

Asia Pacific Region Thematic Analysis Paper - 2

COMMUNITY MOBILIZATION & HIV COMMUNITY RESPONSE TO HIV

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Community mobilization and HIV/Community response to HIV

Introduction

Three decades into the HIV/AIDS epidemic, with investments in individual behavior change programs and the diffusion of new and improved prevention and treatment technologies and services, we have achieved some success in reducing individual risk behavior. However, we know from the experience of gay men in San Francisco, the new wave of infections in Thailand, and increases in risk behaviors in Uganda that such success can be short-lived. These experiences show us that sustained individual behavior change is ultimately dependent on engaging communities in changing the structural context that fosters risk behavior. The paradigm shift from an 'etic' approach of information and education campaigns to a progressively 'emic' approach of empowerment and rights actualization in HIV prevention responses was shaped by a growing awareness of complex social, cultural, political, economic and structural forces that ignited the HIV epidemic in the region. This is especially critical in the face of realization of the link between vulnerabilities that led to risky behavior towards the transmission and acquiring of HIV. In addition, the shift in the HIV response from tackling individual risk behavior to those of community risk due to shared and common vulnerabilities has led to spectacular momentum in the AIDS response, previously unforeseen and experienced. This thematic paper explores the definitions, the theory behind community mobilization and response to HIV, and some examples of community responses. This paper further analyses some of the main challenges and presents learning from approaches of community mobilization, institution building, and community responses to HIV in the Asia-Pacific region.

In this paper we present research and programmatic experiences in community mobilized responses to the HIV epidemic. We highlight ways in which communities along with government and civil society groups can partner for mutually beneficial and enhanced results. We attempt to answer the following questions:

- I. What is community mobilization in the context of HIV?
- II. What is the value added with community approaches in the AIDS response?
- III. What are the lessons learnt?

Definitions

Community groups: In this paper we use the definition for 'community' provided by The Commission on AIDS in Asia (Commission on AIDS in Asia, 2008). In the context of Asia's HIV epidemics, the word 'community' usually refers to those people who are infected or affected by HIV, rather than to people living in specific places. Such communities would include people living with HIV, sexworkers, injecting drug users, transgendered people, and men who have sex with men. In discussing how to involve and support communities, it is important to recognize that not all these people necessarily regard themselves as belonging to a particular 'community'. Some, such as brothel-based sexworkers or men who have sex with men, may readily self-identify as sexworkers or as gay. But others, such as rural women who occasionally exchange sex for money or food, or men who have sex with men but only during specific situations, are unlikely to see themselves as part of such 'communities'. Similarly, migrant workers, seafarers, military personnel, transportation workers - who have certain vulnerabilities to HIV risk due to long periods away from home, relatively high salaries and a risk-taking ethos - might not consider themselves as belonging to a particular community (Connell & Negin, 2010). HIV response must not overlook 'groups' that may not consider themselves as part of a community.

Community organizations: These are formally organized communities through institutions set up and led by a particular community, and they can range from small self-help groups to large trade unions (Commission on AIDS in Asia, 2008).

Community mobilization: UNAIDS defines community mobilization as follows, “A community becomes mobilized when a particular group of people becomes aware of a shared concern or common need and decides together to take action in order to create shared benefits. This action may be helped by the participation of an external facilitator—either a person or another organization. However, momentum for continued mobilization must come from within the concerned group or it will not be sustained over time” (UNAIDS, 1997).

AIDS resilience: At the individual level, AIDS resilience is in place when individuals are able to manage the risks that are present in their environment (Auerbach, Parkhurst, & Cáceres, 2011). AIDS-resilient individuals living in a common geographic area or sharing a common set of activities or identities make up AIDS-competent communities. Members of an AIDS-competent community work collaboratively to support one another in achieving the primary elements of HIV prevention, care, and treatment; the reduction of stigma; support for people living with HIV and their caregivers; cooperation with volunteers and organizations working for HIV-prevention and AIDS-care; and, effectively accessing health services and welfare grants, where these exist. AIDS-competent communities exist where there are effective HIV-related information and services, and where individuals within the community are connected to each other and to external organizations that can provide additional resources and support (Campbell, Nair, Maimane & Gibbs, 2009).

What is community mobilization in the context of HIV?

Community mobilization in the context of HIV refers to the method of response to the epidemic through the communities most affected by the disease. Through an understanding of their unique priorities and needs, communities are well suited to mobilize themselves for resource gathering and advocacy.

Effective community mobilization around HIV can lead to improved outcomes in geographic clusters. It can also provide insight into the mechanisms of effect, i.e. how the intervention works through the key psychosocial factors of identification and collectivization influenced by mobilization (Kuhlmann, Galavotti, Hastings, Narayanan, & Saggurti, 2013).

Four ways that communities can mobilize for an effective HIV response are through:

1. **Knowledge:** Communities (and the CBOs working with them) have greater knowledge about their HIV and AIDS-related needs.
2. **Behavior:** Communities are best placed to engineer behavioral changes, as individual behaviors are often influenced by the social customs and norms of communities.
3. **Capacity:** Communities (and community groups) have some basic capacity to identify, implement, and manage some HIV and AIDS activities. When communities carry out activities, there is more ownership, costs can be lower, and capacity is built within the community. This in turn strengthens long-term sustainability.
4. **Social change:** The community response can strengthen social capital (in the form of increased trust and reduced stigma) through community mobilization. Likewise, it can also engineer positive social changes. Higher levels of community mobilization have also been shown to help improve condom use and reduce perceived discrimination beyond the effects of the core HIV intervention program (Kuhlmann et al., 2013).

In addition, communities have the advantage of immediacy and locality— whereas it may take time for international organizations to roll out an effective response to local disease epidemics, the community is naturally on the front line of the response (Rodriguez-García, Bonnel & Wilson, 2012).

What is the Value Added with Community Approaches in the AIDS Response?

Community engagement increases the “reach” and sustainability of programmes; it is a vital component of the wider “task shifting” agenda given the scarcity of health professionals in many HIV/AIDS and other vulnerable contexts (Campbell & Cornish, 2010). Most importantly, it facilitates those social psychological processes that are vital for effective prevention, care and treatment. When affected communities realize the impact of HIV on them, they are well placed to address the issue appropriately. NGOs have limited staff and communities are larger in number with wider reach and understanding of how to reach their members (e.g. convenient times, appropriate language, etc). Peer outreach workers may have more access to their communities and be more effective in providing prevention counseling and materials, such as cleaning kits and condoms for drug users (Commission on AIDS in Asia, 2008). When NGOs externally run the project implementation, the work may not be as effective. Communities compile action plans, which are suitable to their own context. In work with migrants on HIV, both Nepali and Bangla speaking communities in Mumbai agreed on the importance of sex education for their children; however, the action plans were different. The Nepali community was comfortable providing sex education at home but the Bangla speaking community decided that women should provide information to neighbours’ children with support of the NGO.

The Commission on AIDS in Asia notes a number of advantages of community-based organizations. Their smaller size makes them less bureaucratic than their Government counterparts, and gives them the flexibility to respond quickly to new situations. When programmes piloted by community-based organizations prove successful at the local level, Governments can consider scaling them up to the national level. For example, in China men who have sex with men set up community hotlines to provide support and information on HIV and other issues. By 2007, the Government recognized the importance of working with this group and was funding programmes to support them. Community-based organizations can also be more efficient in service delivery, promoting activism based on the communities’ needs, and generating support of partners. For example, the AIDS ACCESS Foundation of Thailand increased the availability of HIV drugs through collaboration with partners (Commission on AIDS in Asia, 2008).

Community led programs using an empowerment approach to prevention have been successful in increasing preventative behaviors. Project Pragati, an Empowerment programme among women in sex work implemented by Swathi Mahila Sangha and Swasti in Bangalore, India, has shown that community empowerment approaches, that include peer led crisis response, micro-financing systems, and de-addiction programs in addition to HIV preventative information and services, can result in achieving HIV prevention outcomes. One study of Pragati found that program attendance over 4 years was correlated with a decrease in STI incidence and an increase in condom use among participants (Souverein et al., 2013).

Evolution of the approach to community mobilization from individual behavior change

Prevention approaches have shifted from early emphasis on the individual as locus of change (HIV awareness approaches) to the peer group as locus of change (peer education approaches) to the community as locus of change (community mobilization approaches) (Campbell & Cornish, 2010).

Targeting the individual as locus of change, and informed by traditional health psychology, first generation approaches to behaviour change took the form of traditional didactic health education

seeking to provide individuals with information about HIV/AIDS, how to avoid it, and how to respond once infected” (Campbell & Cornish, 2010). However, this study and several other studies noted that mass HIV campaigns did increase awareness, but the amount of behavior change that resulted was doubtful.

The second approach was incorporated for risk reduction and response to HIV, the peer education model. Peers were seen as the best communicators of knowledge and skills, given their “insider” status within hard-to-reach groups. Programmes trained members of “high-risk groups” in HIV/AIDS-related information and skills and sent them back to their communities to disseminate what they learned. This strategy has had a limited impact as shown by many studies and evaluations. A systematic review found that peer education interventions for HIV prevention have a positive but small impact on behavioural and knowledge outcomes and no impact on biological outcomes (Medley, Kennedy, O’Reilly & Sweat, 2009). Furthermore, in 2000, a governmental assessment of HIV peer education programs in Vietnam found that “very limited” numbers of people were reached. Only 20 of Vietnam’s 61 provinces had programs. Most targeted injecting drug users and many targeted commercial sex workers; however, few targeted their sex partners. The nature of education was also incomplete; while some programs distributed condoms, few demonstrated their correct use, and access to clean needles and syringes were often not provided. The authors say that small surveys of clients indicated continuing high-risk behaviors despite repeat contacts with peer educators, suggesting inefficiencies in peer education (van Khoat, West, Valdiserri & Phan, 2003). Evaluations of IEC show that information is necessary but rarely sufficient for behavior change. A woman might be aware of safe sex practices, but the social situation renders her powerless in making her partner(s) adopt such practices. Communities should be involved in analyzing the power hierarchies among them, in order to really understand ways of creating more equity within.

Subsequently, the third generation of responses to HIV/AIDS identifies the locus of change more widely than peer education, seeking to implement changes at the level of communities, in order to create community contexts that support the development of health-enhancing peer norms and individual behavior changes. Community mobilization approaches seek to create and harness the agency of the marginalized groups most vulnerable to HIV/AIDS, enabling them to build a collective community response, through their full participation in the design, implementation and leadership of health programmes, and by forging supportive partnerships with significant groups both inside and outside the community.

The **Sonagachi Project of Kolkata**, India brought to the forefront the importance of community mobilization and development among female sex workers as a means to improving their health and well-being and reduce vulnerability to HIV and STIs. Sonagachi, which began in early 1990s, utilized a three-pronged approach including behavior change communication, condom distribution and STI management. The social vulnerability perspective adopted by Sonagachi led them to develop a broader set of program activities to complement the three-pronged approach. Five intervention areas were (i) facilitating a sense of community among sex workers, (ii) decreasing perceived powerlessness and insecurity, (iii) increasing access and control over material resources, (iv) increasing social participation and (v) facilitating the social acceptance of sex workers. It is this framework and the increases in condom use and the decreases in STIs that were achieved through its implementation which has made Sonagachi a UNAIDS Best Practice Model for HIV/STI prevention among sex workers.

Source: Jana, Basu, Rotheram-Borus, & Newman (2004)

TLF Sexuality, Health and Rights Educators Collective (Makati, Philippines)

TLF was initially focused on training peer educators, but now its focus is more about building these groups to be local players and has thus forged stronger leadership on HIV issues among MSM and transgender people. The upshot of this growth in community leadership has been a newly active political and advocacy role at the local level for the CBOs. Today, TLF-SHARE sits on the country's National AIDS Council and plays a significant role in the national response to HIV and AIDS.

Source: AmfAR (2010)

The AIDS Competence Programme is another community focused prevention programme based on revealing and nurturing community strengths to stimulate local response. These programmes are implemented all over the world, including Asia Pacific in Bangladesh, Cambodia, China, India, Indonesia, Nepal, Philippines, PNG, Thailand, etc, and have demonstrated that **when NGOs/external facilitators** approach the community members as human beings to appreciate, listen and learn, community members feel valued and recognized, which gives them impetus to act on issues of concern and measure their progress. The UNAIDS evaluation of AIDS Competence cites from Thailand that: "between 83% and 87% [of AIDS Competence Process users] are satisfied and confident that the program achieves impact within communities, based on the experiential outcomes that they see or perceive within their communities" (UNAIDS & UNITAR, 2005).

UNAIDS Best practice- AIDS Competence Process (ACP) application in PNG

ACP has been effective in addressing HIV as well as other local issues through local mobilization and empowerment and can complement HIV awareness programs. The inherent practicality of the approach [stimulating action], resulting behavior change, and support of facilitators, local champions and organizations have been instrumental in fostering community ownership. Through an approach based on community strengths in line with the local leadership structure, community members have acquired confidence to take action. Both women and youth have been making increasing input into community decision-making. Communities have used their own resources, while seeking and accessing additional outside resources and services. ACP appears to be effective in sustaining community action in the long run. In some sites, ACP led to the establishment of local CBOs and inclusion in local government plans. In some communities, ACP has been transferred to 2-4 new sites.

Source: WHO & UNICEF (2009)

Lessons Learnt from Community Mobilisation in the AIDS Response

Common vision can stimulate community response to HIV

Approaches, which focus on gaps and needs and how outside agencies can 'teach' the community what to do and fix community problems, reduce the communities to passive recipients of material help. Therefore, using a bottom-up approach of facilitating a shared vision can create a cohesive community. Sonagachi project built community solidarity around occupational identity of the sex workers. In Karnataka, Samraksha and Swasti's work with sex workers demonstrated that it was possible for a community identity to emerge from a **diverse, dispersed** urban group. Community identity is an important factor for successful, sustainable community mobilization.

A strength-based approach promotes community ownership and accesses resources

The most important factor is to begin with the firm belief that people and communities have the potential to address their own issues. For effective community engagement, external

facilitators/NGOs must listen and learn from the community. One dimension of empowerment (power *within*, which measured self-esteem, motivation, and confidence) was strongly associated with condom use among sex workers in Karnataka, India. Another study found that application of AIDS competence in Nagaland with drug users built the capacity of the community to realize their skills and abilities to enact behavior change, such as going for HIV testing and collective action (Rodriguez-García, Bonnel, & Wilson, 2012).

Forced and time bound community development is not sustainable

Community mobilization, building community capacity, and developing trust takes time, resources and comprehensive planning. If considerable time is spent in establishing the right structures and processes community members can be meaningful partners. Time-limited project funding may get certain things done but broader investments in community infrastructure and partnerships are usually required to sustain activities over the long term. Change happens at a varying pace and is not linear. The motivation of communities to come together to practice safe behaviors, form formal organizations or confront injustice, differs from one to the other in pace and intensity. It is important, therefore, to acknowledge this and not force the pace by setting rigid deadlines.

Needs of the community should be prioritized over the needs of the program

Experience has demonstrated that a holistic approach and sensitivity to the needs of the community actually strengthens the deliverables of structured interventions. For example, protecting community members' wish for non-disclosure of identity helps better service access and follow up.

The communities' practical needs (needs that are fundamental such as food, water, shelter, violence free environment, etc) to be prioritized or at least be addressed in a way that the programme gains trust to introduce the activities that are core to the programme. Otherwise, the tension between the cross-purpose needs will only throw the programme out of balance.

During the design phase of Project Pragati, mentioned previously, the NGO facilitator constantly checked back with the community to know their needs and aspirations. These needs were prioritized in programme implementation and activities were adapted to meet them. "This helps to ensure that the programme continues to remain relevant to the community and continues to respond to the emerging needs of the community" (Euser, Sovereign, Rama, et al, 2012). Targeted Interventions should consider and integrate community's needs and aspirations along with their main priority of HIV prevention.

Build leadership styles that fosters relationships

A style of **leadership** that moves away from traditional "lead and follow" approaches towards one that builds trust and fosters relationship. The learning for Samraksha (2009) has been that a broad base of potential leadership has to be facilitated right from the beginning. As some community members take the lead in the project or become part of an external organization, there is a danger of their identification with non-community perspectives and becoming distanced from the community. Different projects in the same area create parallel organizations, which are backed by different donors and NGOs and this can lead to a division in the community. Community leaders can find it difficult to take tough decisions against other members with whom they had a long, close relationship. Shared vision can help the leaders and community to interact on an equal footing and the CBO is not single-leader driven, but has a leadership base from which it drew its leaders. Making space, creating opportunities and building second line and third line leaders is extremely crucial to keep the community together, as power centric communities have been known to fraction and disintegrate.

NGOs should play facilitative and neutral roles

In the period of transition from NGO led HIV programming to CBO led interventions **power struggles** were inevitable. The learning has been that letting go, taking a neutral stand, and facilitating the CBO to reconcile its own differences pays off. Taking sides on the issue or getting involved in resolving the conflict can divide the emerging CBO.

Community mobilization and self-determination frequently need nurturing. Before individuals and organizations can gain control and influence and become players and partners in community health decision-making and action, they may need additional knowledge, skills, and resources. Organizations like Swasti and Ashodaya (India) run regular classes and onsite immersions for the communities to **equip and empower and update** the communities on a variety of issues.

Retaining a person-centric/community-centric approach in programme templates that are totally disease-centric has been a core difficulty. It has been a challenge to convince technical experts that the community-centered perspective is not just rights-based, but the best public health strategy.

Another challenge facing CBOs is often the donor's insistence on separating community building from project deliverables (Samraksha, 2009). Processes for discovery of "self" coupled with those of empowerment are needed before a community can emerge. A denial of this reality poses a huge challenge. The perceived conflict between project objectives and developmental objectives by technical support teams has also been a challenge. A focus on community building is seen to detract from project outcomes. Project managers who do not fully recognize the impact of marginalization and oppression of sex workers often demand short-term concentration on project deliverables. The collectivization and empowerment processes are what can sustain the same programme objectives in the long term. It needs continued support and nurturing. Differing perspectives of the interventionists, which play down the community building processes and push them on targets is detrimental to the larger programme outcomes.

Making this shift real requires investment in new kinds of relationships and dialogue between those with needs and those with the resources to meet those needs. It is a commitment to a process of learning from those at the receiving end of AIDS programs to ensure that those programs meet real needs and address real vulnerabilities (Auerbach, Parkhurst & Cáceres, 2011). Putting communities in the forefront requires skills, attitude and tools, and a concerted effort to gather the perspectives of marginal populations who reside within the community. Unfortunately, there are limited facilitators available for this type of effort (McCloskey, McDonald & Cook, 2013). Government may be wary of empowerment of local communities, as communities may take actions that are **not aligned** with government priorities and accountability requirements.

NGOization of CBOs and unfair expectations

Sometimes when the emerging CBO goes into an accelerated growth phase and begins to manage multiple projects, targets and deliverables can push the CBO in specific directions. The organization itself can then begin to operate within a project mode. Hence it is important to invest in organizational visioning and the community's ability to constantly align their activities with their vision, along with project management and processes essential for carrying out this vision (Samraksha, 2009).

Working with communities to scale out the HIV response increases program coverage

Another dimension of the voluntary spirit can be to seek support to expand the scope and coverage of the intervention by reaching out to new communities. For example, the VAMP sex workers movement team in India carried out a survey of married women in sex work to discover how to reach this largely hidden group. Similarly the drug users mobilization in Malaysia (UNAIDS, 1999)

another important lesson is that members of one marginalized community – if they have already gone through their own mobilization process – may be extremely effective at reaching out to another even more marginalized community. Similarly, Salvation Army and Constellation focus on intentionally facilitating communities to transfer vision, approaches and lessons learned to individuals and communities. Some key outcomes of transfers include way for communities to rapidly gain confidence and address their own issues, progressively addressing deeper and deeper issues. The sharing generates confidence to reach out further to nearby communities.

Resource allocation for institutional growth

It is important to link the integration of structural approaches to budget lines that are sufficiently robust for supporting substantial, long-term efforts and **project cycles of 5-15 years** or more (Auerbach, Parkhurst, & Cáceres, 2011). This is an effort that will respond not to easy fixes or short-term approaches, but to sustained, rigorous, well-informed effort applied over many years. The current one-to-two-year program planning and funding cycles will need to be reframed to five- to fifteen-year cycles in order for the structural changes to take effect and show meaningful impact on AIDS outcomes. WHO and UNICEF (2009) evaluation mention that community mobilization have insufficient follow-up and support, too few opportunities for exchange and mutual reinforcement between communities and financial constraints on facilitators (e.g. limited travel budget, resources). In spite of their important role, donors and governments do not currently earmark funding for core capacity development of community organizations very often (Sarkar, 2010). As a result, participation of communities in HIV responses is held back by a lack of capacity. Government **funding** policies, structures and processes are not well equipped to support, or necessarily aligned with, community priorities. Funding amounts reaching the community, and thus CBOs, are often smaller than originally expected (Rodriguez-García, Bonnel, & Wilson, 2012). However, CBOs are capable of achieving results because of their own fundraising activities, in kind contributions, use of volunteers, and the relatively small size of their catchment areas. An analysis of Avahan Project in India reported funding disruptions, especially to local NGOs and CBOs and to those that employ sex workers as peer educators, given the government's more cumbersome bureaucratic structures for transferring funds (Rau, 2011). These concerns are fueled in part by a long-held suspicion of authority by CBO members, although many have gained confidence about pressing for their rights. The transition from the NGO to the CBO is not usually adequately supported (Samraksha, 2009). This process needs overlapping staffing for at least 18 months to 2 years. If a parallel system were available for some period of time concurrently with the CBOs assuming responsibility, then the process of CBO strengthening for programme management would be faster.

Community mobilization approaches are labour intensive and do need investment but approaches, which are able to build community ownership, can be cost-effective. Investments that are required include capacity building at individual, group and institutional level, systems strengthening, etc.

Cost effectiveness of AIDS competence process. Asian Development Bank conducted The Economic Evaluation of the AIDS Competence Process in Thailand (2011). The ACP saves one QALY using resources valued less than 1 Gross Domestic Product per capita (approximately 140,000 Baht). This savings is a cost-effectiveness benchmark according to the national body managing HIV prevention programmes in Thailand. Findings from this study also suggest that higher numbers of the population exposed to ACP result in greater cost effectiveness overall by improving individual quality of life.

Source: Teerawattanon & Yamabhai, n.d.

Community response efforts should be evaluated for effectiveness

It is better to understand the mechanisms by which community mobilization enhances health outcomes (not just HIV prevention) and which intervention components are most essential for, and efficient at, spurring community mobilization. Future interventions should plan carefully for the evaluation of the community mobilization process and outcomes, including the collection of baseline and non-intervention area data (Kuhlmann et al., 2013).

Monitoring for most community-level HIV projects is built into national scale programmes that often rely on costly behavioural surveillance systems. Valuable information is missed possibly because simple, inexpensive and user-friendly monitoring tools are not available. There is clearly a need for such tools to guide frontline workers in decisions on mid-course programme correction—and to complete the evidence basis for community-led services (Sarkar, 2010). We should not lament the fact that the Avahan programme evaluation process did not incorporate indicators related to community mobilization. Often, the processes involved in community mobilization are more value-based than logically driven which makes the construction of indicators a challenge (Jana, 2012). Samraksha (2009) found that women in sex work found the Management Information Systems for data entering, tracking and reporting complicated which excluded them from this process. If anything, rather than being used as an excuse to avoid adopting structural approaches, the paucity of rigorous evaluations should spur greater investment in such research.

Power dynamics should be monitored and addressed

The existing ecology of powers in a historically marginalized community holds the marginalized group in a fractured and unequal set of interdependencies. In such instances, involving more powerful others, possibly outside the community, is necessary to capitalize on the power to put a stop to the projector offer additional, necessary support. Ideally, as the participatory project develops capacity, independence from those other groups grows; however, participatory projects alone cannot be expected to completely change longstanding power systems. In a true community system where members are held together by their interdependencies, the internal power dynamics will be utilized as needed to reach common goals (Cornish & Ghosh, 2007).

Hold reasonable expectations of what can be achieved

We must clearly state short and long term results expected from any mobilization effort. This is particularly important in broader community initiatives where fundamental changes that are required will take time to take effect.

Parting Thoughts

Effective community mobilization to combat the spread of HIV/AIDS requires partnerships with civil society and government entities. Community members most affected by the HIV epidemic are best suited to approach prevention, treatment, and care according to their own priorities and needs. Empowerment strategies that build the capacity of CBOs to fight the spread of the disease amongst its members can be strengthened with the help of NGO and government-led facilitation.

Evidence from programs and practice reveal that community building processes take time, sometimes a whole generation. The need for organic growth must be felt and advocacy and negotiation with funders, donors, and partners is required for adequate time to prove results. Given that community processes are dynamic and natural, one size fits all strategies and solutions tend to do more harm than show results. The rights-based approaches that are central to community mobilization strategies have varying local and cultural pathways that must be followed according to needs. Critically, the quality of primary risk reduction may be negatively affected if community groups do not play a key and active role.

Furthermore, vulnerability reduction actions, which play a key role in the ecosystem of primary prevention and are required at the individual level, have just been initiated. Without significant efforts, the gains made cannot be leveraged or be strong enough to result in vulnerability reduction. Communities must gather together on critical issues and systematically follow through on them using evidence for advocacy and change.

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