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SCALING-UP HIV/AIDS INTERVENTIONS THROUGH EXPANDED PARTNERSHIPS (STEPs) IN MALAWI

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Abstract

This paper discusses enabling and constraining factors related to the scaling-up of the Scaling Up HIV/AIDS Interventions Through Expanded Partnerships (STEPs) initiative, supported by Save the Children U.S.A. (SC), to combat HIV/AIDS in Malawi. It also discusses potential threats to and contextual factors limiting scaling up of STEPs. The report draws primarily upon the available literature and qualitative data collected during a five-day visit to SC Malawi in December 2002.

STEPs started in 1995 as Community-Based Options for Protection and Empowerment (COPE). COPE was a service-delivery program in Mangochi District to assist children affected by HIV/AIDS. Through evaluations, SC realized that such an approach was unsustainable, not cost-effective, and not scalable. Based on the recommendations of the evaluations and on field experience, the program changed course to mobilize collective action to combat the epidemic. Working in the Namwera community in Mangochi under the National AIDS Commission (NAC), STEPs revitalized the dormant decentralized AIDS committees and their technical subcommittees at the district, community, and village levels.

Based on the positive experience in Namwera, the program changed its initial strategy to that of an external change agent, assisting communities with community mobilization and capacity building so that communities became empowered to act collectively to address their problems. Village AIDS committees (VACs) first identify the vulnerable. Then VACs plan responses on the basis of the nature and magnitude of vulnerability within the villages, needs of the vulnerable, and capacity within villages to respond. The committees also monitor activities and mobilize resources. As the needs of the most affected communities are crosscutting, the program has become truly multisectoral, with activities along the continuum of prevention, care, support, and mitigation. STEPs has also been influencing national policies related to HIV/AIDS and children.

STEPs is now active in four districts and aims to expand to two more by 2005 to cover 15 percent of Malawi's population. Through partnerships and by training other NGOs/CBOs in STEPs' community mobilization model, STEPs and similar models are envisioned to cover 75 percent of Malawi's population by 2005.

Contextual factors critical for scaling-up include an enabling policy environment with a strong commitment of the current government, especially NAC, to a multisectoral approach to combating HIV/AIDS. Organizational factors enabling scaling-up include a well-trained and motivated staff; adoption of a community mobilization model through capacity building of district, community, and village AIDS committees; commitment to documenting and disseminating lessons learned; and reaching more affected populations through partnerships. Factors specific to communities include leadership within the community, whether the communities are urban or rural (rural communities are easier to mobilize), the nature of livelihoods, and the history and culture of the communities with respect to collective action. Planning along with the communities for a phasing down of SC's presence and scaling up of the role and responsibilities of the AIDS committees and funding mechanisms have also been identified as critical in enabling and sustainably scaling up collective action.

Important factors that threaten or limit the scaling-up of STEPs include the magnitude of the epidemic, which is eroding community resources; the current food crisis, which is diverting resources to sheer survival; the gap between the resources that communities need and what they have, which undermines the spirit of volunteerism; weak commitment of donors to a truly community-driven multisectoral response; and the overall context of poverty and underdevelopment, which makes it more difficult to mobilize communities and build their capacities to respond to the multiple challenges of the AIDS epidemic.

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Acronyms

CAC	Community AIDS Committee
CBCC	Community-Based Childcare Centers
CBO	Community-Based Organizations
CI	Chronically ill
COPE	Community-Based Options for Protection and Empowerment
DACC	District AIDS Coordinating Committee
HBC	Home-Based Care
NAC	National AIDS Committee
NACC	Namwera AIDS Coordinating Committee
NGO	Nongovernmental Organizations
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV/AIDS
RAC	Residential AIDS Committee
SC	Save the Children U.S.A.
STEPs	Scaling-up HIV/AIDS Interventions Through Expanded Partnerships
TSC	Technical subcommittee
VAC	Village AIDS Committee

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Key words: scaling-up, community mobilization, HIV/AIDS, Malawi

1. Introduction

Save the Children U.S.A. (SC) is supporting the scaling up of a multisectoral initiative in Malawi to address the challenges that communities and households face due to HIV/AIDS. Scaling up HIV/AIDS Interventions Through Expanded Partnerships (STEPs)[1] is essentially a community mobilization and capacity building approach to address these challenges. The primary purpose of this paper is to examine the scaling up process of STEPs and the factors that are constraining and facilitating this process. Using qualitative methods and a review of the literature, this paper discusses

- the magnitude and the impacts of the HIV/AIDS epidemic regionally and in Malawi;
- Malawi's national response to the pandemic;
- the pilot project and the evolution of the program's community mobilization model (formerly known as COPE);
- scaling up of STEPs and progress to date;
- factors that have facilitated or constrained the scaling-up process, including the catalysts, institutional arrangements, organizational capacities, community-level factors, and financing;
- threats to scaling-up, including HIV/AIDS, the ongoing food crisis in the context of widespread and deep poverty, and underdevelopment.

HIV/AIDS and Children in Sub-Saharan Africa

The scale and impact of HIV/AIDS in Sub-Saharan Africa are by far the largest in the world. Home to an estimated 26.6 million of the 34–46 million people living with HIV/AIDS worldwide, and with 3.2 million new infections and 2.3 million deaths in

[1] Until June 2003, STEPs was known as Community-Based Options for Protection and Empowerment (COPE). However, because of the legal issues involved in the use of the acronym, COPE, due to copyrights, we use STEPs throughout the paper. However, readers should interpret STEPs as COPE before June 2003.

2003, the epidemic continues to grow in the region (UNAIDS 2003). Over 3 million children under age 15 live with HIV in Sub-Saharan Africa (UNAIDS 2002).

In 1980, barely 2 percent of African children were orphans. By the end of 2001, 13.4 million children under 15 years of age had lost one or both parents to AIDS. Currently, 12 percent of all children in the region are orphans, with 10 countries having orphan rates of over 15 percent, more than three-quarters due to AIDS. By 2010, it is estimated that orphans from all causes will number 42 million, about 20–25 million of whom will be orphaned by AIDS (USAID/UNICEF/UNAIDS 2002).

The impact of HIV/AIDS on children is severe and long lasting (see Box 1). Traditionally, extended families absorbed children who lost one or both parents, but now swelling numbers of orphans and the demise of caregivers in the context of worsening poverty is placing an enormous strain on extended families (Haddad and Gillespie 2001; Foster and Williamson 2000; Dieninger, Garcia, and Subbarao 2001; Shah et al. 2002). The general decline of living standards is also an increasingly exacerbating vulnerability of many non-orphans to malnutrition, illiteracy, child labor, and exploitation.

Box 1: Impacts of HIV/AIDS on Children

- **Psychosocial distress** due to parents' illness and death compounded by pervasive stigma and shame attached to HIV/AIDS;
- **Economic hardship** due to loss of income and increased expenditures; children are forced to take on the adult responsibility of supporting the family;
- **Withdrawal from school** to earn and care for siblings and sick parents;
- **Malnutrition and illness** due to generalized poverty and extreme vulnerability to poverty and to neglect and discrimination by adults;
- **Loss of inheritance** due to property grabbing or lack of laws (or their enforcement) to protect children;
- **Fear and isolation**;
- **Increased abuse and risk of contracting HIV** as many children are forced into exploitive and dangerous work—including exchanging sex for money, food, "protection," and shelter.

Source: Adapted from UNICEF 2002.

The most affected countries are those least able to afford to build and maintain the capacity to respond at a level commensurate with the magnitude and complexity of the

epidemic. HIV/AIDS is fast eroding institutional capacities to respond. Nongovernmental organizations (NGOs) have been highly influential in thinking and shaping the response to the epidemic, but their programs tend to be small-scale (DeJong 2003).

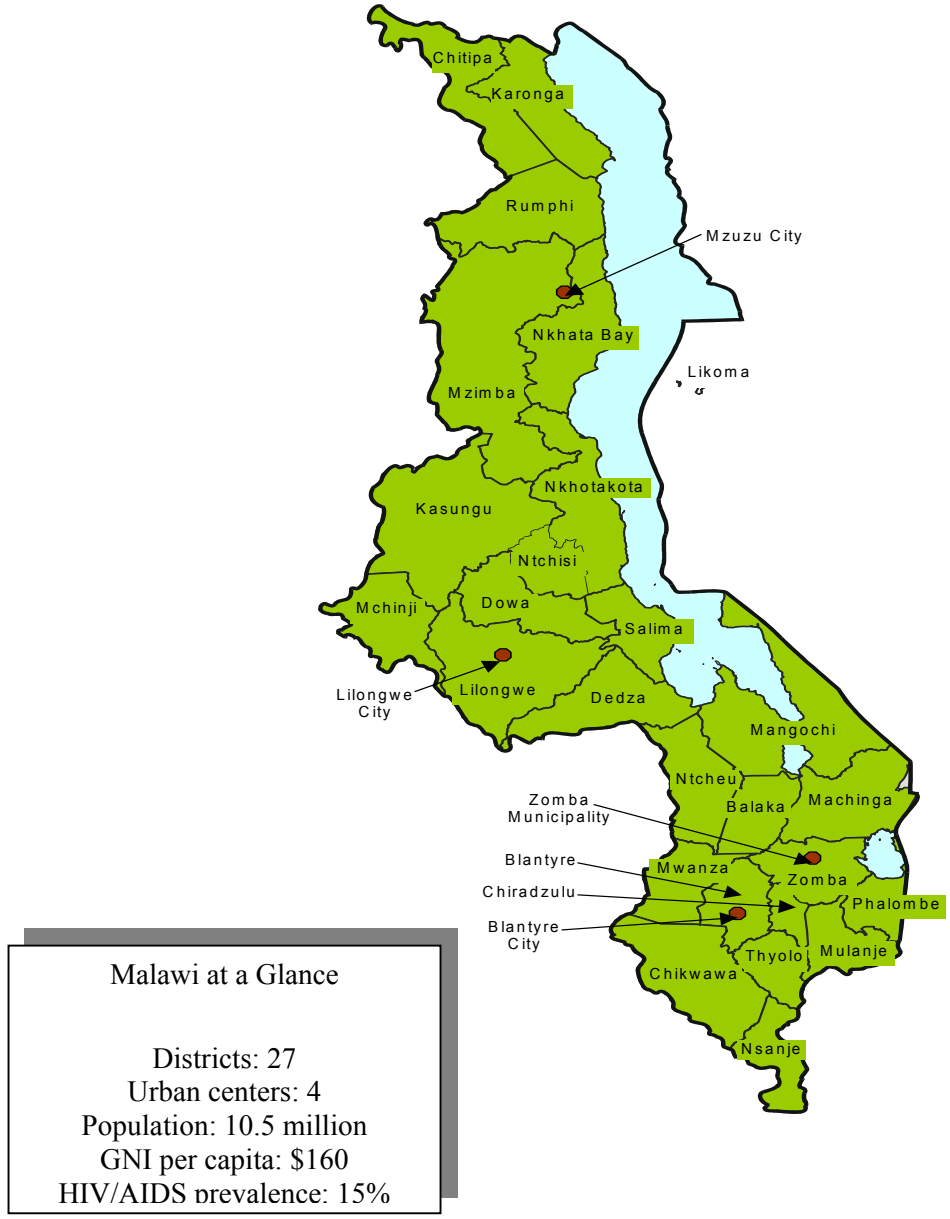
Understanding community responses and capacities is a crucial first step in developing a long-term, comprehensive, and expanded strategy. While there are several studies of community-driven responses to HIV/AIDS (Mutangadura, Mukurazita, and Jackson 1999; White 2002; Silomba 2002; Foster 2002; Hamazakaza and Kauseni 2002; Hsu, Du Guerny, and Marco 2002), there are only limited analyses of experiences in scaling up such initiatives (Hunter 2002; Phiri, Foster, and Nzima 2001; International HIV/AIDS Alliance 2002). This report focuses on this aspect of scaling up and aims to add to the understanding of the process.

Background Information on Malawi

About 60 percent of Malawi's 10.5 million people are below the national poverty line (See Figure 1). Malawi ranks among the 15 poorest countries in the world, with a Human Development Index ranking of 163 out of 173 countries (World Bank 2003a; see Table 1).

Agriculture is the backbone of the Malawian economy, with 85 percent of the population living in rural areas. About 80 percent of the labor force is employed in subsistence farming, contributing 65 percent of GDP. Subsistence agriculture is seasonal, rainfed, and directly affected by pressures on the labor force. Due to poverty, landlessness, and lack of alternate income-generating opportunities, households engage in *ganyu,* or piecework. As the remuneration tends to be meager, households are often locked in a vicious cycle of poverty. Malawi's Gini-coefficient is 0.62, reflecting high income inequality. Differences in resource endowments, access to credit, use of technology, and resultant low productivity along with government policies that have

Figure 1—Map of Malawi



tended to favor the development of large-scale farming at the expense of small-scale agriculture are root causes (IFPRI 1998).

Table 1—Human Development Indicators: Malawi

Indicators	Malawi
Percent of population below national poverty line	60
GNI per capita	$160
Rural population (percent of total population)	85
Illiteracy (percent of population age 15+)	40
Life expectancy at birth (years)	39
Infant mortality rate (per 1,000 live births)	117
Maternal mortality rate (per 100,000 live births)	1,100
Height/age-stunting (percent of total population)	49
Fertility rate (births per 1,000 women per year)	6.6

Source: World Bank 2003a for population and economic indicators; UNICEF (2002) for nutrition and health indicators (http://www.unicef.org/statis/Country_1Page112.html).

HIV/AIDS in Malawi: Magnitude and Impacts

The national HIV prevalence rate is an estimated 15 percent, with 80,000 deaths occurring due to AIDS just in 2001. The epidemic affects women disproportionately, with 56 percent of all adults infected being women (see Figure 2). Of those living with HIV, about 8 percent are children below age 15. The high HIV rates in women, combined with high fertility rates, suggest that future vertical transmission rates could increase significantly. The HIV/AIDS prevalence rates vary by regions—18 percent in the southern region, 11 percent in the central region, and 9 percent in the northern regions. The highest rate of HIV/AIDS is in the most food-insecure, highly agriculture-dependent southern region.

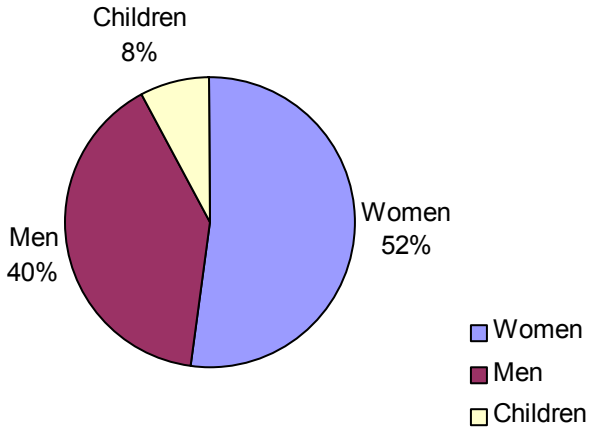
About 470,000 children have lost one or both parents (UNAIDS 2002). In 1995, 14 percent of all children were orphans in Malawi. By 2001, this proportion had risen to 17.5 percent. About 50 percent of orphaning is due to AIDS (USAID/UNICEF/UNAIDS 2002).

The immediate effects of the crisis are staggering. HIV/AIDS accounts for 70 percent of all inpatient hospital admissions and consumes a growing percentage of the

national budget due to lost productivity and increased costs in all public sectors. Life expectancy at birth has dropped from 43 years in 1996 to 39 years in 2000 (World Bank 2003b).

Shah et al. (2002) show that a large proportion of rural households (22–64 percent) are affected by HIV/AIDS. They found that affected households experienced loss of labor (up to 70 percent), delayed agricultural operations, and leaving the land fallow. The results were delayed agricultural productivity, increased dependence on *ganyu*, and increased indebtedness. Ngwira, Bota, and Loevinsohn (2001) elaborate on how micro, meso, and microenvironments contribute to both susceptibility to HIV and vulnerability to AIDS impacts in Malawi.

Figure 2—Proportion of men, women, and children living with HIV/AIDS in Malawi



Source: Constructed from UNAIDS 2002 data.

The National Response: An Enabling Environment

"Government should support the creation of a conducive environment for effective mobilization and utilization of resources, for partnerships to form and for change to occur in those behaviors, values, beliefs and norms which put Malawians at risk of HIV infection."

> "The guiding principle of implementation of the Framework (National Strategic Framework) is collective action through partnerships, their delivery, monitoring and evaluation."
>
> —National AIDS Committee (NAC) 1999

The Government of Malawi has made notable responses to HIV/AIDS. In 1989, under the Ministry of Health and Population, the government established a National AIDS Control Program (NACP) and a National AIDS Secretariat (NAS) to provide technical leadership in HIV/AIDS programs. NACP's main strategy was blood screening and HIV/AIDS awareness creation (NAC 1999). Throughout the 1990s, NACP's response was primarily biomedical.

In 1994, NACP and UNICEF developed the concept of a national network of AIDS committees at district, community (health catchment area), and village levels—the DACC (District AIDS Coordinating Committee) Initiative. These AIDS committees were to be developed involving representatives of the government, NGOs, religious organizations, the private sector, and other interested parties (these structures are discussed in detail in Section 4).

The Malawian president declared AIDS a national emergency in 1999. Malawi adopted a more comprehensive National HIV/AIDS Strategic Framework (NSF) in October 1999 for the years 2000–2004. Developed through a highly participatory process, including NGOs and religious leaders, NSF identified the following nine priority program areas (NAC 1999):

1. Facilitating changes in cultural values/norms to reduce the spread of AIDS;
2. Strengthening dialogue with youth to promote responsible behavior;
3. Empowering vulnerable groups to resist behavior harmful to their health status;
4. Promoting love, care, and support for those infected by or living with HIV/AIDS;
5. Implementing effective, multisectoral mitigation plans in the home, hospital, and workplace;
6. Caring for orphans, widows, and widowers;

7. Strengthening the effectiveness of HIV prevention programs;
8. Establishing a comprehensive and effective information, education, and communication strategy to reduce the spread of HIV; and
9. Increasing accessibility of VCT services for men, women, and youth.

NSF is based on the premise that effective action requires a multisectoral approach, implemented by a wide spectrum of partners encompassing the public and private sectors, civil society, and faith communities.

In July 2001, the National AIDS Commission (NAC) was established, mainly through restructuring of the NACP. NAC is responsible for

- coordinating the national response;
- providing technical and financial support to implementing agencies;
- mobilizing resources to support the various initiatives underway against HIV/AIDS; and
- monitoring and evaluating the progress and impact of HIV/AIDS prevention, care, and impact mitigation.

NAC's 19 board commissioners are drawn from civil society and public and private sectors. NAC also convenes and chairs the Technical HIV/AIDS Working Group (TWG), composed of the government, NGOs, and donors. These subgroups participated in the development of the national proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria, approved in 2002 (NAC 1999; World Bank 2003b).

More recently, a Cabinet Committee on HIV/AIDS Prevention and Care was formed to provide policy and political direction to NAC. The cabinet committee is chaired by the Vice President of the Republic of Malawi, with the Minister of Health and Population as the Vice Chair (NAC 1999).

A study by the Policy Project showed that the policy environment in Malawi improved greatly across seven indicators, with the score for political support rising from 52.1 in 1998 to 70.9 in 2000 (Policy Project 2000; see Table 2).

Table 2—Changes in AIDS policy environment in Malawi, 1998–2000

	Political support	Policy formulation	Organization	Program resources	Evaluation and research	Legal and regulatory	Program components	AIDS policy environment score
2000	70.9	74.2	74.5	62.5	69.7	86.3	69.4	**72.5**
1998	52.1	53.7	61.0	50.7	62.3	83.6	62.2	**60.8**

Source: Policy Project 2000.

2. Objective and Methods

Objective

The broad objective of the study is to examine the factors and processes facilitating and constraining the scaling-up of STEPs in Malawi.

Methodology

This report is based on the literature available on STEPs and qualitative data collected during a five-day visit to SC Malawi and its project areas in Lilongwe and Nkhotakota districts in December 2002. In addition, discussions were held with the executive director of NAC and a few of SC's partner organizations (see Appendix 1). The qualitative data collection methods employed were focus group discussions, key informant interviews, and observations. A checklist of questions (an adapted version of the checklist in the overview) guided discussions (see Appendix 2).

Structure of the Report

The report is structured as follows:

- Section 3 describes the history of STEPs and gives an overview of the various phases of STEPs.
- Section 4 describes the pilot project and the evolution of the program's community mobilization model.

- Section 5 describes the scaling-up of STEPs, discussing in detail the refined community mobilization approach, program activities, and impacts.
- Section 6 discusses the scaling-up process, the communities themselves, and various dimensions of scaling-up.
- Section 7 discusses current and planned institutional arrangements for scaling-up.
- Sections 8 and 9 examine the organization- and community-level capacities required for scaling-up.
- Section 10 highlights potential threats to scaling-up.
- Section 11 discusses the context roof limiting scaling-up.
- Section XII presents conclusions.

3. History and Overview of STEPs

The origins of STEPs are rooted in SC' s experience in working with traumatized orphan children during the Mozambique conflict. The Traumatized Orphan Children (TOC) program was a cross-border program (operating in the refugee camps in Malawi and Zimbabwe and in internally displaced persons camps in Mozambique) that aimed to reunify unaccompanied children with their families. The TOC program placed unaccompanied children either with substitute families or in temporary shelters until their reunion with their family members. Psychosocial and sometimes material assistance, such as school fees and blankets, were provided. About 20,000 unaccompanied children were reunited at the end of the Mozambique war.

SC wanted to apply this experience to other situations. HIV/AIDS was beginning to be a major cause of orphanhood and vulnerability in the region. About 14 percent of Malawi's children were orphans, a quarter of them due to AIDS in 1995 (USAID/UNICEF/UNAIDS 2002). SC initiated a pilot project in Mangochi district, Malawi, to assist orphans and vulnerable children (OVCs) in 1995.

The first stage of STEPs[2] started with funding from USAID's Displaced Children and Orphan's Fund (DCOF) with a commitment of $538,000 for a period of two years, July 1995–July 1997. SC initiated the project in three communities of Mangochi district, (Mangochi Boma, Namwera, and Monkey Bay) in two phases: Phase 1 (July 1995–September 1996) and Phase 2 (October 1996–July 1997). Building on these experiences, and with funding from USAID ($1,619,000), the second stage of the program was initiated and underway from July 1997–September 2002, involving expansion to three more districts: Lilongwe, Dedza, and Nkhota-Kota, covering 302 villages and 9 percent of Malawi's population.

The program is now in its third stage (STEPs), and mainly funded by Hope for African Children Initiative (HACI), a global consortium comprising World Vision International, Care International, Save the Children Alliance, Plan International, and World Council for Religion and Peace. Currently, the Melinda and Bill Gates Foundation funds HACI. STEPs (2002–05) aims to scale up its coverage to 15 percent of the population. In addition, through its partners, SC aims to cover about 75 percent of the population with STEPs and STEPs-like initiatives by partnering with other organizations and the government. STEPs will be the first such partnership program in Sub-Saharan Africa to take up the challenge of going to a national scale.

4. Evolution of the Community Mobilization Model

The Pilot: Stage I Phase 1 (SC as the Implementor)

A needs assessment conducted in Mangochi in 1994, to determine the nature and extent of the needs of HIV/AIDS-affected children and families, preceded the development of the pilot project. Using the results of the assessment, SC designed the project in 1995 to

[2] The phrases first stage and second stage are used for convenience. They were formerly called COPE I and COPE II, respectively.

> "…improve the immediate conditions and long-term prospects for care and healthy development of children affected by AIDS in three communities in Mangochi, promoting a sound policy development and implementation alongside viable program interventions that can be adapted at the national level" (Hunter 2002).

In Phase 1 of the pilot, 15 SC personnel were posted in Mangochi. They designed and implemented a range of interventions through village AIDS committees on a pilot basis in nine semi-urban villages around Mangochi. According to program staff, the pilot did not realize its multisectoral goal due to its input-intensive interventions. The primary focus remained the enumeration of orphans and the provision of psychosocial (e.g., recreational activities) and material support (e.g., providing school fees).

A process evaluation of the pilot identified two challenges with its approach as a service provider and implementer (Donahue and Williamson 1996). First, the cost per beneficiary, estimated at $162, was too high to go to scale in Malawi. Second, there was uncertainty as to whether community volunteers would continue the initiated activities once the program staff withdrew from the communities.

The Pilot: Stage I Phase 2 (SC as Change Agent)

In the second phase, the program adopted a different approach in Mangochi's Namwera community, based on the recommendations of the above evaluation. SC reduced its program staff in Mangochi to nine. In Namwera, SC changed the focus from an implementer to that of an outside change agent: assisting communities with community mobilization and capacity building so that communities become empowered to act collectively to address their problems. The program worked through the decentralized AIDS committee structures of NAC to accomplish this goal.

The Community Mobilization Model: Working through DACC/CAC/VAC

In 1994, NAC, with UNICEF, started the DACC initiative by developing the concept of decentralized AIDS committees: district AIDS coordinating committees (DACCs) at the district level, community AIDS committees at the health catchment area

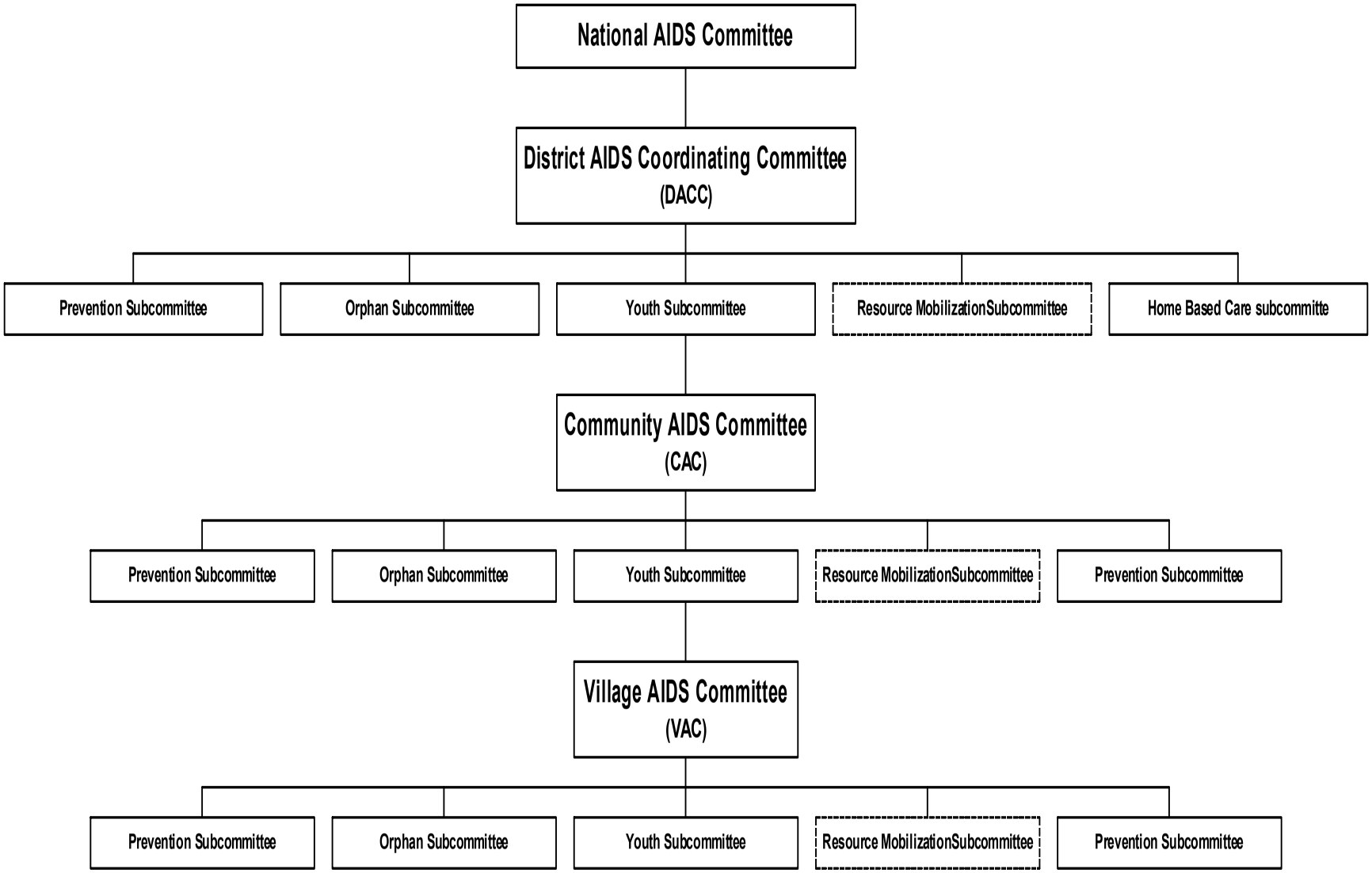
level (CACs), and village AIDS committees (VACs) at the village level. The aim of the DACC initiative was to organize all frontline ministries and NGOs within a district to coordinate their HIV/AIDS activities to maximize resources and responsibilities and avoid duplication of effort.

The DACCs were to mobilize communities to form CACs, which would mobilize villages to form VACs. The committees at each level were to be multisectoral with representation from the government ministries, NGOs, religious bodies, and the private sector. At each level, the committees were to comprise four technical subcommittees (TSC): home-based care, youth, high-risk group, and orphans. These TSCs, at each level, were responsible for identifying problems faced by AIDS-affected families within the community/village and for developing, implementing, and monitor responses to these problems. Each TSC was also responsible for training and capacity building the TSCs at the next level (Figure 3). In practice, however, the top down approach, lack of follow-up support, and few resources provided to implement the mandate resulted in little happening below the DACC level (Phiri, Foster, and Nzima 2001; Williamson and Donahue 2001). TSC activities, mostly of the youth and orphans TSCs, were sporadic.

With the experience of Phase 1 of the pilot, SC recognized the potential of working through these already existing DACC/CAC/VAC structures, other faith-based organizations, and CBOs and NGOs in responding to the epidemic. In Namwera, SC mobilized the CAC, Namwera AIDS Coordination Committee (NACC). SC assisted in capacity building and technical training of NACC. NACC, along with the program, mobilized VACs. The program also facilitated NACC partnerships with other organizations to access various resources. The mobilized communities were envisioned to

- identify problems resulting from the HIV/AIDS crisis,
- develop a plan to address the problem,
  mobilize internal resources,

Figure 3—NAC/DACC/CAC/VAC structure



Note: ---- Indicates STEPs's innovation in COPE II.

- implement activities, and
- advocate on their behalf and thus facilitate establishment and linkages with the government offices, NGOs, donors, and other organizations.

In 1997, NACC with the support of SC, mobilized 16 VACs with 229 active members. The program withdrew from Namwera within eight months. NACC mobilized eight additional villages on its own. NACC evolved from an AIDS committee to a CBO (Williamson and Donahue 1998; Phiri, Foster, and Nzima 2001).

Retrospective assessments by Williams et al. (2000) compared Namwera VACs that participated in the program with villages that did not participate. The assessment found that compared to the nonparticipating villages, the participating villages exhibited

- increased openness about the impact of HIV/AIDS on orphans and other vulnerable groups,
- increased awareness that care for the vulnerable is a community, not just a household, responsibility, and
- continued commitment to respond to HIV/AIDS, even after SC discontinued active support.

However, despite these encouraging achievements, both assessments identified

- inadequate skills and resources at the community level to improve efforts to combat HIV/AIDS,
- distrust toward NACC and low morale among community members, and
- difficulty of NACC in making its role and status clear to some village members.

5. Scaling Up to STEPs: Stage II and STEPs

Since Stage I Phase 2 of the pilot, the strategic objective of the program has been "to mobilize community action to mitigate the impact of HIV/AIDS" (Hunter 2002). The

initiative's strategy as a change agent was fully consolidated during the second stage of the program.

> [STEPs] facilitates the development of effective multisectoral responses, uniting government and nongovernmental organization personnel, religious leaders, businesspersons and concerned community members in efforts to address the needs of children and families affected by the HIV/AIDS pandemic. [STEPs] seeks to accomplish this goal through strengthening capacities of communities, community institutions and organizations and government offices and personnel (Hunter 2002).

SC refined its community mobilization strategies (see following section) and developed training manuals for each TSC. SC retained only two program staff at each of the four districts: the area mobilizers and the economic opportunity promoters. Since 1997, SC has been exploring opportunities to expand partnerships with other organizations. By 2005, STEPs aims to expand to a total of six districts and to build effective partnerships so that other organizations could adopt STEPs-like strategies in other regions.

According to Opoku and Kachiza (2000), the objectives of the program between 1997 and 2002 were the following:

- strengthening community capacity to prevent the spread and mitigate the impact of HIV/AIDS on children and their families,
- strengthening government capacity to lead and sustain effective community responses to the needs of children and families affected by HIV/AIDS,
- strengthening community-based institutions and organizations to provide and support community care for children and families affected by HIV/AIDS,
- examining the program progress critically and documenting and disseminating findings and lessons learned, and
- advocating for policy change that benefits children and families affected by HIV/AIDS at national, district, and local levels.

The Community Action Cycle for Community Mobilization

STEPs's community mobilization strategy adopts three main participatory methodologies: participatory learning and action, training for transformation, and stepping stones (SC 2003). The three core principles underlying the program's community mobilization are communication, respect for culture, and involvement of persons living with HIV/AIDS. The basic community mobilization model is a six-step community action cycle and is presented below (SC 2003).

1. **Preparing to mobilize**. Define the community that will be mobilized, select and develop the STEPs mobilization team, learn more about the HIV/AIDS issues and current beliefs and practices, and build rapport at the district level and with communities.
2. **Organizing the community for action**. Initiate contact with leaders and the community, orient the community and invite participation, discover the community's strengths, and organize groups for action.
3. **Exploring HIV/AIDS issues, focusing and setting priorities for action**. Explore HIV/AIDS with the core group and with the core group in the wider community; analyze the information and set priorities for action.
4. **Planning in collaboration with community and STEPs-Malawi staff**. Form TSCs, identify roles and responsibilities for each TSC and individuals; plan collectively, defining areas and strategies for action and setting time lines.
5. **Community action to implement plans**. Provide care to OVCs, the chronically sick, and other vulnerable people; develop approaches to fund-raising; provide training to community members; establish partnerships and linkages to existing external resources.
6. **Collaborative evaluation of the impact of the actions on community members**. Develop community-based monitoring systems; train district leaders to collect data on activities and provide feedback to communities and villages; develop an evaluation plan, an evaluation team, and instruments; analyze results,

provide feedback to the community to validate results, and share and disseminate lessons learned.

Activities at District, Community, and Village Levels

The main role of the district SC staff in STEPs can be summarized as facilitators for development of networking, resource mobilization, and leadership skills at district, community, and village levels. These skills enable members of the DACC/CAC/VACs to understand the needs of their communities, identify available resources, and lead a collective response to address the identified needs.

The DACC TSCs are responsible for capacity building of CACs and VACs and assisting them with coordination and monitoring of their activities. The responsibilities of CACs and VACs are roughly the same: to identify problems of HIV/AIDS-affected households and children in the area and develop, implement, and monitor responses to the interventions. The CACs work closely with VACs within their area, providing them leadership, training, and support for their local-level efforts (see Table 3 on the composition and responsibilities of DACC/CAC /VACs). The VACs directly implement the interventions at the village level. According to Hunter (2002) and field visits (see, also, Box 2), key activities include the following:

1. **Identification, targeting, and monitoring the vulnerable**. VACs enumerate the households within their village, identify families and children most in need of assistance, and target resources and services to them.
2. **Planning**. VACs plan responses on the basis of the nature and magnitude of vulnerability within the villages, the needs of the vulnerable, and identification of capacity within the villages.
3. **Collective action to meet the needs of the vulnerable**. Working in collaboration with SC and CACs and VACs to organize services for the vulnerable. These include:

Table 3—Composition and responsibilities of DACC/CAC/VACs

Level	Composition	Responsibilities
DACC	• District health, education, agriculture, social welfare and youth officers • District Assembly members • Business leaders, religious/ political leaders • Business leaders • NGOs • People living with and affected by HIV/AIDS	• Create dialogue in the district on HIV/AIDS • Create linkages and coordinate HIV/AIDS activities • Monitor quality and reach of HIV/AIDS activities in the district through TSCs • Build capacity of villages to address their HIV/AIDS needs (e.g., TSCs, leadership, advocacy and community mobilization training, fundraising skills) • Facilitate community- and village-level access to financial, technical, and other resources • Help VACs identify needs, strengths, and solutions • Support advocacy efforts of communities and villages
CAC	• Community health, education, social welfare and youth officers • Traditional leaders, religious/ political leaders • VAC representatives • Business leaders • CBOs, etc • People living with and affected by HIV/AIDS	• Create dialogue in communities on HIV/AIDS • Identify community resources; build on strengths to develop appropriate solutions • Create and support linkages between HIV/AIDS activities at the community and village level • Monitor quality and reach of HIV/AIDS activities at the community and village level • Build capacity of villages to address their HIV/AIDS needs (e.g., TSCs, leadership, advocacy and community mobilization training, fund-raising skills) • Reach out through TSCs to those affected by HIV/AIDS • Facilitate village-level access to financial, technical, and other resources through funding proposals or community-based fund-raising • Help VACs identify needs and strengths and carry out their proposed action plans • Advocate for the needs and concerns of the VACs to the DACC • Facilitate exchange of lessons learned among CACs and VACs
VAC	• People and families affected by HIV/AIDS • Traditional leaders • Village organizations • Traditional healers • Youth • Traditional initiators • Traditional birth attendants	• Create dialogue in villages on HIV/AIDS • Identify community resources • Develop action plan and build capacity of a village to sustainably implement • Reach out to those affected by HIV/AIDS through TSCs • Monitor quality of HIV/AIDS activities in the village • Advocate for village concerns and issues at the CAC and DACC • Conduct community-based fundraising activities to meet village needs

Source: SC 2003.

Box 2: Examples of Activities of CACs and VACs Visited

- Assessing their needs and resource mapping
- Prioritizing actions
- Enumerating OVCs and vulnerable families
- Establishing community-based childcare centers (CBCCS). For example, Kanyambo VAC in Nkhotakota built a CBCC structure with bricks. The CBCC volunteers engage children in various activities.
- Establishing community gardens to benefit OVCs and vulnerable families. For example, Kafuzira CAC and Kanyambo VAC in Nkhotakota established community gardens to grow maize, cassava, and a few other vegetables.
- Establishing anti-AIDS youth clubs. For example, Lumbadzi CAC and Nkhotakota DACC facilitated establishment of youth clubs with the objectives of keeping youth busy, providing an enabling environment to discuss issues surrounding sexuality, and disseminating prevention messages through drama and songs.
- Providing HBC to chronically sick people. This includes provision of basic drugs, if available, helping families of the sick with household chores, moral support, and referral to hospitals and PLWHA groups.
- Making memory books. For example, Kanyambo VAC is a part of the memory book pilot project in Nkhotakota.
- Mobilizing other CACs and VACS through outreach activities such as dramas and songs.
- Mobilizing resources through a number of activities such as walkathons, writing grant proposals, and approaching other organizations for assistance, sales of various goods, etc.
- Organizing open days so other communities could come and observe CAC/VAC activities.
- Identifying the vulnerable; implementing and monitoring emergency food aid distribution.

- *Sustaining livelihoods* (e.g., provision and cultivation of communal fields, agricultural inputs, extension training, microcredit and savings),
- *Education* (e.g., community-based childcare centers, building schools, and assistance to the needy children for primary and secondary schooling),
- *Health* (e.g., HBC for PLWHAs, referrals for adults and children in need of care),
- *Psychosocial assistance* (e.g., social integration of orphans and PLWHAs, visiting homes of PLWHAs, security and protection of OVCs, counseling of guardians and children).

- *Prevention* (e.g., behavioral change communication, life-skills training, peer education, condom distribution), and
- *Activities for youth* (e.g., peer counseling, organizing recreational activities, outreach, participation in decisionmaking, and providing services for the chronically ill and OVCs).

4. **Resource mobilization**. VACs mobilize resources by organizing fund-raising events, accessing small grants from the private and nonprofit sectors, and increasing the productivity of individuals and land within villages (pooling labor, vocational training). In addition, through raising awareness, they aim to generate demand for basic services.

Progress and Impact

Expansion to two more districts under STEPs has been delayed due to the ongoing food crisis. The activities within the four districts continue and their progress until July 2002 is presented below (data from the STEPs MIS system):

- 4 DACCs mobilized;
- 38 CACs mobilized, out of which 4 formed spontaneously[3] in 2001–02;
- 700 VACs mobilized, out of which 49 formed spontaneously in 2000–02;
- 271 youth clubs formed;
- CACs and VACs raised US$13,583 since 1998;
- 28,833 OVCs registered;
- 25 CBCCs established, 12 of which have gardens;
- about 300 VACs are cultivating communal plots to benefit the most vulnerable in their villages;
- 1,902 OVCS returned to school, while 151 found employment; and

[3] CACs and VACs initiated by the community, wherein they organized themselves and initiated mobilization.

- about 35 groups are involved in rotating savings and credit associations.

A series of reviews and qualitative assessments of the initiative were conducted between 1999 and 2002 (Williamson and Donahue 1998, 2001; Feinberg, Serpell, and Williamson 2003; Hunter 2002; Coates 2002). The main findings of these studies and our findings[4] from the field visits are encouraging in terms of the program's ability to enable communities to organize themselves. A summary of these findings is below:

- The initiative is enabling the change in attitudes towards the HIV/AIDS problem (Box 3).
- The initiative is generating significant social capital, reducing the HIV/AIDS stigma (Box 4).

Box 3: The Impact of STEPs on Attitudes

Compared to nonparticpating communities, participating communities exhibit the following:

- better understanding of the link between HIV/AIDS and growing problem of illness and orphanhood,
- acceptance of the problem: they do not blame others,
- acceptance of responsibility to provide care and support to those affected by HIV/AIDS.

Source: Williams et al. 2000 and field observations.

Box 4: The Impact of STEPs on Social Capital

The community mobilization and capacity building resulted in

- VACs resolving their governance problems;
- VACs mobilizing funds and resource people;
- VACs caring for not only orphans but also the elderly and other sick (from whatever the cause) individuals;
- CAC/VACs actively promoting STEPs in other communities;
- Youth active in OVC prevention, protection, and support and HBC activities;
- DACCs and CACs increasingly seeking external resources.

Source: Williamson and Donahue 2001and field observations.

[4] We did not observe any non-STEPs communities.

- Voluntary replication of CACs /VACs shows that communities find the STEPs community mobilization model useful.
- The assessments reported that some women participating in income-generating activities reported diversifying their diet and being able to buy essentials such as school supplies, salt, etc. However, from our observations and past reviews, income-generation and credit activities are the weakest of the activities in the STEPs portfolio. Coates (2002), for example, found that only two of the four districts have groups that accessed credit (Dedza and Lilongwe).
- Evaluations suggest increased demand for health services. Due to the increased capacity of communities, a few district health officers reported increased opportunity for home-care referrals of AIDS-related cases.
- Hunter (2002) calculates the crude intervention cost—by dividing project costs by total number of households in the project area, assuming that the benefits percolate to the entire village—as $75 per household per year and $8 per individual.

Whether the above improvements resulted in better outcomes in terms of reducing the risk of exposure to HIV and mitigating the impact of AIDS has not yet been evaluated. However, empowerment of communities is a key goal in itself. The previous assessments and our field visits show that participating communities are organized and motivated; they accept responsibility of problems and collectively seek solutions.

6. STEP's Scaling-Up Processes

To achieve the goal of scaled-up collective action, STEPs adopts a multipronged approach:

- engaging the communities through the DACC/CAC/VAC structures as discussed in the previous sections,

- participating in shaping the national policies and strategies,
- intensifying strategic partnerships with civil society and NAC to reach a national scale, and
- disseminating STEPs best practices.

A Planned Process

STEPs's scaling-up is planned. The need to scale up was elaborated in the earliest reviews:

> The number of children orphaned and families seriously affected by HIV/AIDS in Malawi is already large and will increase substantially for several years. Unless their problems are addressed on a large scale, extensive socioeconomic difficulties can be expected—perhaps even social instability. It is imperative all parties in a position to act, the government, donors, international organizations, NGOs, businesses, civic associations, religious bodies and community groups—work together to initiate major efforts to significantly reduce these growing problems. The primary significance of initiatives like COPE is the extent to which they can help identify ways to do so (Williamson and Donahue 1998).

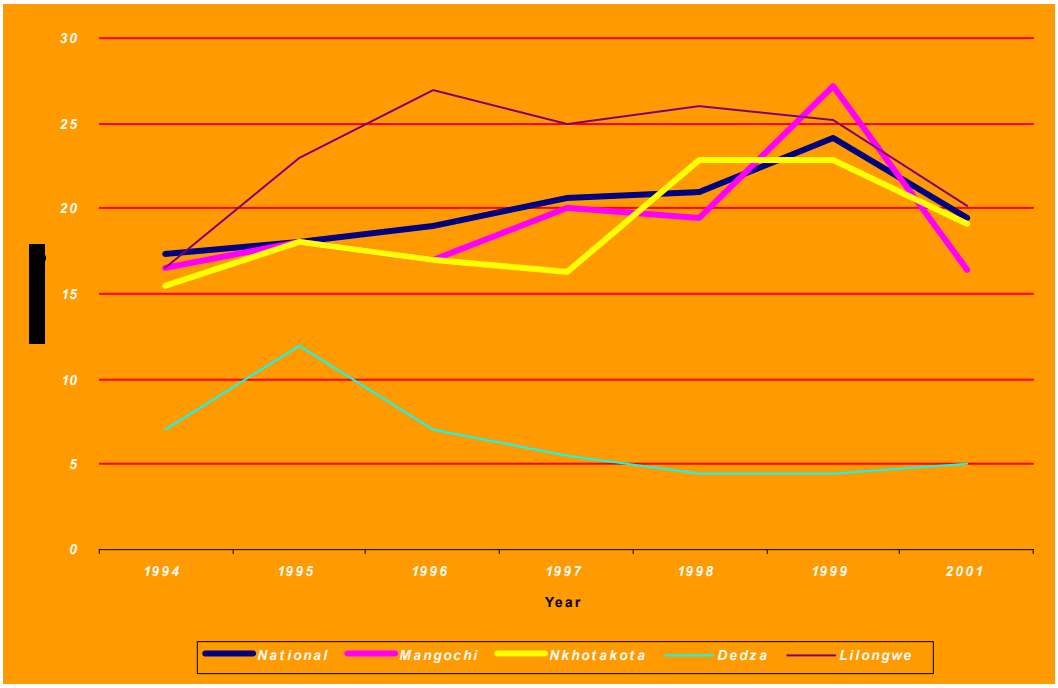
It is, in fact, this long-term view that made the program switch from an input-intensive implementor approach to that of an outside change agent. Expansion to new districts (with the main criteria being high HIV prevalence and absence of other NGOs doing similar work) is planned (see Figure 4). The program's development over the years has been informed by regular assessments and reviews, e.g., a recent study commissioned to understand the factors that determine successful implementation and replication (Hunter 2002).

A Demand-Driven Process: Communities as Catalysts

According to the discussions with the STEPs staff and the CAC and VAC members, within the district, the main catalysts are the communities themselves. According to them, before STEPs, many communities were addressing HIV/AIDS in a

fairly disjointed fashion. SC's initial discussions with the communities showed that the community members felt helpless and ineffective as the scourge progressed. But as they witnessed a much more coordinated effort by STEPs-mobilized CACs/VACs in their neighborhoods, some began to appreciate and demand STEPs services. For example, both Kafuzira and Lumbadzi CAC members informed us that they frequently received requests from villages to help mobilize their VACs. Williamson and Donahue (2001) and Hunter (2002) made similar observations.

Figure 4—HIV prevalence in STEPs districts versus national



Community demand set the pace for scaling-up within the district. "Open days" held by STEPs mobilized VACs and CACs to play an important role in motivating communities to organize themselves. Nkhotakota DACC informed us that, in 2002, three of the nine existing CACs formed spontaneously. Such CACs approach DACC and STEPs for training and capacity building of their TSCs.

A Flexible Process

The first phase of the pilot was primarily an orphan support program. Through the pilot, the program staff and the DACC/CAC/VACs realized the importance of a holistic, multisectoral approach to adequately and sustainably assist the OVCs. The staff noted that in the early phases of the program, village members identified food insecurity as their major concern and one of the main deterrents for effective orphan care. Therefore, food security and other income-generating activities were incorporated into subsequent phases.

A need for proactive and integrated interventions was also elaborated in a review by Williamson and Donahue (2001). Three areas highlighted deserve attention:

- recognizing HBC as a way to prolong parent's lives and to connect care and support of PLWHAs with HIV prevention and protection and assistance of orphans,
- addressing the needs of children well before they become orphans, and
- strengthening the economic resources of households and communities before they are severely affected by HIV/AIDS.

In response to these recommendations, STEPs, with Umoyo Network,[5] is working to improve the HBC component of STEPs (see Box 5). STEPs is also piloting a "succession planning" program. Here, the program encourages discussions between parents/siblings/relatives, through HBC and orphan TSCs, to plan for their eventual deaths. It trained DAC and CAC members in will writing and inheritance rights. The pilot encourages parents to write wills and discuss issues of security and separation from siblings with their children before their deaths. STEPs trained the orphan TSC in preparation of memory books. The purpose is to leave the child a physical reminder of their parents and family. The content of the memory books would depend on the

[5] A network of NGOs working on the population and health issues.

available resources and the priorities of the families. STEPs is planning to initiate systems to protect children from violence and abuse and sensitize teachers about children's problems (Opoku and Kachiza 2000; Hunter 2002). From our field visits, it is clear that STEPs is moving toward a rights-based approach in its programming.

Box 5: Improving the Quality of HBC: A Case of Partnerships

SC, with the Umoyo Network, undertook a national assessment of the HBC services in March 2000. The assessment identified several gaps, including inadequate knowledge and skills of the HBC providers and unavailability of drugs and supplies to the chronically ill. The findings led the program to initiate an activity on behalf of NAC to provide drugs and supplies to the chronically ill on a pilot basis, in addition to training the HBC providers in July 2001. The pilot was conducted in select villages in all the four STEPs-mobilized districts for a period of one year.

In September 2002, SC, with NAC and the Ministry of Health and Population, assessed the effectiveness of the pilot project. Some strengths and challenges identified are summarized below.

Strengths

- The most common drugs (painkillers, aspirin, antimalarial, and multivitamins) are supplied by NGOs.
- There is good storage, inventory, and recordkeeping at the community level.
- Treatment guides and dispensing protocols are being followed.
- Clients took medications according to instructions and felt that drugs relieved their suffering.
- The CAC/VAC and other community members felt that they have a role in sustaining drug supplies by mobilizing resources from communities.

Challenges

- Mechanisms to sustain drug and supplies have not yet been put in place, resulting in an inconsistent supply.
- Referral systems between HBC providers and health facilities were weak, as were linkages between HBC providers and the traditional healers from whom many of the chronically ill seek help.
- Lack of food has been identified as a major limiting factor.
- Communities feel that others, such as the aged, children, and people with emergency medical problems, should have access to drugs.
- The HBC providers perceived drug management to be their core activity as opposed to a holistic approach to care and support of the chronically ill.

Source: Assessment on the effectiveness of drugs and supplies for chronically ill patients in STEPs districts, SC 2002.

Intensifying and expanding partnerships was not envisioned in the initial stages of the program. Until 2001, the program's focus was on its own internal development. Now, informed through the assessments and interactions with NAC and other NGOs, this is the main strategy for STEPs.

Dimensions of Scaling-Up

STEPs primarily adopted a *replication* strategy through the DAC/CAC/VAC structures. However, it is clear that the initiative has many other dimensions of scaling-up (Table 4). By adopting a multisectoral approach, it has scaled up both vertically and horizontally. By increasingly adopting a rights-based community empowerment approach, STEPs is influencing the national policy development. The most important achievements of STEPs in this regard are that it

- played a critical role in drafting National Orphan Care Guidelines;
- coordinated Malawi's first national child abuse study in partnership with the National Task Force on Child Abuse;
- was instrumental in formation of the Wills and Inheritance National Task Force;
- conducted a study on the government policy on wills and inheritance with the Wills and Inheritance National Task Force; and
- actively monitors the orphans, widows, and widowers component of the National Strategic Framework.

Scaling Down to Scale Up

The previous discussion makes it clear that to scale up STEPs to more districts and maintain sustainability, SC had to essentially *scale down* its presence at the district level. In Stage I Phase 2 of the pilot, SC phased out of Namwera within eight months after it began working in the area. Though Namwera continued to function as an independent AIDS coordinating committee, the NACC and its VAC members felt that there was too little time to properly implement the process of mobilization and capacity building (Williams et al. 2000) (also see Box 6). Williams et al. found that NACC and its VACs favored a longer, more gradual phase out, followed by a one-year follow-up period to monitor community performance and to help solve ongoing problems.

Table 4—Dimensions of STEPs's scaling-up

Quantitative scaling-up (or scaling-out)		**STEPs**
Spread	Increasing numbers spontaneously adhering to the organization and its programs, perceiving them to serve their interest/preferences	• Many VACs and CACs are forming spontaneously by demand • Many organizations wanting to adopt the STEPs model
Replication	Successful program (methodology and organizational mode) repeated elsewhere	• Primarily started in Mangochi is now replicated in four districts • Ethiopia (SCUS) and Zambia (CARE) are also replicating the STEPs model
Nurture	Well-staffed and well-funded outside agency, using a specific incentive-based methodology, nurtures local initiatives on an increasingly large scale	
Integration	Program integrated into existing structures and systems and, in particular, government structures after it has demonstrated its potential	• STEPs model is integrated into the decentralized government AIDS committee structures after Phase 1 of the pilot
Functional scaling-up		
Horizontal	Unrelated new activities are added to existing programs, or new programs are undertaken by the same organization	• Now has other activities including food security, resource mobilization that relate to well-being of communities and therefore orphans within the communities
Vertical	Other activities related to the same chain of activities as original are added to existing program (i.e., upward or downward linkages)	• Started with supporting orphans, reducing discrimination and stigma, and prevention • Actively involved in advocacy for OVCs, supporting children (and families) before they become orphans, etc.
Political scaling-up		
First generation	Essentially service delivery	Phase 1 of the pilot
Second generation	Community capacity development for self-reliant action; through better information and mobilization, organization's members or local communities stimulated to participate in the body politic	Since Phase 2 of the pilot
Third	Beyond the community, influence policy reform to foster enabling environment; may involve networking and aggregation of organizations into federative structures designed to influence policy	• SC is currently coordinating a national-level partnership • Played a key role in National HIV/AIDS best practices conference • Member of the National Orphan Task Force of Orphan and played a key role in drafting guidelines for orphan care in Malawi; leading member of Children and Violence Task force; formation of Wills and Inheritance Core group
Fourth	Beyond specific policies, catalyze social movements or direct entry of grassroots organizations, or their leaders, into politics	
Organizational scaling-up		
Internal management	Increasing organizational capacity and improved management processes (links to effectiveness and efficiency)	
Financial viability	Increasing financial viability/autonomy, including self-financing, through subcontracting, consultancy, or fees-for-service	
Institutional diversification	Both internally and externally (including diversification of donors) and linkages with other actors/organizations	• Proactively forms partnerships and alliances with other organizations, including the government. • Currently working on diversification of donors

Box 6: Key Findings from a Retrospective Assessment of the Namwera AIDS Coordinating Committee

- Respondents considered seven months too short a period for the NACC and VACs to implement project activities in Namwera and build adequate capacity for catalyzing community responses.
- The NACC has not been sure about its post-STEPs I role and responsibilities after SC phased out. The VACs have also been unsure about what to expect from the NACC. This created some confusion and misunderstanding. For example, some VACs and community members believe that SC has continued providing materials to the NACC that are not being distributed to the community and that NACC members have been hired to replace STEPs mobilizers.
- Respondents felt that a concrete phase-out plan developed with input from the NACC and VACs would have helped to improve community coordination, sustainability, and trust.
- In addition, a strong local body to provide direction and support to activities at the community level would have minimized the disruption of phaseout.
- The NACC and VACs favor a longer, more gradual phaseout followed by a one-year follow-up period to monitor community performance and help solve ongoing problems.
- This additional time would allow the members of community structures to gain more confidence, acquire additional knowledge and skills, strengthen their networks with other groups, and exchange experiences with other VACs.

Source: Williams et al. 2000.

Based on the experiences in Namwera, the program decided to lengthen its presence in each district to 18 months, maintaining only two staff members in each of the four districts. Our discussions with the program staff revealed that SC originally planned to expand to at least six districts in Stage II by the year 2000. It was to operate in three districts in the first half (18 months) of Stage II. It was to then phase out of these districts and begin operations in the remaining three districts for the next 18 months. This phaseout was expected to be gradual, with the SC program staff gradually handing over responsibilities to DACCs, so that by the end of 18 months, DACC members would be fully equipped to sustain the program.

However, the program staff and the DACC members felt that, while foundations had been laid in these districts, the AIDS committees needed further strengthening. They felt that 18 months had not been sufficient time for the program to fulfill its objectives.

Therefore, Stage II of STEPs reduced the number of districts of implementation from six to four. In our discussions, program staff as well as the DACC members noted that the death and illness would continue to erode community structures. They felt that STEPs might have to continue to train DACC/CAC TSCs to prevent erosion of the AIDS committees. Williamson and Donahue (2001) recommend the program to phase down but not phase out. Our discussions show that the raging food crisis is further eroding the capacities of the communities to become self-reliant, delaying the scaling-up process. As of now, STEPs is not planning to exit from any of the four districts.

> We can't phase out when there is a famine raging. The problem of HIV/AIDS is compounded by the food crisis.
>
> —Justin Opoku, Field Office Director, SC

7. Institutional Arrangements

Many partnerships and alliances continue to be crucial in the scaling-up of STEPs, the most important of which are elucidated below.

Save the Children USA-Government

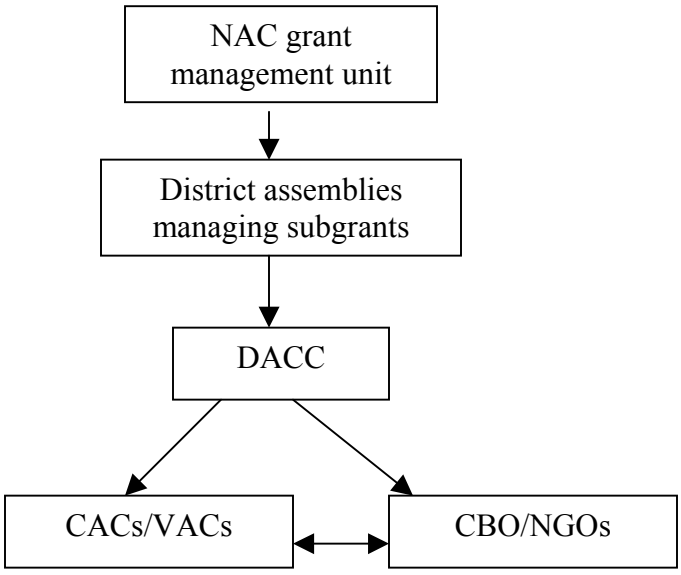
The government's decentralized DACC/CAC/VAC structures are STEPs's key partners. This has many advantages for scaling-up:

- National replicability of the DACC/CAC/VAC structures offers a platform for expanding to other districts.
- It is cost-effective. SC has only two STEPs staff per district.
- The arrangement is potentially sustainable and self-reliant. Mobilized DACC/CAC/VACs can potentially continue taking the leadership role, even after SC withdraws from the districts, as is the case with the NACC.

STEPs seeks to intensify its partnerships with NAC. Many bilateral donors (including the British, U.S., and German governments) and multilateral donors (including the World Bank, European Union, and U.N. agencies) are either currently funding NAC or have pledged funds. The Global Fund to Fight AIDS, Tuberculosis and Malaria approved a grant of up to a maximum of $58,685,440 over two years and $284,110,722 over five years.[6] The five-year funding is contingent upon NAC's demonstrated ability to manage funds in the first two years.

Our discussions with the executive director of NAC show that currently, NAC has neither the capacity nor mechanisms to disburse and manage funds. Therefore NAC is in the process of developing a grants management unit to address the issue (see Figure 5). SC is working closely with NAC (through the Umoyo Network) to develop this system.

Figure 5—The envisioned decentralized funding management



From our discussions with the DACC members, the executive director of NAC, and the STEPs staff, it is evident that the decentralized district-level structures (district

[6] Source: http://www.globalfundatm.org/proposals/round1/approvedproposals.html.

assemblies and the DACCs) and the national NGO/CBOs lack the capacities to absorb funds and scale up responses. Therefore, in the first quarter of 2003, NAC invited proposals from NGOs (including the prominent international NGOs) to build capacity of DACC/CAC/VACs and other local NGOs/CBOs. This project is called the National Umbrella Project. SC, as a lead organization of an NGO consortium that includes ADRA, CARE, Save the Children UK, and Concern Universal, submitted a proposal to build capacity of the district assemblies, DACC/CAC/VAC, and other CBOs in 11 districts and two cities (Mazuzu and Blantyre) in Malawi. The primary components of this capacity building would include

- developing leadership in district assemblies on the issues of HIV/AIDS and multisectoral responses;
- advocating within district assemblies to allocate funding for DACCs;
- building organizational capacity of the AIDS committees and CBOs and training them in the STEPs approach; and
- technical capacity building and training in management of resources from the district to the village level.

The goal is to enable the district assemblies to manage resources related to HIV/AIDS response within the next four years.

Save the Children USA-NGOs/CBOs

> "Through partnerships we aim to reach more affected people, even in the district where SC is absent."
>
> —Victor Kachika-Jere, STEPs staff

The relationship between DACC/CAC/VACs, STEPs, and other NGOs/CBOs is synergistic (Box 6). STEPs taps into the expertise of other CBOs/NGOs in the region to build the capacities of CACs and VACs. For example, in Nkhotakota, STEPs partners with the Nkhotakota AIDS Support Organization (NASO), a CBO that supports "positive

living" of the PLWHAs through a support group for PLWHAs and HBC. NASO volunteers play a key role in training HBC TSC of the Nkhotakota DACC/CACs. The HBC TSCs of CAC/VACs, in turn, refer HIV-positive members in their communities to NASO.

The Southern Africa Root Crop Research Network (SARNet) also collaborated with the program to address household food insecurity in three program districts. Nurseries have been established for improved varieties of sweet potatoes and the starts are being distributed to vulnerable households for cultivation. Williamson and Donahue (2001) describe this partnership as "extremely valuable." A few CACs obtained funding from the Malawi Social Action Fund to start projects such as dairy farming.

Over the last few years, SC trained many NGOs and CBOs in the program approach so they could replicate similar interventions in the districts they work in. The program staff trained four NGOs in the STEPs community mobilization model in 2000 and 2001 (Hunter 2002). World Vision, for example, has mobilized one CAC and 14 VACs after visiting STEPs districts. Since early 2002, Concern Universal in Dedza and Action Aid in Nkhotakota are partnering with STEPs.

In response to the growing demand for the replication of the STEPs model, SC proposed a national implementing partnership between NGOs/CBOs and the government. The Malawi HIV/AIDS Partnership (MAHAP) was initiated in September 2001. It was dedicated to achieving the goal of national coverage, with high quality, effective and efficient community-based HIV/AIDS prevention, care, support, mitigation programs, and advocacy in Malawi by 2005. Fifteen organizations signed the MAHAP terms of reference. SC, through STEPs, was poised to serve as the coordinating partner for the MAHAP. Through this partnership, SC organized the National Conference on Best Practices in June 2002.

But the initiative took a different route in the end of 2002, as it was deemed inappropriate for an international NGO to lead a "national" effort. However, SC continues to work with "clusters" of NGOs such as HACI, NGOs working with Community Health Partnerships (CHAPS) project, and the Umoyo Network to achieve

MAHAP objectives. Partnership with the government through other initiatives such as the Umbrella project also continues (as discussed in the section above).

8. Organizational Capacities for Scaling-Up

Leadership

The STEPs staff in Washington, D.C., and Lilongwe mentioned the vision and pioneering role of Tom Krift and Stan Phiri as critical in developing a scalable community mobilization model. In addition, they emphasized the superior quality of leadership of the field office director, Justin Opoku, as a critical element in motivating the staff.

Capacity Strengthening of STEPs Staff

Scaling-up in coverage and functions requires qualified staff. Until November 2002, the program staff at the field office level included a project officer responsible for program management, an assistant project officer coordinating activities of the district offices, a monitoring and evaluation officer (since 2001), and an HBC officer (since 2001). For the ambitious scaling-up plans, SC recruited a full-time manager for HIV/AIDS programs in December 2002. SC continues to maintain only two program officers at the district level. The program staff is trained to

- work with local leaders and community groups,
- inspire and motivate community members,
- facilitate coordination between various actors,
- provide technical training, especially in HBC and income-generation activities, and
- advocate for vulnerable people.

Program staff noted that SC invests in their training: in the last year, every staff member attended at least one training program. Staff are encouraged to take opportunities to conduct research and disseminate results. Recently, they conducted a study with Save the Children Sweden on the psychosocial needs of the OVCs (Mann 2002). They are also encouraged to attend national and international conferences and present papers. For example, Victor Kachika-Jere presented a paper on the program's community mobilization model at the International AIDS Conference in Barcelona 2002.

Regarding their remuneration, the field office director says, "There is high competition between NGOs. We pay them a competitive salary, with a salary review every year, to attract good quality people."

Documentation and Management Information Systems

The program has developed extensive training manuals, including one on community mobilization and one for training each TSC. SC shares these documents and experiences with other organizations in Malawi and other countries in the region (for example, Zambia and Ethiopia). The purpose of developing the manuals stated in the *Community Mobilization Handbook* (SC 2003) is so that other organizations can

- learn from the STEPs's experience,
- replicate the strategy in their own districts or communities, and
- adapt the STEPs strategy to mobilize their own community-based and -owned responses to mitigate the impact of HIV/AIDS.

SC is also planning to support STEPs's scale-up through various other innovations. For example, it is in the process of establishing community-based learning centers (CBLCs), the main principle of which is "seeing is learning." The idea is to establish a library with all the STEPs-relevant documentation and a training facility in the SC district office in Lilongwe. In addition, in each of the districts, two active CACs and

four active VACs in each of these will be chosen to serve as "living universities," so that they could train other CBOs/NGOs and DACC/CAC/VACs from other areas.

In response to the recommendations of the previous assessments to monitor its progress, the program established an MIS system in 2001. The database is organized by CAC and monitors 53 indicators (Appendix 3).

Data collection is done at three main levels: TSC, village, and community. VAC TSCs record all activities implemented by the villages. TSCs meet monthly as a VAC and consolidate the information from the TSC registers in a VAC form, after discussions among the VAC members. This process enables VACs to track progress made and challenges they face. CAC members participate in these meetings.

At the CAC level, members meet monthly to discuss the information from VACs and consolidate it into a CAC form. DACC is represented when the CAC consolidates VAC data. The CAC completes three forms. One form is for DACC records and the other is for SC field office records. The third form is retained by the CAC. The DACC uses this information to complement its quarterly reports and also to keep track of activities at the district level. At each level, data are collected, analyzed, and shared with partners (such as the traditional authorities, district executive committee, and area development committee) for replanning (Figure 6).

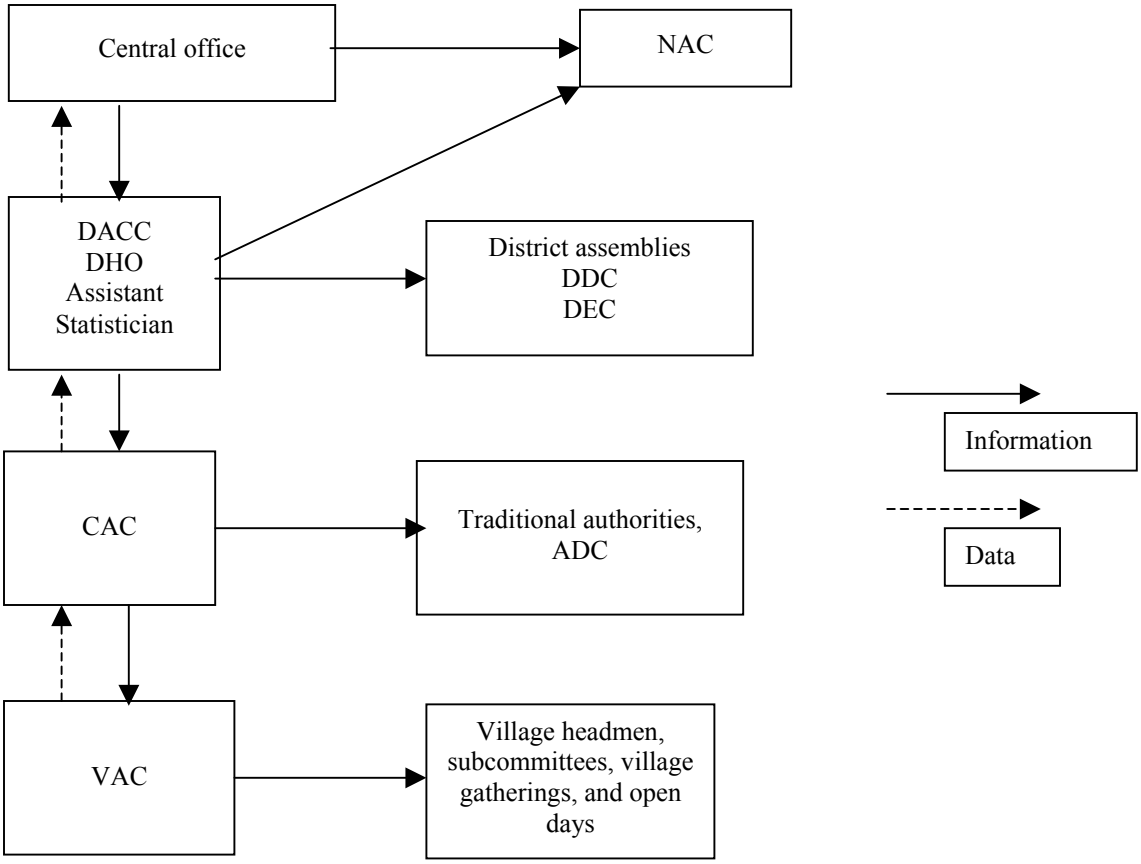
STEPs aims to scale up through partnerships, CBLCs, and dissemination of best practices. At the field office level, STEPs aims to monitor some of the following indicators as it scales up: number of partners and their capacity, resource mobilization, avenues for sharing information, number of best practices documented, capacity strengthening of CBLCs, and visitors accessing the CBLCs.

9. Community-Level Factors that Enable or Constrain Scaling-Up

Our discussants observed that while some communities organize themselves with ease, others do not. For example, although Mangochi is the oldest program district, it is not one of the best performing in terms of collective action. The staff considers Dedza to

be a dynamic district with superior organizing capabilities. Discussants identified many factors critical for effective collective action and subsequent scaling-up within districts. These include training of DACC/CACs, local leadership, natural resources, history and culture of the communities, whether they are rural or urban, and funding flows.

Figure 6—Management information system structures



Notes: ADC = Area Development Committee; DEC = District Executive Committee (Technical arm of DDC); DDC = District Development Committee (Policy body at district level); DHO = District Health Officer.

Training DACCs and CACs

When SC starts supporting the program in a new district, it begins with awareness raising and training for transformation of DACCs. STEPs staff finds many advantages in mobilizing DACCs. These include

- an increased role of the district in coordination and capacity building of HIV/AIDS activities within the district,
- coordination of activities between the district and national levels, and
- increased commitment of DACC members in addressing the challenges of HIV/AIDS.

Initially, SC funded many DACC trainings. DACC members demanded more training. SC learned that this high demand was because of the allowances it paid participants. The trainings, according to the program staff, were expensive and ineffective, with DACC trainings hardly percolating to CAC/VACs due to a low commitment of DACC members. Also, DACC officials from distant parts of the district may not have a sense of ownership and responsibility for local problems. CAC/VAC members are indigenous to the communities and more likely to have ownership of the region and its problems.

The program reoriented the DACCs on "the importance of its role in terms of coordination and resource mobilization." The program increased its CAC trainings. These trainings have been highly effective in mobilizing communities and eliciting their participation. For example, Kafuzira and Lumbadzi CACs said that it was only after these trainings that they felt equipped to engage in a dialogue with the community regarding HIV/AIDS. The Area 18 Residential AIDS Committee (RAC)[7] in Lilongwe district found their visit to CACs in other districts motivating. Kafuzira CAC started CBCCs after its visit to Mangochi CBCCs. However, all the CACs we visited noted that

[7] RACS in urban areas are equivalent to CACS in rural areas.

they require periodic refresher training and more field visits to learn from one another. But refresher training is still rare due to SC's resource constraints (see the *Community Mobilization Handbook* for details of training, SC 2003).

Local Leadership

The program staff and the DACC/CAC/VAC members have consistently identified local leadership as the most critical factor in amassing and sustaining collective action. The role of leadership and involvement of the religious leaders, traditional heads, and chiefs in DAC/CAC/VACs cannot be overstated in determining communities' response. For example, some of the DACC members in Nkhotakota include the traditional head and a priest. Hunter (2002) and Phiri, Foster, and Nzima (2001) make similar observations.

Discussants also identified the vision of the leadership as a critical factor for determining the quality and scale of collective action. Communities with strong and committed leaders are more likely to organize themselves around a common cause than those with leaders who find community organization to be threatening. For example, the program staff identified Dedza's motivated and committed leaders to be critical in mobilizing Kanyezi CAC/VACs and sustaining their collective action. The village members volunteer their time and labor to build houses for the sick, and meet in the evenings to plan for the CAC/VAC events after their daily labor in the fields. In Dedza's Bemeke CAC, leadership was mentioned to be weak, and according to the STEPs staff, the involvement of communities is also low key.

History, Culture, and Livelihood

Communities that have traditionally organized themselves to get things done are more likely to act collectively to address a particular problem than individualistic communities (Foster 2002). The program staff and DACC members observed that the type and nature of livelihoods also make a difference in community participation. For

example, Dedza is a district with fertile land, widespread subsistence farming, and a tradition of communal labor. Mangochi, on the other hand, survives on tourism, which, due to its individualistic nature, renders collective action relatively weak, though it is the oldest program district.

Almost all of the program staff and the AIDS committee members interviewed emphasized the disincentive effect of "handouts"—the sources of which are many, and include tourism and political party campaigning. STEPs staff reported having difficulties mobilizing CAC/VACs in such communities.

The program staff as well as the AIDS committee members noted that competing allowances and input-oriented services by other NGOs are major disincentives to collective action. Volunteers that previously received (or are currently receiving) allowances from other NGOs expect the same from SC. Communities that obtained free services expect STEPs to be a similar program.

> Lots of people expected that they would get assisted then and there [after the initial needs assessment survey], which was not the case. They expected that STEPs would generate employment and that they would earn income by the end of the month. During the initial meeting [dissemination of results meeting], we had to make it clear that "this is our problem, we have to own it, as it affects all of us, find solutions and take care of ourselves rather than depending on others to come from outside to take care for our own children." Such a negotiation took a year and half.
>
> Before [STEPs] there were other programs by other NGOs. There was mass registration of orphans but no assistance followed. So now [in the initial stages of STEPs], people did not want to cooperate. Before they were trained in these issues, they thought that assistance to orphans meant only material assistance. Now they understand the importance of psychosocial support. They also realized that all orphans are not in the same level of poverty. Now they are able to identify the most needy orphans objectively after training.
>
> —Focus group discussion with Lumbadzi CAC members

Rural versus Urban

In its effort to expand to urban areas, SC initiated STEPs in Area 18, an urban slum of Lilongwe, in 2001. The visit to the Area 18 RAC highlights the challenges in mobilizing communities in urban areas. Though SC trained RAC members, it has been experiencing challenges in motivating and mobilizing them (Box 7). The important constraints identified by the program staff and the RAC members are the following:

- Most urban dwellers are not indigenous to the area. They migrate from various parts of the district/country. Local kinship ties and social capital are consequently weak. In our field visits, the Lumbadzi CAC members (a periurban CAC with VACs close to Lilongwe as well as in the interior of the district) confirm the difficulties in mobilizing AIDS committees in urban areas relative to rural areas.
- The urban population is highly heterogeneous in terms of financial status, ethnicity, political affiliations, issues of concern, etc.
- RAC identified time constraints in urban areas as a hindrance in organizing people, as many are formally employed.
- Many other NGOs that provide free services are present. Consequently there is little motivation to engage in unpaid voluntary work.

Some findings from our focus group discussions with the Area 18 RAC include

- lack of ownership of the problem,
- lack of acceptance of responsibility by the members of the TSCs (Box 7),
- recurrent complaints about the lack of resources (many of the RAC members are retired civil servants living on a pension),
- lack of acknowledgment of the advantages of being in an urban area (such as access to information, other government services, human capital within their region).

However, at the end of the discussions, a few RAC leaders acknowledged that their RAC is only a year old and that they need further "enlightenment" as to how they could act together to respond to the epidemic. This emphasizes the need to engage in dialogue with communities for an extended period before they come to recognize, accept, own, and respond to the problem. It also underscores the need for visitors to provide information regarding how to access resources.

Box 7: Expectations of Area 18 RAC Youth TSC

- Expect sponsors to support with resources
- Expect some certificates after training
- Expect study tour, refresher courses
- Campaigns need resources; expect material used in campaigns to be provided by SC
- Expect SC to pay regular visits for guidance and assistance
- Expect SC to give useful gifts in competitions
- Expect volunteers to be compensated
- Expect SC to provide information about the upcoming events such as World AIDS day
- Expect SC not to abandon them

Source: Focus group discussions.

Financial Sustainability

Resource mobilization occurs at all levels of STEPs: STEPs field office, district office, DACCs, CACs, and VACs. Almost all discussants noted that resources should be brought in only when communities have a clear understanding and ownership of their problems, have prioritized their actions, and are committed to finding solutions and taking initiative in mobilizing resources.

> Communities should not be mobilized around money but around activities, which can be funded later on. If they are mobilized around receiving money, they will tell you what you want to hear, e.g., how many times they met, etc. But if they are not ready, the money will not be used for the intended purpose. Even if it is used, it will be for a one-off activity.
>
> —Brenda Yamba, Manager of HIV/AIDS programs, SC

> Following the trainings, we look at ourselves to solve this problem. We identify organizations that could help us. We know how to get assistance depending on our needs. We know whom to report to on various activities.
>
> —Lumbadzi CAC member

Resource mobilization TSCs play a key role in seeking resources to fund activities from their communities as well as from external sources. Other TSCs, especially the youth and orphan TSCs, work along with the resource mobilization TSCs to this end. The DACC/CAC/VACs that we visited undertook the following activities to mobilize resources:

- Writing proposals seeking funds to various organizations. For example, Kafuzira CAC obtained treadle pumps from the Nkhotakota SC grants program funded by Sweden.
- DACCs and CACs are also mobilizing resources from other donors, including WFP and SARNet. Lumbadzi CAC is proactively seeking funds to build a second CBCC, for communication material and for a CAC office.
- Organizing Walkathons, e.g., Lumbadzi CAC.
- Building kiosks in markets so that they could be rented out, e.g., Kafuzira CAC.
- Building a school, e.g., Kanyambo villagers.
- Taking up piecemeal work to assist the vulnerable, e.g., Kanyambo villagers.
- Youth associations, such as the Nkhotakota Anti-Aids Club, charge a nominal fee to members to fund themselves.
- Jumble sale of different items, e.g., clothes, pots, etc.

However, almost all the DACC, CAC, and VAC discussants reported inadequate resources to improve the quality of their programs. All the AIDS committees we visited reported inadequate funds for transportation and communications, limiting their outreach and ultimately limiting scaling-up.

Although volunteerism is the backbone of DACC/CAC/VAC structures, the high dropout rate and recurrent training costs threaten the viability of the services and are decelerating scaling-up. For example, Lumbadzi CAC has trained 32 volunteers in HBC since 2000, but 20 have already dropped out (Section 10).

There is a clear indication that external funding is critical to match the needs of the communities. However, the executive director of NAC, program staff, and Nkhotakota DACC members emphasized that the mode of funding and timing of the resource flows are crucial in building community ownership. They all emphasized that external resources are critical in increasing the impact of community action. However, they also emphasized that external funding should not be used as a "carrot" to lead the process at the community level. To the extent that communities initiate activities with the expectation of receiving funds, the continuation of community action is limited by the provision of the resources. Grants that AIDS committees could access to meet their prioritized needs are noted to have a very high potential in strengthening community action (Phiri, Foster, and Nzima 2001; Hunter 2002).

> "Resources should be used where they are needed, where they can make a difference. This will happen only when communities are mobilized; otherwise it will undermine community solidarity and ownership."
>
> —Justin Opoku, Field Office Director

10. Threats to Scaling-Up

This paper has highlighted some factors that have impeded the scaling up of STEPs:

- **Weak DACCs** could threaten the viability of the AIDS committees. According to the executive director of NAC, the performance of DACCs are inconsistent across districts. Although NAC helps DACCs prepare plans, their implementation remains a challenge in most districts. According to the past reviews and our discussions, two main reasons can be identified: (1) the DACC

coordinator is an employee of the Ministry of Health and Population, limiting a true multisectoral response, and (2) the position is only part-time. The part-time DACC coordinator has little time for district-level HIV/AIDS planning and to effectively coordinate between DACCs and NAC. Currently, NAC is trying to make the DACC coordinator a full-time employee of the district executive committee to enable a concerted multisectoral action.

- **Conflicting priorities of donors and DACs/CACs/VACs**. Discussants emphasized that inflexible funding mechanisms and earmarking of funding streams greatly compromises the multisectoral approach. Weak commitment of donors to a truly community-driven multisectoral response is still pervasive, despite the rhetoric. Donors often want to fund a specific activity, e.g., "orphans issues" as opposed to "youth issues" or "prevention activities." To support a multisectoral community-driven initiative, funding needs to be flexible enough to meet the cross-sectoral and evolving priorities, needs, and capacities of the communities.
- **Paucity of qualified staff** was identified as a major challenge by the field office director. As STEPs is beginning to form partnerships (Section 7), he estimates that SC will require 60 more employees. As many more NGOs are also posed to undertake STEPs-like activities, SC faces competition in recruiting qualified staff.
- **The current acute food crisis** is diverting SC's attention to relief assistance and the attention of the community members to sheer survival. For example, the CBCC activities in Nkhotakota and Lumbadzi CACs have come to a halt. Before the food crisis, children in CBCCs were given one meal on-site, with the produce from communal gardens donated to CBCCs. But with the current food crisis, communities have little to contribute (Appendix 4).
- **The HIV/AIDS pandemic** is quickly eroding the capacity of DACC/CAC/VACs, requiring ongoing training of new volunteers. This is prolonging the length of SC's presence in each district and decelerating scaling-up in other districts.

- An **eroding spirit of volunteerism** was a primary concern of many discussants. There are many reasons for this. Many volunteers are HIV-positive themselves or live in HIV/AIDS-affected households. The burden of caregiving at home, according to the CAC/VACs, competes with volunteer work. Many volunteers move to find work. The morale of the volunteers dwindles as they witness an increasing number of their community members die. Most important, the lack of resources needed to make visible improvements makes volunteers feel hopeless.
- **The National Umbrella Project is unchartered territory for both the NAC and SC** and not all challenges in such a partnership can be foreseen. Critical to the success of such a partnership would be the trust between the government (especially NAC) and the NGOs, and the coherence of vision and action among the NGOs and between the NGOs and the government.
- **Political interference in DACC/CAC/VACs** is a potential threat that could undermine community motivation and ownership. For example, in some areas where STEPs operates, WFP was distributing food aid in response to the food crisis in mid 2002. CAC and VAC members were responsible for identifying the potential recipients (those affected by HIV/AIDS) and monitoring food aid distribution. However, STEPs staff informed us that in one of the CACs in Mangochi, a local politician wanted to be responsible for identifying the recipients and distributing food. This compromised STEPs's activities in the area.

11. Context Roof for Scaling-Up

HIV/AIDS Still Not Well Considered in Poverty Lending

The Government of Malawi has made fighting HIV/AIDS a national priority, and the commitment to a multisectoral approach is evident from the National AIDS Strategic Framework and from interviews with NAC and DACC officials. However, a

multisectoral response is not prominent in the poverty reduction strategies, such as the Malawi's Poverty Reduction Strategy Plan (PRSP) (Jenkins and Tsoka 2003).

> HIV/AIDS came into PRSP as an afterthought. When it comes to translating into action, people writing PRSP[s] do not want to invite NAC. Mindsets have to be changed.
>
> —NAC executive director

Poverty and Underdevelopment

STEPs operates in a context of high HIV and low resources, mostly characterized by low employment, basic services such as health care and schools, and agricultural inputs. Maintenance, growth, and sustainability of community-driven initiatives in these settings is a major challenge.

STEPs has shown that community mobilization is possible in poor communities, but it is not easy. It requires a relatively large investment of time to obtain even modest results. Most volunteers are illiterate and have not been exposed to any kind of training before STEPs, requiring prolonged training and support.

CAC and VAC members expressed disappointment at the modest resources they were able to raise relative to the efforts they had made. HBC TSCs have consistently reported lack of basic drugs, resulting in dwindling motivation. Replenishing the kits continues to be a problem. Local philanthropic organizations and businesses are far too few to support fundraising activities.

> We the HBC have learned the basics of HBC management. But are in problems as there are not enough facilities and resources. Yet the women are working hard to do their job.
>
> —Chorus of a song by Area 18 HBC TSC

12. Conclusions

> The major challenge is the spread—in spite of our efforts, HIV is still out there. We don't see the end in sight. When the war ended in Mozambique, we reunified the kids, packed up, and went home. With HIV/AIDS, it is different. Some can't be reunited here.
>
> —Justin Opoku, Field Office Director, SC

> The big challenge is that HIV/AIDS interventions have to be multisectoral. To facilitate that with limited time and resources, when communities are weakening, is not easy, but very rewarding.
>
> —Victor Kachika-Jere, STEPs staff

STEPs began as COPE in mid-1995 in one district and expanded to four districts covering 9 percent of the Malawian population by the year 2000. It aims to further expand to six districts by the end of 2005 and cover 15 percent of the population. STEPs's scaling-up goes beyond increasing the coverage; from primarily an orphan-support program, it evolved into a multisectoral program, scaling up functionally as well as geographically. Politically, it has evolved from a service delivery program to one that influences national policies. It is institutionally scaling up by partnering with the government and civil society (Table 5).

STEPs strategy focuses on revitalizing and building the capacity of decentralized AIDS committees to prevent the spread of HIV and to mitigate the impacts of AIDS on children, households, and communities. When STEPs starts working in a district/community, it initiates a community mobilization process with the aim of building community capacity to identify problems due to HIV/AIDS, developing a plan to address these problems, mobilizing internal and external resources, assessing achievements, and refining plans and action based on lessons learned.

Some of the key lessons from SC's experience in catalyzing community-owned and managed responses are as follows[8]:

[8] Hunter (2002) and Phiri, Foster, and Nzima (2001) make many similar observations and conclusions presented in the rest of the section.

Table 5—Summary of scaling-up STEPs

	STEPs
Institutional arrangements	• Partnership with DACC/CAC/VAC is central to the STEPs strategy. • Partnership with other NGOs/CBOs to build their capacity in initiating STEPs-like models in other districts and leveraging their presence within the same district. • Partnership with NAC and capacity building of CBOs is the primary mode of scaling up in the next phase of STEPs.
Capacity elements	• Community mobilization has been critical in building capacity. • Training at various levels (DACC/CAC/VACs) is critical. • Funding issues continue to constrain capacity building of the AIDS committees.
Triggers	• Few visionaries in SC. • The success community mobilization model in Namwera was a trigger to expand the strategy to other districts. • Within districts, communities have been catalysts.
Facilitating factors	• Decentralization of AIDS committees to district, community, and village levels. • Working through the existing structures. • Enabling policy environment. • Institutional arrangements. • SC's ability to attract and retain high quality staff and keep them motivated through training, encouraging innovation, and offering competitive salaries.
Limiting factors	• Inadequate training of DACC/CAC/VAC members. • Inadequate funding. • Other factors such as the magnitude of the epidemic, the ongoing food crisis, weak commitment of donors, lack of a full-time DACC coordinator, and the overall context of poverty and underdevelopment.
Scaling-up processes	
Quantitative scaling-up	• The community mobilization model, revitalizing DACC/CAC/VAC structures, is replicated in the four districts. • Other NGOs are also adopting a similar strategy in other districts of Malawi and elsewhere.
Functional scaling-up	• From primarily a psychosocial orphans-support project, STEPs evolved into a multisectoral initiative addressing issues along the continuum of prevention, care, support, and mitigation.
Political scaling-up	• Through STEPs, SC is influencing national policies: it was a member of the National Orphan Task Force and played a key role in drafting guidelines for orphan care in Malawi; a leading member of the Children and Violence Task Force; formation of Wills and Inheritance Core Group.
Organizational scaling-up	• As STEPs scaled up, it recruited an HBC officer and an M&E officer. There are plans for recruiting additional staff to scale up. • STEPs is scaling up partnering with the organizations, including the government.

- External organizations are well placed to act as change agents.
- The change agents should build on existing community responses and structures and seek to improve communication and cooperation among all individuals and organizations working within the area on HIV-related issues.
- The community mobilization process is key to building ownership. According to STEPs staff, "no steps should be missed in the community mobilization process," regardless of the initial level of enthusiasm of the communities.
- Involvement and commitment of a range of local leaders and actors is crucial to build and sustain collective action.

Some key lessons from scaling-up STEPs are as follows:

- An enabling policy environment in Malawi and the commitment of NAC to seek multisectoral solutions to the pandemic have been critical.
- Building on existing decentralized AIDS committees has enabled replication of STEPs.
- The community mobilization approach, along with scaling-down of SC's presence in the districts, has been instrumental in developing and implementing a relatively low-cost, scalable, but time-intensive, strategy.
- Scaling-up has both been planned and flexible. The demand from the communities has set the pace for scaling-up within districts. Communities themselves have also acted as centers of learning, accelerating scaling-up.
- Phaseout has to be planned with communities so that they have a clear understanding of the roles and responsibilities of various actors involved once SC leaves.
- Capacity building through training of STEPs staff as well as AIDS committee members has been critical. But due to the escalating death and dropout rates of committee members, STEPs may have to continue training new volunteers. HIV/AIDS challenges the conventional assumption that communities will continue to carry out activities once they are trained.
- An array of institutional arrangements, with the government as well as the civil society, plays a critical role in STEPs's scaling-up. Documentation and dissemination of findings is critical to this approach.
- Replicating the CAC/VAC strategy in urban areas poses additional challenges in building community ownership, due to the heterogeneity of people living in a geographically defined "community." STEPs could explore the possibility of mobilizing social/interest groups rather than "communities" in urban areas.
- There is a glaring gap between the resources that communities have or are able to mobilize and what is needed to make a long-lasting impact. Strategic material

assistance such as communication material and transportation is critical in scaling-up.

- How finances are channeled can make or break community ownership. Resources to the communities should be channeled only after communities have taken stock of their problem, prioritized their actions, and demonstrated commitment to seeking solutions. Resources should be channeled through sustainable local structures that communities could access as grants.
- STEPs has been and continues to face many challenges that threaten to decelerate scaling-up, including the ongoing food crisis, political interference in the AIDS committees, a dwindling spirit of volunteerism, weak commitment of donors to a truly community-driven multisectoral response, and the overall context of poverty and underdevelopment.

The STEPs experience shows that scaling up multisectoral, community-driven responses to HIV/AIDS is possible but highly challenging. Building such responses in high HIV/resource-poor settings is both resource- and time-intensive. But promoting community ownership and building local capacity is essential for action to be sustained. Donors and other international organizations need to realign their priorities, expectations of sustainability, and timeframes with those of affected communities.

Appendixes

Appendix 1: Interviews and Focus Group Discussions

Key informant interviews with

Save the Children Staff, Washington, D.C.

- Ms. Namposya Serperll, Global HIV/AIDS Program Coordinator

Save the Children Staff, Malawi

- Mr. Justin Opoku, Field Office Director, Save the Children, Malawi
- Ms. Brenda Yamba, HIV/AIDS Program Manager
- Mr. Victor-Kachika-Jere, Project Officer, STEPs
- Mr. Novice Bamusi, M&E Officer
- Mr. Gerald Chidzumkufa, Economic opportunity Officer, Lilongwe
- Mr. Alick Mbewe, Nkhotakota SC District office
- Mr. Ted Chiweyu, Nkhotakota SC District office

Executive Director of the NAC
Nkhotakota AIDS Support Organization (NASO)

Focus group discussions with

- Lumbadzi CAC, Lilongwe
- Nkhotakota DACC members
- Kafuzira CAC, Nkhotakota
- Kanyambo VAC, Nkhotakota
- Nkhotakota Youth Club
- Anti-Aids youth club, Lumbadzi CAC

Appendix 2: Checklist

- History of STEPs
    - Who initiated the program? If initiated by external agents, what was the form of assistance? Financial, technical, material, etc. If initiated by the community, *who* initiated it?
    - Why?
    - How was it conceived and designed?
    - What were STEPs's initial main goals and objectives?
    - How many communities and households did it cover?
    - What were the initial obstacles?
    - Have they been overcome and how?

- Process of scaling up
    - What was the basis for scaling up? Was the pilot very effective? Was it demand driven? Was it funding driven?
    - How is "success" defined? How is it tracked?
    - How did STEPs scale-up? Quantitative, functional, political, and organizational?
    - What was being scaled-up, i.e., the project, the reach of people, ideas, methodologies etc?

- Get all details of STEPs's design and implementation. Core issues to get at:
    - Have the objectives changed over time? If yes, how and why?
    - What is the involvement of the communities? Get a detailed understanding. How has it changed over time?
    - Timeline of the initiation cycle-time and sequence of community mobilization, negotiations, establishment of technical subcommittees, and other forms of assistance.
    - How many communities and how many people are covered? Who decides which communities will be involved? Why? Is there a set of criteria to initiate the project in a given community?
    - What are their roles? What is the level of devolution of authority?
    - What are the different activities under STEPs? Who decides what activities? What is the autonomy/authority given to communities?
    - What is the role of SC?

- Timeline of the project and changes
    - What happened to the project in five years?
    - Has it become more community driven or less community driven?
    - Has it grown bigger or remained the same?
    - Are people involved thinking about improving it or has it become a routine?
    - What is the internal drive versus external drive along this timeline?
    - Has the role of SC and other NGOs, if involved, increased or decreased?

- Get an understanding of how STEPs functions in various communities?
    - Is it more successful in some versus others?
    - Why? Is it the leadership in the community, presence of other organizations, better social cohesion, level of HIV prevalence itself, etc.?
    - The role of volunteerism in scaling up? What are the implications of volunteerism for sustainability in the context of HIV/AIDS? How has this constrained/facilitated scaling up?

- Institutional arrangements
    - Who are the partners at various levels: donors, government (level), other NGOs, CBOs, FBOs, and communities?
    - What is their level of engagement?
    - What kind of conflicts/tensions and synergies exist?
    - How has this changed over time and with scaling up?
    - In particular, what is the involvement of government at various levels? How have government polices helped/hindered the scaling up process?
    - Similarly, donors? How many donors are funding the project? What are the synergies and conflicts?

- Capacity
    - What kinds of capacities (technical, human capital, financial) are critical for CDD? And then for scaling up?
    - Is this any different with HIV/AIDS-related projects as opposed to other projects?
    - How does capacity of partner organizations play a role in scaling up?
    - What community capacities are critical for a CDD to be successful? What kinds of capacities are needed for scaling them up?
    - Funding mechanisms: absorptive capacity of communities may be a problem? How is the problem addressed, if addressed at all?

- Specific indicators:
    - Number of volunteers—have they increased or decreased in numbers?
    - Number of engagements with the community—have they increased or decreased in numbers?
    - How many of the communities are still active?
    - Has the level of participation increased or decreased?
    - Engagement of new people
    - Timeline of activities (and changes) for as many communities as possible (community, participation levels, number of activities, coverage of each type of activity, etc.).

- Future plans

- What polices facilitate/hinder scaling up CDDs in response to HIV responses? Are they unique to HIV or universal?

- What is other enabling environment factors that helped/hindered scaling up?

Appendix 3: STEP's Monitoring Indicators

1. Community Mobilization

- Number of VACs established
- Number of functional VACs
- Number of VACs spontaneously established
- Number of VACs with functional Youth Clubs
- Number of proposals submitted by DACC
- Number of proposals submitted by DACC funded
- Number of proposals submitted by CAC
- Number of proposals submitted by CAC funded
- Replicating STEPs Model
- Number of villages sensitized on issues of child abuse/protection
- Number of villages sensitized on issues of Wills and Inheritance
- Number of villages that have developed systems to prevent and respond to child abuse

2. Food and Economic Security

- Number of VACs with community gardens
- Number of CBCCs with community gardens
- Percent of OVCs and chronically ill patients who had food twice or more the past two days
- Number of persons benefiting from community gardens
- Number of community groups linked to microcredit
- Number of youth sent for V/training
- Number of youth completed V/training
- Number of youth completed V/training employed
- Number of persons trained in basic business management
- Number of persons trained with own business
- Number of groups in the VACs participating/practicing ROSCA

3. Care and Support

- Number of CI patients in the village
- Number of CI patients receiving care from trained care givers
- Number of CI patients visited at least once a week in the last month
- Percent of care givers demonstrating at least four core competencies[9]
- Number of CI patients referred to a health facility
- Number of CI patients referred to a traditional healer
- Number of CI patients referred to the community
- Drugs and supplies availability and replenishment
- Number of OVC in a village
- Number of OVC school age (5 years or older)
- Number of OVC school age in schools.
- Number of school going OVC that have dropped out

[9] Four core competencies refer to pain management; psychosocial support; promoting safer sex practices; and pressure sore management.

- Number of OVC returned to school
- Number of functioning CBCC
- Number of teachers/CBCC workers
- Percent of OVCs participating in extra-curricula activities
- Percent of CI patients with verbal/written succession plans for guardianship for their children
- Number of CI patients with verbal plans
- Number of CI patients with written plans for guardianship

4. Prevention

- Number of condoms distributed by VAC
- Number of condoms distributed by CAC
- Number of trained peer educators
- Number of condoms distributed by youth/peer educators per month
- Percent of youth who have gone for VCT

5. Advocacy

- Participating in various task force work-group activities
- STEPs replication
- STEPs monthly meetings

Appendix 4: Table of indicators

Indicators	1997	1998	1999	2000	2001	July 2002	Totals
Population catchment area	22,793	50,151	146,487	238,544	537,893		995,868
Number of districts	1	3	3	4	4	4	4
Number of CACs mobilized	1	9	4	3	10	7	34
Number of VACs mobilized	16	64	84	124	86	278	652
Number of CACs formed spontaneously	0	0	0	0	3	1	4
Number of VACs formed spontaneously	0	0	0	9	21	19	49
Number of villages with systems to respond to issues of child abuse and wills and inheritance	0	0	0	0	63	15	78
Number of people sensitized on wills and inheritance and child abuse	0	0	0	0	1,184	521	1,705
Number of children reported abused and assisted	0	0	0	0	98	0	98
Number of youth clubs	16	27	56	30	77	65	271
Number of proposals submitted by CACs	0	11	16	24	14	4	69
Amount of money raised by VACs and CACs	0	K135,000 ($3,180)	K160,000 ($3,740)	K300,000 ($4,918)	K66,561 ($1150)	K34,523 ($595.00)	MK696,084 ($13,583)
Number of condoms distributed by VACs and CACs	4,600	8,000	5,200	17,935	20,882	8,705	65,322
Number of youth peer educators trained	64	0	0	0	868	30	962
Number of condoms distributed by youth pear educators	0	6,500	8,000	12,000	10,337	5,000	41,837
Number of HBC providers trained	458	0	0	140	228	41	867
Number of CIs identified	278	298	302	892	790	477	3,037
Number of CIs assisted	261	270	250	769	604	265	2,419
Number of OVCs registered	1,201	1,951	2,872	13,571	5,219	2,019	26,833
Number of OVCs assisted	518	820	1,960	10,284	1,639	134	15,355
Number of functioning CBCCs	0	0	1	3	12	9	25
Number of CBCCs' trained teachers	0	0	22	82	68	0	172
Number of CBCCs with gardens	0	0	1	4	6	1	12
Number of VACs with Communal gardens	0	32	50	110	66	38	298
Number of families benefiting seeds from communal gardens	0	400	600	520	234	66	1,820
Number of groups accessed credit from lending institutions	12	8	12	6	29	0	67
Number of OVCs sent for vocational training	110	12	23	8	51	0	204
Number of OVCs completed vocational training	110	12	23	8	26	0	179
Number of OVCs employed	87	10	19	15	20	0	151
Number of OVCs returned to school	217	301	228	611	527	18	1,902
Number of adults trained in BMT	120	128	160	140	87	0	635
Number of groups doing ROSCA	0	3	9	12	11	0	35

Notes: BMT = business management training; CACs = Community AIDS Committees; CBCCs = Community-Based Childcare Centers; CIs = Chronically ill; HBC = Home-Based Care; OVCs = Orphans and Vulnerable Children; ROSCA = rotating savings and credit association; VACs = Village AIDS Committees.

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