

Community mobilisation: myths and challenges

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As described in the papers in this issue, the Avahan India AIDS Initiative embraced the community mobilisation as a core strategy in its scaled HIV prevention programme, reflecting many of the guiding principles of the Sonagachi project in West Bengal.^{1 2} The National AIDS Control Organisation (NACO), which is the nodal agency responsible for the development of HIV policies and programmes in India, also introduced the concept of community organising and ownership-building as a critical feature of its work.^{3 4} In both cases, the stated objective was to improve the quality and coverage of the HIV intervention programme with special reference to most-at-risk populations, namely the female sex workers, transgender persons, men who have sex with men and people who use drugs. Community mobilisation was envisaged as a process of bringing these marginalised populations to the centre stage of intervention activities. Both NACO and Avahan hoped to build community collectives that would take an active role in HIV programming, not merely as service recipients, but as responsible agencies which would eventually own, run and sustain the programme, as it was done in Sonagachi.

The inclusion of community mobilisation approaches in an HIV intervention programme is a logical and pragmatic way to foster the engagement of community members with the programme and thereby improve their access to relevant HIV-related services. However, it is a task that raises many challenges that need to be identified and addressed to achieve expected results. Community mobilisation approaches address HIV risk among marginalised populations such as sex workers, and address their vulnerability, which is rooted in their social, legal and working environment. Women in sex work have to deal with multiple other stakeholders in their day to day life and face

many diverse challenges, including social alienation, police harassment, extortion of money by local gatekeepers, stigma and discrimination. These concerns usually serve as the major flashpoint for the coming together of individuals as mobilised community members, rather than the threat of HIV, which of course is the main priority of HIV programme implementers. Here lies the challenge: how to enable community mobilisation so that the mobilised community members can support HIV programming. In such settings, we cannot expect sex workers to mobilise around HIV concerns alone, as HIV tends to be rather low on their list of priorities.^{5 6} The development of better service outlets, the provision of quality HIV services, the introduction of microplanning processes are no doubt important programming elements and if properly applied, can improve the outcome of HIV intervention programmes.⁷ However all these intervention components cannot be equated with community mobilisation.

The long-term perspective of the NACO-led national programme and of Avahan was to transfer the ownership of the intervention programme to community-based organisations. While this has effectively been done in Sonagachi, this has not been so easy to achieve elsewhere.^{8 9} It is useful here to reflect that the transfer of ownership of the Sonagachi project to the sex worker collective initially faced stiff resistance from many technical and management experts who had until then supported community mobilisation and collectivisation processes. Such experts are not part of the community, but are members of mainstream society and various social interest groups having their own agendas, underlying values and belief systems. They are often reluctant to relinquish control over programme decisions and may feel threatened by the rising clout of community entities.^{10 11} It is important to stress the fact that community mobilisation is a dynamic process featuring incremental engagement of community members, which in turn strengthens their

solidarity and enhances the community's collective bargaining power vis-à-vis mainstream society. This can be threatening to some who are normally in control. It should also be recognised that the role models and the skill set required to initiate a community mobilisation programme may not necessarily match with the commitment and skills required to facilitate the handover process. The point at which a marginalised community starts demanding full participation in decisions that affect it, and exerting its agency based on equal rights and ownership may not be acceptable in the ambit of power and politics of mainstream society.

At different stages of progress and development, experience indicates that community mobilisation raises different types of challenges within and outside the programme structures, and therefore, different styles of leadership and management are required for successful implementation. Community mobilisation remains largely a political process (especially with respect to marginalised populations such as sex workers), and cannot be equated with capacity building programmes; while they share some key features, the self-directed nature of community mobilisation requires a greater agency than is implied in capacity building programmes.

Developing policy and strategy to help marginalised communities manage and own the process, and the product of interventions is no doubt a bold step; to envisage the social and political challenges inherent in this approach, and the requisite skill and commitment required down the line to address those challenges is an even more formidable task. Taking community mobilisation processes to scale requires a deep understanding of the power dynamics that operate within the community: the interface between the community and the intervention programme, between the intervention programme and the society at large, and among all of the possible actors operating in all possible interfaces within the system. To be successful, community mobilisation strategies need to transform existing power relations in all of these areas.

Finally, we should not lament the fact that the Avahan programme evaluation process did not incorporate indicators related to community mobilisation. Often, the processes involved in community mobilisation are more value-based than logically driven which makes the

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construction of indicators a challenge. This may be viewed more as an opportunity than a failure, if we consider the dynamic and multi-dimensional nature of community mobilisation processes, at individual and community levels. It is not easy to follow such a complex, cascading mechanism using standardised research methodologies. Measuring the impact of community mobilisation by using a theoretical framework based on linear cause and effect relationships may bring more questions than answers. There is now a critical need for the development of robust methodologies and tools to measure the potential factors of change and development in a multidimensional framework. A broadening scope of enquiry, related to intervention strategies and their social impact, and the utilisation of creative formal and informal evaluation methodologies may be helpful.

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REFERENCES

1. **Jana S**, Basu I, Rotheram-Borus MJ, *et al*. The Sonagachi Project: a sustainable community intervention programme. *AIDS Educ Prev* 2004;**16**:405–14.
2. **Wheeler T**, Kiran U, Dallabetta G, *et al*. Learning about scale, measurement and community mobilisation: reflections on the implementation of the Avahan HIV/AIDS initiative in India. *J Epidemiol Community Health* 2012;**66**:ii16–ii25.
3. *The National AIDS Control Program Phase III: to Halt and Reverse the Epidemic in India (2007-2012)*. <http://www.nacoonline.org/upload/Publication/IEC%20&%20Mainstreaming/NACP%20III%20-%20To%20Halt%20and%20Reverse%20the%20HIV%20Epidemic%20in%20India.pdf>
4. *Targeted Interventions Under NACP III, Oper Guidel. Vol. 1*. Core High Risk Groups, National AIDS Control

Program, 2007. <http://nacoonline.org/upload/Policies%20&%20Guidelines/27,%20NACP-III.pdf>

5. **Tucker JD**, Tuminez AS. Reframing the interpretation of sex worker health: a behavioral-structural approach. *J Infect Dis* 2011;**204**(Suppl 5):S1206–10.
6. **Campbell C**, Cornish F. How can community health programmes build enabling environments for transformative communication? Experiences from India and South Africa. *AIDS Behav* 2012;**16**:847–57.
7. **Blanchard JF**, Bhattacharjee P, Kumaran S, *et al*. Concepts and strategies for scaling up focused prevention for sex workers in India. *Sex Transm Inf* 2008;**84**(Suppl 2):ii19–23. http://sti.bmj.com/cgi/content/abstract/84/Suppl_2/ii19
8. **Swendeman D**, Basu I, Das I, *et al*. Empowering sex workers in India to reduce vulnerability to HIV and sexually transmitted diseases. *Soc Sci Med* 2009;**69**:1157–66.
9. **Gruen R**, Elliott JH, Nolan ML, *et al*. Sustainability science: an integrated approach for health-programme planning. *Lancet* 2008;**372**:1579–89.
10. **Biradavolu MR**, Burris S, George A, *et al*. Can sex workers regulate police? Learning from an HIV prevention project for sex workers in southern India. *Soc Sci Med* 2009;**68**:1541–7.
11. **Cornish F**, Shukla A, Banerji R. Persuading, protesting and exchanging favours: strategies used by Indian sex workers to win local support for their HIV prevention programmes. *AIDS Care* 2010;**22**:1670–8.