has political implications because, as large segments of the population move away from their traditional, intellectually isolated habits, their evolving needs demand new

forms of government services such as social security, health care, and unemployment insurance (498).

Much of the political science literature regarding social mobilization post-Deutsch has focused on the political consequences of patterns of social mobilization. For example, Michael Hudson in "A Case of Political Underdevelopment," analyzed the correlation between levels of social mobilization and Lebanon's capacity for mass political participation and institutional strength i.e., political development (822).

The application of social mobilization to the public health field was initiated by practitioners such as Neil McKee, a former UNICEF employee. In 1992, McKee defined social mobilization as follows:

The process of bringing together all feasible and practical intersectoral social allies to raise people's awareness of and demand for a particular development programme, to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance. (McKee 163)

Thus, McKee argues, social mobilization is about building alliances and creating demand among communities (UNICEF 14). His definition of social mobilization fits into a broader context of a development communication model through which advocacy, social mobilization, and program communication are integrated. The innermost ring of this model is advocacy (McKee 164). Advocacy, according to McKee, is the process of organizing information to be communicated through various channels in the hopes of attaining program acceptance among political and social leaders (163). Symbolically, moving outward in the circle, social mobilization involves building intersectoral partnerships and creating participation and buy-in among members of the community (164). The last ring of the circle is program communication (164). Program communication involves targeted communication among specific groups to convey strategies, messages, or training programs through mass media and interpersonal channels (163). According to the model, advocacy, social mobilization, and program communication operate synergistically in large-scale communication campaigns (UNICEF 15).

UNICEF's Master Plan of Operations defines social mobilization more narrowly. This document states that social mobilization "aims at involving the civil society in the planning, monitoring, and evaluation leading to their ownership of the programmes" (UNICEF 12). UNICEF of Pakistan's Evaluation of Advocacy and Social Mobilization Strategy notes

that despite social mobilization being one of the fundamental strategies of the Country Programme for Children, inconsistencies in its understanding by program staff are rampant, contributing to the confusion among Country Programme partners (UNICEF 12). Part of the misunderstanding of what social mobilization constitutes can be attributed to the ever-evolving nature of it as a strategy. Some advocates call for social mobilization to be applied with a human rights perspective. For example, Ford argues that a “top-down” social mobilization paradigm is outdated and should be replaced with a participatory approach in which women and children of the community “advocate directly on their own behalf” (UNICEF 15). UNICEF notes one of the fundamental components of a right-based social mobilization paradigm: “Those who adhere to this concept focus their efforts on developing the life skills of individuals so that they can take greater control over the determinants of health, and so that they can apply pressure for equal access to health resources” (UNICEF 16).

To summarize thus far, McKee and UNICEF’s operational documents apply social mobilization in a much different manner than Deutsch’s broad, inclusive definition. Deutsch appears to be describing a phenomenon of changing patterns of life, one of the consequences of which is increased political involvement derived from the demand for increased government services. Deutsch explains this as a natural, historical process that unfolds within civilizations. McKee and UNICEF conceptualize social mobilization as being tied to a particular cause. Thus, the actual process of social mobilization, as they envision it, involves building the necessary intersectoral alliances to foster community demand and participation, thereby increasing its sustainability (UNICEF 14). McKee and UNICEF envision social mobilization as a tool to achieve a particular end. Deutsch sees social mobilization as something that merely happens.

Tulane University’s School of Public Health and Tropical Medicine, in their Global Social Mobilization Training and Research Program’s primer document, identifies the role that each sector should play in social mobilization when applied in practice. Advocacy, this document explains, should foster a commitment among policymakers to ensure program support and adequate allocation of resources to communities (Ling 3). Ling believes that consensus building and collaboration may be most difficult at the bureaucratic level where various agencies have conflicting jurisdictions and missions (Ling 4). The non-governmental sector can play a role in getting communities involved (Ling 4). Popular participation, including the identification of problems and formulation of solutions, should take place at the community level (Ling 4). At the individual and household level, where behavioral action occurs, education and information campaigns can

encourage sound decision-making and individual empowerment (Ling 4). Perhaps most importantly, Ling argues that these actions should not be performed independently of each other but should be part of a broader strategic mission for social mobilization to be effective (4). Ling states that social mobilization is “a planned decentralized process that seeks to facilitate change for development through a range of players engaged in interrelated and complementary efforts” (4).

Along similar lines of the aforementioned definitions, the Centre for Development and Population Activities (CEDPA) defines social mobilization as “planned actions and processes to reach, influence, and involve all relevant segments of society across all sectors from the national to the community level, in order to create an enabling environment and effect positive behavior and social change” (CEDPA i). While McKee and the UNICEF operational definitions allude to this thought, CEDPA’s definition and Ling’s conceptualization of social mobilization more explicitly state that positive behavioral change is one of the intended outcomes of social mobilization. In fact, CEDPA states that behavior change communication is one of its social mobilization building blocks (CEDPA ii).

The other social mobilization building blocks that CEDPA prescribes are community mobilization, advocacy, and social marketing. Community mobilization involves a deliberate, participatory involvement of local groups and grassroots organizations toward a particular end (CEDPA ii). Social mobilization differs from community mobilization in that social mobilization “has participants and beneficiaries beyond community members” (CEDPA 12). Similar to Ling’s conceptualization, popular participation at the community level is essential. Second, advocacy is performed to achieve specific policy changes, program changes, or resource allocation and can take place in the public or private sector (CEDPA ii). Third, social marketing, as defined by Population Services International (PSI), is “the distribution of needed health products to lower-income persons by marketing through the existing local commercial and NGO infrastructures and by motivating healthy behavior” (CEDPA ii).

These strategies, namely advocacy, community mobilization, social marketing, and behavior change communication, are a set of tools to be used by various actors in the social mobilization process (CEDPA i). CEDPA states that its strategies can be used to “promote conscientization (a state of critical consciousness as defined by the Brazilian educator Paulo Freire) and ultimately link the hands of those having less power, voice, and resources with those who have more” (CEDPA i). Thus, CEDPA’s social mobilization process and end goals, as stipulated in their

training document, sound very much like the human rights-based social mobilization paradigm outlined in the UNICEF evaluation document. In line with this philosophy, CEDPA states that social mobilization is an ongoing process in which various movements may build on each other, collaboratively, to achieve social change, empowerment, or an expansion of rights (CEDPA i). Underscoring the similarity with the rights-based model, CEDPA asserts that “for genuine change to occur, it is important that those most directly affected by the change be integrally involved in the process of determining the nature of the change” (CEDPA i).

CEDPA’s training document also provides some useful historical examples of social mobilization, although they were perhaps not categorized as such at the time of implementation. CEDPA notes, “Gandhi’s grassroots movement in India, the international women’s movement, the anti-apartheid campaign in South Africa, [and] the worldwide environmental movement,” are all useful examples of social mobilization in practice. Each of these efforts ended in “major shifts in societal norms, policies, and laws” (CEDPA i).

One of the critical results of social mobilization is social norm change. To provide a context for how social mobilization might achieve changes in social norms, this paper will draw upon a recent historical example in the United States to increase seat belt use. Seat belt use in the U.S. is an example of a “well-known, high expense risk for which preventive or remedial action is inexpensively available but not adopted” (Boehm et al. 2). Thus, knowledge of the ability to reduce traffic-fatality risk through seatbelts is commonplace but usage historically has been low. Despite legislation stipulating fines for those who fail to wear seat belts, the absence of seat belt use as a norm for appropriate behavior undermines compliance: “Asking for compliance or conformity with a non-existent norm fails” (Boehm et al. 5).

Increases in seat belt usage are most commonly associated with campaigns where normative social pressure is applied (Boehm et al. 6). For example, “Flash for Life” campaigns where drivers and passengers were reminded to buckle-up, campaigns for communities to attain 70% buckling-up compliance, and educational strategies involving media and school programs were all deemed successful (Boehm et al. 3). Essential to each of these successful campaigns to increase seat belt use was the notion that it is a common norm to wear seat belts.

Campaigns to change social norms have also been applied to reducing alcohol abuse on college campuses by countering the notion that

binge drinking was the norm (Teicher 1). Countering misperceptions is now one strategy being used in middle schools to reduce bullying. Professor Perkins, a sociology professor states: “What we’ve seen consistently is that risk behaviors [and] problem behaviors are overestimated which [means] much of the bullying or violence or substance abuse can continue because the people engaged in that think everybody else is doing it” (Teicher 1). In summary, social norm change, one potential objective of social mobilization, has historically been achieved by dispelling the notion that the undesired behavior is a social norm and by enlisting communal acceptance of adopting a safer behavior.

CEDPA’s training document emphasizes the importance of monitoring social mobilization efforts as a dynamic, evolving process to maximize social change, and it provides useful guidelines on how to conduct this process. CEDPA notes that indicators, the criteria for measuring success, must be linked to the objectives of the program: “Indicators are closely linked to objectives. They must be defined as part of the overall campaign plan” (108). There are three broad, useful indicators used when conducting an evaluation. First, input indicators measure human and financial resources allocated to an initiative (CEDPA 108). Second, process indicators “monitor achievements during implementation, serving primarily to track progress toward the intended results” (CEDPA 108). Third, outcome indicators are related to the longer-term results of the campaign (CEDPA 108). An example of an outcome indicator may be an increase in the attendance of prenatal clinics as a result of an initiative working towards this end (CEDPA 109).

One of the inherent challenges in monitoring social mobilization is the establishment of a causal link between social mobilization and a particular outcome. In other words, how does one know that a social mobilization effort to increase literacy among Pakistani women was responsible for rises in literacy as compared to a whole host of other factors? While not a cure-all to this challenge, CEDPA notes that triangulation may be an effective method of validating information. Triangulation is a form of combining different perspectives, methods of inquiry, or data sources to analyze the same aspect of a program (CEDPA 112). To provide an example of triangulation with respect to monitoring the effectiveness of a rally on safe motherhood, one may ask rally participants how the event affected their thinking on safe motherhood (qualitative), monitor the media’s reporting on safe motherhood prior to and after the rally (qualitative), and identify how many more women, relative to a baseline, gave birth in clinics (quantitative) (CEDPA 112).

Organization or Author	Definition of Social Mobilization	Commonalities	Differences
Karl Deutsch-political science academic	<p><i>It denotes a concept which brackets together a number of more specific processes of change, such as changes of residence of occupation, of social settings, of face-to-face associates, of institutions, roles and ways of acting, of experiences and expectations, and finally of personal memories, habits and needs, including the need for new patterns of group affiliation and new images of personal identity.</i></p>	<p>-Implicitly, this definition is similar to CEDPA's and Ling's conceptualization of social mobilization as leading to positive behavior change. However, Deutsch's definition does not state that the behavior change must be positive. Rather, the transition to new ways of acting and changes in personal identity are merely different from the ways of the past, according to Deutsch.</p>	<p>-The other definitions envision social mobilization as being tied to a particular development cause (e.g. women's empowerment, 100 percent immunization rates). Deutsch's definition states that social mobilization is a phenomenon or historical trend.</p>

<p>Neil McKee- former UNICEF employee</p>	<p><i>The process of bringing together all feasible and practical inter-sectoral social allies to raise people's awareness of and demand for a particular development programme, to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance.</i></p>	<p>-Similar to Ling, McKee highlights the necessity of bringing together various stakeholders.</p>	<p>-Mentions the necessity of community participation for the development program's sustainability but does not assert behavior change as one of the goals of community involvement.</p>
<p>UNICEF's Master Plan of Operations</p>	<p><i>Social mobilization aims at involving the civil society in the planning, monitoring, and evaluation leading to their ownership of the program.</i></p>	<p>-Notes the necessity of involving civil society.</p>	<p>-Goes further by saying that civil society should be involved in monitoring and evaluation while other definitions just mention the role of civil society in planning.</p>

<p>Jack Ling- Tulane University School of Public Health and Tropical Medicine</p>	<p><i>A planned decentralized process that seeks to facilitate change for development through a range of players engaged in interrelated and complementary efforts</i></p>	<p>- Highlights the decentralized nature of social mobilization. Emphasizes the importance of community involvement.</p> <p>-Similar to CEDPA, Ling’s conceptualization links social mobilization to empowerment or <i>conscientization</i> (as stated by CEDPA). CEDPA and Ling’s social mobilization conceptualizations may be characterized as a rights-based.</p>	<p>-Asserts that the necessary player in social mobilization are decision and policy makers, opinion leaders, bureaucrats, professional groups, commerce and industry, communities and individuals.</p> <p>-States that social mobilization efforts should not be performed independently of each other but should be part of a broader strategic mission.</p>
<p>Centre for Development and Population Activities (CEDPA)</p>	<p><i>Planned actions and processes to reach, influence, and involve all relevant segments of society across all sectors from the national to the community level, in order to create an enabling environment and effective positive behavior and social change.</i></p>	<p>-Like other definitions, CEDPA emphasizes that intersectoral allies be centered on achieving the same development goal. CEDPA, in its trainers’ manual, outlines the identification of a cause as one of the steps in social mobilization.</p>	<p>-CEDPA takes the human rights approach a step further by asserting that social mobilization strategies can “link the hands of those with less power, voice and resources with those who have more.”</p>

III. Social Mobilization as a HIV/AIDS Strategy

This paper will now provide a discussion of the organizations that are proposing social mobilization as a strategy to combat HIV/AIDS and will provide an analysis of elements of previous HIV/AIDS interventions that, although maybe not identified as such at time of implementation,

could be classified as social mobilization. In an article entitled “The Global Impact of HIV/AIDS,” Piot, Bartos, Ghys, Walker, and Schwartlander of UNAIDS discuss the global impact of AIDS on social capital, population structure, and economic growth, and they propose that a sustained social global mobilization is required to combat the disease (Piot et al. 968). Piot, et al. argues that what is required is as follows:

...nothing less than a sustainable social mobilization. Its key elements are the involvement of affected communities, including individuals who are infected; restructuring of global finance flows so that the essential commodities required for the response can be made available universally; and systematically targeting social exclusion. (Piot et al. 973)

Unpacking this call to action, Piot et al. accentuate the importance of the social environment in enabling risk control: “the capacity of individuals to control their level of risk, that is, their HIV vulnerability, varies widely according to the social environment in which the risk occurs” (Piot et al. 972). This relationship between HIV vulnerability and the impact of HIV is reciprocal, the authors argue, since a greater HIV impact results in the depletion of social stability, cohesion, and support (Piot et al. 972). Piot et al. state that both knowledge of prevention and amelioration strategies already exist, but the gap between this knowledge and what is applied in practice is wide (972). Furthermore, they argue, “The urgent task now is to ensure that the lessons of effective practice are applied at a society-wide scale in every setting, guided both by local context and by scientific evidence” (972). Importantly, Piot et al. distinguish that scientific, effective practices must be grounded in local knowledge.

Piot et al. continue to argue the importance of tailoring interventions to the contextual realities of communities:

“In Managua, Nicaragua, motels are the principal venue for sexual activity outside the home, including a large proportion of commercial and extramarital sex, so actually handing condoms to motel room users results in greater use than does distribution of HIV education materials” (972). They argue that any successful public health intervention in the past has paid careful attention to the social determinants of its success (Piot et al. 972). For HIV/AIDS, the relevant social factors for designing an intervention include this fact:

Its impact is greatest among young adults; the virus is transmitted through intimate behaviours; its impact ramifies across every field of human

endeavour; infection may remain invisible for years; and overcoming the stigmatization of people with HIV infection, or thought to be at heightened risk, is a precondition for explicit action against the disease.” (Piot et al. 973)

Thus, while much of the discussion of social mobilization strategies thus far has been confined to gaining support from national and provincial leaders, as well as from those at the community level, Piot et al. suggest that the nature of social mobilization in combating an epidemic as large as HIV/AIDS must be global. They allude to this by stating that intervention commodities must be made universal via a restructuring of global finances and that the effective practices tailored to community realities must be drawn upon scientific evidence of what has been effective globally.

Second, in their paper entitled “International Response to the HIV/AIDS Epidemic: Planning for Success,” Peter Piot and Awa Marie Coll Seck recount the increased political momentum for tackling HIV and outline a few important lessons for responding to the epidemic (Piot and Seck 1107). First, the authors state, “political leadership is required at all levels to marshal the necessary commitment and resources for the social mobilization on which the response must be built” (Piot and Seck 1107). This component of social mobilization echoes what Ling, McKee, and CEDPA have previously stated about ensuring adequate resources and programmatic support from various levels of government.

Second, Piot and Seck assert that an effective response to HIV must be thought of as a multisectoral task and should not remain focused solely on action within the health sector (1107). Piot and Seck argue: “Just as the impact of AIDS is felt across all social and economic sectors, so too the scale and breadth of the response needs to encompass all elements of national planning” (1107). Fourth, the authors suggest—much like Piot, Bartos, Ghys, Walker, and Schwartlander—those living with HIV should be involved in the effort (1107). Fifth, Piot and Seck mention the importance of rooting the response within communities: “Local actors are able to determine the most effective priorities for action when they are properly informed, and they can act accordingly when they are helped to mobilize the necessary resources” (1107).

Expanding on these guidelines for reversing the epidemic, Piot and Seck mention that the key to reducing vulnerability is to undergo a deep level of change in social structures to increase individuals’ control over risks (1107). They explain: “It might involve making sexual health services accessible, giving marginalized groups protection against discrimination, or

using schools as a resource to involve whole communities in AIDS responses” (Piot and Seck 1107). Furthermore, Piot and Seck mention that responses in Brazil, Cambodia, Thailand, and Uganda were successful because they have built “wide community support, given ‘target’ groups the driving role in designing and delivering change, and participated in changing the social environment” (1107). This statement suggests that, based on these country experiences, a highly participatory intervention in which targeted segments of the population are involved is most successful at combating HIV.

Although the Piot and Seck paper does not explicitly state it, interventions such as the 100% Condom Use Policy in Thailand contain components that, when integrated, appear to be social mobilization in practice. For example, in this campaign, HIV prevention became a political priority from the prime minister to lower levels of government, a nationwide debate of sexual mores ensued; the sex industry was regulated; sex workers underwent intensive education; and skills development, peer interventions, and clients were targeted (Piot and Seck 1108). In this case, intersectoral alliances were formed, awareness was raised, and community participation was strengthened. Piot and Seck note: “Underlying the success of combination prevention are processes of social mobilization that enable communities to become autonomous actors in efforts against AIDS” (1108).

United Nations Development Program (UNDP) Ethiopia’s response to the HIV/AIDS Epidemic employs social mobilization in various facets of the program. First, UNDP has promoted leadership among different levels including civil society. The National Coalition for Women against HIV/AIDS, for example, is “uniquely positioned to mobilize women at all levels in advocating for gender and HIV/AIDS issues from [the] policy level to the grassroots” (UNDP 1). Second, UNDP Ethiopia has implemented an innovative Community Conversation program to “break the silence and address factors fueling the epidemic by stimulating community-based responses, through empowering communities to generate insights on the underlying factors fueling spread of HIV/AIDS in the community” (UNDP 2). Previously taboo subjects have now been brought into community discussion so that practical solutions can be developed (UNDP 2). Third, UNDP has fostered a sense of community spirit in fighting HIV via a “Voices of the Courageous” campaign to “identify positive real life role models of Ethiopians who have taken a responsible stand on HIV/AIDS” (UNDP 3).

IV. Social Mobilization Models and Applications

This paper will now proceed by explaining UNICEF's three advocacy and social mobilization models as a way of introducing a couple of their social mobilization projects in practice and will then provide information on monitoring and evaluation results with respect to these initiatives. UNICEF states that there are three principal approaches to implementing social mobilization. The first, the direct model, involves UNICEF and its partners' lobbying and mobilizing government policy-makers and public servants *on behalf of* children and women (18). Second, and increasingly being used, the intermediary model involves UNICEF and its partners' advocating and mobilizing *for* children and women through intermediaries such as government front-line workers and non-governmental organizations (NGOs) (19). For example, UNICEF has funded organizations such as the Aurat Foundation, an NGO, to push for increasing women's representation in local elections. An additional example is when UNICEF engaged teachers, the front-line workers, to mobilize parents to increase primary school enrollment in the Sialkot Project (19).

Third, the rights-holder model "differs from the other models in that it involves empowering or enabling children and women *to advocate and mobilize on their own behalf*" (20). UNICEF states that Change Makers for South Asia is an example of the rights-holder model in practice: "This initiative brought together 27 young girls and boys from various socio-economic backgrounds to elect two representatives to voice their concerns at a meeting of South Asian countries" (20). Importantly, the rights-based model stemmed from those thinkers who believed that social mobilization should be applied with a human rights perspective such that children and women can negotiate on their own behalf in the future by gaining self-efficacy skills and adopting safer patterns of behavior (UNICEF 16). UNICEF's evaluation document is very clear on what the rights-based model is not: "This approach to communication contrasts with conventional approaches that rely on didactic messages, communication materials such as pamphlets, posters and T-shirts, and mass media" (16)

To provide some concrete examples of social mobilization initiatives, this document will explain the approach, types of stakeholders, and results of two of UNICEF's social mobilization programs in Pakistan. First, a case study of polio eradication and vitamin A supplementation via National Immunization Day (NID) campaigns indicates that in conjunction with the World Health Organization, Rotary International, Pakistan's Federal Ministry of Health, and provincial health departments, UNICEF "helped design the communication strategies for urban, rural, and hard-to-reach groups, and it helped train thousands of polio team members in interpersonal communication and motivation" (UNICEF 45). Some of the

key advocacy, social mobilization, and program communication inputs that UNICEF contributed to the NID campaigns include briefing top political leaders, constructing task forces at the provincial level to plan and coordinate efforts, training 45,000 Lady Health Workers, and 392,000 boy scouts to raise awareness about polio, and preparing messages for mass media and interpersonal communication channels to publicize the NIDs (UNICEF 45).

The results of UNICEF's involvement in the NIDs are mixed. On one hand, awareness has steadily increased. Research indicates that "98% of families with children under 5 years of age are aware of the importance of the polio eradication initiative, following 13 rounds of NIDs since 1999" (UNICEF 45). Despite this, routine immunization coverage, seen by experts as the key to full eradication, has been stagnant over the past decade (UNICEF 46). While an understanding of the value of immunization is widespread, the vaccination of hard-to-reach groups is more elusive (UNICEF 46).

Several monitoring and evaluation practices were performed on UNICEF's polio eradication campaign. Despite the difficulty in establishing a causal link between social mobilization practices and coverage results, assessments have determined the communication strategies that are most effective for various target groups and has discovered where deficiencies lie (UNICEF 46). A review by Favin, Tyabji, and Mackay noted that the communication strategy, while good at raising awareness, was not sufficiently directed towards behavioral change (UNICEF 46). One of the shortcomings of the campaign was the lack of awareness by families of the need to immunize children during every NID (UNICEF 46).

A key finding of this evaluation suggests that enhanced community mobilization may have strengthened the impact of the intervention (UNICEF 47). A door-to-door approach to performing immunization may have undermined the opportunity for communities to own and take responsibility for the initiative, according to Dr. Kyaw-Myint, a senior program officer at UNICEF (UNICEF 47). Thus, in summary, an approach integrating community mobilization in which families could advocate and mobilize on their own behalf and a communication strategy directed at routine immunization as opposed to solely focusing on eradication are suggested strategies to strengthen the impact of NIDs in the future.

Second, UNICEF's Girl Child Project in 1991 is an excellent example of a rights-based approach to social mobilization (UNICEF 49). UNICEF notes that the program "aims to empower adolescent girls to improve their

own status in families and in communities, and to equip them to serve as role models and agents of change in the local environments. It provides them with practical skills with which most can generate income” (49). The emphasis of this program is on providing Pakistani girls with the necessary skills to advocate for their own rights within their communities and to improve their status in families in regards to health, education, and economic self-reliance (UNICEF 49). The project entailed significant social mobilization as male and female community members, schoolteachers, and families were mobilized, and intersectoral alliances were formed with provincial education officials and teachers’ associations (UNICEF 49).

The Girl Child Project can be characterized as social norm change. While previously Pakistani women played a limited decision-making and income-generating role, this initiative provided training for and advanced the social norm for women to play a more influential role in the household.

The project was deemed a success. Qureshi, an evaluator of the program, noted that the trained girls, when compared to the untrained, demonstrated “a marked improvement in the girls’ influencing and persuasion skills, especially with male members of their families who are the decision-makers” (UNICEF 50). The project is quite cost effective, as the cost is about \$40 US per girl child (UNICEF 51). Empowerment of women in their communities and families has tremendous spillover effects regarding reproductive rights and advocacy of children’s education, making this initiative an essential one for achieving long-term improvements in standards of living for women and children. One noted shortcoming of the initiative was the lack of follow-up for participants who had completed the training (UNICEF 51). Some graduates requested further guidance in accessing credit and marketing their products and services after the completion of the program (UNICEF 51). In summary, the program is a successful example of the employment of a rights-based approach and is an affordable way to make a meaningful impact. Greater follow-up among training participants may be required to ensure that women maintain their position as agents of change in the long run.

This paper will now proceed by explaining one additional social mobilization application and then synthesize the challenges and lessons learned from these applications. The Measles Initiative is a partnership of the American Red Cross, the UN Foundation, the World Health Organization, UNICEF, and the Centers for Disease Control and Prevention, who united to reduce measles deaths globally by 90 percent by 2010 (measlesinitiative.org). Building on the Rotary-led polio-eradication model, the strategy for reducing measles deaths involves

“repeated vaccination campaigns reinforced by routine vaccination” (measlesinitiative.org).

The Measles Initiative is comprised of four major elements: *planning* the coordination among partners to determine target populations, resource needs, and logistics; *the cold chain* (supply) process of ensuring that the necessary resources are delivered to vaccination posts; *social mobilization* (create the demand), which involves creating an awareness of the importance of immunization among families in the target group; and a *follow-up* involving the processing of results to determine successes, shortcomings, and future program plans (measlesinitiative.org). Thus, social mobilization, as defined here, while integrating elements of many of the aforementioned definitions, appears to be most closely aligned with McKee’s definition in that it highlights awareness raising and demand creation.

To raise awareness and create demand, the Measles Initiative employs many innovative social mobilization tactics as part of its broader campaign. In addition to the banners, brochures, and posters that have previously been associated with social marketing campaigns, the Measles Initiative produces, in village centers, plays “that emulate the vaccination process and the harm that could come to a child if he or she is not vaccinated” (measlesinitiative.org). Importantly, the Measles Initiative enlists the help of children through their participation in song creation and via parades that highlight the importance of vaccinations (measlesinitiative.org). Teachers also encourage their students to bring their siblings in to get immunized (measlesinitiative.org). One observant of the Measles Initiative’s social mobilization campaign in Uganda noted, “It is important for people to hear these messages from their friends. They internalize the information and are convinced. They figure ‘How can a friend do anything bad to us?’” (measlesinitiative.org).

The technical and financial support of the Measles Initiative has contributed to the reduction of measles deaths by 60 percent in Africa from 1999 to 2005 (redcross.org). Two major challenges lie ahead for the Measles Initiative to attain its goal of reducing measles mortality by 90 percent by 2010. First, the WHO notes: “Priority countries must continue conducting follow-up vaccination campaigns every three to four years targeting children nine months to five years of age until their routine immunization systems are capable of providing all children with two opportunities for measles vaccination” (WHO Fact Sheet).

Second, while much success has been attained in Africa, high measles

mortality rates persist in India, Indonesia, and Pakistan (WHO Fact Sheet). In order for the Measles Initiative to attain its goal, targeting these countries is a necessity. In summary, social mobilization, one of the factors contributing to the success of the Measles Initiative, was centered on creating awareness and developing demand for its vaccination campaigns. The employment of high levels of participation among children involving plays, parades, and songs contributed to the success of the initiative.

V. Conclusion

This paper has outlined several definitions of social mobilization from the academic and organizational literature. In summary, any social mobilization effort involves the following critical components: community participation in raising awareness of a development objective or to change social norms or patterns of behavior; a multisectoral nature that involves not only mobilizing the community but raising awareness among state-level and federal decisionmakers; and a long-term impact on the mobilized community to achieve social change, empowerment, or an expansion of rights (CEDPA i.).

Drawing from the aforementioned practical examples, social mobilization appears to be most effective when it is applied from a rights-based approach. That is, members of the community are empowered to become agents of change in their local environments through participation in the implementation of the desired programs. Disease eradication, as was the case in polio, is most effective when communication efforts are aimed at increasing routine immunizations. An important component to the continued success of any social mobilization effort is the following up of participants. The use of a mixture of qualitative and quantitative results is the best tool for analyzing the effects of a program.

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Annex F: Social Mobilization Model

Social Mobilization

A Process of Facilitation

by

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November, 2007

I. Executive Summary

This paper builds on the Social Mobilization Literature Review (Chapter One) . In this chapter we set out the principal characteristics of the social mobilization process which become apparent from the literature review, and propose a phased approach to the implementation of social mobilization programs.

The principal characteristics of the Social Mobilization process are that it: sets out to deliberately change a detrimental social norm; involves all (relevant) segments of society; leads to the construction of alliances between these segments; and is participatory. Furthermore, practitioners of social mobilization facilitate rather than direct outcomes (as in the traditional “project” setting); they strive to amplify messages from societal actors; and they create systems of accountability.

The first Analysis Phase in this process involves key stakeholders conducting an analysis of the destructive social norm they hope to address, developing consensus about how the norm should be changed, who should be involved in the process, laying out a roadmap for next steps, and beginning to define accountability structures.

During the second Mobilization Phase, key stakeholders engage relevant sectors in society that can drive the transformation of destructive social norms. It is critical for sector leaders to fully understand the nature and consequences of the destructive social norms; the rationale for mobilizing to change it; and to be given an opportunity to define their role in the mobilization effort. The outcome from this stage includes detailed plans for each of the individual sectors, as well as an outline of any assistance they might require in the process.

During the third “Alignment Phase,” sector leaders are brought together to review and assure the compatibility of their mobilization plans, and to identify opportunities for inter-sectoral collaboration. The objective of this phase is to assure that sector level efforts are harmonized, mutually reinforcing, and collaborative wherever possible.

The fourth “Implementation Phase” includes both the execution of individual sector level mobilization plans, as well as the support of these efforts with an “Amplification Communications” campaign. Sectors (such as media, government, civil society etc.) will receive support when and where appropriate in the development and implementation of their mobilization activities from key stakeholders who have specific technical expertise. The Amplification Campaign developed during this phase, furthermore, should unite all of the disparate sector level activities under one umbrella, thus reinforcing the sense of national unity regarding the transformation of the target social norm. This campaign will also assure the message and results from individual sectors’ activities reach all members of society.

The Fifth Phase of social mobilization includes monitoring results from sector level activities, the reach of communications activities, changes in perceptions about the target social norm, and changes in the incidence of the target behavior or phenomena driven by the target social norm. While traditional monitoring and evaluation strategies can be employed in this process, we propose to broadly disseminate results from the mobilization process; doing so will create a sense of accountability for those who have made commitments to bringing positive change in their society.

II. Social Mobilization Process: Five Phases

A. Overview

The review of social mobilization definitions and programs allows for the construction of a prototype social mobilization process as presented here. As noted in Chapter I, the principal characteristics of this process are that it: focuses on deliberately changing a detrimental social norm; involves all (relevant) segments of society; leads to the construction of alliances between these segments; and is participatory.

Social Mobilization Process: Overview of Five Phases						
		1. Analysis	2. Engagement	3. Alignment	4. Implementation	5. Evaluation
Activities		•Facilitated meeting with <u>core group of stakeholders</u>	•Facilitated meetings and planning <u>with each sector</u>	•Facilitated <u>inter-sectoral meetings</u> •Sharing strategies , and lessons learned	•Sector level mobilization •Amplification Campaigns	•Assessment of process and results
	Outcomes	Action Plan : 1. Identify Social norm. 2. Campaign Objectives 3. Outcomes. 4. Sector Partners. 5. Next Steps 6. Steering Group.	Sector Level Action Plans : 1. Expression of Commitment. 2. Activities 3. Budget 4. Support Plan	Inter-Sectoral Alignment : 1. Joint statement of mission. 2. Joint Activity Plans 3. Accountability Structures	Social Change 1. Healthier actions and behaviors. 2. New public perception of "norm"	Insights 1. What has changed? 2. What has worked? 3. What did not work, and why?

Key characteristics of the process outlined here build on prior successful experience with and recommendations for social mobilization. These characteristics include:

1. That it is a "**facilitated**" rather than "managed" process.
2. That it includes communications activities which **amplify** endogenous processes rather than generating message content exogenously by an external implementer.
3. That **accountability**, although only implicit in the existing literature, is an explicit part of the process.

Brief comments on these three important central characteristics follow here.

A "facilitated" rather than "managed" process.

As this document is intended primarily for practitioners of social mobilization, as well as those who would support such programs, the role and expectations of the practitioners should be clear. In a break from health communications and "social

marketing,” where the practitioners are actively or directly engaged in achieving a specific outcome, we propose that practitioners of social mobilization are akin to midwives. They will assist a given group, social system etc. evolve in a way that the group has determined is beneficial.

Communication vs. Amplification

Health communications programs, including social marketing programs, have traditionally developed message content exogenously (by an external agent, health communications expert etc.) and then targeted those messages inwards to a specific target population. This program breaks with that tradition and will not design communications content exogenously, but will instead “amplify” messages, activities, aspirations etc. that are produced endogenously by local participants in the social mobilization process. As described below, and as discussed in the literature review in chapter 1, the **amplification** of endogenous messages is a key factor that distinguishes social mobilization from previous health communications efforts.

Ownership and the “accountability function.”

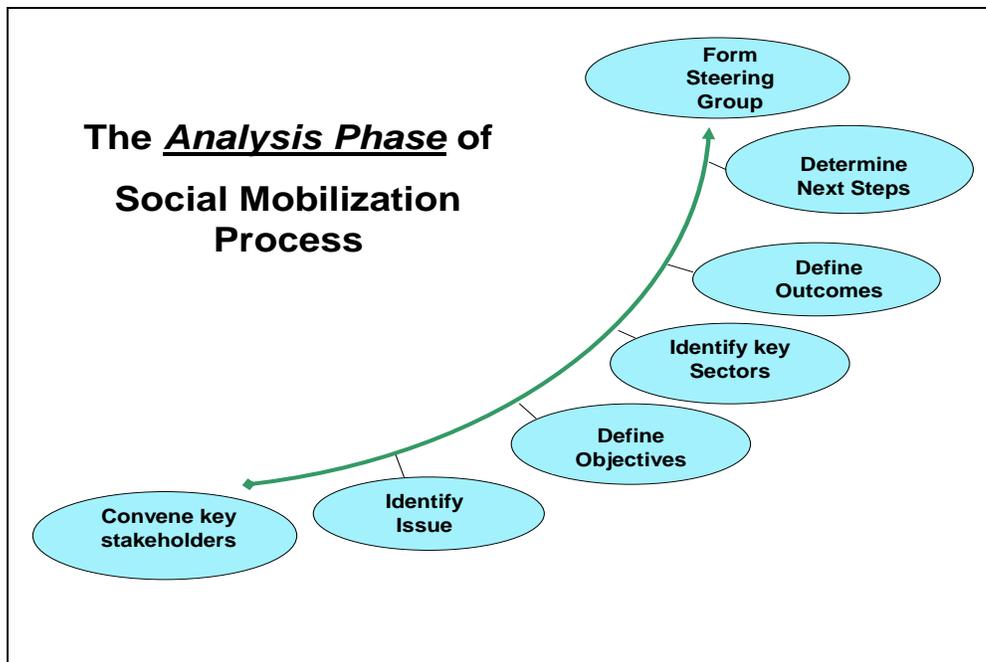
Finally, while the implementation of social marketing and behavior change communication (BCC) programs are not explicitly limited to development agencies with specialized skills and/or donor funding, in practice this is most often the case. With social mobilization, however, we see the opportunity for broad ownership of the “implementation” process. This broad ownership is a significant distinguishing factor from non-mobilization programs, and one that creates a sense of societal accountability.

As explained below, various sectors/actors in society “own” a role in the implementation process, and they will be held accountable to their peers, and other members of society, for successfully executing it. Furthermore, the Monitoring and Evaluation component of social mobilization can facilitate accountability by broadcasting results from this program, and changes or lack thereof in the target social norm, to the public at large.

B. Phase I: Analysis

1. Overview

The Analysis Phase described below will be conducted through a meeting of partners interested in bringing about change of a destructive social norm. The composition of participants should be broad enough to cover both expertise and experience with the social norm being addressed, as well as those familiar with public health implications of this social norm. External agents and international agencies could also be useful during this process. We recommend, however, that the number of participants be kept relatively small (10-15). The analysis is likely to take two to three days, but the duration may vary. We recommend that the participants engage a professional (neutral) facilitator to help assure that the meeting objectives are accomplished.



2. Issue identification

The first goal of this meeting is to agree what specific social norm the social mobilization effort will address. This step should include a brief review of how specific social norms are related to health and social outcomes, and should be rooted in both the peer review literature as well as the participants' expert experience with the issue. As such, it would be helpful if representatives of both the academic/public health community worked jointly with practitioners with relevant field experience.

3. Definition of objectives

During the "definition of objectives," participants will determine the specific outcomes that will result from the social mobilization effort. For example, "as a result of this social mobilization campaign, all sectors of society will cease to tolerate violence against women, and will take discrete actions that result in a dramatic/significant reduction of acts of sexual (or other) violence targeting women."

4. Determination of relevant sectors to engage, and actors

The third key step of the Analysis Phase will be to prioritize which sectors should be involved in the social mobilization program. Examples of sectors might include: "business community, government leaders, community/local leaders, faith community, media, students, uniformed services etc." While it is ultimately the aim to engage all sectors of society, such ambitious expectations risk derailing the program in the early stages. As such, we suggest that the group initially try to limit the number of sectors to five.

In addition to this, the group should work to determine what the "point of contacts" should be for each of the sectors, and how best to initiate a dialogue with that contact.

5. Define Outcomes

Outcomes from social mobilization should be measurable. While a detailed monitoring and evaluation plan is beyond the scope of the initial meeting, the group should discuss what types of indicators could demonstrate progress. We propose, furthermore, that outcomes be tracked at both the level of process and health/social impact. At the process level, it is likely that we will monitor self reported views on the social norm in question (including scales measuring degrees of agreement/disagreement), as well as participation in or exposure to social mobilization activities. Health/social impact indicators are likely to capture the incidence of the behavior/action associated with the target social norm. For example, a program focusing on sexual violence would be likely to include, as one of its indicators, incidence of forced sex report by women of various age cohorts.

6. Determination of next steps

Activities at this stage of the process would involve establishing a key list of follow-up actions, persons responsible for those actions, and a time table for the next phase of the process.

7. Formation of Steering Group

The steering group would be that set of individuals committed to following this process through. This could be formalized, or not, as the group sees fit. If formalized, the steering group might provide a form of governance structure for the movement. If external resources (donor funding) were committed to this activity, it would be important that the recipient(s) of the funding are held accountable to the local steering group. We propose, furthermore, that this accountability be built into any funding instruments developed by donor agencies.

C. Phase II: Engagement

1. Overview

This second phase of the process involves engaging leaders in various sectors as identified in the “Analysis Phase.” Specific outcomes, as discussed below, would include: greater understand regarding the need for social mobilization; commitment to the social mobilization objective; and articulation of their role in the process of changing the target social norms. This approach to the development of a social mobilization program draws directly from the literature, as noted in chapter 1.

Finally, the UNICEF definition which states that “*social mobilization aims at involving the civil society in the planning, monitoring and evaluation leading to their ownership of the programs*” was instructive in the development of this section. What follows here are practical, concrete steps to assure that that happens.

2. Sector level engagement

This level would involve meeting with key leaders in the target sectors to share results of the “analysis” phase, explain why their sectors have been targeted and have the potential to contribute to this campaign, and initiate the process of planning sector

specific activities. This will be an iterative and participatory process, the success of which will depend on key actors in the sector taking ownership of process. Specific outcomes of this stage of the sector level engage include:

- (i) Expression of sector support for change of target social norm;¹⁰
- (ii) Agreement from sector leaders/representatives that their sector has a role;
- (iii) Commitment to engaging in mobilization process by replicating the engagement process within their sector;
- (iv) Designation of a “point of contact” for this sector.

3. Sector level planning

After the initial sector level engagement (a), representatives of the sector will be asked to decide on concrete steps that they and their members can take to advance the change of social norm(s) as proposed by the social mobilization program. As there will be tremendous variability between sectors, and within sectors across geographic zones, suggesting specific actions that can be taken to support a social mobilization effort would not be useful. However, we believe it is possible to categorize the *outcomes* of actions, and suggest that sector level plans, whatever details or strategies they include, be designed to accomplish the following *outcomes*.

(i) Understanding

Sector level actions must assure that individuals are aware of the target social norm, its detrimental outcome, and the desirability of changing it. All subsequent actions will be based on each individuals’ grasp of these issues.

(ii) Commitment

The understanding achieved above should lead to a commitment from individuals within the network to changing the detrimental social norm. It will be essential that the network generally, along with specific individuals within the network, clearly articulate their commitment to changing the destructive norms, and their alignment with the larger social mobilization initiative generally.

(iii) Personal conduct: accountability

Individuals within the network should conduct themselves in a way which reflects awareness of and commitment to changing the target social norms. The sector should determine if and how it might be possible to hold individuals within the sector accountable for their actions.

¹⁰ This “expression of support” could take many forms, and will likely differ with every sector. Some may prefer a formal signed statement (which is advantageous), others may simply make oral commitments at this stage. The complicating factor, which can only be addressed during the implementation, is the extent to which those expressing support truly represent the views of the sector. In cases of trade unions, or hierarchical structures such as the “Uniformed Services,” the legitimacy of such representation will be straight forward. With decentralized sectors, such as the “business community, however, representation will be less clear.

(iv) Replication

A movement to change social norms is only as effective if it is moving. This motion, the movement itself, is perpetuated by a replication of understanding, commitment, and accountability throughout the sector specific network. As such, sector level planning should consider actions that will engender such “replication” throughout their network.

4. Resources required?

The sector should consider what resources will be required to implement their plan, and where those resources will be obtained. To the extent possible, resources should be generated within the sector. (Doing so creates ownership and demonstrates commitment.) However, where additional resources are required and appropriate, the sector leaders (coordinators) should be clear about the level of funding required, how those funds will be accounted for, and what the ultimate impact will be.

5. Support plan

The support plan might be best considered a work in progress. At the early stages of the sector level mobilization, it may be unclear what types of support are needed or possible (over and above the resources needs described above). For the early stages, we recommend the sector leaders consider the possibility of:

- (i) Development of printed communications materials to be used in the sector specific outreach activities.
- (ii) Development of radio/video products to help disseminate messages, objectives both within the sector, and to the general public.
- (iii) Assistance coordinating with media to assure coverage of sector events.
- (iv) Technical or other assistance to help with training, logistics, event coordination for facilitation

D. Phase III: Alignment

1. Overview

This is the stage during which those sectors engaged in the social mobilization program present and review their plans, look for opportunities to reinforce each others work, and commit to “accountability” structures or processes to assure the activity stays on track. We anticipate that accomplishing this objective would take one to two days, and would be facilitated by the steering committee and other relevant parties.

2. Multi-sector review of sector plans

A representative of each of the sectors involved in the social mobilization initiative would present their plans to other sector representatives and the steering committee. Sharing these sector specific plans will serve several purposes as follows.

3. Assure alignment to common goals and objectives.

If plans are not shared across sectors, it is likely that different interpretations during the planning stage could lead to inconsistencies in focus or direction during implementation. Such differences could seriously compromise the campaign by sending conflicting (or erroneous) messages. Just as crippling would be significant differences in the sector level campaigns that prevent them from being recognized as a single “intersectoral social [alliance]” as called for by McKee.

4. Synergy: finding opportunities for inter-sectoral reinforcement

While not always feasible or appropriate, it is likely that joint activities between sectors will send a more powerful message than those initiated by a single sector. One can imagine the powerful sense of community that could arise from a rally or public event being jointly sponsored, for example, by the uniformed services, women’s groups, and faith based organizations (or any other combination of sectors that may not have traditionally worked together).

5. Creation of vehicles (or structures) to assure accountability.

The members will need to determine how best to hold each other accountable, and how to make their initiative generally accountable to the public. There is no simple or clear solution to this problem, and numerous successful strategies may arise in discussions among local partners. It is likely that the similarities that such accountability structures will have will include:

- Transparency about objectives and intent to take action;
- Public access to sector wide statements or aspirations on the target social norm;
- Involvement of the mass media in the dissemination of sector wide commitments;
- Independent evaluation of sector level success (perhaps from representatives of other sectors);
- The creation of a forum to report on results from sector level activities.

E. Phase IV: Implementation

1. Overview

The two parts of the implementation process described below are complementary. The first, “sector level plans,” describes the actualization of activities developed internally by leaders and/or members of each of the participating sectors. The concurrent and coordinated implementation of these plans represents what was described in the previous chapter as “planned actions and processes to reach, influence and involve all relevant segments of society across all sectors from the national to the community level to create an enabling environment and effect positive behavior and social change.”

The second part, “Amplification” refers to a communications campaign (or series of campaigns) that assure that the sector level activities reach and influence as many members of society as possible.

2. Execution of Sector Levels Plans

Each sector will be responsible for the implementation of plans built on the internal assessments and adjusted as need be in the “Alignment” phase. We do not believe it is possible to either predict or describe what actions will be implemented in a given country or sector, but we can offer illustrative examples.

- Peer to peer discussions
- Group discussions at workplaces or in homes about target social norm
- Speaking out in public forums (political, educational, religious, social or recreational events)
- Marches, rallies, other sector specific gatherings
- Public displays of messages (banners, posting signs)
- Engaging mass media (radio call in, sending video clips to television stations)
- Wearing a pin, arm band, clothing, or any other decoration or adornment that is associated with the social mobilization movement.

3. Amplification

(i) Development of Amplification Plan

Development of the amplification plan should begin as soon as the sector level plans have been completed. The key document for the Amplification plan will be a “communications brief” as used in traditional communications and social marketing programs. The fundamental difference of this amplification plan, however, is that the communications brief will be driven solely by the content of the sector level plans.

The key objectives of this brief will be explain: a) how the sector level plans can be linked, and b) how the “reach” of sector level activities can be extended nationally.

The communications brief for the amplification plan will need to consider the following issues:

- Creation of visual (or other) linkages that unify the sector level plans. Doing so will create a sense of unity and coordination, and help demonstrate the pervasiveness of the social mobilization movement.
- Development and placement of materials for radio and television.
- Utilization of visual media such as billboards, posters, pamphlets, flyers etc.
- Development of “promotion” materials that can be used by each of the sectors can distribute to help them achieve their objectives. Such materials, as utilized in social marketing campaigns, may include: pens, t-shirts, school supplies, key chains, drink coasters, aprons, bumper stickers etc.

- Provide pedagogical materials that will help actors within a given sector familiarize their members with social mobilization objectives and strategies.
- Facilitation of outreach to remote or hard to access populations.

(ii) Budgeting the amplification plan

This amplification plan will require resources, and may require assistance from agencies expert in the development and execution of traditional communications programs. The difference, however, is that the “communications brief” as described above, is driven by the composite of the sector level plans.

(iii) Managing execution of the amplification plan

The partner or agency implementing the Amplification plan must take responsibility for the production, distribution and utilization of all materials produced for this campaign, including the development, production and placement of produce for use in mass media.

F. Phase V: Monitoring and Evaluation - Reporting Back

This phase of the social mobilization process includes monitoring results from sector level activities, the reach of communications activities, changes in perceptions about the target social norm, and changes in the incidence of the target behavior or phenomena driven by the target social norm. While traditional monitoring and evaluation strategies can be employed in this process, we propose to broadly disseminate results from the mobilization process; doing so will create a sense of accountability for those have made commitments to bringing positive change in their society.

We propose that the results from regular monitoring and evaluation process be shared not less often than every six months in public forums and media. This would create a sense of accountability for each of the individual sectors, and would create an incentive for them to act on commitments made during the initial planning phases.

Social Mobilization Process: Overview of Five Phases

	1. Analysis	2. Engagement	3. Alignment	4. Implementation	5. Evaluation
Activities	<ul style="list-style-type: none"> •Facilitated meeting with <u>core group of stakeholders</u> 	<ul style="list-style-type: none"> •Facilitated meetings and <u>planning with each sector</u> 	<ul style="list-style-type: none"> •Facilitated <u>inter-sectoral meetings</u> •Sharing strategies , and lessons learned 	<ul style="list-style-type: none"> •Sector level mobilization •Amplification Campaigns 	<ul style="list-style-type: none"> •Assessment of process and results
Outcomes	<p>Action Plan :</p> <ol style="list-style-type: none"> 1. Identify Social norm. 2. Campaign Objectives 3. Outcomes. 4. Sector Partners. 5. Next Steps 6. Steering Group. 	<p>Sector Level Action Plans :</p> <ol style="list-style-type: none"> 1. Expression of Commitment. 2. Activities 3. Budget 4. Support Plan 	<p>Inter-Sectoral Alignment :</p> <ol style="list-style-type: none"> 1. Joint statement of mission. 2. Joint Activity Plans 3. Accountability Structures 	<p>Social Change</p> <ol style="list-style-type: none"> 1. Healthier actions and behaviors. 2. New public perception of “norm” 	<p>Insights</p> <ol style="list-style-type: none"> 1. What has changed? 2. What has worked? 3. What did not work, and why?