Techniques and Practices for Local Responses to HIV/AIDS

Part 1: Techniques

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This Toolkit is a joint publication between the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Royal Tropical Institute.

Information

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Preface

It is people who must respond to HIV/AIDS. For their responses to be effective, they need commodities, information and money. However, these can only support — and not substitute for — a people-driven response. Individuals, households and communities that respond effectively to HIV/AIDS take ownership both of the issue and of its solution. To progress towards AIDS competence, they forge partnerships with local sources of support, with individual and peers and also with local government, social service departments, community-based and non-governmental organizations or the private sector. This is, briefly, what we have learned from effective local responses, the responses by people where they live and work. How can one foster such effective responses at large scale?
This toolkit represents a new and excellent resource for the many committed to this goal. The techniques and practices presented here have been "distilled" from local responses around the globe. This toolkit offers the techniques and practices for others to adapt to their own context. To the extent possible, it includes a contact address so that various actors can contact each other to share their experience with the various techniques and practices, and make a synthesis of lessons learnt from their use.
We wish that the publication of their Toolkit would stimulate new connections for more effective Local Responses. UNAIDS is looking forward to learn more from those new connections.

Michel Sidibé
Director of Country and Regional Support Division
UNAIDS, Geneva

Acknowledgements

We like to express our appreciation and gratitude to the partner organisations for the warm reception during the visits of the KIT consultants, for the discussions on strategies for learning and sharing knowledge and for the arrangement of the meetings with NGOs active in Local Responses in their respective countries. These partner organisations are AIDSNet and AIDS Education Project of the University of Chiangmai in Thailand, Christian Health Association Zambia (CHAZ) in Zambia, UNASO in Uganda, ABIA in Brasil, Programme d'Appui au Programme Multisectoriel de Lutte contre le SIDA et les IST / World Bank in Burkina Faso and The Caribbean Regional Epidemiology Centre (CAREC) in Trinidad and Tobago. We are also thankful to the UNAIDS Country Coordinators in these countries and the UNAIDS Caribbean Team for their insight in programmes on Local Responses and their valuable advice in clarifying specific aspects of the institutional arrangements and regulatory framework for HIV/AIDS in these countries.

Madeleen Wegelin and Georges Tiendrebeogo from KIT brought together the techniques and practices contributed and adapted them to the framework, initially assisted by Carolien Aantjes. After sending them back to the various sources for comments, they were reviewed by a group of colleagues from KIT. The illustrations were made by Barbara van Amelsfoort of KIT. We like to thank the many individuals and organisations for taking time to talk and write to the KIT consultants about their programmes and for the frank analysis of the impact and challenges of these programmes. We are also grateful for suggestions from many people working in HIV/AIDS around the world on organisations that could contribute to the documentation of techniques and practices for Local Responses.

A special word of thanks goes to Luc Barriere-Constantin of the Africa Division of the Country and Regional Support Department, UNAIDS and Jean Louis Lamboray of the UNAIDS/UNITAR AIDS Competence Team for their continuous guidance, advice and support as well as their comments on the draft practices and techniques and the links with the Self Assessment for AIDS Competence.

Finally, without financial support, the toolkit would never have been possible. For this, we therefore thank the Japanese government, the government of The Netherlands and the UNAIDS departments of Technical Network Development (TND) and Information Centre (IRC).

Introduction

In 2001 UNAIDS initiated the development of a toolkit with techniques and practices for AIDS competence in consultation with the UNAIDS Secretariat, with the UN Theme Groups in different countries and members of the UNAIDS Technical Network on Local Responses to HIV/AIDS.
The toolkit aims to further strengthen the capacity and competence of different actors to address HIV/AIDS at local level. Experiences worldwide contributed to the identification and selection of practices and techniques for the toolkit and they meant for all with an interest in furthering local responses to HIV/AIDS.
The Royal Tropical Institute (KIT) in the Netherlands manages the project for UNAIDS.

This document presents the techniques that have been contributed to the toolkit. The techniques are available in English, French and Portugese in hard copy and on CD-rom. In addition, they are posted on the Local Response e-workspace (LR_toolkit@ews.unaids.org) for further discussion and are available on the UNAIDS website (www.unaids.org) and the KIT website www.kit.nl/health/html/aids_.asp. Techniques help a facilitator to support an audience to analyse their own situation and to establish their needs and priorities, in order to plan interventions.
The practices, that also form a part of the toolkit, are presented in a separate document, available in hard copy in English and also on the cd rom, the e-workspace and the websites.

In this document we first describe the reasons for developing the toolkit and the process that was followed for the collection of techniques and practices. It continues with a description of how you can contribute and/or access the practices and techniques and how to use them. The last part of the introduction describes the link with the framework for Self Assessment of AIDS Competence and concludes with an overview of the techniques. The rest of the document consists of twenty techniques. Annex 1 provides guidelines on how to write a technique enabling readers to contribute to the toolkit and expand the common knowledge base. In a second annex, the framework for Self Assessment of AIDS competence is presented, developed by the UNAIDS/UNITAR Aids Competence Team.

Why a toolkit for local responses

Local Responses to HIV/AIDS imply the involvement of people where they live - in their homes, their neighbourhoods and their work places. For HIV/AIDS prevention and impact mitigation, each individual, family, community and organisation needs to deal effectively with HIV/AIDS, in other words, needs to become “AIDS-competent”. AIDS competent societies acknowledge the reality of HIV/AIDS and assess how HIV/AIDS affects different aspects of life and organisations. Based on this assessment, AIDS-competent societies build their capacity to respond and take concrete measures to reduce vulnerability and risk. Learning and sharing experiences with others is an important aspect of building capacity and avoids time and energy spent on re-inventing the wheel.

Crucial in a strategy for learning and sharing across communities, organisations and countries, is the documentation of experiences that have proven to work in a specific context. Often, such experiences tend to remain local and are rarely documented. Even if they are, these are often lengthy case studies and not very accessible. The toolkit and the discussion on the e-workspace provides a platform where experiences are available in a short, concise format in which the source for further information is given to facilitate practical application and adaptation to another local context. The development and implementation of a strategy for learning and sharing in each country will help to get the experiences to those that can use them best.

The process followed to collect the practices and techniques documented

Partners that already collaborated in the UNAIDS local response network, developed a format for the practices and techniques that form the backbone of the toolkit, during a start-up workshop (held in Uganda in May 2002). In addition, the strategy for the project was discussed as well as approaches for a knowledge exchange strategy within and between countries.

Subsequently, KIT finalised guidelines for writing practices and techniques (see annex 1). Organisations in the local response network, partners that participated in the workshop and contacts made at international conferences, played an important role in identifying practices and techniques for the toolkit. In addition, KIT staff visited six countries (Brasil, Burkina Faso, Trinidad and Tobago, Thailand, Uganda and Zambia) to document practices and techniques. In the countries, practices and techniques already available in the toolkit were shared and in-country knowledge exchange strategies were discussed. In three countries this was also linked to workshops on self-assessment.

Who contributes to the toolkit, who uses it and how can it be accessed

The organisations that contributed to the toolkit are diverse, some of these organisations function as umbrella organisations for local NGOs, such as AIDSNet in Thailand, UNASO in Uganda, CHAZ in Zambia and Somos in Brasil. They helped to contact their participating NGOs to share their practices and techniques and will also be instrumental in disseminating and using the tools. Other inputs result from NGOs implementing the Local Responses agenda in the six selected countries with the support of the World Bank (MAP) and other UNAIDS co-sponsors, such as UNICEF, UNDP and WHO or from NGOs that are linked to international NGOs such as Save the Children, Action AID, International HIV/AIDS Alliance, Oxfam and international faith based organisations.

National facilitators for Local Responses, district support teams or umbrella organisations are a key audience for the use and further development of the toolkit because their task it is to motivate, facilitate and support communities in planning their own responses. They make use of participatory techniques in this work and the tools in this document give them additional options. With respect to practices, it is through this mechanism that effective responses can be fed back to the policy level (National AIDS Councils or Programmes) and to sector ministries for possible integration in national policies.

The practices and techniques in the toolkit, are presented and discussed in the Technical Network on Local Responses to HIV/AIDS with about 700 members working in all continents and at all levels of the response. The members of this network meet virtually in the Local Responses to HIV/AIDS e-Workspace. They

exchange lessons with regard to their work in e-mail discussions and contribute to the collective learning on responses to HIV/AIDS. The Local Responses e-workspace hosts three e-mail discussion forums. One on the City-Aids programme (LR_City-Aids@ews.unaids.org) focussing on responses to HIV/AIDS in cities, one on the Toolkit for Local Responses (LR_Toolkit@ews.unaids.org) where new practices and techniques related to Local Responses are discussed, and one on general information related to Local Responses (Localresponse@ews.unaids.org). The Local Responses e-workspace further accommodates document libraries, an event calendar, a contact list and links to related websites.

It is expected that with a substantive initial collection of practices and techniques in the toolkit, organisations are motivated to share their experiences in using and adapting the practices and techniques and thus enhance global learning. We ask the users of the toolkit to contribute to this discussion by sending a response to the e-workspace on the following questions:

- For what purpose have you used the practice/technique
- What adaptations have you made
- What is the outcome of the use of the practice/technique

In addition all users are invited to contribute new practices and techniques so the content can evolve continuously and a platform for exchange is established on the website and in the e-workspace. The facilitator of the toolkit will give support in documenting the practices and techniques in the common framework.

What are practices and techniques

A practice describes a process that is carried out by an organisation/ institution/ community to address one or more specific problems. It can serve as an example and/or inspiration for others that are confronted with a similar problem. The practice describes in a practical way the whole process of implementation as it has taken place and gives an analysis of critical issues and lessons learnt. The source of information is included to ensure that more details of the process can be obtained if necessary. A practice usually has a longer time frame and it must be sustainable in the context in which it is applied.

A technique is a procedure that is used for a specific purpose at a certain stage during a process of intervention, described in a practical step-by-step fashion. Many of the techniques are applied in development programmes that aim at community mobilisation and empowerment and are adapted for use in HIV/AIDS programming. Although some techniques are for use specifically at community level, there are also techniques that are applied at sub-district and district level by local government staff and by NGOs. Because most organisations have experience with participatory techniques, the toolkit does not include a specific training manual but is a collection of techniques that can be adopted in an existing approach.

The framework for Self Assessment of AIDS competence

Since the formulation of the toolkit project, UNAIDS has formed a partnership with UNITAR to create and share knowledge from effective responses to the HIV/AIDS epidemic. As a starting point a self-assessment process is designed in which people (groups and organisations at various levels) self assess where they are already performing good practice, where they might improve, what gaps in knowledge and experience exist and how these can be overcome (see annex 2). This process helps to guide sharing of knowledge and interaction between organisations and groups of people and can be seen as a technique in

itself. The process will generate additional practices and techniques that can be included in the toolkit. The toolkit is thus complementary to the self-assessment process as it provides a framework for documenting practices and techniques and a common source of practical examples that can help organisations to advance from one level of competence to another.

Overview of the techniques presented in this document

This document presents 20 techniques for application in different stages in the planning cycle. In each technique the purpose and use of the technique is described as well as a practical guideline on how to proceed. It further discusses the impact of the technique and the critical issues for success. The source of the techniques mentions organisation(s) that have used the technique and can be approached for further clarification, enhancing exchange of knowledge. Some techniques are applied in a different way than described and where this is already known, this is mentioned in the technique in the editor's note for learning. Users that are applying techniques in another way, are invited to share this in the e-workspace discussion.

In the table below, an overview is given of the techniques and the stages where they can be applied. In addition is mentioned in which stages in the self-assessment framework, the techniques could help to take action.

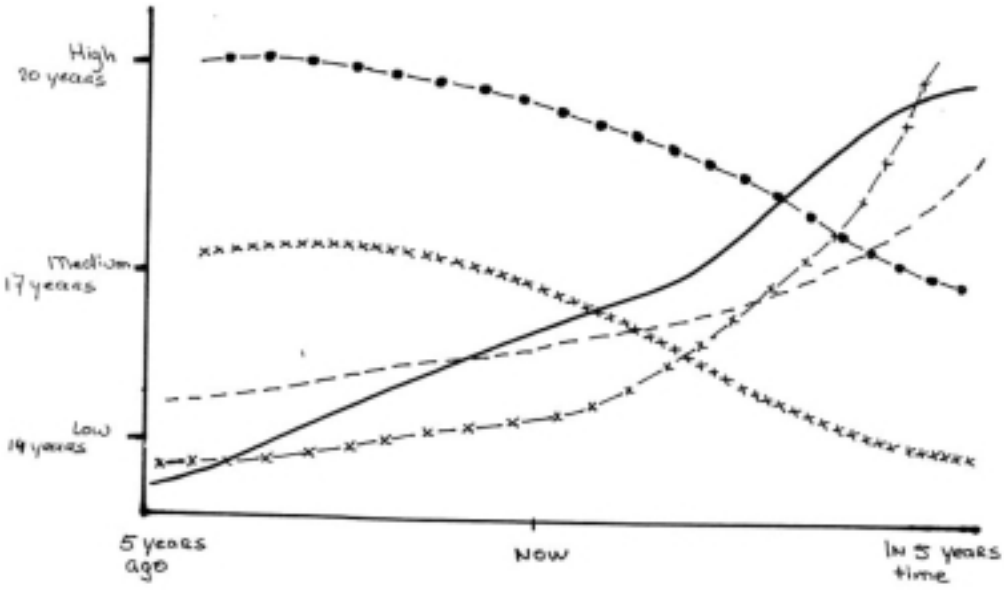
Stage in the planning cycle	Technique competence framework	Stage in self assessment for AIDS
Awareness raising and mobilisation	1 AIDS Trend Appraisal	Measuring change, step 1
	2 Family dynamics	Care and prevention, step 2
	3 Appraisal of risk behaviour	Acknowledgement and recognition, step 1
	4 Occupational risk	Identify and address vulnerability, step 1
	5 Wildfire	Acknowledgement and recognition, step 3
	6 Body mapping	Acknowledgement and recognition, step 1
	7 3 pile sorting	
Situation analysis	8 Mapping	Identify and address vulnerability, step 2
	9 Seasonal calendar	Identify and address vulnerability, step 1
	10 Story with a gap	Acknowledgement and recognition, step 2
	11 Transect walk	Acknowledgement and recognition, step 2
Planning	12 Problem tree	
	13 Problem ranking	
	14 Force field analysis	Mobilising resources, step 1
	15 Carts and rocks	Mobilising resources, step 1
	16 Venn diagram	Inclusion, step 2
	17 Role perceptions	Ways of working, step 3
	18 Action planning	Mobilising resources, step 3
Monitoring and evaluation	19 Spiderweb	Measuring change, step 4
	20 SWOT analysis	Adapting our response, step 5

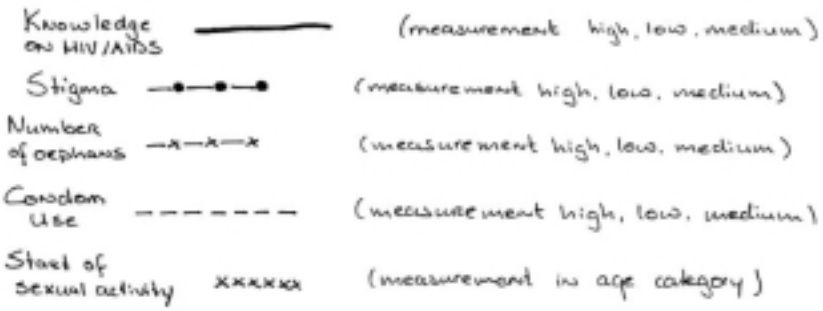
1 Technique: AIDS trend appraisal

Section	Content
1 Description of technique	Participatory methodology to assess changes in relation to different aspects of HIV/AIDS in the community.
2 Level of intervention	Community level.
3 Stage in planning cycle	Awareness raising, planning.
4 Purpose and use of technique	• HIV/AIDS conditions continuously change. This exercise enables the community to see the development of different aspects related to HIV/AIDS over time in a systematic way • The exercise is helpful to assess the perception of different groups about the past, it raises awareness on the future and helps to plan for preventing and solving problems to be faced
5 Requirements for facilitation	• Good knowledge on basic facts of HIV/AIDS to answer questions when these come up during the exercise • Ability to deal with the emotions of the participants when they see discouraging trends • Ability to motivate participants to think of interventions that they themselves can undertake • A non-judgemental attitude
6 Duration	Approx. 2 hours
7 Materials required	• Flip chart paper • Pens/markers • Locally available objects like pebbles, leaves etc.
8 Methodology	1 Divide the group into small groups (5-8 people in each group). 2 Ask each group to select one or more aspects in relation to HIV/AIDS in the community (for instance: changes in knowledge about HIV/AIDS, number of people in the community who contracted HIV/AIDS or died of AIDS, HIV/AIDS infection in specific community groups, attitude towards condom use, attitude towards PLWA, number of orphans). 3 For each of the aspects selected, the group develops a rough measurement scale (high, medium, low or age categories). 4 The groups analyse the selected aspect to see what it was like 5 years ago, what it is like now and what it will be like in the next 5 years. 5 They show the results on paper or on the ground indicating the changing trend with a fluctuating line.

Section	Content
	6 It is also possible to ask the groups to analyse more than one aspect at the same time. 7 The results are presented and the trends of the different aspects analysed are compared to see if there is an interrelationship (for instance migration and HIV infection rates). 8 This is followed by a discussion on action that can be taken in the community in prevention and impact mitigation.
9 Impact	• The exercise enables a discussion among community members on the HIV/AIDS situation in their community. People might have different perceptions and by stating these, this could open up a lively discussion whereby a lot of information/data can be subtracted and a first step can be made towards a planning process • A negative impact may be that specific community groups or individuals are 'blamed' for the AIDS situation in the community or that confidentiality is not kept and names of PLWA's are mentioned. The facilitator has to be alert that this is not happening
10 Critical issues for success	• The division of the groups has to be done carefully, separating age and gender or mixing these on purpose to encourage discussion within the groups. It is best to discuss this first in the group as a whole and to let them decide • The facilitator has to encourage the groups to analyse the trends well and to assess the reasons for it by asking questions such as why, when, how and who. This will help the group to decide what they can do in future to change the trend
11 Source of technique	AIDS Education Project, Faculty of education, Chiangmai University, 50200 Chiangmai, Thailand, email: duongsaa@chmai.loxinfo.co.th Programme d'Appui au Programme Multisectoriel de Lutte contre le SIDA et les IST (Seydou Kabré or Victorine Yaméogo), 01 BP 6464 Ouagadougou 01, Burkina Faso pmls@cenatrin.bf
12 Editor's note for learning	This activity is very useful to assess trends in the community and to assess perceptions on these trends with the different groups. At the same time it gives insight in the level of awareness and knowledge related to HIV/AIDS transmission and prevention. The discussions and analysis can already lead to suggestions for interventions in future. These suggestions have to be noted down to be included in action planning at a later stage.

Example of an Aids Trend Appraisal





2 Technique: Family Dynamics

Section	Content
1 Description of technique	A participatory technique that assists participants to explore the implications of HIV/AIDS on family life.
2 Level of intervention	Community level.
3 Stage in planning cycle	Awareness raising, mobilisation.
4 Purpose and use of technique	To assist participants to reflect on the impact of HIV/AIDS on family- and community life.
5 Requirements for facilitation	Ability to deal with emotions of participants during the exercise.
6 Duration	2 hours.
7 Materials required	• A number of sets of cut out figures, each representing a different type of family, each having members of a different age and sex such as: • a single mother with infants and young children • a household with a father, mother, young children and a grandmother • a young girl with an infant • and so on, depending on types of families existing in the local context: some of these figures will need to be colour-coded with a red dot on the reverse side to indicate the presence HIV
8 Methodology	1 The group is divided into subgroups of 4-5 persons. 2 Each group receives a set of silhouettes representing one family/household. 3 Each group is asked to give 'life' to their family by discussing the questions; what would the people in the household be doing? What are the relations between family members? How does the family survive? What are the goals and dreams of the family as a whole as well as of each individual household member? 4 Participants turn over the silhouettes and discover that at least one family member has a red dot on the back of the silhouette. The person/people with the dot is HIV positive. 5 Participants discuss the implications: what has changed within the family? How will the family manage their situation when the infected person(s) falls ill? What will happen when the infected person(s) die? Could that person transmit HIV/AIDS to the other family members? If so, how and what are the implications of this? How have the family members' dreams and ambitions changed as a result of the HIV infection?

Section	Content
	6 Participants report back in a plenary session what they have been discussing. 7 Participants place their silhouette families in the centre of the room. They represent the community at this point in time. Participants now visualise this community in five years time. Who would still be there? Participants remove the silhouettes they think will not be part of the community in 5 years time. They then discuss the wider implications of this for the community as a whole (lack of funds in saving societies, inability to operate and manage the water system, irrigation system etc., support to orphans). 8 Participants once more return to their subgroups to discuss what could be done at household level to care for family members with AIDS. How can their lives be made as comfortable as possible and how could they be treated with dignity? 9 Participants go back to the plenary group and place all the silhouettes in the centre of the room, again representing the community. The community has now to decide what to do with the problems associated with HIV/AIDS. The only condition is that someone from the family affected by HIV/AIDS has to ask for help from either another family or the broader community. 10 Participants put themselves in the role of one of the silhouette family members that had been defined at the beginning of the session. They either ask for help or respond to the one asking for help during this plenary group discussion. They can do that by offering help with cooking or cleaning, or using their position to support the family member affected by HIV/AIDS. For instance a 'store owner' who is a member of one the silhouette families' offers to assist in paying the school fees. A discussion takes place whereby participants look for ways to support the affected household members, while taking the 'role' of a family member. This way the discussion avoids becoming too personal.
9 Impact	• Participants can create their own situations and experience the impact of HIV/AIDS through their figure families, thus learning in a creative way • Making use of figure families gives life to typical situations faced by families affected by HIV/AIDS, without giving the participants the feeling that they are talking about their own family – this facilitates discussion
10 Critical issues for success	Participants go through a process, which can be quite emotional as it may remind them of their own experiences with HIV/AIDS they have not been able to share with anyone. The facilitator has to keep a close eye on the direction of the discussion and has to provide time after the session to give emotional support to participants on a one to one basis. The result of the discussions may be used in action planning if this focuses on community based support to PLWA and their families.
11 Source of technique	Adapted from "Strengthening Community Responses to HIV/AIDS", UNDP July 2000. HIV and Development Programme. www.undp.org/hiv/publications/toolkit/toolkit.html Corporacion Kimirina Ramirez Davalos 258 y Paez, Quito, Ecuador kimirina@quik.com.ec
12 Editor's note for learning	In Ecuador, the technique is adapted for use in NGOs and schools. In this case it is not the family, but members of an organisation and a school members. The red dots on the figures are put in the figures after the initial analysis.

Example of figures to be used in the technique

3 Technique: Appraisal of risk behaviour

Section	Content
1 Description of technique	A participatory technique that helps participants identify different types of risk behaviour or conditions that may lead to risk behaviour.
2 Level of intervention	Community.
3 Stage in planning cycle	Situation analysis, awareness raising.
4 Purpose and use of technique	• To increase awareness that there are many different risk behaviours and that many different (groups of) people are at risk to become infected • To arrange risk behaviour in order of importance with regard to number of people at risk • To develop targets and target groups for awareness interventions/campaigns using appropriate methods
5 Requirements for facilitation	• The facilitator needs to observe the groups, but only explain risk behaviour when participants request clarification (for instance: is there a risk for transmission in having a haircut or going to the dentist?) • Ability to facilitate discussion on sensitive/taboo subjects and norms and values in the community
6 Duration	1 hour.
7 Materials required	Paper and pen to note down risk behaviours. Seeds to rank the behaviours.
8 Methodology	1 Divide the group in small groups of 5-8 persons according to relevance (f.i. men, women, youth, different ethnic groups). 2 The sub-groups are asked to consider what behaviour in the community leads to contracting HIV. List behaviour on the left side of the paper. 3 The sub-group discusses the number of people practising each risk behaviour. Objects (f.i. seeds) ranging from 1-10 in number are put behind each behaviour indicating behaviour that is practised by few (1) or by many (10). A division in three types (few, medium, many) is also possible. When discussing who practices what behaviour, the facilitator may ask questions to help: which group of people, which sex and what age are involved in this kind of risk behaviour. 4 When all groups have finished, they present the results to each other and discuss. 5 The facilitator notices that there are many types of risk behaviour but that not all are equally risky and that not all may be voluntary (such as a wife not being able to demand condom use from her husband who she knows has a girlfriend).

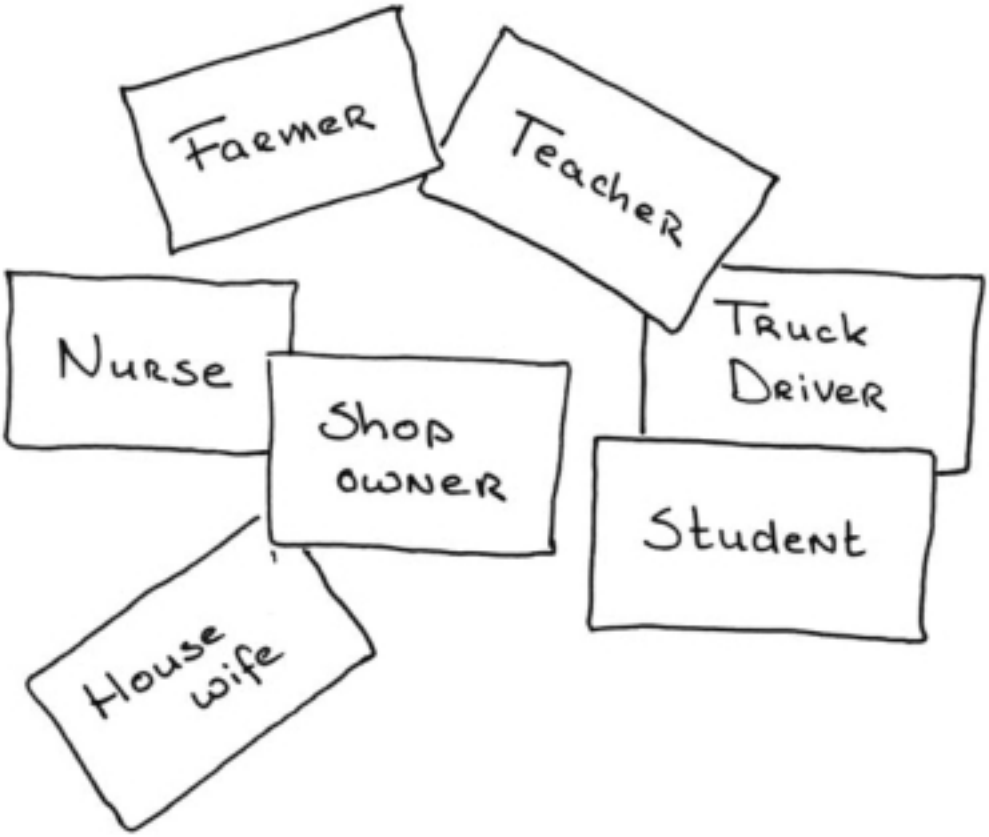
Section	Content
	Some behaviour is in itself not risky (such as consuming alcohol) but may lead to risk behaviour (unprotected sex). 6 The facilitator subsequently discusses which behaviours and which target groups should be addressed in prevention campaigns. Possible target groups may be men, women, expecting mothers, male and female youth, sex workers, drug users.
9 Impact	• This exercise makes people realise that risk behaviour is not confined to a few people and that HIV is an issue that confronts all • Awareness on different types of risk behaviour is increased and misconceptions on transmission can be redressed • The facilitator has to be very alert that certain groups (sex workers, injecting drug users) are not being blamed adding to the already existing stigma
10 Critical issues for success	The importance of this activity lies in teaching about AIDS (risk behaviour for contracting HIV) not by lecturing but by letting participants discover and learn for themselves.
11 Source of technique	AIDS Education Project, Faculty of education, Chiangmai University, 50200 Chiangmai, Thailand, email: duongsaa@chmai.loxinfo.co.th JSA Consultants Ltd. P.O. Box A408, La, Accra, Ghana. E-mail: jsa@africaonline.com.gh
12 Editor's note for learning	The differentiation of groups of people practising risk behaviour is likely to also address increased risk for mobile populations such as students, seasonal labour, truck drivers and the need for prevention campaigns before the mobility takes place.

Example of appraisal of Risk Behaviour

4 Technique: Occupational Risk

Section	Content
1 Description of technique	The risk for HIV/AIDS infection of people in different occupations is discussed.
2 Level of intervention	Any group (workplace, community, youth, students, peer educators, teachers, NGOs).
3 Stage or area of action (cycle)	Awareness raising, mobilisation.
4 Purpose and use of technique	• Raise awareness that most people are vulnerable to HIV infection • Reduce levels of discrimination against groups e.g. PHA
5 Requirements for facilitation	The facilitator must count him/herself as person with risk and know the culture of the people. S/he must have the ability to encourage open discussion and not be judgemental.
6 Duration	1-2 hour, depending on group size.
7 Materials required	Small cards, markers.
8 Methodology	1 Ask the group to mention occupations that are common (as many occupations as there are participants). 2 Write these occupations down on cards. 3 Each person gets a card with an occupation. 4 Divide the space in two parts, a low risk side and a high risk side. 5 Each person assesses the occupation on the card. 6 Each person chooses to sit on the high risk side or the low risk side of the circle. 7 Discussion guided by facilitator on why occupations are considered high or low risk.
9 Impact	• Increased levels of awareness about risk behaviour and vulnerability of all • Reduced discrimination/stigmatization as individuals become more sensitive
10 Critical issues for success	Only select occupations that are familiar to the group.
11 Source of technique	AIDSNet, Chiangmai, Thailand aidsnetn@loxinfo.co.th JSA Consultants Ltd. P.O. Box A408, La, Accra, Ghana, jsa@africaonline.com.gh
12 Editor's note for learning	This technique can be used in many different settings. For instance in a training context, in workplace programmes etc.

Example of occupations selected in the exercise



5 Technique: Wildfire simulation

Section	Content
1 Description of technique	Wildfire is a participatory exercise that simulates the spread and some of the repercussions of HIV/AIDS. During the exercise there is a continuous discussion on participants' feelings about their own (simulated) behaviour, the impact HIV/AIDS has on their lives and those close to them, as well the exploration of the issues related to support for PLWHA and ways to stop sexual transmission.
2 Level of intervention	Any community, organisation, companies. Training.
3 Stage in planning cycle	Awareness raising, mobilisation.
4 Purpose and use of technique	In order to be able to work effectively within the epidemic, it is important for participants to experience what it feels like to be exposed to HIV infection personally. The simulation enables the understanding of: • The speed of transmission of HIV, the notion of a sexual network and ways to stop HIV sexual transmission • What it may imply to be exposed to or infected with HIV: stigma and discrimination, emotional turmoil, need for support • Various social factors that influence help seeking behaviour for men and for women, and the need to counsel those seeking to undertake an HIV/AIDS test, as well as the necessity to create a supportive environment • Why the epidemic affects everyone, not just others
5 Requirements for facilitation	Wildfire is both procedurally complex and laden with sensitive personal issues. The facilitator needs to have counselling skills and ability to cope with emotions, and a non-judgemental attitude. The facilitator should have attended the simulation as a participant and must review the notes thoroughly in advance. Consider the following variables in preparing for the exercise: whether or not participants are all male, all female or mixed; whether the participants are from the same country or from different countries or regions; the relative level of knowledge and the types of attitudes participants have about the HIV epidemic; the familiarity of participants with voluntary counselling and testing procedures and services; the degree to which an atmosphere of openness and a willingness to share feelings has developed among the participants.
6 Duration	1,5 hours.
7 Materials required	Space for 15 - 25 participants to stand in a circle, chairs for all participants The resource person will need 20 envelopes, each containing a card. Ten of the cards should read "your result is positive" and ten "your result is negative.

Section	Content
	Because of the nature of this exercise, it is critical that no observers are present, and that no one joins the exercise once it has begun.
8 Methodology	**1** **Explain the purpose of the simulation exercise**: simulation (not a role play) to help them experience some of the feelings associated with HIV/AIDS. Emphasize the need for confidentiality and mutual trust within the group for people to feel they can be open in the exercise. **2** **Explain the procedure**: 1) Ask participants to put down anything they are holding and to stand in a circle facing inward. Approach one participant and shake the person's hand. Tell him/her and the rest of the group that for this exercise a handshake is equivalent to having unprotected sexual intercourse. 2) While still holding the participant's hand, explain that we need some mechanism to indicate personal exposure to HIV and a light scratch on the palm of the hand during the handshake is the chosen method. Stress that a scratch on the palm indicates that the person has had unprotected penetrative intercourse with someone who has had intercourse with an infected person. It does not necessarily mean that the person is infected since the virus is not transmitted during every act of unprotected intercourse. 3) Demonstrate the hand scratch to the person with whom you are shaking hands and display it to all the other participants. Stop your handshake. Tell everyone that this was only a demonstration and that no one, at this stage, has been exposed to HIV in the exercise. 4) Ask people to shake hands gently since, for many, the thought of having unprotected intercourse is difficult. **3** **Select a participant to be HIV-infected.** Tell the group that you will shortly ask them all to close their eyes and that you will then walk around the circle several times during which you will touch one person on the shoulder. For the course of the exercise, the touched person will be HIV-infected. The person whose shoulder you touch is not to tell any other group member. However, he or she will scratch the palm of every person's hand shaken during the exercise. Tell the group that if, during the course of the exercise, any of them is scratched on the palm, that person must then scratch the palms of other people he or she shakes hands with. Remind people every time they shake hands they are having unprotected sexual intercourse. Walk around the group and lightly touch someone on the shoulder. **4** **Participants experience the invisibility of infection**. After touching a single person, ask the participants to open their eyes and see if they can identify the person in the group who is HIV-infected. Bring out the point that one cannot tell if a person is infected by looking at him or her. Briefly discuss with the group how they felt as you walked around the circle. You should concentrate on facilitating the group to provide answers and information rather than giving it yourself. Bring out the point that even in a game, people are fearful of being HIV-infected and do not want to be touched. **5** **Demonstration of sexual networking**. Remind participants that there is one person HIV-infected for the exercise. Tell them that as the game begins this person will scratch the palms of those with whom he or she shakes hands. Those whose palms are scratched then scratch the palms of all the hands they shake after they are scratched. Stipulate the maximum number of handshakes per participant: up to 3 hand-shakes per person for a group of 10 to 15 participants, and up to 4 hand-shakes per person for a group of 15 to 25.

Section	Content
	Ask everyone to participate. Step out of the circle and ask the participants to begin shaking hands with whomever they wish up to the stipulated number. 6 **Demonstration of the randomness of exposure to HIV.** After the handshakes stop, step back into the centre. Ask all those who had their palms scratched during the course of the exercise and the person who had her or his shoulder touched at the beginning to step into the middle of the circle. Ask the others to return to the outer circle seats. Seat the inner circle. Encourage the group to discuss what it is like to be in either position, those on the outside first, followed by those on the inner circle. Possible questions for **outer circle**: How was your behaviour different from that of the people in the inner circle? How did you end up in the outer circle while the others are in the inner circle? How do you feel about the people in the inner circle? Possible questions for **inner circle**: What are you thinking now that you realise it is possible that you are infected? What are you feeling now that you realise it is possible that you are infected? Would you tell anyone you may be infected? Whom? How likely do you think it is that your confidentiality will be respected? What can be done to strengthen this? Would you tell your sexual partner or partners you might be infected? What support would you need at this stage? To whom will you turn? **Outer circle**: Will you continue having unprotected sexual intercourse? **Inner circle:** Will you continue having unprotected sexual intercourse? **Outer circle:** Would you have sexual intercourse again with a person in the inner circle? (If necessary, remind everyone in the inner circle that they have been exposed to the virus but it is not yet known if transmission has taken place. At some stage during the discussion, participants may ask about the possibility of an HIV antibody test. Reassure them that voluntary and confidential testing with counselling is available. 7 **Knowledge of one's HIV status: voluntary/confidential testing with counselling.** Offer the test to all in the inner circle; discuss the testing procedure, and the meaning of positive and negative results. If a participant does not want to be tested, the facilitator should explore the reasons for this decision. The person could be asked: 1) You are possibly infected. Do you have all the information you require to decide what you are going to do in light of this? 2) Are you going to ensure that no one else is put at risk from your behaviour? 3) What support will you need to sustain your behaviour? The person should then be asked to move to the outer ring. Ask people in the outer circle what choice they would have made and why. Shuffle the test result envelopes and pass them to those in the inner circle, asking participants not to open their envelopes but to hold them. This symbolises the waiting time between taking the test and receiving the results. Questions include: 1) What does it feel like to be waiting for your result? 2) What support would you need during this period? 3) Would you tell anyone you had taken the test? Whom? 4) Would you continue with unprotected sexual intercourse? Why/why not? 5) Would you be able to concentrate fully at work and/or home? 8 **Testing without consent:** Before asking those in the inner circle to open their envelopes, give envelopes to a number of the women in the outer circle telling them that they are pregnant and have been tested without their knowledge or consent. Give envelopes to a smaller number of men telling them that they were tested without their knowledge or consent while being

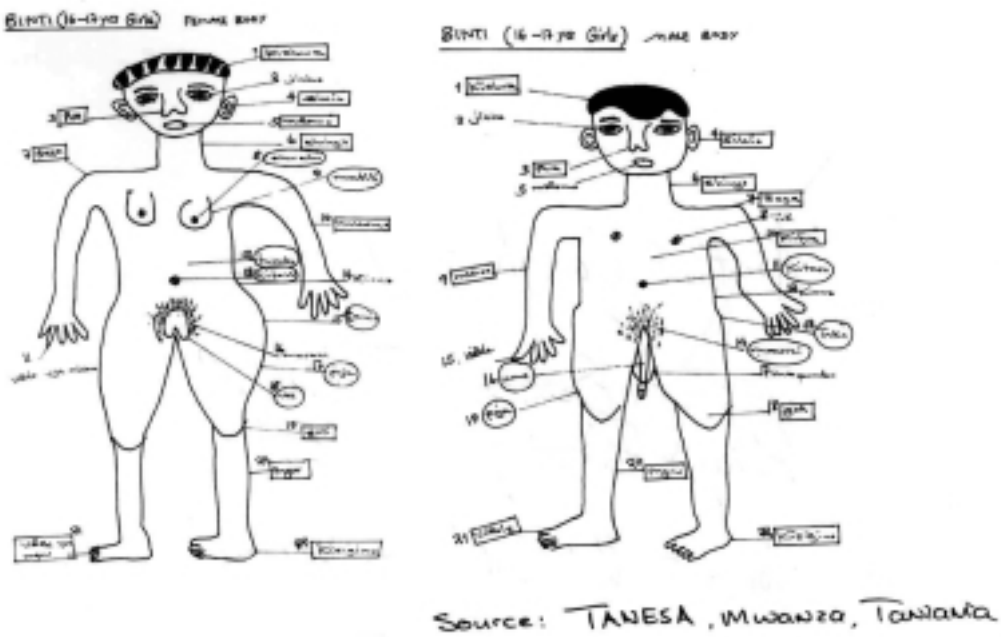
Section	Content
	treated for TB or a sexually transmitted infection or when they joined the military. Explore how these individuals feel about being tested without their consent. Then ask all to open the envelopes. 9 **Developing strategies to live with the news that one is not infected**. Ask each person his or her test result. Discuss with each person with a negative result what impact this has had on her or him: 1) How does it feel to get a negative result? 2) Are you going to change your behaviour in order to remain uninfected? 3) Do you have all the information you require about safe sex? 4) Where would you get further information? 5) What support will you need to sustain your safe behaviors? The facilitator discusses the window period for HIV antibody testing and the need for a follow-up test if people have had unprotected penetrative intercourse during the previous three months. Ask those with a negative result to replace their cards in their envelopes and to give them back to the facilitator, then ask them to join the outer circle. 10 **Developing strategies to live with the news that one is HIV-infected.** Each person with a positive result is now encouraged to discuss his or her reactions. The facilitator asks questions such as: 1) Which thoughts crossed your mind when you received your result? 2) What is your immediate reaction to the result? 3) Will you tell people your result? 4) How do you think they will react? 5) Will you tell your spouse/partner/sexual partners? 6) Will you tell your children? 7) Will you tell your work colleagues? Employer? 8) What support do you need for all this? 9) Do you want to have children? How will this test result affect that? The positive aspects of knowing one's infection status should be discussed: the possibility of making changes to remain well, the possibility of planning for one's future and that of one's children, the prompt diagnosis and treatment of opportunistic infections. The difference between being infected and having an HIV-related illness, including AIDS, should be made clear. There should be some discussion of how to disclose infection status and the possible consequences of disclosure. When the discussion has covered all of the concerns, ask those participants who received a positive result to place their results in the envelopes. Take the envelopes back one by one reminding the participants that this has been an exercise only and as they pass the envelope to you they also "pass back the virus". When taking back the envelopes, ask each participant to stand and step out of the inner circle. Ask them how they feel and whether they need any help. Then ask them to move to the outer circle. 11 **Developing strategies for living with the virus in our midst.** After everyone has moved to the outer circle, ask all participants to stand in a circle again. Explore with the participants some strategies for living with the virus in our midst. Questions could include: 1) How can we co-exist with this virus, live with it in our midst without becoming infected? 2) How can you help members of your family or friends to protect themselves? 3) How can you support those who are already affected? Ask each participant to reflect on the exercise and say a word or name a colour to express her or his feelings or thoughts. Emphasise that the exercise is now over. At the end, participants may feel like giving each other some kind of support: a word, a smile, a touch, and a hug, or "handshakes without scratching". A break, preferably a meal break, must be taken after this exercise to give participants time to think about the exercise and how it affected them. The exercise can affect participants

Section	Content
	profoundly, and it is important to be sensitive to this in the hours and days that follow. Participants may wish to spend time in "support" groups immediately after the exercise and this option should be offered.
9 Impact	The simulation exercise is very powerful and helps in developing a sense of personal engagement and a fuller understanding of the epidemic and its implications. The simulation in Senegal, Ivory Coast and Burkina Faso led to: immediate personal commitment to act and to support each other; immediate personal commitment to act in order to reduce individual, age-gender and sectoral vulnerability to the epidemic, and to anticipate its various impacts; the formulation of comprehensive workplace policies and programs taking into account the needs of PLWHA.
10 Critical issues for success	• An experienced facilitator who has gone through the exercise as a participant is an absolute necessity • All participants must treat any personal information that is shared during the course of the exercise as confidential
11 Source of technique	Africa Consultants International: Gary Engelberg, Dr Fatim L. Dia, and A. Boubacar Diallo. Tel.: +(221) 825 3637, Email: aciannex@enda.sn www.acibaobab.org Royal Tropical Institute: Dr Georges Tiendrebeogo, Tel: + (31) 20 568 8578; Email: g.tiendrebeogo@kit.nl, www.kit.nl UNDP HIV and Development Programme, New York www.undp.org/hiv/publications/facilitatorsnew.doc
12 Editor's note for learning	This exercise was developed with the support of UNDP HIV and Development Programme and has been adapted and implemented by various organisations in Africa, the Caribbean and Thailand with different audiences such as NGOs, religious organisations, UN staff, decision makers, parliamentarians, the business sector, youth and women groups, etc. Recently it was done in Malawi with a health sector NGO before the elaboration of their VCT strategy and the design of the pilot VCT centres. The most important lesson learned is the need for attitudes change and a move from the "THEM" to "US" perspective, which requires at professional and personal levels an in-depth understanding and internalisation of the issues surrounding HIV/AIDS including its emotional aspects. There are variations in the simulation, for instance the hand shaking is replaced by putting seeds of two colours in envelopes, the exchange of seeds stands for unprotected penetrative sex. In Thailand, the exchange is done by liquid in vials (some vials have a different liquid of the same colour) after the exchange of liquids a substance is added to all vials and the infected ones get a different colour. However, the discussions during the exercise are the same and lead to the same result.

6 Technique: Body Mapping

Section	Content
1 Description of technique	Participatory technique to help people understand their body better in relation to sexual activity and reproductive health.
2 Level of intervention	Community, men, women, youth peer educators, adult peer educators.
3 Stage in planning cycle	Awareness raising, planning.
4 Purpose and use of technique	• To gain insight in perceptions of people of different sex and age of their sexuality and to increase mutual understanding of these perceptions • To discuss differences between biological facts and local beliefs • To discuss risks of HIV transmission and ways to avoid this • To use the results in planning sexual education activities help plan interventions
5 Requirements for facilitation	Non-judgemental attitude. Knowledge on HIV/AIDS.
	Being comfortable and stimulating in discussing local specific terminology of body parts, sexual behaviour and other sensitive issues.
6 Duration	1.5 hours.
7 Materials required	Large sheets of paper. Markers/pens.
8 Methodology	1 Explain the purpose of the exercise. 2 Divide the group by age and sex (with youth groups the division in age group may be 10-14 and age group 14 – 17; with men and women, it may be useful to divide married and unmarried people, depending on the local culture). 3 Ask each group to draw a figure of a male and a female body and ask them to label the body parts that have a sexual function. They may include the vernacular names for the parts (this helps breaking down barriers). 4 Ask each group to indicate the body parts that are vulnerable to HIV transmission. 5 The groups present their results and explain what they have drawn and why. 6 This is followed by a discussion that may include implications of different perceptions between men and women, sexuality problems, vulnerability to HIV infection, implications for awareness raising and education.

Section	Content
9 Impact	• Increased understanding and reflection about male and female bodies and sexual practices • Increased ease in discussing sexual issues and differences in perception • Increased understanding of vulnerability and risk
10 Critical issues for success	• The division of the groups by sex and age is very important because this influences the ease of discussion within the groups • It has to be stressed that the drawing of the body does not need to be 'correct' • If the groups are embarrassed about labelling the body parts that have a sexual function, it may be useful to start labelling all body parts first and only in a second round indicate the parts that have a sexual function (with youth in schools, this may be an easier way to start)
11 Source of technique	TANESA, P.O.Box 434, Mwanza, Tanzania tanesa2@africaonline.co.tz ZHECT, P.O.Box E 835, Lusaka, Zambia zhect@zamnet.zm
12 Editor's note for learning	This technique has been used for a long time in reproductive health to map women's perceptions of their reproductive system as this helped to understand attitudes towards anti-conception. In Zambia the technique is used for adult peer educators to map pleasure and danger spots in order to increase mutual understanding of sexual pleasure between the sexes and so increase the effectiveness of the peer educators. The technique is also used in awareness raising for harm reduction whereby the different places for injecting drugs are indicated and discussed.



7 Technique: Three pile sorting

Section	Content
1 Description of technique	Participatory methodology to assess the level of knowledge on HIV/AIDS transmission among participants.
2 Level of intervention	Community level.
3 Stage in planning cycle	Awareness raising, mobilisation.
4 Purpose and use of technique	• To assess the level of knowledge of participants on HIV/AIDS • To clarify basic information about HIV/AIDS, modes of transmission and prevention • To dispel AIDS related myths
5 Requirements for facilitation	• Knowledge on HIV/AIDS transmission & prevention • Non-judgemental attitude • Ability to encourage discussion among participants
6 Duration	45 minutes to one hour.
7 Materials required	• Prepare beforehand about 20 statements on sexual behaviour and behaviour related to living with and caring for PHA. Include behaviour with high, low or no risk of infection. (e.g. unprotected sex with a woman who is menstruating, breastfeeding by a positive mother, sharing a cup, kissing) • Three large cut-out circles, each approx. 2 feet in diameter, labelled 'high risk', 'low to medium risk' and 'no risk' • A bowl for the pieces of paper
8 Methodology	1 Ask the participants to divide themselves into teams. 2 Place the three large circles in the centre of the floor and explain their labels. 3 Show the bowl with pieces of paper and explain that each paper has a different behavioural statement written on it, presenting different degrees of risks. 4 Pass the bowl around and each team takes one piece of paper. 5 Each team decides in which of three circles it the behaviour belongs (high, low, no risk). 6 The choice is presented and justified to the rest of the group. 7 In the discussion other participants can agree or disagree. 8 The presenting team can transfer the piece of paper to another circle if it changes its mind on the basis of the groups' discussion. 9 Participants set aside the pieces of paper that may require further investigation if there is no consensus or a need for more information.

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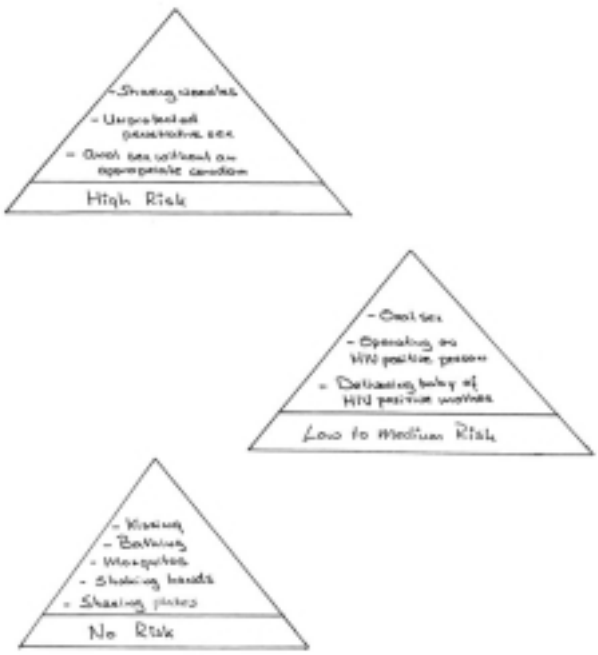
	10 The facilitator does not take sides or act as a final judge in the case but encourages the participants to critically examine their points of disagreement by raising appropriate questions for further reflection.
9 Impact	The discussions increase the level of knowledge with participants on transmission of HIV. The discussions sharpen the ability of participants to distinguish facts from myths and misconceptions.
10 Critical issues for success	Participants have to have some level of knowledge on HIV/AIDS to be able to participate in the exercise.
11 Source of technique	KIT, P.O. Box 95001, 1090 HA Amsterdam (m.wegelin@kit.nl) Corporacion Kimirina Ramirez Davalos 258 y Paez, Quito, Ecuador kimirina@quik.com.ec
12 Editor's note for learning	This technique can be very useful at the onset of a workshop or a community session on HIV/AIDS to assess the level of knowledge from the participants. On this basis a decision can be made to give further information about basic facts or to continue with other activities. An alternative to increase the participants' involvement, would be for one group to prepare the statements on paper for another group to do the sorting. In Ecuador, the statements are divided in two piles, true or false. The facilitator acts as a final judge, correcting or giving more information as necessary.

Examples of statements



8 Technique: Mapping

Section	Content
1 Description of technique	Making a map of the community to identify places of risk for contracting HIV.
2 Level of intervention	Community.
3 Stage in planning cycle	Situation analysis, mobilisation.
4 Purpose and use of technique	• Facilitates discussion on HIV/AIDS issues • Structure and present visually places where sexual risk behaviour takes place, where it is negotiated or where people feel at risk of contracting HIV • Increase understanding of risk perceptions and vulnerability of the different village groups • Provide a basis for the development of village action plans
5 Requirements for facilitation	• Relevant HIV/AIDS and social/cultural knowledge • Insight in different groups that make up community • Able to encourage open discussion • Gender and age sensitivity
6 Duration	Introduction: ½ hour. Making maps: 2 hours. Presentation and discussion: 1½ hour.
7 Materials required	Newsprint, markers, all kind of materials available in the village such as pebbles, twigs, seeds, beans, leaves, buttons.
8 Methodology	**1 Introduction** • Explain the objectives (see section 4) • Explain the methodology • Ask participants to divide themselves in groups (men, women, boys, girls) **2 Making maps** Members of each group draw a map of their community and indicate the places where sexual risk behaviour takes place, where it is negotiated or where people feel at risk of contracting HIV. First the general map of the village is drawn, indicating roads, streams, trees, (clusters of) houses and important places in the community such as the church/mosque/temple, the health post etc. Then risk areas are indicated with different materials used for different places (brothels, hotels, market, shops, water points, schools, gardens).

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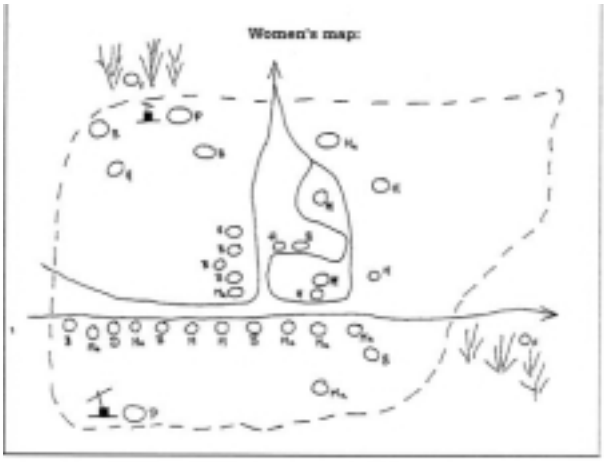
	3 Discuss problems and solutions After completing the maps, the participants discuss in their own group the problems that men, women, boys and girls face in avoiding the identified risk situations and behaviours. These might include, for example, drinking habits and alcoholism, exchanging sex for gifts and money, lack of condoms, insufficient community sanctions against sexual abuse and violence and so on. They also discuss ways to change these situations. **4 Presentation of maps, problems and solutions** The groups present the maps and the identified problems to one another and explain their proposed solutions. This is followed by a discussion on the separate maps and identified problems/solutions. Each of the maps are then transferred to paper and a list of problems/solutions is made per group.
9 Impact	• People start discussing HIV/AIDS risks in a roundabout way. They usually like making the maps • Communities start to think about actions that they themselves can take

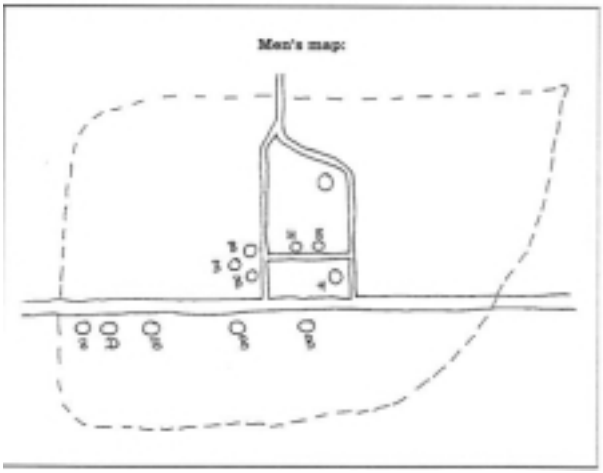
10 Critical issues for success	• Before members select the map makers, clarify that illiterate people are just as capable of drawing maps as others
	• Maps cannot be right or wrong and do not have to be to scale
	• The facilitator observes, clarifies or (when necessary) encourages discussion by asking questions such as:
	  ◦ where else do you meet prospective partners apart from a bar
	  ◦ what happens if people go to the market to buy food without money
	  ◦ where and when do women fetch water or collect firewood
	  ◦ etc. depending on the local circumstances
	• It has to be emphasized that risk behaviour or negotiation not only takes place in the obvious places as bars, but also in less obvious places as schools, around water wells etc.

11 Source of technique	This tool is being used in one form or the other in many places and for many purposes (village development, water and sanitation, agricultural planning). The technique as described here is being used in Magu district in Tanzania Contact: Gabriel Mwaluko, TANESA, P.O.Box 434, Mwanza, Tanzania, email: tanesa2@africaonline.co.tz Programme d'Appui au Programme Multisectoriel de Lutte contre le SIDA et les IST (Seydou Kabré or Victorine Yaméogo) 01 BP 6464 Ouagadougou 01, Burkina Faso pmls@cenatrin.bf

Section	Content
12 Editor's note for learning	The tool is excellent for a start of village level activities. The different maps can later be used as a starting point in focus group discussions. In a subsequent activity the specific problems can be put in a matrix ranking (see technique problem ranking and stakeholders to take action can be identified with respective roles and responsibilities (technique Action planning). In Magu district, the village mapping resulted in the formulation of by-laws. These were then communicated through theatre and music groups to the village at large. The mapping activity could be expanded to also mark houses/compounds that have been vacated or where in the past 4 (or so) years people have died (not necessarily due to AIDS - that would be too sensitive to ask). This will give an indication of the extent of the AIDS problem. See also discussion on mapping in the e-workspace (ews.unaids.org) for further references and experiences.



P = pump
H = hotel
B = bar
M = market
D = disco
Ma = store
F = forest

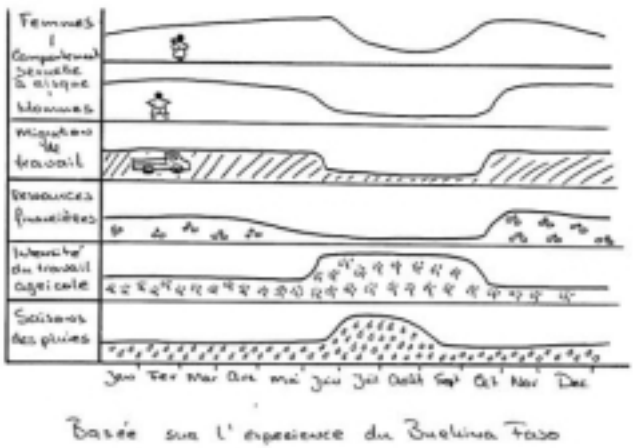


Source: TANESA, Mwanza, Tanzania

9 Technique: Seasonal calendar

Section	Content
1 Description of technique	Participatory technique that shows the changes in activities of people during the different seasons. These may determine periods of increased risk for HIV transmission in the community, as well as periods where care and support become easier or more difficult.
2 Level of intervention	Community level.
3 Stage in planning cycle	Situation analysis, planning.
4 Purpose and use of technique	• To gain insight in people's time spending, movement away from/back to the community and f.i. changes in financial position • To identify specific periods in which the risk for HIV transmission in the community increases • To identify specific periods in which care and support tasks are easier or more difficult to provide • To integrate the outcome of this identification in planning of interventions
5 Requirements for facilitation	• Understanding of changes in seasonal activities • Ability to guide people to understand the implications of their seasonal activities
6 Duration	1-2 hours.
7 Materials required	• Large sheets of paper • Markers/pens • Locally available materials (drawings in the sand with a wooden stick/branch, pebbles, seeds etc.)
8 Methodology	1 Ask participants to discuss how community life changes during different times of a year, starting with general aspects such as the rainy and dry seasons, agricultural activities, income. 2 Draw a time line on a piece of paper or in the sand and ask people to indicate in which way they would sub-divide the time line into shorter periods (these may be months, seasons or agricultural cycles). 3 Discuss with the participants which aspects of community life that change during the seasons they want to include in the calendar. These may be climate (dry or wet season), agricultural activities, migration, labour requirements, incidence of illness, availability of money, availability of free time, celebrations, sexual activity.

Section	Content
	4 Ask the participants to chart the fluctuations of each of these aspects over the year drawing lines above the time line. This will result in a number of fluctuating lines above each other. 5 Discuss the different lines and see if there are any relationships between the fluctuations in each of the aspects. Analyse the linkages and discuss the implications for HIV transmission and care and support activities. 6 If the calendar has been made on the ground, transcribe it to paper for future reference.
9 Impact	The calendar focuses on different aspects of community life and will show if and how these aspects are interrelated. This may for instance increase. understanding of changes in vulnerability to HIV transmission over the year, with implications for planning and implementation of prevention activities.
10 Critical issues for success	The activity may be done by different groups (men, women, rich, poor, youth) focusing either on different aspects or on the same aspects. Results may indicate different perceptions and this can be useful for mutual understanding and planning of interventions.
11 Source of technique	KIT, P.O. Box 95001, 1090 HA Amsterdam, The Netherlands (m.wegelin@kit.nl) International HIV/AIDS Alliance Ukraine. 5 Dymytrova Street, building 10A, Kiev 03150, Ukraine deshko@aidsalliance.kiev.ua
12 Editor's note for learning	This technique is used a lot in planning rural development activities and may be familiar to many communities. It is therefore a good way to integrate HIV/AIDS into other sectors.



Basée sur l'expérience du Burkina Faso

10 Technique: Story with a gap

Section	Content
1 Description of technique	A participatory technique which gives insight in knowledge and perceptions of people in the community on different issues related to HIV/AIDS.
2 Level of intervention	Community level.
3 Stage in planning cycle	Situation analysis, planning.
4 Purpose and use of technique	• Insight in knowledge and perceptions of people in the community on issues related to HIV/AIDS • Insight in actions that people take to change a given situation
5 Requirements for facilitation	• Ability to stay in the background while participants discuss the issues • Ability to probe and guide the participants
6 Duration	45-60 minutes.
7 Materials required	• Two drawings or pictures, one picturing the 'before' situation and the other picturing an 'after' situation
8 Methodology	1 Divide the participants into two or three sub-groups. 2 Present the 'before' picture (for instance a field full of maize, a healthy person, a functioning water pump) and discuss what it depicts. 3 Present the 'after' picture (an empty field, a sick person, a non-functioning pump) and discuss what it depicts. 4 Participants brainstorm in their groups on what happened during the 'gap' of the story. What are the reasons and/or what has been done between the 'before' and the 'after' picture For example the maize field did not get planted because of illness or death in the family; the pump is in disrepair because the trained caretaker died. 5 Each group presents their story on what took place in the gap. 6 Discuss what steps could be taken to improve the situation.
9 Impact	The exercise is fun and people like it. A mix of serious and less serious issues may be presented which facilitates discussing sensitive issues.
10 Critical issues for success	The story has to depict a reality in the community in order for people to identify with the story. For example a person sick with AIDS in a community with many AIDS patients (to start a discussion on how to stay healthy longer); a child with parents and a child living in the street in a community with many orphans and children (to start a discussion on what the community can do to care for orphans).

Section	Content
11 Source of technique	KIT, P.O. Box 95001, 1090 HA Amsterdam, The Netherlands (m.wegelin@kit.nl)
12 Editor's note for learning	• It may sometimes be possible to use photographs. This is often liked. These, however have to show a reality that also exists in the community where the activity is carried out • Usually the sequence is from bad to good, but the reverse order is also possible. This may even be done at the same time. For instance child sick – child healthy. Story: take the child to the health post, give the child medicines, take the child to the traditional healer, go to pharmacy etc.; Child healthy – child sick. Story: the child ate something wrong, the child has AIDS, the child went swimming etc. • The activity can also be used for planning: how do we go from a 'before' situation to an 'after' situation

Before: healthy man

After: sick man

Gap: what happened?

11 Technique: Transcess walk

Section	Content
1 Description of technique	A transect walk is a walk cross-cutting the community to explore settlement patterns, basic services and land use. It may give insight in the impact of HIV/AIDS on land use, cropping patterns, agricultural production, housing and income generating activities.
2 Level of intervention	Community.
3 Stage in planning cycle	Situation analysis.
4 Purpose and use of technique	• To refine understanding of the community and its vulnerability to the impact of HIV/AIDS • To explore the impact of HIV/AIDS on agricultural production, food security and income generating activities • To assess access to basic services such as water supply and firewood that have a direct impact on the living conditions of PHA • To explore the extent of out-migration, dissolution of households and housing conditions of PHA • To verify the community map (see technique community mapping)
5 Requirements for facilitation	Open mind and ability to question causes and effects of what is seen in an indirect way (some aspects may be sensitive such as land left unproductive because the household is affected by HIV/AIDS).
6 Duration	Depending on the length of the walk and aspects to look at, it may take up to 4 hours.
7 Materials required	Note pads and pens.
8 Methodology	1 Assemble the people to be involved in the walk (NGO members, community members, local government staff). 2 Together list information that is considered useful if more is to be known on vulnerability to the impact of HIV/AIDS in terms of land use, production patterns, cropping patterns, food security and income generating activities. Include access to basic services and visible consequences of ill-health in the community. 3 Review the community map and identify area(s) for the transect (it may be necessary to split up in different groups). 4 Select a starting point for the transect and divide the tasks of note taking and drawing. 5 Start walking, observe and take time for discussions with people living in the area, focus on critical issues (step 2).

Section	Content
	6 At the end of the walk, the participants draw a diagram of the territory covered and write the key features observed. 7 The diagram (or diagrams in case of more than one walk) are presented and the participants agree on the key features eventually developing a list of problems and resources.
9 Impact	• The transect will help non-community members understand the living and working conditions of the community better and give more insight in the specific vulnerabilities of the community • Community members focus on use, trends and problems associated with the impact of HIV/AIDS and can discuss how to better the use of existing resources to improve the living conditions of all, but especially the households affected by HIV/AIDS
10 Critical issues for success	• Care has to be taken to cover different sections of the community with different conditions to get a good overall impression • Information identifying problems and opportunities obtained during the transect has to be noted for further use at a later stage • Make sure data are obtained from men, women, youth, elderly, PLWA and from various socio-economic groups
11 Source of technique	IRC International Water and Sanitation centre, P.O.Box 2869, Delft, The Netherlands (general@irc.nl) KIT, P.O. Box 95001, 1090 HA Amsterdam, The Netherlands (m.wegelin@kit.nl)
12 Editor's note for learning	During transect walks, very often issues are noticed that would not come up during community discussions. For instance, in Nigeria, many compounds/houses were deserted because families had broken up - it had not been mentioned before. Also, linkages between services such as water supply and HIV/AIDS may not be made and a broken down water system may not be mentioned although it has a direct impact on the living conditions of PLWA. The problems identified can be used later in other activities such as problem ranking, force field analysis and action planning.

Example of a transect

Housing	Forest	handful houses 1 deserted house	houses occupied by extended families	Rich houses few poor houses 1 widow's house	1 orphan headed house	few houses	River
Fields crops		potatoes, onions.	potatoes, onions	few vegetable patches and fruit trees	rice fields, vegetables	rice fields, grassland	
Safe water supply	tap ground water source	source, ground water	ground water source	- tap water	ground water (downstream) dirty	dirty river water	
Live stock		goats chickens	goats - chickens	goats chickens cows	chickens cows buffaloes	buffaloes	
Health care	-	-	-	village hospital 1 doctor	-	-	
Recreation	"picknick" area	-	-	bars	-	1 bar	

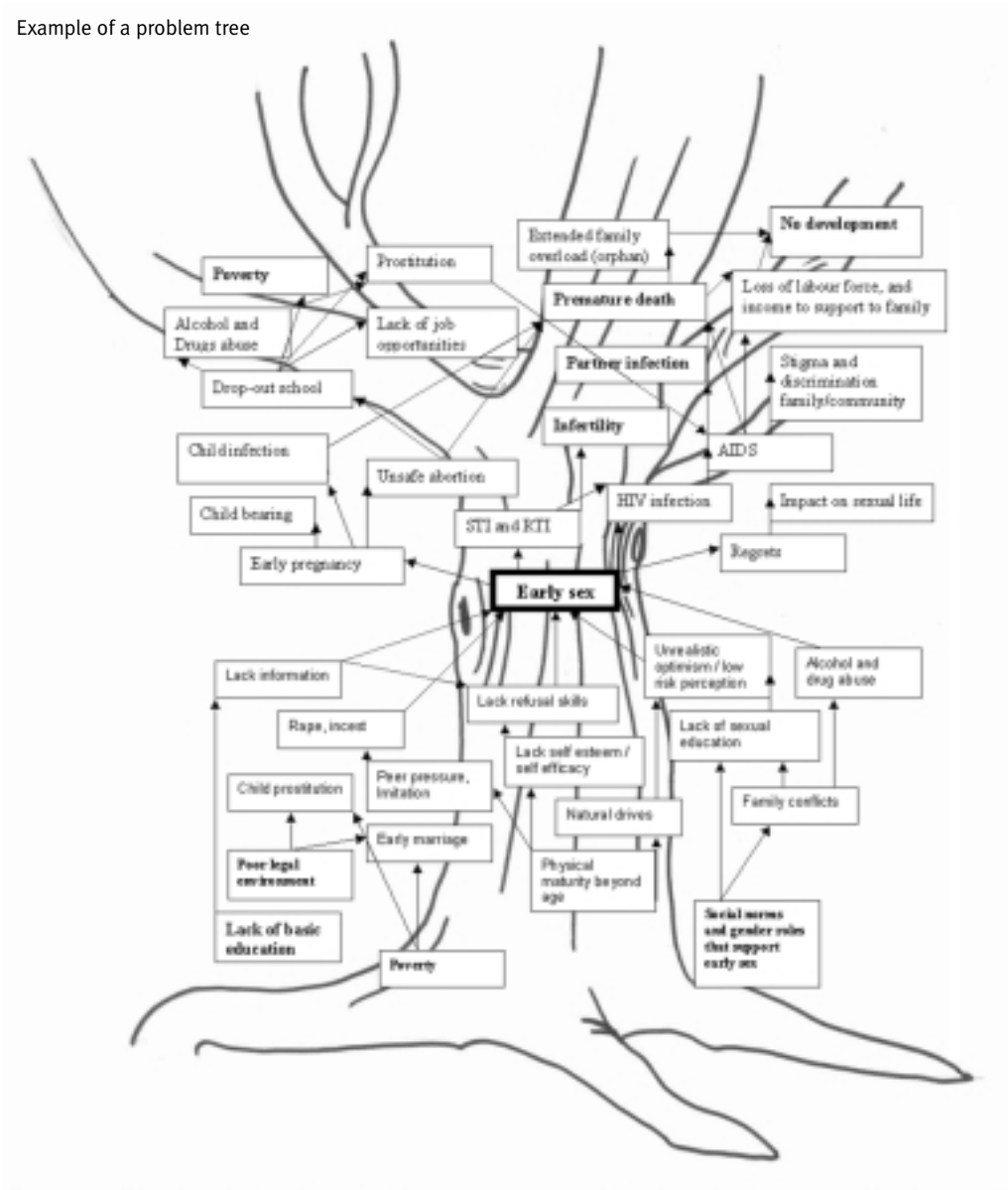
12 Technique: Problem Tree

Section	Content
1 Description of technique	A participatory technique to carry out a thorough analysis of a problem, its root causes and its effects. Such analysis facilitates the search for solutions that address the more hidden causes of a problem.
2 Level of intervention	All levels.
3 Stage in planning cycle	Situation analysis.
4 Purpose and use of technique	• Helps to visualise the complexities of a problem, its causes and its effects • Helps to identify and analyse the most important causes to facilitate a search for solutions
5 Requirements for facilitation	• Familiarity with the technique • Ability to guide participants to focus on the relevant causes and effects
6 Duration	Approx. 2-3 hours.
7 Materials required	• Large sheets of paper or cardboard • Small coloured index cards • Markers/pens
8 Methodology	1 Explain that before being able to solve a problem, people must understand what is causing it and what its consequences are. Present the image of a tree to introduce the 'problem tree' technique. The trunk of the tree signifies the problem, the roots are the causes of the problem, the branches are the consequences of the problem. 2 Agree on a problem to be analysed (this may be the result of a problem ranking exercise - see technique problem ranking, mapping or transect walk) and put this on a card in the middle of the sheet of paper. Ask each participant to think of possible causes for the problem and let them write each cause on a small card. Place these on the left side of the paper. Continue to collect responses until no one can think of anything else. The facilitator may want to group the causes in categories. 3 Ask the participants to identify the most direct causes from the list by asking "the problem exists because..." or 'but why exists the problem...". These cards are placed horizontally under the problem card (the tree trunk) and form the roots. Repeat this by asking the same question for this row of cards: these are the secondary causes for each root. Repeat this procedure for subsequent levels. Use the cause cards made in step 2 whenever possible.

Section	Content
	4 Ask each participant to think of possible consequences of the problem and let them write each consequence on a small card. Place these on the right side of the paper. Continue to collect responses until no one can think of anything else. The facilitator may want to group the consequences in categories. 5 Ask the participants to identify the most direct consequences from the list by asking "what is the consequence of this problem...." or "and so what happens". These cards are placed horizontally above the problem card (the tree trunk) and form the branches. Repeat this by asking the same question for this row of cards: these are the secondary consequences for each branch. Repeat this procedure for subsequent levels. Use the consequence cards made in step 4 whenever possible. 6 Once all cards have been placed on the board, explain that the group will now examine the logic of the tree. Start from the bottom and read: "the phenomenon A leads to B" If the group agrees with these statements, trace an arrow from the bottom up. Repeat the process for the remaining causes and consequences. 7 From the newly developed tree, ask the participants to select the most important causes they feel they can and want to address. Some causes are beyond the influence of the participants, so they need to concentrate on those causes that can be successfully addressed and that have a tangible result.
9 Impact	• Stimulates participants to analyse a problem in- depth and helps them realise that roots often involve daily activities that can be successfully addressed • Helps participants realise that problems and causes are often interconnected and that addressing a problem without addressing its causes may result in a non-sustainable solution
10 Critical issues for success	• The group of participants should not be larger than about 10 people otherwise managing the discussion will become difficult. In case there are more participants, the group has to be split up and the composition of the groups should be selected depending on the problem to be analysed • The facilitator has to ensure participants do not stray too far from the original problem • When working in a community, it may be better to use drawings of causes and consequences rather than written text to enable illiterate people to take part in the exercise
11 Source of technique	Programme d'Appui au Programme Multisectoriel de Lutte contre le SIDA et les IST (Seydou Kabré or Victorine Yaméogo), 01 BP 6464 Ouagadougou 01, Burkina Faso pmls@cenatrin.bf International HIV/AIDS Alliance Ukraine. 5 Dymytrova Street, building 10A, Kiev 03150, Ukraine deshko@aidsalliance.kiev.ua
12 Editor's note for learning	• Participants may find it difficult to distinguish between primary and secondary causes and consequences. The question "what comes first" may help • If participants are not happy with the problem tree, it can be redone using the same cards in a different order

Section	Content
	• The wording of the causes of the problem has to be value-free to avoid blaming and stigmatising • There are likely to be causes identified that cannot be addressed at the level of the participants such as laws, religious rules, politics. It is useful to still discuss these issues and decide together how best deal with them • As a follow-up to this exercise, the problem tree can changed into an objective tree. The problems are then expressed in the form of objectives and also the causes and consequences

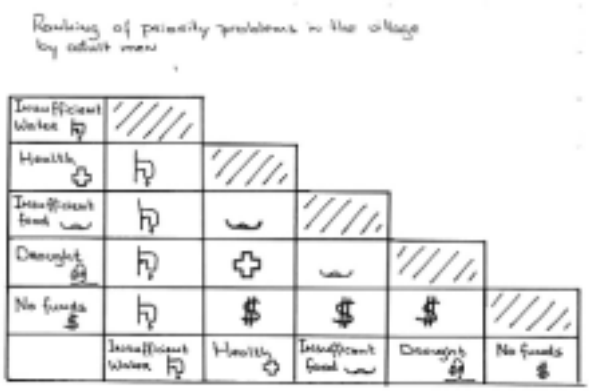
Example of a problem tree



13 Technique: Problem ranking

Section	Content
1 Description of technique	A technique to help participants to prioritise their problems in a transparent manner.
2 Level of intervention	Community level, but can be used at other levels as well.
3 Stage in planning cycle	Situation analysis, planning.
4 Purpose and use of technique	Not all problems are equally important and different groups may have different priorities. The technique assists each group (men, women, youth, rich, poor) to prioritise their problems. At the end of the session, a list of village priority problems is formulated that is a compilation of all the groups' priority problems.
5 Requirements for facilitation	• Ability to explain the procedure well • Ability to assist the groups in defining their problem precisely • Ability to resolve conflicts in the groups
6 Duration	3 hours.
7 Materials required	Paper, pens or any locally available materials (seeds, pebbles, sticks, beans).
8 Methodology	1 Introduce the exercise and recapture problems that were identified in earlier activities (during community mapping, transect walk). Discuss the need to identify which problems are most important. Agree on how many priorities each group can submit (for instance 5). 2 Separate the group into relevant sub-groups and ask each group to brainstorm on the problems that they face. These are drawn or written down. They select from the long list 5 priority problems by voting (using stones, seeds or another method). 3 To make a priority ranking among these five problems, a matrix is made. Each problem is written or drawn on two cards. One set of cards is placed in a vertical row, the other set (with the same problems) is placed in a horizontal row. Draw a grid between the rows. All squares that have the same option in both rows are crossed out. 4 The first card at the bottom of the vertical row is compared with the first card on the horizontal row, the participants discuss which one is preferred and the selected choice is filled in the matrix. This process is continued comparing all problems and selecting a priority until the matrix is filled. 5 Count how many times each problem was selected in the matrix and add up the scores. This results in a ranking of priorities for the group.

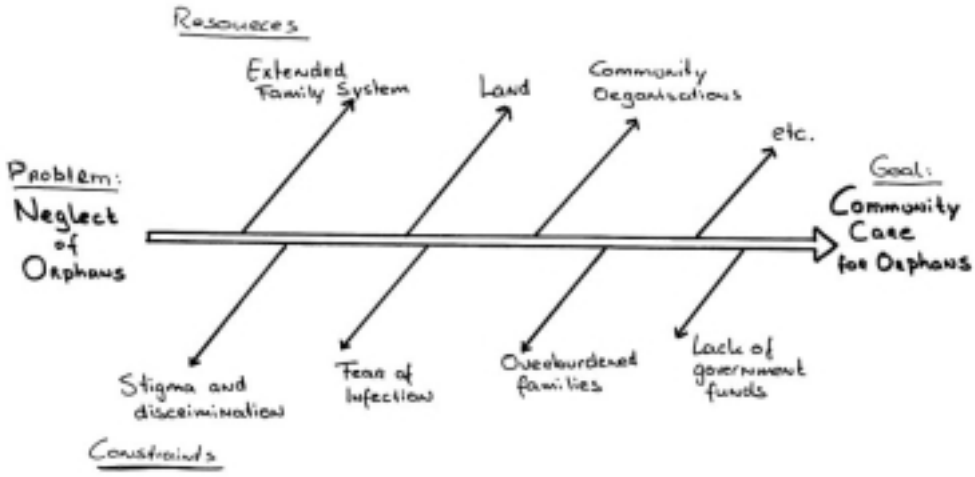
Section	Content
	6 The group results are presented and discussed. The list of community priority problems is a compilation of the results from all groups.
9 Impact	• The technique ensures that traditionally disadvantaged groups have equal opportunities to voice their problems and that these problems are included in the community list • Problems are discussed at length in the process of ranking leading to increased insight • The presentation of results from each groups leads to mutual awareness and increased understanding
10 Critical issues for success	The groups have to formulate the problems as precisely as possible in order to use them later in action planning. It is important to agree with the group if problems in general are assessed or if there is a focus such as health, income generation, food production, livelihood, vulnerability to HIV/AIDS.
11 Source of technique	JSA Consultants Ltd. P.O. Box A408, La, Accra, Ghana. E-mail: jsa@africaonline.com.gh International HIV/AIDS Alliance Ukraine. 5 Dymytrova Street, building 10A, Kiev 03150, Ukraine deshko@aidsalliance.kiev.ua
12 Editor's note for learning	The same procedure can be used to prioritise options in any situation and at any level. The technique can also be used to start a discussion on the development of criteria for scoring for a more refined preference ranking. In that case, problems/solutions are set off against a number of criteria that have been agreed upon (such as accessibility, ease of use, cost, satisfaction) and these are scored. The total score for each problem/solution is added up and provides the ranking.



14 Technique: Force field analysis

Section	Content
1 Description of technique	A participatory technique that helps participants identify constraints and resources in achieving a desired situation.
2 Level of intervention	District level.
3 Stage in planning cycle	Planning.
4 Purpose and use of technique	• To analyse resources available with different stakeholders in the district to reach a set goal • To analyse constraints of different stakeholders in reaching the goal • To plan on how to use the resources to overcome the constraints • To lead participants to the planning process
5 Requirements for facilitation	• Ability to guide the participants through the analysis of resources and constraints • Ability to ensure that resources and constraints of different stakeholders are taken into account • Ability to help participants to relate resources and constraints to achieve the goal
6 Duration	1-2 hours.
7 Materials required	Flip chart paper. Markers.
8 Methodology	1 The participants select a problem that they want to address (see technique: problem ranking, transect walk). 2 The participants agree on a goal to be achieved with respect to the identified problem within a given time span. 3 On a large piece of paper, an arrow is drawn with the problem put on the left, at the beginning of the arrow, the goal to be achieved on the extreme right at the point of the arrow. 4 Small arrows pointing in the direction of the goal represent the resources or helpful forces that assist in achieving the goal. Add the label 'resources' above the arrows. 5 Small arrows pointing in the direction of the problem represent constraints and forces that are hindering achieving the goal. Add the label 'constraints' below the arrows. 6 Divide the group in sub-groups (depending on the situation inter-sectoral and multilevel stakeholders may be put in a mixed group, or separated in different groups). Each group receives a copy of the chart.

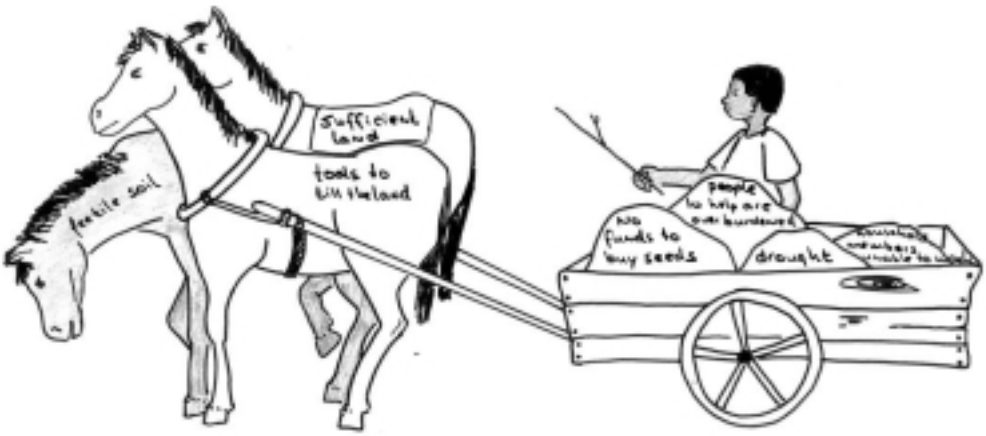
Section	Content
	7 In the groups the participants discuss the resources and constraints to reach the goal and fill these in at the arrows. It may be necessary to differentiate between stakeholders. 8 Each groups subsequently assesses how they can use the identified resources to overcome the identified constraints. It may be necessary to differentiate between stakeholders. 9 Each group reports back in plenary and the results of the sub-groups are discussed.
9 Impact	• The activity helps people to become aware of the different resources and constraints of each stakeholder and therefore improves mutual understanding • The activity may also lead different stakeholders to combine their resources to overcome the constraints to reach a common goal
10 Critical issues for success	• The goal or desired situation has to be realistic and sufficiently attainable to avoid an unsatisfying result and frustration • It may be possible that the analysis leads to the identification of competing interests of different stakeholders. In such case, a discussion needs to be held to find a way out of this conflict
11 Source of technique	KIT, P.O. Box 95001, 1090 HA Amsterdam, The Netherlands (m.wegelin@kit.nl) Adapted from UNDP 'Tools for Community Participation' by Lyra Srinivasan, 1990. PROWESS/UNDP Technical Series. 304 East 45th Street, New York, NY 10017, USA
12 Editor's note for learning	This technique can be used to start the action planning process: each constraint is separately analysed and steps are identified to address the constraint making use of the resources available. If needed, a strategy to obtain resources from elsewhere may be developed.



15 Technique: Carts and rocks

Section	Content
1 Description of technique	A participatory technique to help a community in identifying the resources and constraints related to the achievement of a set goal.
2 Level of intervention	Community level.
3 Stage in planning cycle	Planning.
4 Purpose and use of technique	• To analyse resources available in the community to reach a set goal • To analyse constraints in reaching the goal • To plan on how to use the resources to overcome the constraints
5 Requirements for facilitation	• Ability to guide the group through the analysis of resources and constraints • Ability to ensure that resources and constraints of different groups are taken into account • Ability to help people to relate resources and constraints to achieve the goal
6 Duration	1 hour.
7 Materials required	Appropriate locally available objects to represent the goal to be achieved, the animals to pull the cart (symbolizing resources) and the rocks to put in the cart (symbolizing constraints) and the cart itself (for instance a box).
8 Methodology	1 Participants select a HIV/AIDS related problem they would like to address, and agree on the goal to be achieved in a given period. An appropriate object is selected to symbolise the goal. 2 Use a large object (f.i. a cardboard box or a bowl) to represent the cart and place it some distance from the goal but facing in that direction. The cart represents the community aspiring to move towards the goal. 3 Participants identify the available resources at hand in the community that will help them to succeed in achieving the goal. For each resource identified, place an object in front of the cart. They symbolise the animal(s) harnassed to pull the cart towards the goal. 4 Participants discuss constraints in achieving the goal. For each constraint identified, the group places an object (f.i. a rock or a piece of paper) in the cart. This visualizes the additional weight or forces holding the community back from achieving the goal. The size of the object should correspond with the complexity or weight of the constraint it represents. 5 The participants reflect back on the real situation and analyse positive and negative forces and consider which resource can be most helpful in overcoming which constraint.

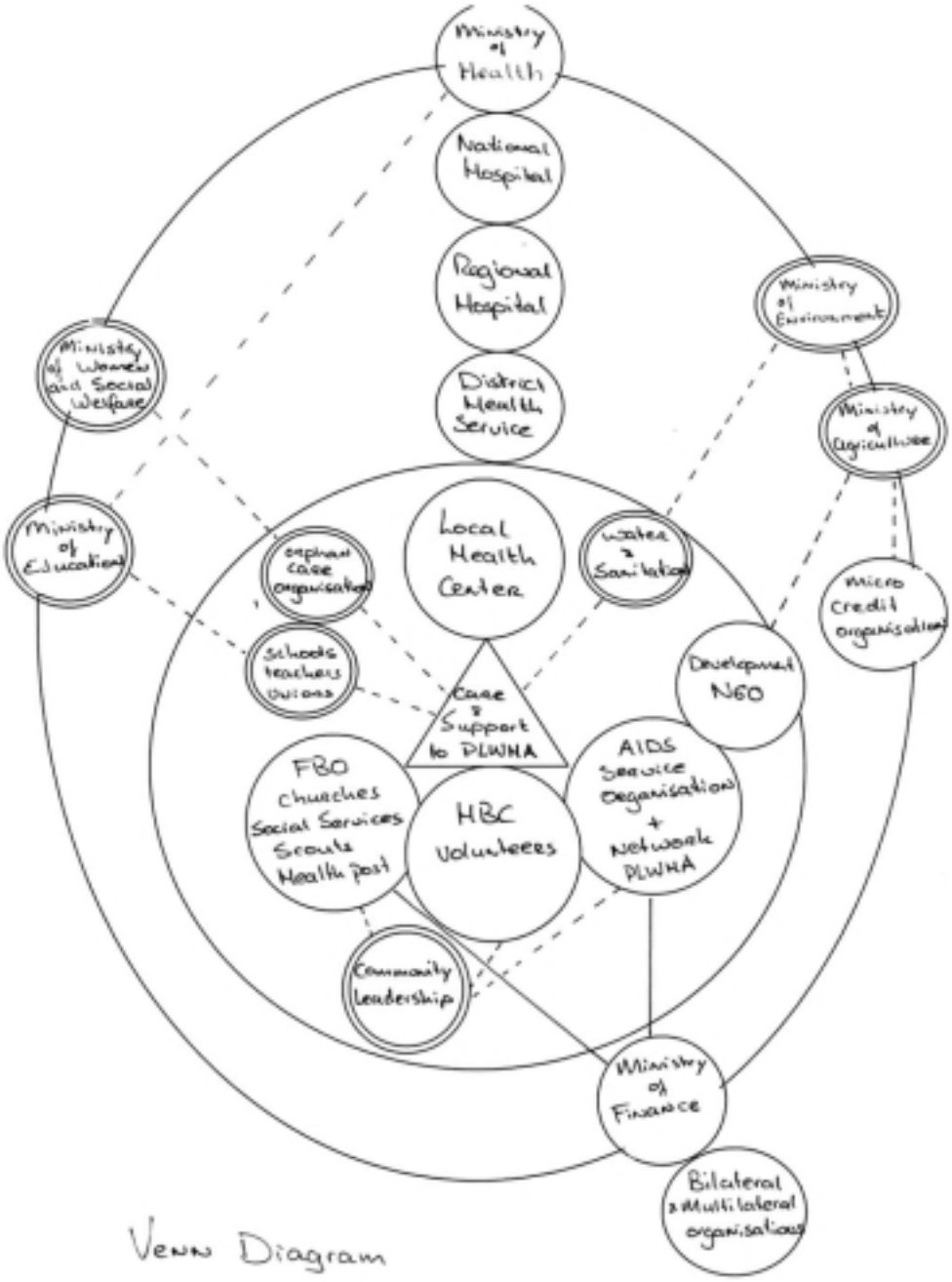
Section	Content
9 Impact	The exercise can turn out to be unsatisfying for participants when the goal to be reached is too far fetched and difficult to attain. Therefore the facilitator has to motivate the participants to keep the goal 'small' and achievable.
10 Critical issues for success	Care has to be taken that resources and constraints of different groups making up the community are being mentioned. It may be necessary to divide the group into small groups representing different groups in the community (male, female, young, old, rich, poor). However, the goal to be reached has to be the same for all groups. The different groups then present their cart and rocks to each other and together a cart, animals and rocks representing the views of all groups is developed. It is important to stress that resources include non-material resources such as skills, values, relationships and this also applies to the constraints, for instance stigma.
11 Source of technique	KIT, P.O. Box 95001, 1090 HA Amsterdam, The Netherlands m.wegelin@kit.nl IRC International Water and Sanitation centre, P.O.Box 2869, Delft, The Netherlands general@irc.nl
12 Editor's note for learning	The activity can be taken a step further by analysing which constraints cannot be overcome by resources available in the community and by identifying where and how these could be obtained from outside. This can be a first step in action planning.



16 Technique: Venn Diagram

Section	Content
1 Description of technique	Participatory technique for visualisation of institutions/groups/places, their importance and their interrelation with regard to HIV/AIDS prevention and care in the community.
2 Level of intervention	Community level/District level/Regional level.
3 Stage in planning cycle	Planning.
4 Purpose and use of technique	• To help participants get a view on the responsibilities and inter-relationships of institutions/groups/places in and around the community with regard to HIV/AIDS prevention and care in the community • To help participants to identify the resources, the overlap and the gaps in institutions and organisations they can access to improve the situation • To improve multi-sectoral planning and implementation
5 Requirements for facilitation	Ability to summarise feedback from participants during the activity.
6 Duration	1 hour.
7 Materials required	• Paper of different sizes (circle shaped) • Markers/pens • Glue
8 Methodology	1 Ask the participants to name any formal and informal groups/institutions active in a HIV/AIDS related aspect (for instance care for PLWHA) in and around the community. 2 Participants sum up what these groups /institutions do and the degree of contact overlap between them in terms of activities and decision-making. 3 Label circle-shaped paper of different sizes with the name of the persons or institution identified (the 'importance' of the institutions should indicate the size the circles should get). 4 Participants arrange the circles in such way that the degree of contact overlap in terms of decision-making and/or operation between the institutions becomes clear. Overlap occurs if one institution asks or tells another to do something or if they have to co-operate in some way because their responsibilities are (partly) the same. 5 The arrangements of the circles is as follows: separate circles means no contact, touching circles means that information passes between institutions, small overlap means that some co-operation in decision-making and operation

Section	Content
	exists and large overlap means that considerable co-operation in decision-making and operation exist. 6 Once everybody is satisfied about the way the circles are arranged glue them. 7 Participants explain their drawings. 8 The group discusses the levels of existing co-operation, but also where co-operation is lacking. 9 Discuss the implications of insight gained (for example five organisations are providing home based care and no organisations address support in farm production to affected families).
9 Impact	• This type of exercise can positively influence the collaboration between institutions and sectors • People may disagree on the importance of different institutions, which is good to discuss as it gives more insight
10 Critical issues for success	There have to be participants in the group that have insight in the different activities that different groups do in the community and/or in the district.
11 Source of technique	Population Council, Afrique Occidentale et Centrale 01 BP 6250 Ouagadougou 01, Burkina Faso (Lydia Saloucou) Isaloucou@popcouncil.bf Corporacion Kimirina Ramirez Davalos 258 y Paez, Quito, Ecuador, kimirina@quik.com.ec
12 Editor's note for learning	• It may be interesting to have men, women and youth make their own Venn diagrams as the knowledge about and the perception of institutions may well be different • It is good to ensure that also people, who do not know much about institutions active in the community, are present as it will increase their information and access to these institutions • The Venn diagram can also be used to assess where young people meet and where prevention activities could take place. It is used in this way in Northern Thailand by peer educators


Ministry of Health
National Hospital
Regional Hospital
District Health Service
Ministry of Women and Social Welfare
Ministry of Education
Ministry of Environment
Ministry of Agriculture
Micro Credit organisation
Local Health Center
orphan care organisation
schools teachers unions
water & Sanitation
Care & Support to PLWHA
Development NGO
FBO churches Social Services Scouts Health post
HBC Volunteers
AIDS Service organisation + Network PLWHA
Community leadership
Ministry of Finance
Bilateral & Multilateral organisations
Venn Diagram

17 Technique: Role perceptions

Section	Content
1 Description of technique	A participatory technique that helps clarifying tasks and responsibilities of actors working at different levels within a programme.
2 Level of intervention	District level, programme level.
3 Stage in planning cycle	Planning.
4 Purpose and use of technique	• To overcome misconceptions and unrealistic expectations about the roles of actors at different levels • To assess actual activities of actors at different levels • To improve teamwork within a programme
5 Requirements for facilitation	• Ability to handle misconceptions or misunderstandings between participants in a diplomatic way • Understanding of the organisation of the programme in a district
6 Duration	1.5 hour.
7 Materials required	Paper and markers/pens.
8 Methodology	1 The participants make an overview of the different levels involved in a programme. 2 Divide the group into subgroups according to the identified levels. This is likely to include actors from different stakeholders (health sector, NGOs, CBOs, volunteers). 3 Each subgroup defines its own role and the roles of the level above and the level below them (where applicable). Participants write the roles as they perceive them. This results in a vertical column covering three levels. 4 The groups each post their results in a vertical column next to each other, in such way that the roles of another level, as seen from different perspectives, can be compared in a horizontal direction. 5 Participants carefully read the perceptions of all other groups. 6 Participants discuss the discrepancies in views about each other's roles and the implications for future planning. 7 Participants now discuss what activities are actually being carried out at the different levels in relation to perceived roles. 8 Participants come up with suggestions on how to work more effectively now that they have an improved understanding of each other's roles, expectations and actual functioning.

Section	Content
9 Impact	The exercise clarifies perceptions that different actors have of each other's functions. The discussion on actual activities helps to reveal the discrepancies in expectations and the gaps in service provision. On the basis of this, improved planning and division of roles and responsibilities is possible, leading to improved service provision.
10 Critical issues for success	• There have to be sufficient participants from different levels and different stakeholders to make this activity worthwhile • Participants have to be open to discuss their perceptions without having the feeling to be judged on their individual performance. It may be necessary to establish ground rules before starting the exercise
11 Source of technique	Adapted from UNDP 'Tools for Community Participation' by Lyra Srinivasan, 1990. PROWESS/UNDP Technical Series. 304 East 45th Street, New York, NY 10017, USA
12 Editor's note for learning	This activity can also be done across sectors. For instance in a district where different sectors (education, health, agriculture, social services) are involved in AIDS prevention activities. In that case, the different groups are composed of single sector actors that fill in their roles and responsibilities at different levels and fill in what they think one or two other sectors are doing. This is useful to identify overlaps between the sectors and to discuss expectations between the sectors on each others' roles.

Example: the continuum of care in HIV/AIDS in a district

Levels:	Group 1: hospital level actors	Group 2: Health centre level actors	Group 3: Health post level actors	Group 4: Community level actors	Group 5: Households/ PLWA
Hospital	Functional roles	–			
Health centre	–	–	–		
Health post		–	–	–	
Community			–	–	–
Households/ PLWA				–	–

Clarification:

'–' in the table means: here the roles are filled in per level by the actors on their own functions and by the actors for the level below and above on the perceptions of the functions that that particular level has. For the bold grid, an example is given below.

Hospital level actors can include: DHMT, doctors, nurses, counsellors of public hospitals, staff of private hospitals, private practitioners working in hospitals, Mission hospitals (NGOs), VCT centres
Health centre actors can include: doctors, nurses, counsellors of public health centres, staff of NGO health centres, private practitioners, traditional healers, VCT centres
Health post actors can include: staff of public health posts, staff of NGO health posts, private practitioners, traditional healers
Community level actors can include: public health workers, counsellors, NGO health workers, home based care volunteers, church organisations, CBOs involved in home based care, private practitioners, traditional healers
Households: family of PLWA, PLWA, neighbours

Example for hospital and health centre levels

Levels:	Group 1: hospital level actors	Group 2: Health centre level actors	Group 3: Health post level actors
Hospital	**Perception of hospital level staff on their own functions** • Effective treatment of symptomatic infections • Palliative care • Training health centre staff and NGO staff • HIV testing • Responding to referrals from health centre level • Collecting available information (statistics) • Coordinating the health sector response at district level	**Perception of health centre staff on functions of hospital staff** • Effective treatment of symptomatic infections • Palliative care • Training health centre staff and NGO staff • HIV testing • Responding to referrals from health centre level • Collecting *and releasing* available information (statistics) • Coordinating the health sector response at district level • *Information about universal precautions for carers* **Perception of actual activities carried out** • Treatment of symptomatic infections • HIV testing	

Levels:	Group 1: hospital level actors	Group 2: Health centre level actors	Group 3: Health post level actors
		• Training NGO staff • Collecting data	
Health centre	**Perception of hospital level staff on functions of health centre staff** • Treatment of symptomatic infections • Palliative care • Training NGO staff and health post staff • Providing drugs, condoms and other supplies • Information to the community on prevention and care • Referral to hospitals • Reporting on HIV/AIDS cases and activities **Perception of actual activities carried out** • Referral to hospitals • Palliative care • Training NGO staff only	**Perception of health centre staff on their own functions** • Treatment of symptomatic infections • Palliative care • Training NGO staff and health post staff • Providing drugs, condoms and other supplies • Information to the community on prevention and care • Coordinating all initiatives and actors • Referral to hospitals • Reporting on HIV/AIDS cases and activities	**Perception of health post staff on functions of health centre staff** • Treatment of symptomatic infections • Palliative care • Training NGO staff and health post staff • Providing drugs, condoms, other supplies, • *Transportation support to carry out activities at community level* • Coordinating *and supporting* all initiatives and actors • Referral to hospitals • *Releasing information* on HIV/AIDS cases and activities **Perception of actual activities carried out** • Palliative care • Interested in coordination rather than providing support on activities of the health post • Training NGOs and not health workers • Collect data, but no feedback

18 Technique: Action planning

Section	Content
1 Description of technique	A participatory technique to develop an action plan to address problems and their possible solutions identified during other community activities (see techniques mapping, transect, problem ranking, problem tree, force field analysis, Venn diagram).
2 Level of intervention	All levels.
3 Stage in planning cycle	Planning.
4 Purpose and use of technique	• To assist the participants to clearly formulate their objectives and to create commitment to reach these objectives • To develop a plan of action that is feasible and represents the views of different stakeholders that are to be involved in the implementation
5 Requirements for facilitation	• Prepare for this activity by listing problems, possible solutions and stakeholders identified during other sessions • Ability to guide the participants in determining actions to be taken in the short-, medium and long term • Ability to explain the need for indicators that are specific and easily monitored
6 Duration	Depending on the number of problems to be addressed, at least two hours per problem.
7 Materials required	Poster paper, markers.
8 Methodology	1 Recall outcome of earlier sessions and agree on the priority problem to be addressed and the objective to be reached. Put these on top of a large sheet. List strategies to be used. 2 Underneath this, draw a matrix with six columns with the headings: Activities (what do we want to do); How (how are we going to do this, specific steps); Who (who is responsible for each activity/step); Resources (materials and funds needed, source indicated); When (specific dates or duration); Indicators (how is progress measured). 3 Divide in small groups and ask each group to fill in the matrix. 4 Present group work, discuss and agree on the action plan. 5 Repeat for each problem. 6 Compile and agree on overall action plan, indicating a logical order of activities.
9 Impact	• The process helps participants to systematically plan for all activities and to agree on the approach to be used and the persons responsible for that activity

Section	Content
	• The formulation of the indicators assists in specifying what outcome is expected from each activity • The process of action planning in itself helps to create commitment for its implementation
10 Critical issues for success	• The action plan has to be made with the stakeholders that will be involved in its implementation • Care has to be taken that various groups making up the community are represented and that a consensus is reached on the final action plan
11 Source of technique	Programme d'Appui au Programme Multisectoriel de Lutte contre le SIDA et les IST (Seydou Kabré or Victorine Yaméogo), 01 BP 6464 Ouagadougou 01, Burkina Faso pmls@cenatrin.bf KIT, P.O. Box 95001, 1090 HA Amsterdam, The Netherlands m.wegelin@kit.nl
12 Editor's note for learning	In case of time constraints, it is also possible to have the different groups each addressing a different problem and developing an action plan. In such case it is essential that the group as a whole agrees on the specific problem and the objective of the action plan beforehand. The presentation and subsequent discussion has to be facilitated well to ensure that differing views are taken into account and a consensus is reached on the final plans.

Example of an Action Plan

Problem adressed: Neglect of orphans

Objective: Community care for orphans

Strategy:
1 School support to orphans
2 Awareness raising in community
3 Provision of basic necessities (food, shelter, schooling)
4 etc.

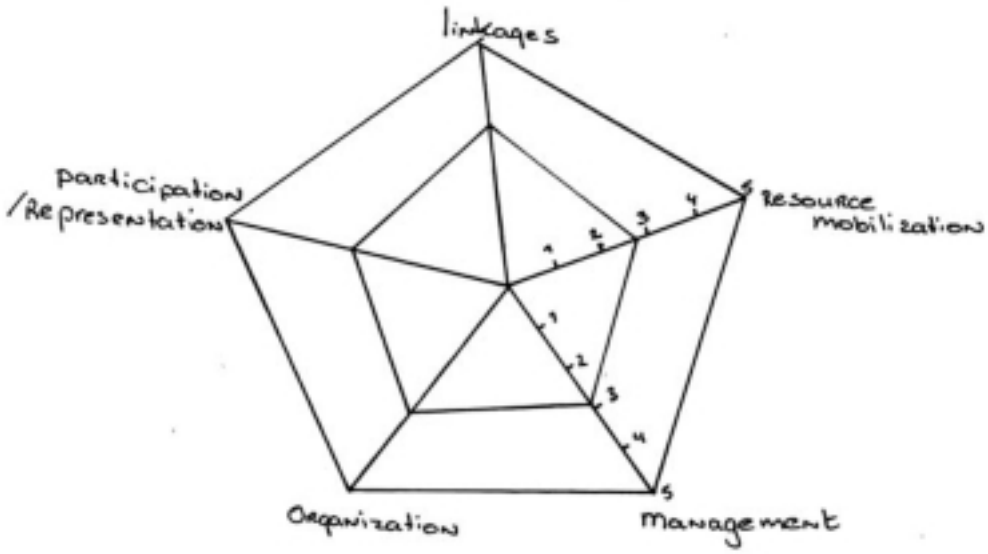
Activities for strategy 1	How	Who	Resources	Period	Indicator
Talk to director	visit	Responsible staff of NGO	Basic information on orphans	week 1	Formal agreement
Develop manual for orphan counseling	adapt existing manual	NGO	NGO + funder	week 2 – 5	manual printed
Identify teachers for training	criteria for selection	NGO + director	NGO + school	week 4 + 5	teachers selected
etc.					

19 Technique: Spiderweb for monitoring and evaluation

Section	Content
1 Description of technique	Participatory technique to help organisations and/or groups in a community to assess their capacities in specific areas related to their functioning as an organisation.
2 Level of intervention	Community.
3 Stage in planning cycle	Monitoring and evaluation.
4 Purpose and use of technique	• To identify key elements of a sustainable organisation • To develop indicators to measure performance in these elements • To self assess performance in the identified key elements • To assist in planning for improvement in the identified elements
5 Requirements for facilitation	• Insight in functioning of community organisations • Experience in developing indicators • Ability to summarize the discussions into concrete statements for indicators
6 Duration	3 hours.
7 Materials required	Poster paper, markers.
8 Methodology	1 Start by asking the group: what is a spider, what does a spider do, how does it build its web and why does it build a web. Guide the discussion to a conclusion that in a web the strands/pillars are important to keep the web whole and functioning. If one strand breaks or is weak, it affects the whole web. The web can be used as a symbol for an organisation. 2 Brainstorm on what the group considers important aspects of a sustainable organisation and list the answers. 3 Cluster the answers into five or six key elements for instance: participation/ representation, organisation (how established), resource mobilisation, management, linkages. These are the strands of the web. 4 Draw the spider web with the strands naming the key elements. 5 The group now looks at each of the elements and develops a continuum with 5 stages on increasing performance, each with their own indicator. This may be done in small groups. Examples of indicators: **For participation**: Lowest performance: one sided representation, only community leaders no representation of different groups in the community Highest performance: organisation represents variety of interests in the community.

Section	Content
	For organisation: Lowest performance: organisation created by outsiders, members appointed, activities imposed. Highest performance: organisation established by community itself, members elected, activities self initiated. **For resource mobilisation:** Lowest performance: no funds raised in the community, organisation passively depending on outside funding. Highest performance: large part of resources raised within the community, successful in raising funding from outside. **For management**: Lowest performance: tasks and responsibilities not clearly defined, decided by director alone, no monitoring on performance. Highest performance: regular team meetings where tasks and responsibilities are agreed, system of monitoring operational. **For linkages**: Lowest performance: no or few links with public sector and organisations active in the same field. Highest performance: active in networking, strong links with other organisations, collaboration in implementation. 6 The group agrees on the indicators and assesses its own performance on each of the elements by indicating the stage where they are. 7 Draw a line connecting the stages and see how the contours of a spider web appear. 8 Discuss the result: what does it mean, where should we improve, where do we want to be in a years' time, how can we improve. 9 Finalise the exercise by listing some concrete activities to improve performance.
9 Impact	• Because the group identifies its own key elements and indicators, it helps to build self-awareness • The discussion on indicators in itself increases understanding on the requirements of a sustainable organisation • Self-assessment increases commitment for improvement
10 Critical issues for success	• The group has to be guided well to look critically at its own performance, there is often a tendency to overstate this • The self assessment has to be done for the organisation as a whole, not for individual performance as this may result in blaming
11 Source of technique	Adapted from "Keep it working", IRC, P.O.Box 2869, Delft, The Netherlands www.irc.nl

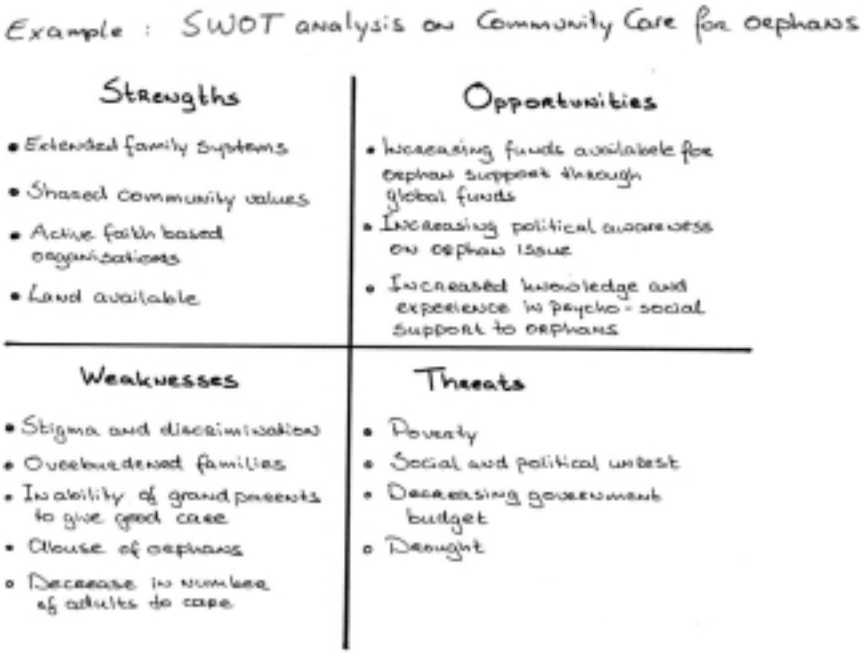
Section	Content
12 Editor's note for learning	• The exercise can be repeated over time to monitor performance. The web is likely to change over time and this can be marked on the same paper, resulting in a visual overview of improvement • The results of this exercise can be used as a start for action planning (see technique action planning) • The technique here is described as a self-assessment tool, but can also be used by community members to assess the performance of an organisation that delivers a community service • The technique can also be used to monitor activities of an organisation, in which case the key elements (strands) are the activities carried out by the organisation



20 Technique: SWOT Analysis

Section	Content
1 Description of technique	Participatory activity to analyse strengths and weaknesses of an ongoing programme and to assess the opportunities and threats to improve the programme.
2 Level of intervention	Community/district/regional level.
3 Stage in planning cycle	Planning. Monitoring and Evaluation.
4 Purpose and use of technique	To help people analyse their programme, it's successes and difficulties in a systematic way. It will help them to address current weaknesses and threats to the programme and to adjust it to bring about the desired results.
5 Requirements for facilitation	• Ability to guide the participants in assessing their programme using the SWOT analysis • Ability e to assist the participants to develop action on the basis of the outcome of the SWOT analysis
6 Duration	Approx. 2-3 hours.
7 Materials required	• Flipchart paper • Markers/pens
8 Methodology	1 Divide the group in smaller groups of 6-7 persons when the group is larger then 15 people. 2 Draw one horizontal and one vertical line on a large size paper and divide it into 4 equally sized parts. Give each group such a piece of paper. 3 Write the name on top of each part, stating: 1) **S**trengths, 2) **W**eaknesses, 3) **O**pportunities and 4) **T**hreats. 4 Identify with the participants the topic for which the analysis is to be made. This will be (part of) a programme in which they are currently involved. 5 Have the groups deal with each of the elements one by one, by asking the participants to mention as many Strengths, Weaknesses, Opportunities and Threats as they can in relation to the programme. 6 Discuss how weaknesses and threats can be avoided or dealt with by making use of the Strengths and Opportunities. 7 Make sure these ideas are as concrete as possible so that they can be formulated as activities once consensus has been achieved. 8 Discuss what external assistance is needed to deal with the weaknesses and threats that cannot be overcome by strengths and opportunities and formulate activities to be undertaken with this external assistance.

Section	Content
9 Impact	This exercise can encourage people to critically look at a programme and gives different stakeholders the opportunity to understand each others' perspective.
10 Critical issues for success	Make sure there is a common understanding of the sections of SWOT in the group. Definitions can be: *Strengths*: those aspects that work well, aspects that you are proud to tell others. The best qualities of different stakeholders. *Weaknesses:* Those aspects that do not work so well, the things that you would prefer others not to know about. The negative qualities of different stakeholders. *Opportunities:* The possibilities within or around the programme for positive change. The chances to change things for the better. *Threats:* The outside influences that could easily worsen the situation. Limitations that stop change from happening.
11 Source of technique	Corporacion Kimirina Ramirez Davalos 258 y Paez, Quito, Ecuador kimirina@quik.com.ec JSA Consultants Ltd. P.O. Box A408, La, Accra, Ghana E-mail: jsa@africaonline.com.gh
12 Editor's note for learning	This tool is very useful in the planning phase and/or monitoring and evaluation as it leads participants to reflect on a situation/programme from a positive as well as a negative perspective. The outcome can be used to formulate possible solutions and action plans.



Annex 1: Guideline on how to write a technique

What is a technique

A technique is a procedure that is used for a specific purpose at a certain stage during a process of intervention, described in a practical step by step fashion. It helps a facilitator to get an audience to analyse their own situation and to establish their needs and priorities, in order to plan interventions. The audience from one community or organisation can be divided into different groups with a different background (rich, poor, male, female, adolescent, adult, child, other section, other level) ensuring that views of all are taken into account.

Often techniques are generic in nature and have been developed in different disciplines such as agriculture, water and sanitation, gender programming – in fact all programmes that aim at community mobilisation and empowerment. Techniques known from other disciplines can be included in the catalogue, even when they may not have been adapted (yet) for use in HIV/AIDS. The technique is a description and not a prescription and can thus be adapted.

Format of a technique

Title

The title has to mention first that this is a technique. This has to be followed by a short title. Often techniques are known by a certain title – this can be used. For instance: Technique: community mapping

1 Description of technique

Brief description of the technique. This is needed so people can see in an instant if the technique can be useful for them.

2 Level of intervention

This describes at what level the technique can be used. This does not automatically imply that it can only be applied at this level. The generic nature of many techniques allows it to be used with different audiences/types of communities at different levels (for instance a VENN diagram can be used at community and at (sub)district level.

3 Stage in the planning cycle

For users to quickly have an overview of the techniques in the catalogue, we have grouped the techniques by stage in the planning cycle. Users can subsequently pick a technique that is most appropriate for them at a specific stage. There are however also techniques that can be used at different times, in the planning cycle (for instance during the situation analysis and later during monitoring or evaluation to detect the differences in the time period). Stages are:

1 Mobilisation and awareness raising
2 Situation analysis
3 Planning
4 Implementation (there are no techniques for this, but the companion document on practices presents practices that have been implemented)
5 Monitoring and evaluation

4 Purpose and use of the technique
This describes the result that is expected from using the technique. It also describes the various uses the technique may have such as: inventory of possibilities for action, priority ranking for action, and assessing roles of different actors.

5 Requirements for facilitation
For some techniques special skills may be necessary. These should be mentioned here. Of course being a good facilitator requires special skills such as relevant knowledge on the subject, ability to encourage open discussions, being non-judgemental, and being age and gender sensitive. These do not necessarily have to be repeated.

6 Duration
Here the time required to do the technique/exercise is given.

7 Materials required
All materials that are needed for implementing the technique are mentioned here. Examples are flipcharts, newsprint, papers, markers, pictures, boxes, pebbles, bottle tops etc.

8 Methodology
Step-wise description of all activities in the implementation of the technique. This has to be done in such a way that someone completely unfamiliar with the technique will be able to facilitate the process.
Often a technique can be divided in different sections. Each of these has to be described in the step-wise manner.

9 Impact
This section describes possible impact other than the intended result. These may be positive or negative, but have to prepare the future facilitator for the possible consequences of using the technique.

10 Critical issues for success
This section gives hints to the facilitator on issues that need to be taken into account when applying the technique. These may for instance refer to a specific context that can positively or negatively impact on the procedure, to the composition of the different groups or to specific gender aspects that may play a role in the technique. It may also pertain to a location where the technique can best be applied or to a clarification or suggestions that the facilitator may have to make during the procedure.

11 Source of technique
Although many techniques have become generic and available in many different toolkits and manuals, we have included one or more sources to create an opportunity for exchanges between users. Also for the techniques that are not in 'the public domain', sufficient details should be included for readers to be able to contact these persons/organisations. It is also useful to refer to documentation in which the technique is described (both virtual and/or hard copy).

12 Editor's note for learning

This is done by the editors (KIT) and will include a reflection on the technique. It can give a connection to other techniques included in the document, especially if they can be used in sequence. If the technique has been used in a different way, it will also be mentioned here.

13 User feedback

When the techniques have been used and/or adapted by others, it will be good if users give feedback. This will enrich the learning from experiences and will be included in the description of the technique. The users are therefore asked to contribute to this discussion by sending a response to the e-workspace on the following questions:

- For what purpose have you used the technique
- What adaptations have you made
- What is the outcome of the use of the technique

Annex 2: The Self-Assessment of AIDS Competence: *A Human Capacity Development Framework*

This annex includes:

- Some answers to Frequently Asked Questions
- A diagram of the whole process, and
- Some tips for facilitators

What is AIDS Competence?

AIDS Competence means that we as people in families, communities, in organisations and in policy making:

- *acknowledge* the reality of HIV and AIDS,
- *act* from strength to build our capacity to respond,
- *reduce* vulnerability and risks,
- *learn and share* with others and
- *live out* our full potential.

Who is this for?

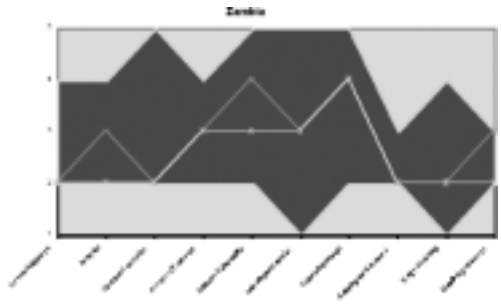
- Any group (whether a nation, district, organisation or community) that wants to assess their competence in responding to HIV/AIDS: *National AIDS council, districts, local neighbourhoods, young people, a business, health workers, church leaders…*
- Any partnership, whether global, national, regional or local that wants to assess their competence in responding to HIV/AIDS: *a sub-district, a city, a national partnership forum…*

What are the basic premises of the framework?

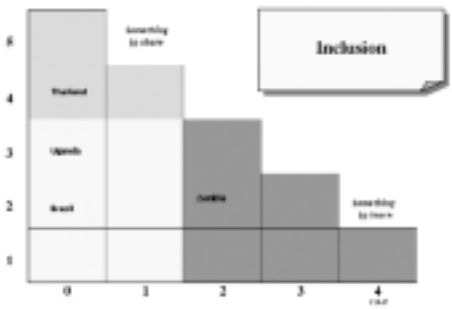
- Effective responses are grounded in the strengths of communities and in their collaboration with service providers and policy makers.
- Communities, organisations and people influencing policy can continuously develop human capacity to achieve AIDS Competence.
- We can use our own knowledge and experience, and adapt that of others, so that everyone becomes more competent in dealing with HIV and AIDS.
- Everyone has something to share. Everyone has something to learn.

How is the tool to be used?

The assessment measures the key practices that lead to AIDS competent nations, communities and organisations. There are 10 key practices each with 5 levels from BASIC to HIGH. Groups are invited to assess themselves using the criteria for each of those practices as a guide. They compare present with past performance and set targets for the future. They can also compare their performance with that of other groups. The key output is a “river diagram” which gives a quick summary overview of actual and target scores for each group. The range of scores are shown for comparison in the form of a river.



For more detail on a particular practice a “stairs diagram” shows group scores and their desire for improvement, presenting those with something to learn and something to share. As groups progress through the levels, they build their capacity to deal with HIV and AIDS. The stairs diagram can be used between comparative groups such as districts, or organisations; and in addition it can be used by ‘partners’ working together and transparently, yet from different perspectives in order to match groups that have something to learn or share from each other.

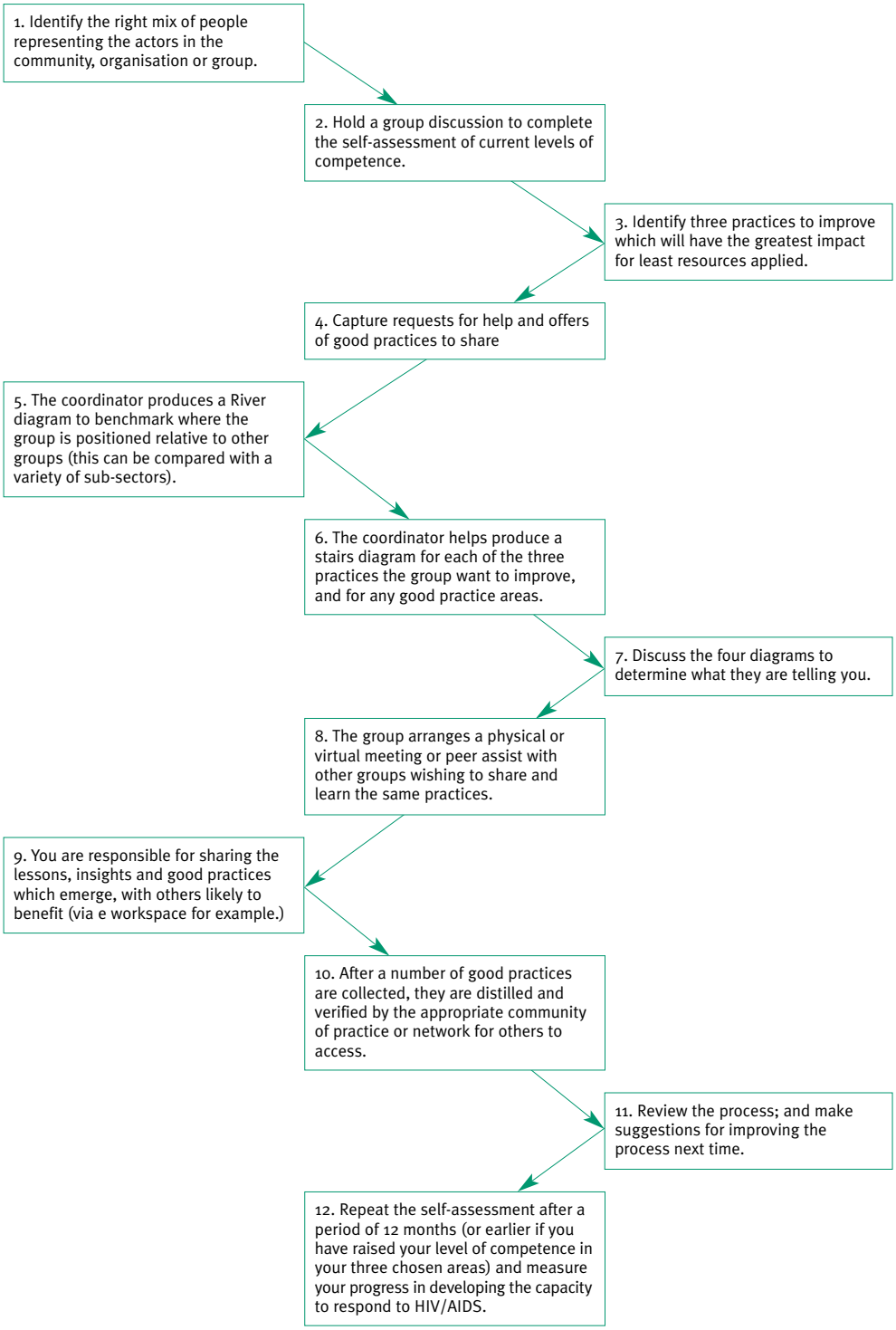


Why would we choose to use is the tool?

- For strategic planning to optimise the use of limited resources
- To assess our degree of AIDS Competence and measure the improvement over time
- To set specific targets for improving practices for AIDS Competence
- To identify what knowledge we have to share, and what we want to learn from others

If you want to know more about the self-assessment framework and the river diagram contact Jean-Louis Lamboray (lamborayj@unaids.org) or Geoff Parcell (parcellg@unaids.org)

The Self-Assessment process



Facilitation tips

... for facilitating a self-assessment session for a common entity

1 Involve a good cross section of people (of the nation, city, organization, or community) representing a diverse set of views. 15 to 25 people is a good number to deal with. Members of a regularly constituted group are likely to reach consensus more quickly, though including different people will introduce new perspectives.

2 Allow half a day to a day for this process. Give some thought to the setup of the room. A circle with everyone with an equal voice is to be encouraged. If the group is large consider breaking into smaller groups to allow the quiet ones a voice.

3 Manage the pace of the discussion so they spend approximately equal time on each practice. The first will take the longest time as people get used to the process.

4 It is useful if the group leader sets the context and gives an overview relevant to the group. This may involve explaining all practices and the river diagram. The role of the facilitator is to support them through the process. Encourage an open discussion and encourage different viewpoints.

5 Facilitation skills required for this exercise include good oratory skills, knowledgeable about the self assessment framework, a wide vocabulary (in the local language preferably), flexible, open minded, able to use stories to illustrate a point.

6 One lead facilitator, but real time coaching of that facilitator by others works well. If the group is to split several facilitators will be needed.

7 Explain that the benefit of using a common assessment tool is that it provides a strategic framework for action and a common language to make effective sharing possible. That sharing can only be effective for the practices that are common.

8 At this stage if the group wants to add additional practices, or indeed sub practices let them do so.

9 Emphasize that this process is not a competition between people, but shared learning about issues and approaches, by people who have a shared vision that AIDS competence is possible.

10 The self-assessment approach is different from evaluation by others. It is less threatening, more subjective and more engaging.

11 The discussion of what level the group is at for each practice is a key benefit of the process. Aim for the group to reach a common view, or at least recognize why there are differences.

12 Use a single practice to demonstrate the process, let people appreciate there are steps from one level to another. Walk them up the steps, and then get them to choose the level they are currently at. Encourage discussion about why people in the group chose different levels, giving concrete examples, and how they obtain an agreed level.

13 After working through all practices, get the group to select three practices they wish to improve in the next 12 months. Also get them to share experience and discuss ideas for the steps or actions they will take to do this. (Three will ensure a degree of focus; they can later move on to improve other practices.)

14 For those three practices, get people to plot themselves on the stairs diagram vertically, and then mark how many steps they want to improve horizontally. Get those at level 5 and 4 to offer to share with those who want to learn. Agree a time to share and learn, either immediately or in the future. Even people at level 5 usually have something to learn from the experiences of others.

15 The approach should be very flexible - not only is it possible for people to work with flipcharts or blackboards, indicating levels in written form, but there are other ways - such as groups placing themselves at a position between one and five, which are pre-assigned spaces within a workshop room, or an open-air space. Make it fun.

16 Recording – Assign someone to record the process and the outcome. Often a lot of good ideas come out of the discussions that are not part of the self-assessment. Record these too. Likewise, if groups wish to record evidence to support their conclusions, encourage them to do so.

The Self Assessment Framework

	1 Basic	2
Acknowledgement and Recognition	We know the basic facts about HIV/AIDS, how it spreads and its effects.	We recognise that HIV/AIDS is more than a health problem alone.
Inclusion	We don't involve those affected by the problem.	We co-operate with some people who are useful to resolve common issues.
Care and prevention	We relay externally provided messages about care and prevention.	We look after those unable to care for themselves (sick, orphans, elderly). We discuss the need to change behaviours.
Access to Treatment	Other than existing medicines, treatment is not available to us.	Some of us get access to treatment.
Identify and address vulnerability	We are aware of the general factors of vulnerability and the risks affecting us.	We have identified our areas of vulnerability and risk. (e.g. using mapping as a tool)
Learning and transfer	We learn from our actions.	We share learning from our successes but not our mistakes. We adopt good practice from outside.
Measuring change	We are changing because we believe it is the right thing to do but do not measure the impact.	We begin consciously to self measure.
Adapting our Response	We see no need to adapt, because we are doing something useful.	We are changing our response as a result of external influences and groups.
Ways of working	We wait for others to tell us what to do and provide the resources to do so.	We work as individuals, attempting to control the situation, even when we feel helpless.
Mobilising resources	We know what we want to achieve but don't have the means to do it.	We can demonstrate some progress by our own resources.

3	4	5 High
We recognise that HIV/AIDS is affecting us as a group/ community and we discuss it amongst ourselves. Some of us get tested.	We acknowledge openly our concerns and challenges of HIV/AIDS. We seek others for mutual support and learning.	We go for testing consciously. We recognise our own strength to deal with the challenges and anticipate a better future.
We in our separate groups meet to resolve common issues (e.g. PLWA, youth, women).	Separate groups share common goals and define each member's contribution.	Because we work together on HIV/AIDS we can address and resolve other challenges facing us.
We take action because we need to and we have a process to care for others long term.	As a community we initiate care and prevention activities, and work in partnership with external services.	Through care we see changes in behaviour which improve the quality of life for all.
We can get treatment for infections but not ARVs.	We know how and where to access ARVs.	ARV drugs are available to all who need them, are successful procured and effectively used.
We have a clear approach to address vulnerability and risk, and we have assessed the impact of the approach.	We implement our approach using accessible resources and capacities.	We are addressing vulnerability in other aspects of the life of our group.
We are willing to try out and adapt what works elsewhere. We share willingly with those who ask.	We learn, share and apply what we learn regularly, and seek people with relevant experience to help us.	We continuously learn how we can respond better to HIV/AIDS and share it with those we think will benefit.
We occasionally measure our own group's change and set targets for improvement.	We measure our change continuously and can demonstrate measurable improvement.	We invite others ideas about how to measure change and share learning and results.
We are aware of the change around us and we take the decision to adapt because we need to.	We recognise that we continually need to adapt.	We see implications for the future and adapt to meet them.
We work as teams to solve problems as we recognise them. If someone needs help we share what we can.	We find our own solutions and access help from others where we can.	We believe in our own and others capacity to succeed. We share ways of working that help others succeed.
We have prepared project proposals and identified sources of support.	We access resources to address the problems of our community, because others want to support us.	We use our own resources, access other resources to achieve more and have planned for the future.