

Universal Access to HIV and AIDS prevention, treatment and care: Communication Challenges

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DRAFT 27 November 2006

Introduction

With the passing of '3 by 5' initiative¹, the talk, particularly since the 2005 G8 summit in Gleneagles, is of Universal Access to Treatment, Care and Prevention. While the essential package of services required is yet to be finalised for this Universal Access, it will certainly require creative communication planning and programming. However, as we explain in this paper, the communications elements that should support this work need to be collated and presented in an accessible way to AIDS managers in the field. The objective of this paper is to present some of the challenges of Universal Access from a health communication viewpoint, and to outline possible tools available to AIDS policymakers, donors and managers who are engaged in shaping the response in the most affected areas.

Any endeavour to link current efforts in treatment, care and prevention, not to mention linking HIV and AIDS to broader public health issues, will require sophisticated communication techniques, drawing upon the best elements from different methodologies. Creating demand for these newly configured, more integrated services, raising awareness on related health issues, mobilising communities and battling stigma will all require a concerted communication effort. The programmes and activities required to enable Universal Access are diverse and complex. The global AIDS response is now a sophisticated, differentiated effort, working in complex institutional arrangements at local, national and international levels. Every aspect of this response will need to be mobilised in order to achieve Universal Access. The communication challenges involved will be as numerous and complex as the myriad of tasks and agencies involved.

In order to avoid creating an unmanageable checklist of different communication issues and challenges within the Universal Access effort, this paper has a very simple structure. It takes the most authoritative current statements on Universal Access and shows in broad brush-strokes where

¹ The '3 by 5' initiative, launched by UNAIDS and WHO in 2003, was a global TARGET to provide three million people living with HIV AND AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment (ART) by the end of 2005.

different communication tools might be of use. The question constantly guiding this paper is how can donors, programmers and policymakers at the country level, working on Universal Access, best benefit from the fields of knowledge present within the health communication community?

What is Universal Access?

In 2005, the G8 governments committed to Universal Access to HIV prevention, care and treatment. This commitment, from the world's richest governments, was endorsed by all UN Member States at the World Summit at the end of that year. From that moment, all the world's governments have formally accepted the challenge of: **"Developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of Universal Access to treatment by 2010 for all those who need it."**²

These statements of global commitment mark a turning point in global AIDS policy, and came about because the continued spread of HIV and the heavy burden of AIDS continue to undermine communities, nations and global development.

Civil society has always played a crucial role in pushing for greater political commitment on AIDS, and the events last year were good examples of that work. High level advocacy, linked to grass roots activism, is increasingly forcing governments to make a stand against AIDS. This is what happened leading up to the G8 and World Summit meetings, and continued throughout the High Level Meeting on AIDS in New York in May/June 2006.

Early in 2006, the process of developing a roadmap of the route to Universal Access began, led by UNAIDS and the UK's Department for International Development (DFID). A Global Steering Committee was established, made up of national governments, donor governments, UN agencies and representatives from global civil society. Its function was to listen to and learn from the experiences of individuals at every level in society to gain insights and provide hope; to identify what actions were needed at a global level and to act as a political forum.

Consultations took place at every level, national and regional, with thousands of people contributing. Seven regional consultations were held, under the leadership of the African Union, the Caribbean Community Secretariat and Pan-Caribbean Partnership against HIV and AIDS, the Commonwealth of Independent States and the Latin American Horizontal Technical Cooperation Group on HIV and AIDS in Latin America and the Caribbean, and with the participation of the Association of Southeast Asian Nations and the South Asian Association for Regional Cooperation.

² Broomberg J, Soderlund N, Mills A., Economic analysis at the global level: a resource requirement model for HIV prevention in developing countries, Health Policy. 1996 Oct; 38(1):45-65.

The report resulting from these consultations is used to structure the outline of communication approaches below.

So what does health communication have to offer?

Communication is a vital component of every AIDS intervention. However, what is meant by the term varies from situation to situation and from person to person. By its nature, communication needs to be tailored to address the challenges raised by individual audiences, objectives, local cultural practices and social understandings as well as the domestic political environment. In this regard, HIV communication is particularly complex as it infringes on issues that are socially, culturally and politically sensitive, particularly as the ultimate objective is to ask people to change attitudes and behaviour.

HIV communication has evolved with experience; understanding has deepened and the range of communication strategies and methodologies broadened.

At one time, in some countries, it was thought sufficient to concentrate solely on raising awareness, the assumption being that knowledge leads to change. Though awareness *per se* is certainly a prerequisite to the eventual adoption of alternative attitudes and modes of behaviour, it is itself a politically charged topic. It raises questions of who is elected to speak to whom?; who selects or censors the issues that are to be addressed?; how are the messages to be disseminated?; what will be the impact of such messages on the different social groups within the region? In brief, who has ownership? Misplaced attempts to raise awareness have resulted in hysteria at one extreme to outright rejection at the other. Both consequences have helped to exacerbate stigma and discrimination of marginalised groups.

Today, the extent to which attitude and behaviour are governed by the social, cultural, political and physical environment is better understood. So, while awareness is still paramount, there are other factors that need to be addressed if behaviour is to change, and these require a range of approaches in terms of communication strategies.

Though, in some ways, it is artificial to demarcate the separate approaches, as none are mutually exclusive, one tending to merge into another, they can be broadly categorised as follows:

- national and international advocacy communication
- health promotion programmes
- social marketing
- mass media
- communication for social change and social mobilisation
- participatory communication
- advocacy communication to include the voices of people living with HIV in decision-making processes.

As will be evident from the examples cited, programmes often overlap different fields of communication. Indeed, as a project matures, the objectives will change requiring different communication techniques. For instance, China, which is in the process of a massive health education programme relating to HIV and AIDS, may find that, over time, it will have to adjust its present and very necessary top-down approach to more of a community-led, bottom-up strategy, and develop social mobilisation programmes for those communities most at risk.

The fact is that all of these approaches will be necessary if Universal Access is to become a reality. On the one hand, it will remain crucial to build on the present levels of awareness of HIV and AIDS, not only among the existing adult population but also among the emerging generation of adolescents and children; awareness that isn't just based on an academic knowledge but also invokes a clear understanding of what is and isn't safe practice and behaviour. On the other, those living with or those at risk of HIV and AIDS need to be heard, to be brought into the circle of decision making on the issues that directly affect their lives, so helping them to make changes for themselves and avoid the entrenchment of a range of dynamics that could be unsustainable and even create dependency.

Linking Universal Access with health communication

Faced with the ambitions of Universal Access, the Community of HIV communicators now enters a new era in which it has but a relatively short space of time to rise to new levels of effectiveness, subtlety and sophistication to meet the challenge. It will also come under closer scrutiny.

In the drive to achieve Universal Access by 2010, communications specialists will face a constant pressure to show results more quickly as well as to demonstrate the cost effectiveness of their programmes. The danger is such short term outlooks may militate against longer term approaches that seek to address the driving causes of AIDS and thus undermine the future of the whole project. For instance, it may be politically expedient to concentrate on health education and information on health issues as such programmes can be delivered relatively swiftly and inexpensively with easily quantifiable results. However, they can also serve to mask the broader array of power imbalances, typified by lack of resources, gender and inequality, that actually prevent those living with HIV and AIDS to seek access to treatment and care. As the report on the follow-up to UNGASS notes, 'consultations described the fear — fed by widespread stigma and discrimination, violence against women, homophobia and other HIV-related human rights abuses — that discourages people from seeking the information and services that will protect them from HIV infection or determine whether they are already carrying the virus'.³

It is well to remember that Universal Access is not just about information and education but, more fundamentally, about the empowerment of those who are least powerful.

³ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.3

To this end, the Global Steering Committee on Universal Access has already identified many of the most pressing concerns of Universal Access. The Committee produced a report that has now become a [report from the UN Secretary-General Kofi Annan to the High Level Meeting on AIDS](#). This report, and the debates on its content - in particular the national targets it sets - formed a substantial part of the deliberations at the recent UN High Level Meeting on HIV and AIDS in New York.

The report is made up of the findings held in the many national and international consultations that took place as the groundwork for Universal Access was undertaken – supported by UNAIDS. Below is a brief distillation of the main finding of the report, incorporating challenges in achieving Universal Access – together with some of their comments about moving forwards. These are observed from the perspective of health communication, with different health communication methodologies listed throughout.

The report spoke about the setting and supporting national priorities. Its recommendation was that no credible, costed, evidence-informed, inclusive and sustainable national AIDS plan should go unfunded.⁴

The report notes that this requires predictable and sustainable financing. This in turn requires campaigning and advocacy at national and international level.

Some of the most exciting current thinking in this area can be found in Panos AIDS Programmes work on social movements⁵. The World AIDS Campaign and UNAIDS have also come up with practical guides on campaigning and advocacy.

Advocacy, when informed by evidence, is a powerful tool to influence positive political, social, economic and cultural change in the AIDS response. Combined with effective, visible and vocal campaigning, advocacy is not only essential in galvanising broad-based political commitment and mobilising financial support but it is also indispensable in placing AIDS on political agendas and pressurising governments to hold true to their promises and commitments.

The report stresses AIDS funding needs should be met with greater domestic and international spending and enable countries to have access to predictable and long-term financial resources.⁶

The report notes we need to strengthen human resources and systems. This requires structural interventions, but also more technical forms of communication, including skills training for health workers, to make the most of existing resources.⁷

⁴ *ditto* p.8

⁵ www.panos.org.uk.

⁶ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.9

⁷ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.10

If Universal Access is to be achieved, the disparate elements of health services and health care delivery need to be more effectively linked and communication reinforced. Weak health systems need to be strengthened through better organization. Infrastructures need to be established so that resources are not only made more widely available but are also in place where they are most needed. The means by which health care is delivered need to be re-examined so that the responsibility for treatment is devolved down the traditional clinical hierarchy to a broader base of health workers.

Some steps have already been taken along these lines. WHO is currently promoting a number of radical integration methods. Tasks, which were once the province of highly trained specialist clinicians, are now being handed to nurses, home-based carers and dispensary workers. Work that was being done by specialist centres is now being done by general health facilities. And people living with HIV and AIDS are being trained for outreach and community support.⁸ These measures, and more, help link the elements of treatment and support, allowing for better referral between the health care and community settings.

Guidelines produced by WHO establish consistent standards in terms of health care delivery but encourage local adaptation. Different modules can be added to suit particular contexts, for example, on drug injection. They also offer initiatives on how to strength health systems by providing tools for training, planning and patient delivery. One example of how extensively WHO have thought through its plans for change is its recommendation that the management of TB and HIV and AIDS be integrated as opposed to the more usual division of the two into separate specialities. It helps alleviate widespread human resource limitations by rethinking how tasks are allocated.⁹

Radical new thinking, such as that demonstrated by WHO's initiative, will be essential if programmes are to reach the required scale where the millions needing treatment under Universal Access are to receive it.

On the basis of the consultations, UNAIDS stressed that large-scale measures to strengthen human resources to provide HIV prevention, treatment, care and support and to enable health, education and social systems to mount an effective AIDS response. The kinds of large scale measures will almost certainly include major health promotion programmes.¹⁰

The pivotal point in contemporary understanding of what is mean by health promotion occurred in Ottawa in 1986, when, for the first time, the term was comprehensively defined. The Ottawa Charter, as it is known, states:

⁸ UNAIDS / WHO, *Progress on Global Access to HIV Antiretroviral Therapy, An update on "3 by 5"*, June 2005, p.22

⁹ WHO Guidelines for IMAI, including "Patients Self Management and Carers Booklet", WHO 2005 and "Flip Chart for Patient Education", WHO 2005

¹⁰ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.10

'Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being'.¹¹

So health promotion may be regarded as a holistic approach that concentrates less on the risks of specific diseases but more on lifestyle and other factors that enhance the well being of the individual. The Charter's inventory of the fundamental conditions and resources required includes shelter, education, food, income, social justice, and equity.

Despite its ambitious scope, politicians and clinical practitioners around the world are coming to regard health promotion as increasingly desirable as they face the mounting costs of delivering health care.

The relevance of health promotion in regard to Universal Access needs hardly to be stated. A healthy, self-aware population helps minimise the risk of the spread of AIDS, while people living with HIV and AIDS can enjoy a more productive, positive and longer life if their care is centred on the well being of the whole person rather than exclusively on treating the disease.

Given the breadth of its ambition, health promotion employs the whole gamut of communication approaches, including policy advocacy, health education, and topic or arena focussed interventions. An example of the former would be a promotion on sexual health, while the following is a good example of the latter.

The management of a hotel in Thailand became concerned about the risks their employees ran of contracting HIV and AIDS as they fitted the demographics of new HIV infections in the region. They initiated a workplace prevention programme for their staff that integrated HIV and AIDS awareness and prevention strategies into a broader health promotion agenda, which also encourages the employees to support local HIV-positive children.

Such enlightenment has benefited the hotel too; morale has increased; staff turnover reduced and fewer days are lost for health reasons.

The consultations led by UNAIDS found that affordable commodities were needed. From a communication perspective, availability of these commodities

¹¹ http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

is only one part of the picture. There needs to be a demand for them, which is where social marketing may play a role.¹²

The commercial marketing of goods and services is a highly sophisticated discipline that can change attitudes and alter behaviour as well as simply shift product. In best practice, it is always consumer led, meaning that it seeks to understand the attitudes, desires and motivations of its customers within a given market in order that it can wholly meet them. The key parameters that help define what is required go under the headings of product and/or service, packaging, price, promotion and point of delivery.

Ideally, the product or service will not just meet the expectations of the desired audience, but exceed them. The packaging will be appropriately distinctive and help heighten the anticipatory promise of the product. The price, classically, is positioned to be as high as the market can bear; in highly competitive markets, it is depressed; in luxury or lifestyle markets, it is inflated. Promotion is invariably single-minded in that any message must compete with the thousands of others that, likewise, are seeking front of mind attention from the consumer. Finally the product or service must be delivered to the consumer precisely when it's wanted and where it's wanted.

Social marketing differs from commercial marketing most characteristically in that it is not motivated by profit. So where price of commercial goods is positioned to be as high as the market can bear, social marketing will attempt to price products as low as the least paid can afford.

Social marketing also differs in that the issues it deals with, the attitudes and behaviours it desires to change are fundamentally more complex and sensitive being deeply ingrained in cultural and social codes. This is especially true of matters related to AIDS. However, there are certain products and services, as well as awareness and attitudinal campaigns, which are tailor made to benefit from social marketing techniques. These include some of the commodities identified in the report, like male and female condoms, children's nutrition and HIV prevention technologies.

The Caribbean Social Marketing Programme for HIV & AIDS (CARISMA) provides an insight into how sophisticated social marketing programmes can be.

Founded in 2005, they are actively engaged on a number of projects, one of which is the promotion of condoms. One set of issues they are presently focussed on is the limiting factors to condom access in the Caribbean, i.e. availability, price, confidentiality and provider attitude. Their objective is to build a Total Condom Market by increasing availability and so grow the market in all sectors – free, commercial and subsidised/social marketed products.

¹² UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.12

An important component of generating the market is to chart sales of condoms, both to monitor success of their enterprise and measure the frequency of use of condoms and, therefore, the change in people's sexual behaviour. Though the data for the free and subsidised markets is easily accessible, distributors regard information about their sales as commercially sensitive. Despite this, CARISMA have devised a methodology for ascertaining the necessary public health figures without disrupting the private sector.¹³

The report stressed the need to remove major barriers — in pricing, tariffs and trade, regulatory policy, and research and development — to speed up access to affordable, quality HIV prevention commodities, medicines and diagnostics.¹⁴

Experience teaches that there are a number of steps that need be taken before an individual will choose to change his or her behaviour. Condensed, they can be headed as awareness, appreciation, attitudinal change, behavioural change.

Before an individual can change their attitude to a topic or issue, they must first be aware of it to be in a position to appreciate how it might impact on them. This might give them sufficient cause to re-examine and change their attitudes to the topic. Only when they have adjusted their attitudes will they have sufficient motivation to act and adapt their behaviour.

Behaviour change communication (BCC) is a means of managing and developing this process. Of necessity, it must have a clear understanding of the audience it is addressing in order to tailor appropriate messages that will help them effect the hoped for change. To be effective, it must be sensitive to their cultural and societal traditions and allow the audience to develop its own messages at its own pace. Effectively it is an interactive process. So the basic facts about HIV and AIDS can be disseminated in a language or through the use of small media – pantomime, drama, visual representations – that is easily understood and appreciated by the community.

BCC can have broader objectives, for instance, it can address the issue stigma and discrimination; it can help empower sex workers to negotiate for safer sex; it can encourage partners to recognise the dangers of infidelities and reinforce the need for condom use. It can contribute to the development of a sense of confidence in making and acting on decisions. Behaviour change may be needed not only on the part of those at risk, but also of those who make decisions. BCC can lead policymakers and opinion leaders towards effective approaches to the epidemic.

There is currently a national campaign running in Ghana under the slogan of

¹³ http://www.carisma-pancap.org/Documents/CARISMA_BROCHURE.pdf

¹⁴ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.12

Stop AIDS, Love Life. Among those who are at risk of HIV and AIDS in the country, because of the nature of their work, are the commercial drivers. They are more likely to have a number of non-regular sexual partners and less likely to use condoms.

A behaviour change communication programme is now working to help the drivers increase their knowledge of AIDS and change to safer sexual practices. The campaign uses the mass media and a range of participatory activities including peer education. It has been reported that, so far, the results in relation to all the objectives look encouraging.

One of the challenges related to this area that the report noted were stigma, discrimination, gender and human rights. These challenges can only be overcome by communication, and a whole range approaches will be pertinent in order to tackle the different aspects of stigma. Mass media interventions are one part of the required response to stigma, one example being edutainment.¹⁵

The mass media, both privately and publicly owned, have an important role to play in the fight against AIDS. With their broad reach and large audiences, they can and have used their resources to educate people about AIDS, provided positive role models and helped address stigma. The term "edutainment" stands for a combination of entertainment and education through which the media disseminates information. With creative flair, they have written into soaps, songs, cartoons, comics, theatre and other art forms, credible storey lines bearing messages that encourage healthy behaviour. Not only does such drama reach huge numbers but it can also have an immediate and long lasting impact, especially when combined with grassroots communication work.

South Africa's Soul City is a shining example of what may be achieved with edutainment.

Though it is a multi-faceted project that encompasses every form of media, it is most widely known for its regular series of thirteen 1-hour TV programmes that are broadcast on SABC.

In the twelve years since its inception, it has covered every aspect of life relating to HIV and AIDS, from personal finance to rape, alcohol misuse to depression. Each series is developed through a formative research process, consulting with audiences and specialists. Other materials, like the three full colour booklets that are issued each series, are tested with community participation to assess their efficacy. Such has been its success that it has been shown in many other parts of Africa as well as Latin America, the Caribbean and South East Asia.

The report stressed the need to protect and promote the AIDS-related human rights of people living with HIV, women and children, and people in vulnerable groups, and ensure that they are centrally involved in all aspects of the

¹⁵ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.14

response. The voices of those living with HIV and AIDS will be crucial here, and an enabling communication environment is required for that to happen.¹⁶

The purpose of creating an enabling communication environment is founded on the belief that the voices of those most affected by HIV and AIDS have the right to freely express themselves on those issues that personally affect them without the fear of censorship, penalization, stigma or discrimination. And, furthermore, that they have the right to be included in the decision-making process and to scrutinize and debate any decisions made.

Thus, the generation of an enabling communication environment encourages public debate, advocacy and social cohesion under the shelter of a free press and broadcast media, a pro-actively responsive government and an engaged civil society.

It supports governments which positively encourage a transparent approach to all the issues surrounding HIV and AIDS, are open to civil society demonstrations, tolerate critical reaction to their policies, and hold themselves accountable to the marginalised communities in their society.

Furthermore it promotes civil society groups, businesses, state organisations, civil servants, and the media in all their actions to widen the debate on HIV and AIDS both inside their own organisations and to the wider community.

In many countries, radio plays a key role in disseminating information on HIV and AIDS. In surveys covering 36 countries, about half of female respondents and 70 percent of males mentioned hearing about AIDS on the radio.

Four years ago, with the assistance of USAIDS, Local Voices, an enabling communication programme, was established in Nigeria and Kenya to train journalists, talk show hosts and disc jockeys on the most effective and engaging methods of integrating HIV and AIDS information into their daily broadcasts. Station owners and managers were also canvassed to gain their support for high quality reporting on the issues surrounding the pandemic.

Other initiatives, including awards and travel grants, were installed to encourage journalists to investigate and report on HIV and AIDS throughout their country; to motivate them to become more actively engaged with the issue; and to give them the confidence, through their associations, to take responsibility for ongoing programmes within their respective regions.

In order to protect rights, the report noted that targets and accountability are required. Civil society is already involved here, holding policymakers to account. Participatory communication helps capture some of the characteristics of these efforts, and is particularly well suited to allowing those

¹⁶ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.14

most affected by the virus hold policymakers to account. Some of the social change and human rights forms of communication are also relevant.¹⁷

Participatory development communication is based on a human-centred approach that values the importance of interpersonal channels of communication in decision-making processes at the community level. The thrust of its focus is on facilitating change.

Participatory communication encourages people to take charge of their own futures through dialogue, participation and self-regulated planning and so build a capacity to respond to the needs of change. It is sensitive to the time scales that communities operate in rather than external demands for short-term results. The communication process is also tailored to the group in terms of content, language, culture and media and so is relevant to their circumstances.

Ultimately, the objective of participatory communication is to allow the community to understand for itself the reality of an issue like HIV and AIDS, and so own and respond to it in a manner that is appropriate to the group, rather than be half-heartedly persuaded from an exterior position.

The challenge in developing a participatory programme is to avoid the risks of manipulation and community conflict; also to recognise that the costs of participation, in terms of working time devoted to the process, can be unevenly afforded within a community. However, after more than two decades of experimentation, many development communication practitioners and researchers testify to the value of this approach.

On World AIDS Day 2005, a 'Know Your HIV Status', the first of its kind in the world, was launched in Zambia to offer confidential and voluntary HIV testing and counselling, with the aim of reaching all households by the end of 2007.

To develop the campaign a group of partners have, among other activities, established radio listening clubs. It is a the perfect exemplar of participatory communication, allowing, as it does, all parts of the community to actively engage in an on-going debate on matters arising out of the issue; the powerful speak to the weak, the timid to the bombastic. These local discussions are all recorded so that they may be played back before a panel of experts, policymakers and other key figures for their comments. The whole is edited and then aired on national radio. And so the cycle continues, with the local population now being able to comment on the wisdom of its public figures.

Similar to participatory communication in its ambition, though from a different tradition of thought, is the **human rights approach to communication**, which is most notably championed by Unicef.

¹⁷ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.14

By stressing that, above all, the individual has rights as a human being, this approach places an onus on the decision making process to begin by first recognising and respecting those rights. In other words, no decision should be made over the head of the individual, or rights holder. He or she need be brought into the process from a position where they understand their own situation, have the knowledge to determine their own vision, and the power to negotiate in their own right. They create and negotiate their vision – and realise their rights – by communicating, first within their own group and then with those in a position to bring about change.

Communication for social change is another related approach that recognises communication *per se* as being a cultural and political force. It proposes that very process of public and private dialogue is a means by which people define themselves, their needs, and how to acquire them in order to improve their own lives. It encourages the use of dialogue within communities to identify collective problems, arrive at decisions and implement solutions to development issues.¹⁸

Finally, the report stressed that in every country in 2006 ambitious AIDS targets should be set. It noted that these should reflect the urgent need to massively scale up HIV prevention, treatment, care and support, and move as close as possible to the goal of universal access by 2010. This will require social mobilization. As of August 2006 there was little action being taken to set these country targets, and civil society was not heavily mobilized.¹⁹

Social mobilisation builds on the understanding of communication for social change by emphasising the need for political coalition-building and community action. Ownership is gained through wide community participation as a counter to innovations being externally imposed. Social mobilisation is closely interlinked with advocacy. It strengthens advocacy efforts and relates them to social movements and social marketing activities.

The People's Health Movement has an inspiring vision. Its Charter states: 'Equity, ecologically sustainable development, social justice and peace are at the heart of our vision of a better world – a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich one another; a world in which people's voices guide the decisions that shape our lives'.²⁰

The Movement arose out of a unique mobilisation exercise that involved people in village meetings, district meetings, national events and regional

¹⁸ <http://www.communicationforsocialchange.org>

¹⁹ UN General Assembly, Scaling up HIV prevention, treatment, care and support, 24th March 2006, A/60/737, p.16

²⁰ <http://www.phmovement.org/files/hivaid-english.pdf>

workshops to prepare for a global gathering – the People’s Health Assembly (PHA) in Bangladesh. One thousand, four hundred and fifty-three participants from 92 countries came to Assembly in 2000, which was the culmination of 18 months of preparatory action around the globe.

Despite facing continuing challenges in the intervening years, the movement is today having an increasing impact on health policy and practice.

Conclusion

We stated at the opening of this paper that any endeavour to link current efforts in treatment, care and prevention, not to mention linking HIV and AIDS to broader public health issues, would require sophisticated communication techniques. And on the following pages, we have attempted to summarise the range of different methodologies currently being employed. However, the year 2010 looms large; Universal Access to HIV and AIDS Care, Prevention and Treatment Services is now only four years distant. Though much has been achieved, and here we have reported on some outstanding successes, the challenges remain daunting. It is not enough that governments have committed to Universal Access; it is not even enough if they are genuine in their attempts to deliver Universal Access; so long as those who are most affected by HIV and AIDS feel isolated from their communities and wider society through stigma, discrimination, violence, gender inequality, lack of resources, and location, they will not feel themselves free to seek the care and resources they need. And so Universal Access will fail.

HIV communicators know the challenges, they are itemised at length in the UN Global Report on AIDS 2006. They have the communication tools; and, providing donor countries keep their promise, they have the funding. The task they face is to unify their efforts in each region of each country so that the barriers to Universal Access are surmounted, and every individual in need of care, prevention and treatment services feels empowered to seek them.

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Thank you.