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Women's Empowerment and Community-based Health Care Systems for the Fight against HIV/AIDS in Southern Africa: Review and Discussion of Key Policy Documents

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Introduction[1]

The HIV/AIDS epidemic has severe and multifaceted consequences in the rural areas of Southern Africa. Notwithstanding the recent decrease of HIV prevalence and incidence rates in some countries, women remain the group most severely affected by HIV/AIDS, not only because in some areas the incidence rates are higher for women than for men but also because women are often those in charge of taking care of people living with HIV/AIDS in the household and in the community (see Pallotti 2009).

In this context of crisis, the intervention guidelines and funding[2] are set by the key actors of the international development agenda in the field of HIV/AIDS, namely the UN umbrella organization for HIV/AIDS UNAIDS and the World Bank as well as European aid agencies, USAID, the Global Fund for AIDS, TB and Malaria, and other actors such as the Bill and Melinda Gates Foundation (Stillwaggon 2006: 184) that, in the last decade, have highlighted, "the growing 'feminization'" of HIV/AIDS (UNAIDS 2004: 8, Piot 2008; see also for discussion O'Laughlin 2009), particularly in sub-Saharan Africa. In order to fight the feminization of AIDS, implying the existence of a specific and direct relation between gender inequalities within "traditional" households and the spread of HIV/AIDS, a series of interventions have been recommended, namely the formalization of separate land rights for women, microcredit programs, labour-saving crops and support for home-based care. O'Laughlin (2009), in an extensive analysis of the limited impact in terms of women's empowerment of these interventions, argues that they are based on a micro-level explanation of the AIDS epidemic, the inequality of gender relations in the household, while omitting the historical, political, social and gender analysis at community level, as well as the structural questions of class and race. According to O'Laughlin, these interventions – usually implemented at small-scale level and involving a limited number of women in rural communities that are deeply unequal from the gendered point of view, tend to entrench and reproduce, rather than limit, gender inequalities and the spread of HIV/AIDS in Southern Africa, as stressed for example by Akintola (2006) in a study on informal caregivers in two semi-rural communities in Southern Africa, where she found that home-based care can create "troubles for the troubled" in that it is usually poor, unemployed and unmarried women who are the household head and breadwinner as well as in charge of caring for

[1] This paper has been presented at the 4th European Conference on African Studies, held in Uppsala, Sweden, from 15 to 18 June 2011. The panel in which it was presented, organized by the Centre of Historical and Political Studies on Africa and the Middle East of University of Bologna, focused on "Empowerment, Decentralization and Poverty: The Role of Local Communities in the Fight against HIV/AIDS in East and Southern Africa".

[2] Among the most recent literature on this, see Edström and MacGregor (2011) for an updated analysis of the impact of global health resources for HIV/AIDS on affected communities in Southern Africa; Simon Morfit (2011) for a discussion of the impact of AIDS prioritization by international donors on NGOs in Malawi and; Peiffer and Boussalis (2010) on the positive effect of HIV/AIDS directed foreign aid on a developing country's response to the epidemic.

the sick.

In the current context of decentralization reforms, that include the decentralization of health services, a recommended intervention – and now a key pillar of the UNAIDS Treatment 2.0[3] approach – is the promotion of a community-based approach to HIV/AIDS treatment, care and prevention (of which home-based care is considered a part of). Certainly not a brand new intervention in the realm of HIV/AIDS programs implemented since the mid 1980s in Africa – in Uganda, for example, the first community-based home-care programs were initiated by TASO[4] in the early 1990s (see Iliffe 2006: 98-111) - the community-based approach is now being vociferously advocated by several key actors in the international community as a crucial and much-needed strategy for mobilizing communities and for increasing adherence to ART treatment, as the following review of key documents shows.

My aim in this paper is to review key policy documents of the global and national actors in the fight against HIV/AIDS in order to highlight and discuss the key elements supporting the community-based discourse as well as its ambiguities, in particular in terms of women's empowerment and promotion of gender equality.[5] I base my arguments on a desk research, focusing mainly on the review of academic literature and policy documents, that has been carried out in preparation of a first period of fieldwork to be conducted in Mozambique between August and September 2011. The primary aim of the fieldwork will be to select key experiences of community-based interventions in the field of treatment, care and prevention, to analyze the historical, political, social and gender context in which these interventions are taking place and to connect with key stakeholders in the communities selected in preparation for a second period of fieldwork. I am grateful to my colleagues Mario Zamponi and Arrigo Pallotti for having encouraged me in preparing this preliminary paper for the ECAS conference and I look forward to receive your comments and feedbacks.

What exactly are we talking about? Defining and discussing Community-Based Health Care (CBHC) and Home-Based Care (HBC)

[3] http://data.unaids.org/pub/Outlook/2010/20100713_outlook_treatment2_0_en.pdf
[4] TASO is the The AIDS Support Organization, an indigenous Ugandan NGO funded in 1987. See: www.tasouganda.org
[5] This research is being carried out under the "Community-based System in HIV Treatment" (CoBaSys) program, funded under the ACP Science and Technology Program. While the programme results are not being discussed here, I would like to acknowledge the inputs for analysis emerging from the Focus Groups reports realized by the African partners of the consortium. For further information see www.cobasys.eu

Orienting oneself in the maze of the acronyms defining the different types of HIV/AIDS interventions carried out at community and home level can be quite complicated as much as is to agree on a common definition of CBHC and HBC. The idea of a community-based approach to HIV/AIDS treatment, care and prevention usually implies that people living with HIV/AIDS (PLWHA), and especially those living in rural areas or in resource-limited settings (a much-liked definition in several of the policy documents that I have reviewed), not only need access to clinical but also to community services that can positively impact on adherence to ART treatment as well as improving the quality of life of PLWHA through psychosocial support, prevention education, voluntary counseling and testing, income-generating activities, support to children affected by HIV/AIDS and orphans and home-based care.

Within this general frame and areas of intervention, definitions of community-based health care and home-based care are several and overlapping. The 2001 South African National Guideline on Home-Based Care and Community-Based Care[6] defines CBHC as " the care that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people, encourages traditional community life and creates responsibilities", whereas HBC, "an integral part of community-based care", is defined as "the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health including care towards a dignified death". The document clearly explains the rationale for supporting CBHC and HBC: shortage of hospital beds and of health professionals, lack of resources for treatment, unsuitability of over-crowded hospitals for patients with terminal or long-term diseases, and the costs of institutional care. Different stakeholders are also identified, including the formal system of health and social workers; the non-formal system encompassing NGos, CBOs, traditional leaders and healers; the private sector; the informal sector of families, volunteers and caregivers and; the "client/consumer". The Department for Social Development[7] defines the services provided by organizations offering HBC and CBHC which receive funding and support from the Department itself as, among others: care, counseling and support; provision and distribution of condoms; establishing support groups; providing information to improve access to services; providing ARV and palliative care: providing food parcels and supplements.

The Namibian National Policy on Community-based Health Care (RoN 2007: 11) broadly defines it as "a community programme on health and care, in which the community is actively involved in

[6] http://www.capegateway.gov.za/Text/2003/define_homebased.pdf
[7] http://www.dsd.gov.za/index.php?option=com_content&task=view&id=97

identifying their problems and needs, prioritising them and mobilising their own resources to meet those needs. The community fully participates in dealing with appropriate activities required to solve the problems". In the listing of the kind of interventions that CBHC includes, HIV/AIDS is first mentioned among the reproductive health services, including "the prevention and control of sexually transmitted infections" and, more specifically, in the section dedicated to Home-based Care, defined as a "huge part of CBHC" and "an essential component of the continuum of care for persons living with HIV/AIDS" (*ivi*: 13). The role of HBC is further restated in the country's National Policy on HIV/AIDS (RoN 2007a: 27): "(the Regional and the Constituency AIDS Coordinating Committee), traditional authorities and local authorities shall take a leading role in ensuring that communities have access to home-based care and in supporting groups and organizations that provide home-based care".

The two examples above show how home-based care is usually understood as one of the strategies of the community-based health care approach. However, it is not uncommon to read about Community Home-Based Care (CHBC), which has been defined as "the care given to an individual in his/her own environment (home) by his/her family and supported by skilled welfare officers and communities to meet not only the physical and health needs, but also the spiritual, material, and psychosocial needs" at the 1st Southern African Development Community Conference on CHBC held in Gaborone in March 2001. The idea of CHBC, intended as home-based care delivered primarily through volunteer networks in the community in collaboration with NGOs staff (not necessarily health professional) has been defined as opposed to facility-based HBC programs, which are linked to health care facilities and whose services are delivered by the health center staff together with volunteers (PHR*plus* 2004: 3). In this often cited evaluation of the costs of providing HBC to PLWHA in Rwanda, the consultants of PHR*plus* (2004) also highlight that while the latter primarily focus on the medical aspects of care, CHBC "emphasize psycho-social support to PLWHA and their families" and focus on "assisting HIV-affected households in protecting their property; income-generating activities; and assistance with school fees for PLWHAs and their children" (*ibidem*). With the report main findings being that community-based HBC reach more PLWHA than facility-based HBC and that the monthly costs per patient are higher for facility-based programs, it is not surprising to find a general support for the kind of intervention envisaged by the CHBC approach, as in the World Bank Multi-Country HIV/AIDS Program for Africa (MAP).[8]

[8] See also, for example, Pathfinder International Fact Sheet on Community Home-Based Care: http://www.pathfind.org/site/DocServer/PF.Fact_Sheets.HIV.CHBC.pdf?docID=6285

In a 2005 review of CHBC programs implemented under the MAP, researchers found that, notwithstanding the "great need for services and support provided by community home-based care (CHBC) program to persons infected and affected by HIV/AIDS" (Mohammad, Gikonyo 2005: v), CHBC face overwhelming challenges: lack of properly trained personnel and of technical expertise in the area of implementation; lack of institutional resources; inadequate ART support; lack of proper nutritional support for PLWHA; a poor referral system and logistical issues and lack of resources, all linked to the scarcity of funds. Among the recommendations made, the researchers highlight that "for a CHBC program to succeed in its goal it requires the community's active stakeholder participation in the implementation and monitoring of programs to increase the impact and sustainability. This will involve PLWHA groups, local leaders and community groups such as faith based groups, youth groups etc. This may result in the community's mobilization and advocacy efforts to organize resources for prevention, care, and support activities" (ivi: 13): in fact, they argue, "a stronger community involvement could inevitably result in greater adherence rates, decrease in stigma and discrimination and a better understanding of HIV/AIDS" (ivi: 17).

The idea that a stronger community involvement can increase the adherence rates is a based on a series of academic medical researches on directly observed therapy (DOT) with HAART, that is, a community approach to therapy where for each HIV patient there is a community-health worker who observes the ingestion of pills, offers moral support and information to the patient and his/her family. Social support (such as assistance for school fees) is often included in the DOT-HAART therapy, as well as monthly meetings for patients and their helpers (Farmer *et al.* 2001: 405). Zachariah *et al.* (2007), in a study carried in a rural district in Malawi among HIV-positive individuals placed on antiretroviral treatment (ART) in order to verify if community support influences ART outcomes, found that the individuals who were offered community support were associated with a considerably lower death rate and better overall ART outcomes than those who did not receive support. Guaraldi (2009), discussing the relevance of referring HIV patients to a volunteer of patient's choice that can be remunerated according to the duration of his/her commitment, argues that "community involvement, with particular regard to PLWHA volunteers, goes far beyond the fundamental health activity they can provide and witness a new cultural era where 'silence' of AIDS in Africa is definitely broken".

Mainstreaming the community-based approach to HIV/AIDS care and prevention

The 2010 UNAIDS Outlook report, published in July 2010, contains a new approach to HIV treatment aiming to simplify the way HIV treatment is currently provided, to scale up access to treatment and, ultimately, to drastically reduce AIDS-related deaths and new HIV infections. This

new approach, called Treatment 2.0, is built on five pillars: 1. Create a better pill and diagnostic; 2. Treatment as prevention; 3. Stop cost being an obstacle; 4. Improve uptake of voluntary HIV testing and counseling and linkages to care and; 5. Strengthen community mobilization. According to the report, "community-based approaches to build trust, protect human rights and provide opportunities for socialization directly improve the ability of people to use HIV services and to benefit from antiretroviral therapy and prevent new infections" (UNAIDS 2010: 8). Therefore, "strengthening community mobilization efforts can increase demand for HIV prevention, treatment and testing, ensure protection of human rights, advocate for equitable care and provide community-based prevention and care support services" (*ivi*: 9). According to David Barr, a UNAIDS consultant, "without the engagement of affected communities, it's impossible to get the people who are most at risk into care", in particular those "who experience severe discrimination when they seek out health services – the rural poor, men who have sex with men, drug users and sex workers", who "have a very good reason not to trust public health officials and public health services that their governments run" (*ibidem*).

The idea of a community-based approach to HIV treatment and prevention is not a new one: since the 1978 Alma Ata Conference there are been an increasing support to community participation in the planning, implementation and management of health interventions in developing countries. In the mid 1990s, interventions aiming at increasing community participation within the realm of HIV prevention were successfully implemented mainly by gay volunteer groups in the US, while pilot projects of community-based prevention strategies among female sex workers were being initiated in Madras, India (Ashtana, Oostvogels 1996: 133 ff). In the same period, again in the US, a huge debate was flourishing on the inconsistently practiced yet much needed for its empowerment impact community participation in prevention planning and intervention research (see Beeker *et al.* 1998 for a review of the debate).

Notwithstanding this long time advocacy for community participation, it is interesting to note that other key institutions (and donor agencies) in the development world are following UNAIDS in focusing on the role that communities can play in the global fight against HIV/AIDS. The World Bank, for example, has recently released a Policy Research Working Paper whose authors aim at defining and classifying the types of community responses to HIV/AIDS as a part of a larger evaluation exercise to assess the results achieved by community organizations in the fight against HIV-AIDS. In fact, the authors argue, in the last decade there has been massive increase in donor funding for this kind of initiatives, but the support to community-based organizations is largely

based on "conventional wisdom, the assessment of CSO[9]s themselves, anecdotal observations and context-specific case studies" rather than on robust data (Rodriguez-Garcia *et al.* 2011: 4). If confronted with the WB's Africa Region HIV/AIDS Agenda for Action 2007/2011, the second stage of the Multi-Country HIV/AIDS Program for Africa (MAP),[10] is interesting to note that the WB is shifting its emphasis from "principal financier to facilitator and knowledge contributor" in the relation between communities and the private sector (WB 2007: 8). Indeed, the Pillar 2 of the 4 that build the Agenda for Action is the "scal(ing) up of targeted multi-sectoral and civil society responses", with the WB efforts directed at strengthening health systems and fostering private-public partnerships to address the HIV/AIDS challenge (*ivi*: 9).[11] This follows the stage 1 of the MAP where the WB aimed at promoting and supporting active mobilization and engagement of civil society, which, according to the WB data, has led to the implementation of 60,000 community-level subprojects (*ivi*: 20).

The UNAIDS (2010) and WB (2011) documents are only the last of a long series of policy papers and reports stressing the relevance of community initiatives. In 1999, UNAIDS published a review of household and community responses to HIV/AIDS in rural sub-Saharan Africa where it was highlighted that "the community-based programs that are dependent on external support have been very responsive to the needs of those affected by AIDS" and a series of possible policy options to strengthen the capacity of communities to cope with HIV/AIDS were presented, including the enhancement and mobilization of community capacities and the strengthening of community responses (UNAIDS 1999: 45-46).

A 2003 document prepared by the United Nations Office of the Special Adviser on Africa argues that "local responses are the most immediate and direct intervention strategies" that "can initiate an empowerment cycle" for the whole community (OSAA 2003: 34). The authors highlight a series of limitations to community responses such as, among others, temporal challenges, the internal vulnerability to HIV/AIDS, lack of resources and dependency from donors, operational and planning inefficiencies, limited outreach and, incomplete participation and representation; and even though they call for the involvement of communities "in developing assessment systems to

[9] Civil Society Organizations.
[10] See: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20415735~menuPK:1001234~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html
[11] The support of public-private partnership is one of the key elements of the World Bank policy in other sectors, including agricultural development and water management: for a discussion on this issues in Mozambique, see Pellizzoli (2010).

determine the extent of the problem, raise awareness and promote informed decision-making" (*ivi*: 52), they stress that "only governments and intergovernmental multilateral institutions are equipped to operate on the scale that is necessary if the HIV/AIDS epidemic is to be addressed in a sustainable manner", and that "assigning such roles to communities and their respective CSOs is both irresponsible and counter-productive" (*ivi*: 53).

Some food for thought: what is missing in the CBHC debate?

What is a community?

UNAIDS (1997: 3) defines a community in a wide and inclusive sense as "a group of people who have something in common and will act together in their common interest". It is also highlighted that whereas in the past community mobilization has implied initiatives at village or local level, today the global AIDS pandemic has challenged these traditional ideas, leading to the emergence of national and even global communities sharing concerns to prevent, care and treat HIV/AIDS (*ibidem*). Rodriguez-Garcia *et al.* (2011: 5-6) describe two types of communities, that can however be combined: (1) "community as a cultural identity", comprised by individuals that share common characteristics, circumstances, experiences, interests, concerns or behaviors. In this respect, a community could be made of, among other, PLWHA; (2) "community as a geographic sense of place", intended as a group living in a specific geographical location or administrative entity. Beside this, sub-regional communities should also be taken into consideration, "given the fact that HIV and AIDS have important transnational features" (*ivi*: 6).

Those who have a background on African studies are well aware that these broad definitions of community are highly problematic when applied to African rural contexts. While a review of the academic discussion on rural communities is not within the scope of this paper, it is important to highlight that any intervention at community-level, however broadly and widely defined, has to take into consideration the historical, political and social processes that have brought to the "creation" of that specific community. While Rodriguez-Garcia (see above) blames the "context-specific" accounts of community-based initiatives as the reason for the lack of conceptualization and systematization of these kind of interventions, Stillwaggon critically highlights how policy documents tend to restrict information about the context of HIV/AIDS in poor countries to slogan and cover photos (2006: 181) as well as to small-scale successful stories that continue to be recounted to support quite uniform policy options. I argue, with Baylies (2000), that the recognition and promotion of community initiatives in the fight against HIV/AIDS should not distract policies and expenditures from examining the underlying systemic economic, social, and political causes of the

poverty in which the epidemic flourishes as well as the structural causes of inequality inherent to the community as resulting from the historical, political and social processes.

There are, in my view, three further problems with this broad notions of community. The first is that arguing that a community can be made of PLWHA implies that PLWHA might have the same interests, concerns, behaviors. However, it seems to me that is hardly so: even when living in the same geographical location, PLWHA might differ for age, gender, economic status, access to services and care, household status, proximity to key stakeholders, voice, as well as the stage of the disease, which can clearly impact on their capacity to access and participate to the "community". The second is strictly linked to the first: the idea of a community as a group of people that act in their common interest conveyed by UNAIDS might well be instrumental to support generalized interventions but it inevitably recalls the orthodox economics models of the household as unitary entities "governed by 'natural' proclivities to benevolence, consensus and joint welfare maximization" (Chant 2003: 24) and the related feminist critique which has highlighted how households are characterized by competing claims and interests, unequal access to resources and different levels of power. Failing to understand the different and often competing interests of the members of a community can reproduce and further entrench structural inequalities. The third problematic issue is related to the idea of an international or regional community of PLWHA: while the claim to a global community may sound appealing for those donors who argue against "context-specific case studies", it can be a quite misleading basis for effectively responding to challenges of HIV/AIDS in Southern Africa. In this respect, O'Laughlin (2006: 34)[12] argues that the "predictable outcome (…) is that the dualism of the colonial health system will be recreated in treatment for AIDS - ART for upper and middle-income groups and those working in the formal sector, particularly in the urban areas; home-care and slow death for those in rural areas not covered by and NGO project".

Where are the women?

So far, women have hardly been mentioned. Indeed, in the policy documents briefly presented here, gender concerns are often present, but do not broadly inform the analysis: rather, it is quite invariably stated that gender inequalities place the burden of HIV/AIDS disproportionately on women, either because they are those in charge of caring for the sick members of the household, or because they risk to lose the household assets after the husband death, or for being at greater risk of HIV infection. Often, the specific vulnerability of older women, which might have taken on the role of primary care providers of their children and grandchildren, is recognized. However, none of these documents specifically address the gender implications of CBHC, that is to say the ways in which

[12] In her paper, O'Laughlin makes specific reference to South Africa and Mozambique.

this kind of interventions impact on the gendered structures of inequality at community level and contribute to (or limit) women's empowerment. In this respect, it is important to stress that the specific focus of the majority of HIV/AIDS interventions on women[13] has often disadvantaged men in access to treatment. How this is impacting on gender structures and gender relations has to be understood (for example, how this is deterring men from approaching testing services; see Campbell, Gibbs 2010: 330) while moving from the idea that men are 'naturally' violent and, therefore, the only solution possible is to promote women's autonomy (O'Laughlin 2009a).

It should not come as a surprise that there is, however, a series of policy documents that focus on women and AIDS and that take into consideration the impact of community-based interventions – as it usually happens for all that has to do with gender in the development arena. In *What works for women and girls. Evidence for HIV/AIDS interventions*, a publication of the Open Society Institute (Gay *et al.* 2010), it is once again stressed how most care and support programs often rely on women's household unpaid labour, with women considered as "default volunteers" (*ivi*: 342). But as the title of the document guarantees, the authors list what certainly works for women and other promising strategies based on a very partial analysis of experiences carried out in several parts of the world: continued group and individual counseling to relieve psychological distress; peer support groups; linking outside assistance from home- and community-based care programs with household care; training men to provide voluntary home care assistance; home-based ART to increase family support and; reducing stigma (*ivi*: 347 ff).

In *Keeping the promise: an agenda for action on women and AIDS* published by the Global Coalition on Women and AIDS, the three pillars of the agenda are securing women's rights, investing more money in AIDS programs that work for women and increasing women's participation. Community- and home-based care are listed among the AIDS programs that work for women even though, in being less expensive for the health systems, they displace many of the costs onto patients and care-givers. The envisaged solutions to reduce this burden is to provide stronger economic support to care-givers and supply practical help so that care-givers can access pensions and social transfers. With respect to the third pillar, it is stressed that more funds should be devoted to building the advocacy and leadership skills of women at national and community levels so that they can participate effectively.

The Political Declaration that has just been adopted at the 2011 UN General Assembly High Level

[13] For example through sentinel testing in antenatal services, or in micro-credit interventions to enhance women's economic empowerment and thus reduce the risk of abusive relationships.

Meeting on AIDS reinforces the mainstream commitment "to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan, through strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys".[14] During the General Assembly, a specific panel on "Women, girls and HIV" (notably, not on gender), identified as the "game-changers" (intended as an "innovative approach that is catalytic in nature, provoking results beyond the target group or original objectives and serving to trigger change in the HIV response")[15] community-based participatory learning approaches; community mobilization; multisectoral health services interventions; microfinance programmes; increased access to education; the sport and recreation sector; social media and information technology. A great emphasis is placed on the role that the newly established UN-Women can play in combating HIV/AIDS by promoting gender equality and the empowerment of women (Political Declaration art. 22). How this can happen without considering the issue of gender relations in the context of HIV/AIDS interventions remains to be seen, and particularly so in a broader context where the emphasis is put on promoting women's access to the market through microfinance interventions and private land rights, strategies which are often based on evaluation researches that take the form of brief account of site visits and summarization of secondary sources that produce the tendency to "transfer models for intervention developed in one setting to other contexts" with little or no attention to why these strategies might work in a situation but not in others (Evans, Lambert 2008: 468). These recommended policy interventions are placed within a mercantilistic discourse, argues O'Laughlin (2009) and fail to recognize that an effective response to the HIV/AIDS crisis is a redistributive reform of public health systems.

Who participates?

The issue of participation at community-based level is a key one, that possibly recollects many of the ambiguities inherent to the community-based health care approach. According to Loewenson (2000), "participation can be viewed as a means to enhancing health goals in terms of coverage, access, and effective utilization of health care, as well as improved prevention of disease. It is also conceived of as an end in itself, building networks of solidarity and confidence in social groups, building institutional capacity, and empowering people to understand and influence the decisions that affect their lives". However, "without supporting institutions and guidelines, mechanisms for

[14] http://www.un.org/ga/search/view_doc.asp?symbol=A/65/L.77
[15] http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110601_HLM_Pannel4.pdf

community involvement may simply serve as vehicles for "local capture" by local elites or powerful groups" (PHR*plus* 2004a: 48), thus excluding women and other vulnerable groups.

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