

This document forms part of a series of publications that document field experience in HIV and AIDS. The mission and the report was undertaken by Ellie Bard, intern with UNHCR in Impfondo, Republic of Congo.

These are intended to share experiences among practitioners and program managers in various refuge situations and thereby strengthen responses to the needs of refugees and other persons of concern to UNHCR.

Should you have any questions about this document, please, contact the HIV-AIDS Unit at UNHCR HQs; hiv aids@unhcr.org

Other titles in the HIV/AIDS Field experience series:

Assessment of HIV/AIDS Behaviour Change Communication Strategies employed by NGOs in Kakuma Refugee Camp, Kenya (December 2002)

Evaluation of the Introduction of Post Exposure Prophylaxis in the Clinical Management of Rape Survivors in Kibondo Refugee Camps, Tanzania (October 2005)

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FOREWORD

HIV/AIDS continues to affect Sub-Saharan Africa (SSA) more than any other region in the world. In this sub-continent, women constitute up to 60% of people living with HIV and AIDS, poverty and gender inequalities are extreme, and misconceptions about HIV/AIDS leading to high levels of stigma and discrimination. Numerous cultural and religious beliefs relating to sexual practices and condom use, as in many other parts of the world, lead to risky behaviour that can spread the virus. SSA is also the region with the largest number of conflicts during the past decade.

In view of the seriousness of the HIV epidemic in SSA, UNHCR and its partners have attempted to develop innovative HIV and AIDS prevention and care strategies to respond to this disease among conflict-affected, displaced populations, and their surrounding host communities. It is the affected populations themselves that are the key to such approaches. Their coping mechanisms, resilience and ingenuity are inspiring. This Field Experience, entitled "*Community Conversations in Response to HIV/AIDS: A capacity building project with refugees and the host population, Republic of Congo*" is one such innovative programme. It illustrates how communities can be empowered to fight AIDS by initiating, facilitating and supporting their own communities, and to ultimately sustain hope for a more positive future. This Field Experience describes a unique way of making individuals and communities themselves be the agents of change for effective responses to HIV/AIDS.

This is the first time UNHCR has used this approach to mobilise refugees and the host population to combat HIV/AIDS. The results are encouraging. They show that community members have a tremendous capacity, despite difficult circumstances, to learn from themselves, increase their knowledge and change their behaviour. I hope this document will be a valuable source of information for UNHCR and other organisations engaged in humanitarian responses.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change and Communication
CAR	Central African Republic
CEMIR	Comité d'Entraide pour les Migrants et les Réfugiés
DRC	Democratic Republic of Congo
CNLS	Conseil National de Lutte contre le SIDA
GoC	Government of Congo
HIV	Human Immunodeficiency Virus
IP	Implementing Partner
IRC	International Rescue Committee
NGO	Non-Governmental Organisation
RoC	Republic of Congo
PLWHA	Persons living with HIV/AIDS
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

Executive Summary

This report describes an innovative capacity building project implemented by the United Nations High Commissioner for Refugees (UNHCR). The “Community Conversations” approach is being used in the Republic of Congo (RoC) to mobilise refugees and the host population, themselves, to find effective responses to the HIV/AIDS crisis.

Background and Objectives: UNHCR has three field offices in the Likouala region in the North of RoC which is host to 57,000 refugees from DRC, most of whom arrived in the year 2000. These refugees live in 89 sites stretched along 600km of the Oubangui and Congo rivers. Livelihoods are primarily dependent on fisheries and agriculture. There are many socio-cultural norms which contribute to the spread of HIV/AIDS in this area including polygamy, extra-marital sex, poverty and the weak position of women, as well as other economic and social difficulties encountered particularly by refugees. Very little data on the prevalence of HIV is available, with HIV preventive activities being minimal until now.

In November 2003, a UNHCR exploratory mission to evaluate HIV/AIDS interventions recommended that HIV/AIDS training of focal points of social groups should be organised to promote behaviour change. This programme aims to arouse community mobilisation and participation among women, men, the host and refugee populations to “touch the soul of the community” and create behaviour change.

Methods: The “Community Conversations” approach which leaves space for dialogue, mutual learning, reflection and introspection, was chosen in collaboration with the Government of Congo (GoC). Following community mobilisation in October 2004, four six-day training sessions took place in Impfondo, Betou and Loukolela, with GoC providing the two trainers, and a total of 104 refugee, 27 local and 17 Implementing Partner (IP) staff taking part in the seminars. 45% of participants were women.

Results: Between December and March 2005, 92 “Community Conversations” took place. The average number of participants per activity was 85 with all sectors of society taking part. Tools learnt in training such as strategic questions, story telling and transect walks were used. Facilitators work in integrated refugee and local groups, on a voluntary basis. Many “taboo” subjects are discussed and false beliefs uncovered. There is demand for “Community Conversations” from diverse community members, and there are signs of behaviour change: reproaches to men by their wives about their behaviour, reports of fewer commercial sex workers and demand for condoms.

Discussion and Conclusion: A strong, mixed gender, refugee and local team can have a tremendous influence on community response when its approach is facilitative in nature, when they work by invitation, and when they demonstrate genuine care by encouraging everyone to participate. The collaboration between UNHCR and GoC has been successful as has that between refugees and the host population, both of whom continue to benefit. There were some constraints relating to lack of resources, climatic problems and cultural attitudes preventing women from attending training and feeling free to discuss issues. However, an environment has been created where people can now talk freely about many hitherto private and whispered subjects, and this truly can lead to behaviour change.

It is essential that the approach of “Community Conversations” be supported and expanded to other regions of RoC and other countries in the region; that the experience be widely publicized; and that resources continue to be allocated to support the process which should be seen as an investment in long-term, sustained refugee and local community responses to HIV/AIDS in an integrated manner.

1. Introduction

Human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is a pandemic with catastrophic and far-reaching consequences. Sub-Saharan Africa remains the worst-affected region by HIV/AIDS, hosting 10% of the world's population but almost two thirds of people living with HIV – some 25 million.¹ In sub-Saharan Africa, women make up 60% of people living with HIV with prevalence among 15-24 year-olds being 6.9% among women compared to only 2.2% among men.¹ This is frequently attributed to poverty and is also due to skewed power relations and inequalities between men and women. These inequalities, together with other cultural and religious beliefs relating to preferred sexual practices, sexuality, and condom use – are often prohibitive to HIV preventive behaviour in these communities.

In the face of the challenge of the HIV/AIDS pandemic, belief in the capacity of both male and female members of communities to change, care, share and transfer their experience with others and sustain hope is fundamental to an effective response. The ways that organisations work with communities in this process can either strengthen this capacity or inhibit it from reaching its full potential.

This report describes an innovative capacity building project implemented by the United Nations High Commissioner for Refugees (UNHCR). The “Community Conversations” approach is currently being used in the Republic of Congo (RoC) to mobilise refugees and the host population, themselves, to find effective responses to the HIV/AIDS crisis. This is the first time UNHCR has used this approach and the results are very positive, showing that both female and male community members have a huge capacity to discuss “taboo” subjects, change their behaviour and fight against the HIV/AIDS pandemic.

2. Background

2.1 Institutional Context

UNHCR has three field offices in the Likouala region of RoC at Impfondo, Betou and Loukolela (*map, Appendix 1, p23*). Refugees benefit from a multi-sectoral assistance from UNHCR who has the mandate of providing international protection to the refugees together with the Government of Congo (GoC) who also provides physical security and numerous other services; these include such services that respect the international conventions governing refugees in general, women at risk, child protection and prevention of harmful practices.

When applicable, UNHCR promotes voluntary repatriation and/or resettlement. At present, some areas of origin of these refugees in the Democratic Republic of Congo (DRC) are thought to be safe so that voluntary repatriation of refugees to parts of DRC began in April 2005. UNHCR assistance programmes are implemented through Non-Governmental Organisations (NGOs) with the *Comité d'Entraide pour les Migrants et les Réfugiés* (CEMIR) carrying out activities in the Impfondo and Loukolela areas, and the *International Rescue Committee* (IRC) in the Betou area.

In November 2003, a UNHCR exploratory mission took place to evaluate HIV/AIDS interventions in the Likouala region.² One of the recommendations made were those concerning Behavioural Change and Communication (BCC), notably: “to organise formal

HIV/AIDS training of focal points of social groups (e.g. youth, women, religious leaders, refugees' leaders and local surrounding populations)" so that "a pool of resource persons capable of carrying out and continuing activities when they repatriate will have been created." Previously, no training of refugees on HIV/AIDS issues had been organised except for some training of health personnel.

In October 2004, following these recommendations, UNHCR established the initiative of "Community Conversations" in Response to HIV/AIDS in the Likouala region of RoC. Key actors in this project were the "Conseil National de Lutte contre le SIDA" (CNLS), UNHCR, Implementing Partners (IPs) working with UNHCR, and refugee and host populations. The project was initiated and managed by the UNHCR HIV/AIDS Coordinator for Central Africa; Community Services Officer for UNHCR, RoC; UNHCR Medical Coordinator for RoC; HIV/AIDS Intern for UNHCR, RoC; and Medical Coordinators for the IPs in each location. Available funds had to be spent before the end of 2004, providing minimal time for a detailed problem analysis involving target groups in the community.

2.2 Project Area

The Likouala region lies in the North-east of RoC with DRC to the East and Central African Republic (CAR) to the North. There are approximately 57,000 refugees from DRC living in this region, of which 51.5% are female.

Refugees from DRC in the Likouala region:

Age group	No. of males	No. of females	Total
0-4	5,080 (18%)	5,128 (18%)	10,208 (18%)
5-17	11,574 (42%)	11,473 (39%)	23,047 (41%)
18-59	10,098 (37%)	11,540 (39%)	21,638 (38%)
60 +	833 (3%)	1,141 (4%)	1,974 (3%)
Total:	27,585 (100%)	29,282 (100%)	56,869 (100%)

These refugees live in 89 sites stretched along 600km of the Oubangui and Congo rivers which form the border between RoC and DRC. The majority of these refugees arrived more than 5 years ago and live in constant contact with the local RoC population with whom they share the same language. Both refugees and surrounding populations are mostly Christians of various denominations. Peoples' livelihoods are primarily dependent on fisheries and agriculture which are the main occupations.

2.3 Target group vulnerability to HIV/AIDS

There is a complex relationship between conflict, displacement and HIV/AIDS.³ However, refugees are vulnerable to HIV for many reasons including the precariousness of life, lack of information, economic and social difficulties, reduction in resources and services, lack of recreational activities, and mobility. Whether or not this vulnerability translates into increased infection is context specific and depends upon numerous inter-connected and often countervailing factors.

Among both the host population and refugees in this area, there are socio-cultural norms which contribute to the spread of HIV/AIDS. Polygamy and extra-marital sex are widespread, and adolescents start to be sexually active at a very young age when they may not be confident or informed enough to protect themselves.

The weak position of women in society means they often do not have the power to negotiate condom use, and many women are pushed by economic difficulties to have exploitive sexual relations in return for food, money or presents. Inheritance of women, where a man inherits his brother's wives after his death, contributes to the spread of HIV, as does sexual exploitation and violence. One young woman recounted that "*[a]ncestral customs weigh on women. Certain men do not accept the views of their wives and just impose their own will.*" HIV/AIDS is not openly discussed as it is related to many taboo subjects such as sexual practices, the role of women, and death.

There is very little accurate data on the prevalence of HIV in RoC. A study carried out in 2003 by CREDES, a French public health consultancy firm, estimated the HIV seroprevalence of 1.3% in Impfondo.⁴ However, many health care professionals believe it is much higher. The level of HIV/AIDS interventions by the GoC, NGOs and United Nations (UN) agencies in the Likouala region until now has been minimal. False beliefs and negative attitudes related to HIV/AIDS are widespread, as illustrated by the results of the Impfondo quiz competition carried out as part of World AIDS Day activities in December 2004 by CEMIR and UNHCR. Questions were read out on the radio and put up on posters around town. A total of 20% of the 225 respondents showed extreme views against persons living with HIV/AIDS (PLWHA), with 16% saying that PLWHA should be excluded from the community; the same proportion stated that PLWHA should be killed. Prayer was thought to be an effective way to fight against AIDS by 84% of respondents to this quiz.

There are no officially reported AIDS cases in the region even though medical staff diagnosed many such cases over the years. Patients who are clinically diagnosed with AIDS are, for the most part, not told what their illness is as the medical personnel feel it is better for them not to know because of the lack of treatment as well as shame and stigmatisation to the family that may result if confidentiality is not respected. This denial of the existence of AIDS in the community is a large barrier to both HIV/AIDS prevention and care.

3. Objectives of the project

1. To facilitate female and male refugee and local community members, themselves, to identify HIV/AIDS as a serious problem for their community and as a result to arouse community mobilisation and participation to create behaviour change;
2. To ensure that women play a key role in all activities so that they have the power and possibility to express their opinions, discuss their experiences and influence the decisions and behaviour of individuals and communities relating to HIV/AIDS;
3. To identify and develop skills to act as a regional resource "pool of facilitators" (both women and men) who can give support to local action against HIV/AIDS;
4. To strengthen the capacity of all organisations working in the area to facilitate community responses to HIV/AIDS.

Although the UNHCR mandate is to work with refugees and other persons of concern, an active decision was taken to involve both refugees and host communities in this project. These two populations live in such close contact that in order to tackle the problem of HIV/AIDS among refugees, it must be tackled among the host population in an integrated manner.

4. Methods

“In the face of a phenomenon so intricately linked into the fabric of our society and as personally and professionally threatening as the HIV epidemic, it may be that only programmes which penetrate the soul of the community, organisation or nation will be effective.” (Ian Campbell, Technical Adviser, Salvation Army, 1997)

4.1 Choice of Approach

The approach entitled “Conversations Communautaires” (“Community Conversations”) was chosen in collaboration with the CNLS.⁵ This approach has been previously implemented in some other African countries, including Ethiopia, Rwanda, Nigeria, Senegal and Côte d’Ivoire, with great success.^{6,7} This approach differs from other approaches which consisted of assembling people for sensitization sessions and distributing leaflets, leaving communities with messages but with limited possibility for dialogue, mutual learning, reflection and introspection.

In addition, the former methods left the deliverers of information with no further insights into the experiences, practices and beliefs among women and men which influence the propagation of HIV/AIDS. These insights should and can influence effective programme planning and implementation and “Community Conversations” hopes to enable this to happen.

This new approach is based on the reality of existing social dynamics/relationships and the concerns of the local people. It aims to create “spaces” of trust and mutual respect in which the preoccupations of the community are explored, with the participation of men, women, young, old, rich, poor, people living with HIV/AIDS and those who are not. This capacity building approach begins with a determination of where both men and women are with respect to their perspectives of the HIV/AIDS situation and their interest in change. In this way it hopes to touch the soul of a community or organisation.

Through these processes of inclusive interaction, collective or social learning occurs, power relations shift, changes are initiated, ownership and responsibility for change is strengthened, and local capacities and resources are mobilised. These latter include but are not limited to material resources, time, social capital, skills, knowledge, values, and tradition. This new environment contributes to behaviour change among women and men and to the development of efficient responses to HIV/AIDS as well as other socio-economic problems. Furthermore, since the programme was implemented in an integrated manner with both refugee and surrounding host communities, the same processes listed above within a community will also occur between two communities.

The following ways of working are fundamental to the approach:

- Sensitivity to local, family and community experience – working by invitation and commitment, not imposition;
- Facilitation rather than intervention of “experts”;

- Participation of all members of a community regardless of age, gender, social status, ethnic group, religion and other factors;
- Participatory approaches with space for listening, inclusion, agreements and disagreements as well as expressions of concern;
- Formation of teams of facilitators of mixed gender, age and ethnic group;
- Belief that communities have capacity to identify change, own change and transfer change to other communities.

4.2 Community mobilisation

Which villages would participate was selected on the basis of population size, distance from other villages and presence of health centres. Action zones were created so that every village in the area would be visited by facilitators even if they themselves did not have their own.

Starting from October 2004, participating villages were mobilised to identify local facilitators. UNHCR or IP staff visited each village to explain the objectives of the project and what was required of the community to participate. The refugee president and “chef du village” (chief of local population) were always consulted and played a key role in the choice of facilitators by the village. In some villages, interest in the project was so high that a vote took place to choose facilitators. Communities were asked to provide an equal number of male and female facilitators to achieve a gender balance. Many refugee sites in the region are small and these sites were asked to choose only one male and one female facilitator.

In the larger towns of Impfondo, Betou and Loukolela, the local authorities were contacted and gave their full support to the programme, including sending their own representatives to take part.

The following criteria were taken into account in the choice of local facilitators:

- Good basic knowledge of HIV/AIDS;
- Respect for rights and dignity of PLWHA;
- Availability, patience, willingness and engagement;
- Sensitivity towards gender issues;
- Capacity to work in a team;
- Good knowledge of the community;
- Capacity to communicate;
- Respect for confidentiality;
- Respect for difference and diversity;
- Recognition of resources available in response to HIV/AIDS;
- Mastery of local language.

4.3 Provision of materials

Materials and equipment were provided for the training sessions and facilitation that occurred afterwards, as well as bicycles to help with the movement of facilitators. Materials included t-shirts, facilitation guides, exercise books, pens, envelopes, markers, conference paper, wooden phalluses for condom demonstrations and condoms.

4.4 Training sessions

In November and December 2004, four training sessions took place in Impfondo (2), Betou (1) and Loukolela (1), each lasting six days. These were in partnership with the CNLS who provided two trainers, specialists in the approach, to run the training sessions. The programme for these training sessions can be seen in *Appendix 2, p24*. On the last day of each training session there was a practical session where the whole group went to a nearby village to put into practice what they had learnt during the week.

A total of 148 facilitators (45% of whom were women) were trained, which included 104 refugees, 27 local people and 17 supervisors from IRC and CEMIR who would be responsible for following up activities. Participants came from 26 of the 52 refugee sites in Impfondo, 12 of the 34 sites in Betou and 3 of the 3 Loukolela sites; overall 41 out of 89 sites in the region took part (46%). It was not possible to train facilitators from every refugee and surrounding community site because of lack of time and resources. Participants came from the whole spectrum of professions and social classes with ages ranging from 18 to 69 years. Among the facilitators were refugee presidents, “chefs du villages”, religious leaders, leaders of women’s groups, health workers, teachers, members of youth groups, fishermen, housewives, salespersons, farmers, students and many more.

Locals, as well as refugees, were chosen to participate from the larger towns and refugee sites. Coming from the main town of Impfondo, an equal number of refugees and locals were trained (8 of each), representing the population balance of the town. This was also the case in Loukolela town. However, from Betou town centre, 7 refugees and 2 locals were trained as the majority of the population are refugees.

In other larger sites such as Njoundou and Liranga in the Loukolela area, 8 refugees and 2 locals were chosen to participate from each site. The majority of refugees in the Likouala area live in smaller surrounding communities with large majority refugee populations. Due to lack of resources, only refugees were chosen to participate from these sites, and it is for this reason that there were significantly fewer locals than refugees involved in this programme.

Summary of participants by training session:

	Impfondo I			Impfondo II			Betou			Loukolela		
	Women	Men	Total	Women	Men	Total	Women	Men	Total	Women	Men	Total
Refugees	12	14	26	13	15	28	14	11	25	11	14	25
Locals	2	4	6	0	2	2	2	7	9	4	6	10
IP staff	1	1	2	4	2	6	0	4	4	3	2	5
Total	15 (44%)	19 (56%)	34	17 (47%)	19 (53%)	36	16 (42%)	22 (58%)	38	18 (45%)	22 (55%)	40

Summary of participants at all training sessions:

	Women (%)	Men (%)	Total
Refugees	50 (48%)	54 (52%)	104 (100%)
Locals	8 (30%)	19 (70%)	27 (100%)
IP staff	8 (47%)	9 (53%)	17 (100%)
Total	66 (45%)	82 (55%)	148 (100%)

As can be seen in the table below, the overall number of facilitators trained amounts to 1 for every 380 refugees living in the Likouala region.

	Impfondo I	Impfondo II	Bétou	Loukoléla	TOTAL
Total refugee popn	34,500		16,800	5,600	56,900
Total facilitators trained	34	36	38	40	148
Ratio of facilitators to refugee popn	1 : 490		1 : 440	1 : 140	1 : 380

These training sessions ran smoothly and were very well received by participants. This can be seen in results from the evaluation questionnaire filled in on the final day (*Appendix 3, p25*). Seventy percent of the participants cited the atmosphere of the seminar as “very good”, with 96% citing “good” or “very good”. Seventy-nine percent thought the trainers were “very good” with 98% answering “good” or “very good”. An atmosphere of trust and warmth was created among the whole group, using techniques such as reflection sessions for thinking time and coffee breaks where people were encouraged to continue discussions. One woman said *“I thought this seminar would be like all others but it’s completely different, like nothing else I’ve ever experienced”* and a man made the following comment *“[t]hank you for the way we work in a group with no-one monopolising the conversation.”*

After the first few days discussion began to fuel itself and many conversations took place on subjects of social norms, cultural practices and traditions which contribute to the inequality between men and women and favour the propagation of HIV. One woman who has 5 children said that she thought that polygamy and inheritance should stop as they are a danger to the community. Her brother-in-law who was also present objected to her speaking forcefully about established cultural practices and asked her to sit down to which she replied *“[w]e women have a right to express our opinions and I will not stop speaking as I believe strongly in what I am saying.”* At first the women seemed more timid than men but as the seminars progressed women took part animatedly in all discussions.

Members of the refugee and local populations interacted very well during the training sessions, with no problems encountered. All group work was carried out in groups of mixed gender, age and nationality. Some close friendships were built up, resulting in informal “teams” of facilitators containing both refugees and locals who subsequently went out and facilitated together.

There was a test administered to all participants at the start and end of the training sessions (*Appendix 4, p27*). Some questions related to HIV/AIDS knowledge and some to the “Community Conversations” approach. The average result of the test was 68% before training sessions and 76% afterwards, showing that the teaching was effective.

The sessions were carried out in a mixture of French and Lingala, at the request of the participants. During a group activity about previous methods to HIV prevention which

have not worked, one group reported “[i]n the past there has been no understanding of HIV/AIDS because of a lack of constant dialogue and a difficulty with understanding the French language which is the only language of people who come to inform us.” This illustrates clearly the importance of communities discussing these issues in their own mother tongue.

There was a session on the follow-up of activities towards the end of the training sessions. This included how to document each activity using a pre-prepared form (*Appendix 5, p29*) and the distribution of calendars to help facilitators plan their activities and send dates in advance to UNHCR/IPs. A letter explaining the aim of “Community Conversations” and asking for full support from village authorities for HIV/AIDS activities was given to facilitator teams from each refugee site for them to pass on to their refugee president and local “chef du village.” A focal point for the follow-up of “Community Conversations” has been named in each of the IPs in Impfondo, Betou and Loukolela who is responsible for collecting documentation, carrying out supervisions, provision of materials to facilitators and writing the monthly report on activities.

5. Results

5.1 Activities carried out

Between December 2004 and March 2005, 92 “Community Conversations” took place, with an average of three facilitations per month for the three sites of Loukolela. The average number of participants per activity was 85, with participation of all sectors of the community (e.g. old, young, rich, poor, men, women, locals and refugees). A wide range of occupational groups took part with the greatest participation from students (36% of all participants), fishermen (24%) and farmers (22%). One village in the Impfondo area carried out at least 10 “Community Conversations” in the first three months. All facilitators worked in teams of minimum two (one woman and one man where possible), with larger teams in the main towns. Facilitators used a variety of tools learned in training such as strategic questioning, story-telling and transect walks.⁵ Condom demonstrations were carried out by some facilitators but only at the request of the communities, and often in smaller, single sex groups.

In the Impfondo and Loukolela areas, facilitators work on an entirely voluntary basis with only small incentives such as didactic material and T-shirts provided by UNHCR. Facilitators in the Betou area were taken from community agents who already have a salary from IRC, and community leaders who have micro-projects supported by IRC to motivate them to carry out activities. Local and refugee facilitators work together in teams wherever there are trained locals. In the Loukolela area, all facilitation teams have at least one local member. In the sites of Liranga and Njoundou, all 10 facilitators (made up of refugees and locals) meet to organise and discuss each “Community Conversation,” taking it in turns to carry out the actual facilitation.

5.2 Topics discussed

Many diverse topics related to HIV/AIDS were discussed during these “Community Conversations:”

- Women’s vulnerability to HIV/AIDS;
- Poverty, adultery, polygamy and inheritance of women as factors which expose people, especially women, to HIV/AIDS;

- Whether HIV/AIDS exists among poor people as well as rich business men;
- Prostitution;
- How local customs and community action be used to slow the spread of HIV;
- Modes of contamination of HIV and how individuals can protect themselves;
- How to use condoms, whether there are any risks involved, where they can be obtained;
- The origin of AIDS, where and when it was discovered, and whether it truly exists or is just fabricated by white people;
- How PLWHA can be identified, and whether they should be isolated, killed or looked after by the community;
- Lack of hospitals, resources and medicine to care for PLWHA;
- Lack of testing facilities in the region and when they will arrive.

5.3 False beliefs

During the “Community Conversations,” facilitators uncovered many beliefs held by the community related to HIV/AIDS which are untrue:

- HIV/AIDS is a punishment from God and therefore religious people cannot become infected;
- Prayer cures HIV/AIDS;
- HIV/AIDS is a witchcraft;
- Only prostitutes can get HIV/AIDS;
- AIDS is a disease invented by white people to discourage lovers (SIDA = “Syndrome Imaginaire pour Decourager les Amoureux”);
- HIV can be transmitted by river water, sweat, mosquitoes, tsetse flies and other modalities;
- Condoms are infected with HIV, they make you sterile and are only for prostitutes;
- PLWHA cannot have children.

5.4 Factors contributing to success of activities

These are some factors cited by facilitators:

- Support and participation of refugee presidents and “chefs du villages”;
- Implication of religious leaders, nurses, social workers, director of schools and other influential people who helped to mobilise people;
- Door to door strategies to inform people of activities;
- Active listening during “Community Conversations” from both facilitators and the population.

5.5 Difficulties encountered by facilitators

- Absence of some “chefs du villages” and non-participation of the host population;
- Mobilisation not done well as village crier demanded money for it;
- Disinterest of certain individuals resulting in low attendance;
- Lack of visual support and information on HIV/AIDS;
- Lack of condom distribution discourages people to attend;
- Distrust of activities due to the late start of the approach;
- Lack of means of transport to visit other villages and facilitate there.

5.6 Requests from communities

During “Community Conversations,” participants often discuss their needs in combating HIV/AIDS. These include:

- Photos of persons infected by HIV/AIDS;
- Educational materials on HIV/AIDS;
- Condoms, both male and female;
- HIV testing centres;
- Antiretroviral therapy for PLWHA;
- Materials to ensure that universal precautions are respected;
- More assistance from supervisors during “Community Conversations”.

5.7 Supervisions

Between December 2004 and March 2005, 30 supervisions of facilitators took place. These supervisions consisted of visits to refugee sites by UNHCR/IP staff members to talk to facilitators about their activities, successes, problems and needs in order to encourage and motivate the facilitators and to resolve problems. A supervision form was used (*Appendix 5*). In addition, supervisions aimed to improve documentation of each activity by facilitators. In general, facilitators were extremely proud of the work they were doing and were motivated to continue their work in the fight against HIV/AIDS. One female facilitator said to a supervisor “[i] am so proud to be doing this work and knowing that I am saving lives. I am not at all embarrassed to give condom demonstrations because when we are talking about a life and death situation like HIV/AIDS, there is no point being embarrassed.”

5.8 The beginning of behaviour change

This is a long-term project and behaviour change does not happen overnight. However, during the first three months of “Community Conversations” signs of community mobilisation and behaviour change were observed. These can be seen by the following evidence:

- Demand for more and regular “Community Conversations” from communities with facilitators;
- Invitations to facilitators to facilitate in other villages, including some villages across the border in DRC who had heard about the new activities happening;
- Community leaders becoming involved in the community discussions and advocating for ways to protect their communities from infection;
- Increased openness of both men and women to explore and address difficult and sensitive issues related to HIV/AIDS;
- Discussions on HIV/AIDS occurring in families;
- Increased demand for information on HIV/AIDS and what people can do to prevent it;
- Visits to facilitators’ homes by community members asking questions on HIV/AIDS or asking for condoms;
- Reproaches to men by their wives about their sexual behaviour;
- Fewer prostitutes visible in the streets;
- People choosing to use their own razors instead of sharing;

At the end of one “Community Conversation” in a village in the Impfondo area, the community decided “[w]e must unite our efforts to reduce mortality from HIV/AIDS in our village.”

6. Discussion

6.1 Lessons learnt

This capacity building project shows that HIV/AIDS prevention strategies have the potential to “touch the soul of a community,” thus changing attitudes and behaviour and saving lives. Results so far demonstrate that, given the opportunity, both women and men, by themselves, have the capacity and desire to reflect on their concerns, discuss taboo subjects in front of many people and make decisions and changes related to HIV/AIDS. There is evidence that these refugees and surrounding local populations have the will and ability to take in hand their own situation. In a short time and with limited resources, behaviour was already beginning to change, and it is vital that the continuation of the programme is ensured.

There is great demand for this approach. Word has spread from village to village and across the border to DRC, where villages are asking for this approach to be implemented. This shows that the people themselves feel that this approach is worthwhile and effective, and are sufficiently interested in “Community Conversations” that they wish to discuss them with other people.

Many positive things can be learnt from this project. Women, as well as men, have the ability and commitment to take an active role in the fight against HIV/AIDS, and if pushed, men will allow women to be involved in projects such as this one. A strong, united, mixed gender refugee and local team can have a tremendous influence on community response when its approach is facilitative in nature, when they work by invitation, and when they demonstrate genuine care by encouraging everyone to participate.

During “Community Conversations,” relationship-building between facilitators and community members is critical to the ongoing process of change and capacity development. Looking at the problems experienced by facilitators and the factors contributing to the success of activities, the involvement of community leadership is clearly vital to an effective local response to HIV/AIDS. This community leadership includes refugee presidents, local “chefs du villages”, religious leaders, school directors and many others.

This project demonstrates that UNHCR can work successfully with both the host population and refugees, and that the collaboration of refugees with local people can enhance the effectiveness of a project. In sites from which locals took part in training sessions, refugee and local facilitators work together in teams. This collaboration enables facilitators to engage both refugees and locals in the fight against HIV/AIDS which concerns all people, and to bring together these two communities to create open discussion. This programme has been very beneficial to the host country population as minimal HIV preventive programmes were present previously.

UNHCR and the CNLS created a successful partnership with UNHCR providing the funding and the CNLS the expertise. This is a good example of a UN agency working

with national government to benefit all parties concerned in an integrated manner. The facilitation guide provided by the CNLS⁵ is extremely useful to facilitators as it provides a clear methodology and leads to a process of professionalism. In addition, supervision of facilitators is a good way to motivate them, improve their work and permit a sharing of experiences. However, this was a mostly UNHCR and IP-driven initiative with no involvement of District or Ministry of Health staff in the supervision or follow-up of the project, and the programme would benefit from greater involvement and support of the local authorities.

Finally, “Community conversations” yielded numerous positive results for minimal financial input. This approach is sustainable because after training it requires few resources and allows communities to find their own responses to the HIV/AIDS pandemic. It is also an approach which enables refugee facilitators to continue their work after they repatriate. This is extremely important in RoC as repatriation to DRC has already started.

6.2 Constraints

Due to cultural attitudes it was not easy to find female facilitators. Each participating village was asked to choose one male and one female facilitator. At first, many communities were hostile to choosing a woman and there were people who strongly refused on the grounds that men are ‘much more able’. In an initial visit to one refugee site, an older man said *“but why should we send women to be trained when they are uneducated and incapable and men will do a much better job?”* However, the important role of women in this project was explained to them and ultimately a participation rate of 45% females was achieved. The outcome was not ideal given that 51.5% of the refugee population are female, but it was a positive step towards females being equal actors in the fight against HIV/AIDS at the community level.

Due to limited resources, we could not train facilitators from all 89 sites. We chose sites so that all non-participating sites were close to a participating site. However, facilitators often lacked the means or time to travel to other sites which were only accessible by water. This was especially difficult for women who were busy tending to large families and income generating activities.

In addition, many of the smaller sites had only refugee facilitators even though some habitants were locals. This created some tension during activities, with the local president not supporting activities in some sites and discouraging locals to attend. This may be due to resentment at not being involved in the activity; difficult relations between refugee and local communities living together; or mistrust of a possibly controversial activity involving discussion of certain “taboo” subjects relating to HIV/AIDS.

The dispersion of sites along the river, together with climatic and resource constraints, made it difficult to access certain sites during the dry season, meaning that supervisions did not take place regularly in all sites and correspondence between facilitators and supervisors did not always arrive. “Community Conversations” organised by local facilitators should have taken place at the request of the community and at a convenient time. Most communities decided that a convenient time was Saturday or Sunday afternoons. This made it difficult for supervisors to attend activities to help improve

Monitoring behaviour change is not easy and much of the evidence so far is anecdotal. For example, although it was noted in several communities that there were fewer commercial sex workers seen in the streets, it is possible that they are just less visible because of increased awareness of the dangers. It is clear from the observations of facilitators and others that people are taking an increased interest in HIV/AIDS, shown by the demand for activities and questions fired at facilitators at their homes, in the streets and during “Community Conversations.” Even though the evidence recorded here is based on small numbers of people it is obvious that large steps forward are being taken in the fight against HIV.

6.3 Recommendations

This project needs consistent support and follow-up for it to continue in the positive and hopeful manner in which it has started. Recommendations are divided into two categories:

1. Recommendations that aim to reinforce and sustain the engagement of local facilitators and their ability to carry out “Community Conversations”:

- Motivations for facilitators. These could include t-shirts, caps, material to make clothes, pirogues to travel to other sites, and bicycles;
- Provision of materials for facilitation and documentation of “Community Conversations” such as pens, marker pens, conference paper, documentation forms and condoms for demonstrations;
- Assignment of a UNHCR staff member to manage the project in the whole region following the departure of the HIV/AIDS intern in March 2005;
- Continued supervision of facilitators by UNHCR/IP staff with increased involvement of District and Ministry of Health Staff;
- Reinforcement of the capacity of facilitators to carry out their work; this could be achieved by visits to sites by the CNLS trainers. Such an effort would boost the morale of the facilitators as it would be clear that they have not been “forgotten”;
- Collaboration of UNHCR with partners in DRC so that facilitators are supported to continue their work after repatriation.

2. Recommendations that aim to reinforce the effect of “Community Conversations” on the community and contribute to an expanded community response to HIV/AIDS:

- Creation of multi-sectoral HIV/AIDS committees at the site level who meet to discuss HIV/AIDS issues and possible solutions, as had been recommended previously by the Regional HIV/AIDS Coordinator. Facilitators would be key members of these committees;
- Training of peer educators;
- Formation of anti-AIDS clubs in schools where questions linked to HIV/AIDS can be discussed;
- Increased provision and consistent supply of condoms. As people become more aware of HIV/AIDS and identify it as a serious problem, they need the means to protect themselves and their communities. Condoms should be available in numerous places at all times in every site;

Reinforcement of “Community Conversations” and HIV/AIDS education with the use of films, theatre and visual aids. Such media are effective in a rural setting where literacy

is low. This can be seen by the success of the Positive Lives Exhibition (a photo exhibition of PLWHA throughout the world) carried out in March 2005. Audio-visual equipment is available in Impfondo and Betou as well as HIV/AIDS films in French; these should be taken to all sites and shown to refugee and surrounding communities. Films in Lingala would be especially useful.

6.4 Suggested ways forward

The results from this project are hopeful and positive. It is essential that the approach of “Community Conversations” be continued and expanded so that many more facilitators and communities can benefit.

The following are suggested ways forward to build on this existing experience:

- Expansion of the process to other regions of RoC and other countries in the region;
- The current experience should be widely publicized among the NGO, UN and AIDS communities as well among governments;
- Resources should be allocated to continue this process and document future results, especially outcome as opposed to process indicators; this project should be seen as an investment in long-term, sustained refugee and local community responses to HIV/AIDS in an integrated manner.

7. Conclusion

“Community Conversations” has created an environment where women and men can talk freely and unselfconsciously about many hitherto private and whispered subjects. The need for HIV/AIDS behaviour change is discussed widely but practical methods to actually bring about this change are not. The “Community Conversations” approach truly can result in behaviour change as well as change in attitudes. The “soul of the community” can be touched if the approach comes from within rather than from outside experts, and as a result, people can find their own responses to HIV/AIDS.

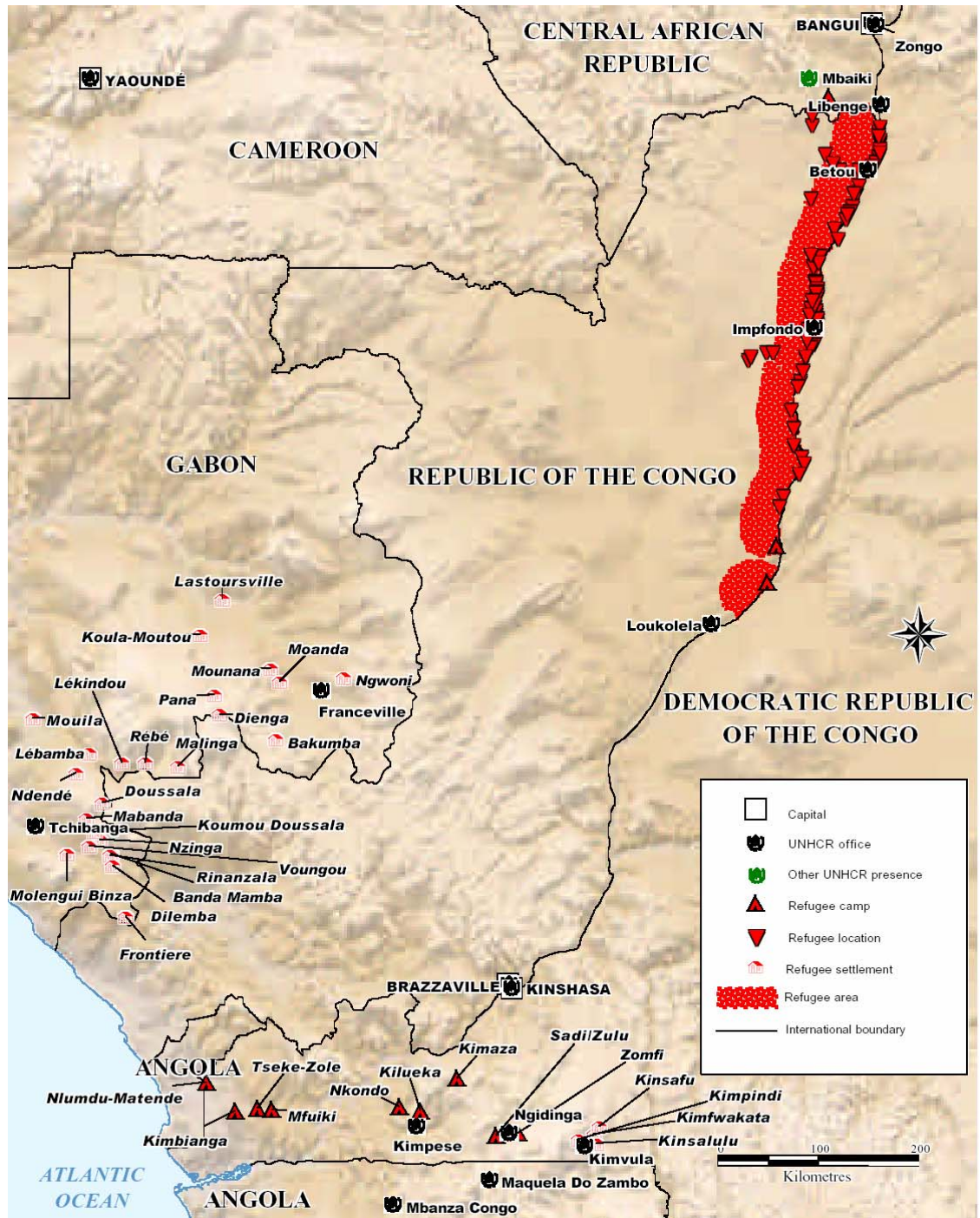
This integrated approach involving the host and refugee populations has been beneficial to both of these communities and the community they form as a whole. Additional resources for HIV prevention have been brought to an isolated area of RoC by the presence of refugees and UNHCR. This is a good example of an integrated public health programme that avoids the creation of parallel HIV services which can be not only expensive and duplicative but also detrimental to relations between refugees and locals. The integration of the host population into this programme has resulted in close ties between refugees and locals and has helped to reduce the misperception that “HIV is in not in our community but their community.”

During the last few years the AIDS community has focused more on treatment than prevention, as antiretroviral therapy becomes more affordable and accessible. However, prevention must be linked to treatment in order to reduce HIV transmission. Behaviour change is a large, complicated and difficult task. However, the “Community Conversations” approach has enormous potential and should be supported and expanded so that many more people can benefit from it.

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2. Etat de lieu des programmes VIH/SIDA en faveur des réfugiés, RDC et République du Congo, November 2003, UNHCR
3. HIV/AIDS among Conflict-affected and Displaced Populations : Dispelling Myths and Taking Action, Paul Spiegel, UNHCR, Disasters, 2004, 28(3):1-17
4. Les Conversations Communautaires en Réponse au VIH/SIDA, CREDES 2004, Annexe 1
5. Les Conversations Communautaires en Réponse au VIH/SIDA, CREDES 2004, Guide du Facilitateur
6. Upscaling Community Conversations in Ethiopia, 2004, UNDP/UNAIDS
7. Strengthening Community Responses to HIV/AIDS in West and Central Africa, A Capacity Building Approach, Vol 2, UNAIDS 2001.

Appendix 1: Map of Republic of Congo showing location of refugees
 (Source: www.unhcr.org)



Appendix 2: Seminar timetable

Day 1

8h30- 9h00	Opening ceremony
9h00- 9h45	Introduction of participants
9h45-10h15	Expectations and fears of participants
10h15-10h45	Coffee break
10h45-11h15	Participants' rules
11h15-11h45	Pretest
11h45- 13h30	Basic knowledge of HIV/AIDS and STIs
13h30-14h30	Lunch break
14h30-16h00	Methodological framework of "Community Conversations"

Day 2

8h30- 9h00	Morning reflection
9h00- 10h30	Stock-taking of current approaches
10h30-11h30	Coffee break
11h00-11h30	Plenary discussion
11h30-13h30	Socio-cultural dynamics and the HIV/AIDS epidemic
13h30-14h30	Lunch break
14h30-16h00	Analysis of social capital and HIV/AIDS

Day 3

8h30- 9h00	Morning reflection
9h00- 10h30	False beliefs and misunderstandings linked to HIV/AIDS
10h30-11h00	Coffee break
11h00-13h00	Competencies of facilitators: active listening
13h00-14h00	Lunch break
14h00- 15h00	Strategic questions
15h00-16h00	Facilitation process

Day 4

8h30- 9h00	Morning reflection
9h00- 10h30	Transect walk
10h30-11h00	Coffee break
11h00-13h00	Community mapping
13h00-14h00	Lunch break
14h00- 16h00	Story telling methodology

Day 5

8h30- 9h00	Morning reflection
9h00- 10h30	Story telling methodology
10h30-11h00	Coffee break
11h00-13h00	Story telling methodology
13h00-14h00	Lunch break
14h00- 16h00	Plan of action for organising "Community Conversations"

Day 6

8h30- 9h00	Morning reflection
9h00- 10h00	Documentation and follow-up of activities
10h00-10h30	Coffee break
10h30-11h30	Evaluation of seminar
11h30-12h30	Lunch break
12h30- 16h00	Field visit
16h00- 17h00	Closing ceremony

Appendix 3: Evaluation Form

Evaluation of “Community Conversations” seminar

How did you find...

	Very weak 1	Weak 2	Satisfactory 3	Good 4	Very good 5
1. The coffee break ?	1	2	3	4	5
Comments :					
2. Lunch ?	1	2	3	4	5
Comments :					
3. The evening meal ?	1	2	3	4	5
Comments :					
4. The seminar room ?	1	2	3	4	5
Comments :					
5. The seminar timetable (the working hours)?	1	2	3	4	5
Comments :					
6. The seminar materials?	1	2	3	4	5
Comments :					
7. The seminar rules ?	1	2	3	4	5
Comments :					
8. The atmosphere ?	1	2	3	4	5
Comments :					
9. The trainers ?	1	2	3	4	5
Comments :					
10. The general contents of the seminar?	1	2	3	4	5
Comments :					
11. The group work ?	1	2	3	4	5
Comments :					
12. The plenary work?	1	2	3	4	5
Comments :					
13. Morning reflection ?	1	2	3	4	5
Comments :					
14. Session on knowledge of HIV/AIDS/STIs?	1	2	3	4	5
Comments :					
15. Stock-taking of current approaches ?	1	2	3	4	5
Comments :					

16. Socio-cultural dynamics and the HIV/AIDS epidemic?	1	2	3	4	5
Comments :					
17. Exercise of the old wise man ?	1	2	3	4	5
Comments :					
18. Social capital?	1	2	3	4	5
Comments :					
19. Active listening ?	1	2	3	4	5
Comments :					
20. Strategic questions ?	1	2	3	4	5
Comments :					
21. Transect walk / mapping?	1	2	3	4	5
Comments :					
22. Speech and language ?	1	2	3	4	5
Comments :					
23. Story telling methodology ?	1	2	3	4	5
Comments :					
24. Condom demonstration?	1	2	3	4	5
Comments :					

With regards to the seminar logistics, (food, room, transport reimbursements...) what would you like to add?

.....

In terms of the contents of the seminar, what would you like to add ?.....

.....

Other comments :.....

.....

Appendix 4 : Pre and post-test

Test on “Community Conversations” training session

1. What is AIDS?.....

.....

2. What does “seropositive” mean?.....

.....

3. How is AIDS transmitted?

- | | | | | |
|---|------|--------------------------|-------|--------------------------|
| a) Sexual intercourse : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| b) Blood : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| c) Mosquitoes : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| d) Going to hospital : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| e) Kissing : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| f) Mother to child : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| g) Greeting an HIV-positive person : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| h) Witchcraft : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| i) Sharp objects : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| j) Eating with an HIV-positive person : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |

4. How can AIDS be prevented ?

- | | | | | |
|-----------------------------|------|--------------------------|-------|--------------------------|
| a) Condoms : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| b) Voodoo / charms : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| c) Abstinence : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| d) Fidelity : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| e) It cannot be prevented : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| f) Prayer : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |

5. A mother can transmit HIV to her child...

- | | | | | |
|--------------------------|------|--------------------------|-------|--------------------------|
| a) During pregnancy : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| b) During birth : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |
| c) While breastfeeding : | true | <input type="checkbox"/> | false | <input type="checkbox"/> |

6. A person infected with HIV can appear in good health.

true false

7. A person infected with HIV can be recognised by the naked eye.

true false

8. How can we know that someone is infected with the virus that causes AIDS ?.....

.....

9. The main goal of “Community Conversations” is to give technical medical information about HIV/AIDS to people.

true false

10. During “Community Conversations,” facilitators must ensure that those who don’t always speak out are given the opportunity to communicate their point of view.

true false

11. During “Community Conversations,” we must avoid raising delicate issues which may arouse many different attitudes and opinions.

true false

12. ”Social Capital” is the cement which links individuals to their community.

true false

13. When practising the technique of “strategic questions,” we must often use the word “why.”

true false

14. When practising the technique of “active listening,” you must strongly put forward your own point of view.

true false

15. Those who want to behave in a way that reinforces and values the potential of everyone, must be always conscious of their use of language.

true false

16. Story telling methodology is a way of understanding social interactions, together with their influence and impact..

true false

17. Documenting “Community Conversations” is not important.

true false

18. What more do you know about “Community Conversations” ?.....

.....
.....

THANK YOU !

Appendix 5 : Documentation for Community Conversations (format)

DOCUMENTATION FOR FACILITATION OF “COMMUNITY CONVERSATIONS”

Community / village :.....

Date of meeting / activity :

Duration of activity :

Names of facilitators :

Members of the community present (Number of men / women / young people / adults):

	Adults	Young people	Total
Males			
Females			
Total			

Occupation of community members present :

	Yes / No	Number
Fishermen		
Teachers		
Priests		
Business men		
Farmers		
Nurses		
Soldiers		

Stages of facilitation process :.....

Tools employed :.....

Difficulties / challenges encountered :

Factors contributing to success of activity :

Burning questions / generating themes :

False beliefs :

Non-generating themes :

Needs identified :

Results / changes observed or cited by community :

Conclusions reached / decisions made (by community) :

Date

Signature.....

Appendix 6 : Supervision form (format)

SUPERVISION FORM FOR “COMMUNITY CONVERSATIONS”

Name of supervisor.....
Visit date
Site visited
Names of facilitators present.....

Number of CCs facilitated.....
Number of CC reports : a) written..... b) sent to UNHCR..... c) received.....
Planned itinerary for CCs (eg every Saturday morning).....
Location of CCs.....
Facilitators' needs for CC facilitation.....
Explain support of the site president.....
Explain support of the community.....
Explain community reaction to CCs.....
Who publicises the activities and how ?.....
Who speaks out during CCs (men, women, children... ?).....
Difficulties encountered.....
Tools / concepts / aptitudes which have been useful and why?.....
Tools / concepts / aptitudes which have not been useful and why?.....
Concepts / tools which facilitators would like clarified more fully.....
Results / successes achieved with this approach.....
How do you feel to be facilitating these activities ?.....
Other facilitators' comments.....

Problems encountered by supervisors.....

Understanding of approach :	Very good	<input type="checkbox"/>	Satisfactory	<input type="checkbox"/>
	Good	<input type="checkbox"/>	Bad	<input type="checkbox"/>
Quality of reports written :	Very good	<input type="checkbox"/>	Satisfactory	<input type="checkbox"/>
	Good	<input type="checkbox"/>	Bad	<input type="checkbox"/>

Actions taken.....

Actions to be taken.....

Date.....

Signature.....