# Community, Care, Change, and Hope:

## Local Responses to HIV in Zambia

By
Sue Lucas

THE
SYNERGY
PROJECT

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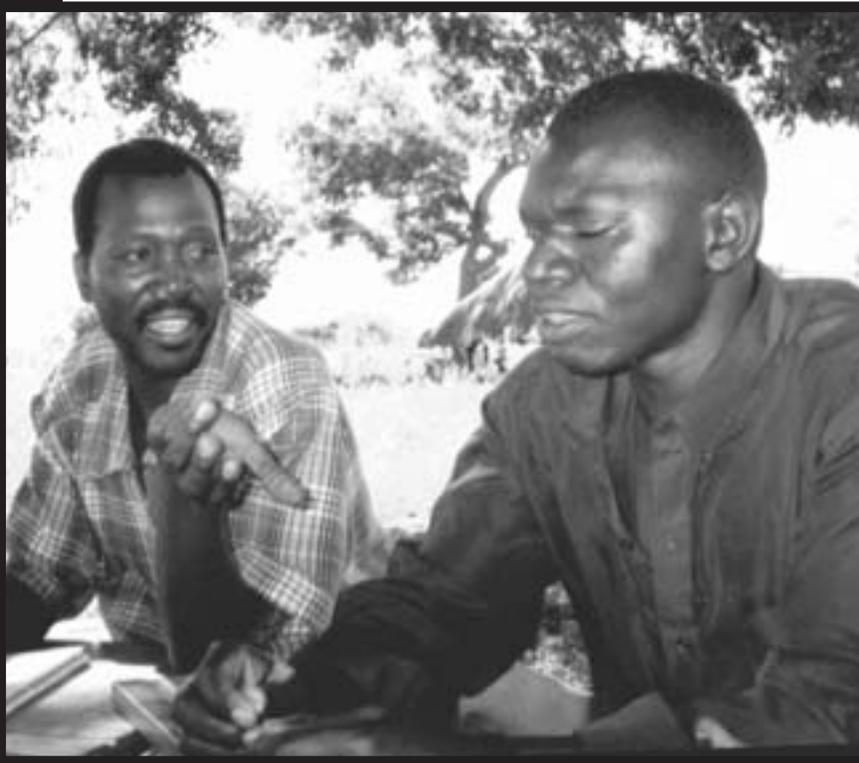
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Synergy Project case studies review programming models that demonstrate "good or promising practice" in the response to HIV/AIDS in resource-poor settings. The case studies describe the specific challenge addressed, the successes achieved, and the lessons learned in the process of implementing a model in one setting. Such documentation and dissemination to others who design and manage programs in the field are essential tasks contributing to an effective global response. If the goals set by the President's Emergency Plan for AIDS Relief, the World Health Organization 3x5 Initiative, and the United Nations Millennium Goals are to be achieved, program planners and managers need to replicate and bring to scale successful models in order to avoid known pitfalls, and to build on the solid foundation of achievements in existing programs and projects.

Good or promising practice, in this context, refers to knowledge about what is and is not working, or to what appears to hold promise in the fight against HIV/AIDS in resource-poor settings. The ability to learn from the experiences of others, and to improve and adapt those experiences to different field situations is essential for building the capacity to implement national programs. It is not only documenting and disseminating lessons learned, but also the ongoing process of feedback, reflection, and analysis that allow continued improvements to occur.

# SUMMARY

This case study documents a successful model for facilitating a strong community response to HIV/AIDS. The Salvation Army Change Program in Ndola and Choma Districts in Zambia illustrates the facilitation process stimulating an appropriate local response to HIV/AIDS an essential component of human capacity development. "Human capacity development means developing the will, skills, capacities and systems for an effective response to HIV."

The model builds on local strengths and resources, stimulating ordinary people to address the barriers that prevent them from using HIV/AIDS information and services to prevent new infections, compassionately care for those who are infected, and mitigate the effects of the epidemic on families and the community. Only by addressing personal risk, stigma, and the potential for personal and societal change will the demand for and use of voluntary counseling and testing, prevention of mother-to-child transmission, and antiretroviral therapy services increase. Thus, building human capacity in the community to become "AIDS competent" and respond effectively to HIV/AIDS is an essential intervention alongside the strengthened and expanded health services that are being rolled out with the President's Emergency Plan for AIDS Relief, and the Global Fund to Fight AIDS, Tuberculosis and Malaria resources.

Evidence for the success of the facilitation process in Zambia includes:
- Establishment of community gardens to provide food and some income from the sale of surplus food to orphans in 17 communities in one area
- Demand from community members for voluntary counseling and testing, resulting in testing of 85 people in one community and requests that testing be provided in several nearby communities
- Increase in the numbers of people reached in home-care programs and in the quality of support provided to them
- Increase in the numbers of communities organizing themselves to respond actively to HIV
- Change in risky activities—the local cultural practice of sexual cleansing of widows replaced by alternative rites that do not increase transmission of HIV, and sharp personal implements such as razors no longer being shared

# PREFACE

It is the rainy season in southern Zambia. Grass and trees slope gently to the horizon. The unpaved road from Choma to Zambia's only coal mine has been recently graded and is in reasonably good condition. It runs between large estates and is bordered by woodland that is protected from cutting and burning for charcoal.

Turning off, the road becomes a track overgrown by tall grasses. The trees thin out. Maize takes up the bigger fields. Vegetable gardens flourish on smaller patches. Between them, small herds of cattle and the occasional goat graze the unfenced meadowland. Thatched houses and huts dot the horizon, linked by paths.

The rutted track ends in a puddle, and a footpath leads to a group of small houses surrounding the local school. A hundred meters down the path, men and women, some of the women with babies, sit on the grass or on wooden school benches in the shade outside an empty cinder block warehouse.

They are discussing HIV, describing what they have done in their village to stem the epidemic. They say their behavior and that of their young people have changed. "Sexual cleansing [of widows] is a thing of the past.… There is less promiscuity.…We no longer allow children to stay out overnight.…The utensils—razors—we have one each. Drinking sprees are fewer, and we return home now in good time." Among the group are two local volunteer facilitators: community members like all the others. One says, "It is not easy to change. Some accept it; some do not. As the days pass—it has been three years now—many people have started to understand why change needs to happen." Someone adds, "There are more deaths. People ask why, and fear they will leave their children." They describe how they support orphans by working together to cultivate land. Any surplus food is sold in Choma to help provide books and uniforms. They share their problems, too. Usually, there is not much to spare from the gardens they cultivate, and sometimes they cannot think of the future because there are too many orphans now.

Among the group is a woman visiting from a nearby village. She says, "Where I stay, there are no groups that teach like this one does. Can these groups come to where I live?"

*Mutandalike, March 18, 2003*

Villagers discussing what they have done to stem the AIDS epidemic in Mutandalike.

# ACKNOWLEDGMENTS

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# INTRODUCTION

Early in the course of the HIV epidemic in Africa, people recognized that controlling the spread of the virus could not be achieved by health services alone. Human rights, community participation, multisectoral approaches, and the role of culture have all been accepted as essential parts of an effective response to the epidemic. But despite these calls, technology (in the form of condoms, antiretroviral therapy, antiretroviral drugs to prevent mother-to-child transmission, the use of clean syringes and needles, and vaccine research) is still the major element of most interventions and absorbs the majority of funds available to fight HIV and AIDS. Health services are still the main conduit for donor funding for HIV, and health ministries still control most government spending. Programs are often evaluated in terms of condoms distributed and reported condom use, number of people who hear or see messages about HIV, or number of vulnerable people provided with means of prevention. While all these responses are essential parts of an effective response to HIV/AIDS, it is clear from the experience of the last 20 years—and from the ever-increasing spread of the virus—that they are not sufficient.

The missing element is human capacity development—the ability of people to respond to the epidemic. In many places, people still have not acknowledged HIV or changed their beliefs and behaviors in response to a devastating epidemic. Without acknowledgment, communities have not been able to take control of how to use technology; hence, technical solutions have been imposed on them. Without developing the human capacity for change, communities are losing hope because their own strengths are not being taken into account, and organizations and institutions providing services and technological interventions are relying on external analysis without understanding the potential that lies within community leadership. As a result, not much significant, long-lasting change is taking place.

Human capacity development issues were discussed and developed at a series of meetings (Brazil and Geneva in 2000, Ouagadougou in 2001, and Barcelona and London in 2002) that included participation from civil society, governments, donors, international organizations, the commercial sector, and people living with HIV in both resource-rich and resource-poor settings. As a result of the meetings and discussions, and the existing documentation on human capacity development in practice, a definition and framework were developed and core concepts and ways of working are being refined. The term was defined at the meeting in Barcelona in 2002 as follows:

*Human capacity development means developing the will, skills, capacities and systems for an effective response to HIV.*

This case study describes The Salvation Army response to HIV in Zambia. It specifically examines a current partner, the Lusaka Change Programme, in order to portray the response in action, to assess its challenges and successes, and to depict the people and communities involved.

# BACKGROUND

## HIV IN ZAMBIA

Zambia has been hit hard by the HIV epidemic. The average HIV infection rate among adults was estimated at 19.7 percent at the end of 1998. In some urban regions, this rate probably reaches at least 25 percent. Surveillance centers recorded HIV infection rates of 5 percent to 31 percent among pregnant women across 18 sites in 1998 (UNAIDS 2002). The U.S. Agency for International Development (USAID) estimates that approximately 1.2 million children had lost one or both parents to AIDS by the end of 2001, and youth-headed households are reported in many rural and urban areas. There are approximately 45,000 street children (USAID 2002).

There are signs of change, however. The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that the rate of infection across the country among pregnant women under age 20 dropped from 27 percent to 17 percent between 1993 and 1998. In rural areas, infection rates in this group dropped from 14 percent to 6 percent in the same period (UNAIDS 2002).

The Government of Zambia first developed a strategic plan to address HIV/AIDS in the mid-1980s, which has been updated and developed into separate five-year plans since then. The Central Board of Health has overall responsibility for the implementation of health services in Zambia. The National AIDS Council, established in 2001, has working groups to address key areas of HIV/AIDS. These groups include representatives of the government, United Nations agencies, and nongovernmental organizations (NGOs). Donor agencies have supported government responses to HIV, NGOs in Zambia have been active from the start of the epidemic, and there is a well-established Zambian network of people living with HIV. While there is still a significant level of denial and secrecy about HIV, there seems to be a greater openness concerning the epidemic in Zambia than in surrounding countries. A major contribution to this achievement is the response of Zambians living with HIV, and the strength and leadership of a few key people who have been open about their own infection.

## THE SALVATION ARMY APPROACH TO HIV

The first Salvation Army response to HIV was the establishment of a home-care and prevention program linked to Chikankata Hospital, a Salvation Army Mission Hospital that was established in 1946 in a rural area, near Mazabuka, in southern Zambia.[1]  In 1986, when

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[1] For more details of the Chikankata program in the 1980s and early 1990s, see Williams (1990).

the first patient with AIDS was presented at the hospital, the infection was becoming evident in the area: people were sick, and deaths were more frequent. Inpatient hospital care was not an option, as all other services would be overwhelmed. Some sort of care in the community was to be an essential response. Consultation with the communities around the hospital made it clear that there was already a community reaction, and while it was not always positive toward people and families affected by HIV/AIDS, there was, nevertheless, an awareness of a new health threat and the need for a way to address it. As the care was developed, so was the concept of community counseling, a process of bringing communities together to hear about their concerns and ideas for a response, and to facilitate change. The hospital home-care team learned how to give information when this was appropriate, and how to stay alongside communities as together they gradually came to terms with HIV as a part of their lives, and as communities started to seek their own solutions.

By 2003, The Salvation Army had established a response to HIV in 126 locations in 36 countries. The approach, based on the original experience in Chikankata Hospital, builds on the strengths of communities and facilitates communities to take their own decisions about how best to respond to the epidemic. The overall aim is to help communities become "AIDS competent"—that is, to acknowledge the existence of HIV and its effect on communities and individuals, to develop the capacity to care for affected people, to change in response to HIV, and to discover hope for the future. Communities that develop this sort of competence also transfer their learning and

approaches to other communities, thereby creating a sustainable and expanding response to the epidemic.

The success of the facilitation process in Zambia includes outcomes beyond the facilitation process itself, which justifies its inclusion as a best practice for addressing HIV/AIDS. The successful outcomes include lateral transfer of change from one community to others that did not directly experience the facilitation process; outcomes include:

- Establishment of community gardens to provide food and some income from the sale of surplus food to orphans in 17 communities in one area
- Demand from community members for voluntary counseling and testing, resulting in testing of 85 people in one community, and requests for testing to be provided in several nearby communities
- Increase in the numbers of people reached in home-care programs and in the quality of support provided to them
- Increase in the numbers of communities organizing themselves to respond actively to HIV
- Change in risky activities—sexual cleansing of widows replaced by alternative rites that do not increase transmission of HIV infection, and sharp personal implements such as razors no longer being shared

The experience of working through The Salvation Army approach to human capacity development has led to the identification of key concepts, an analysis of how these concepts relate to each other in practice, and the development of new ways to
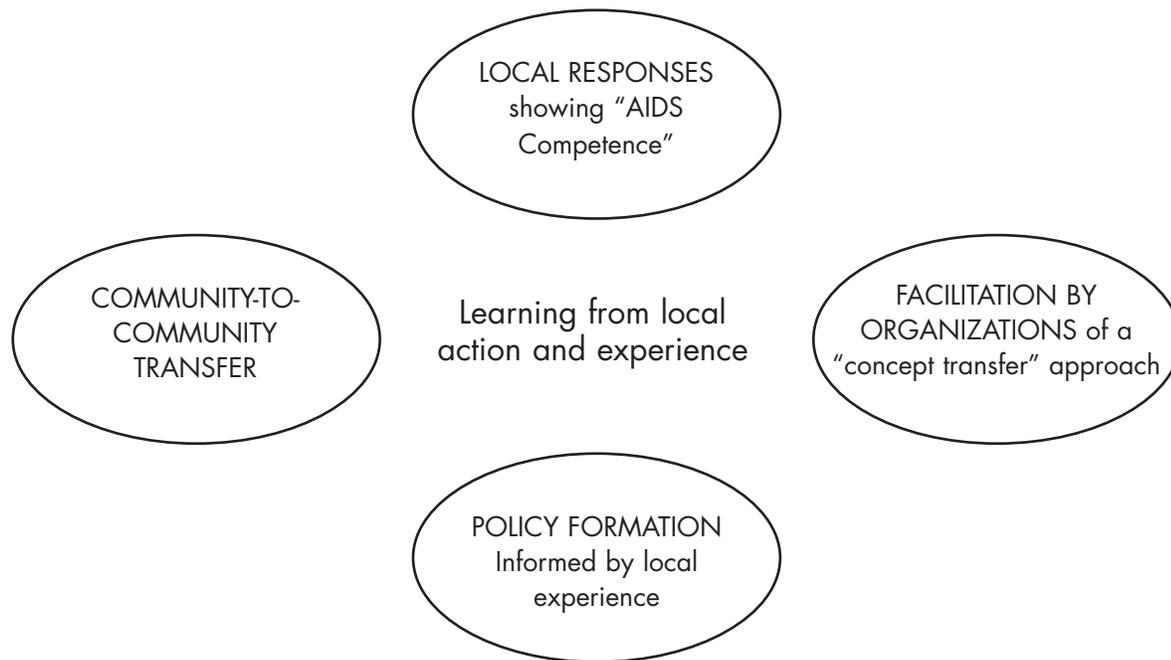
Figure 1. Human Capacity Development (HIV/AIDS)
(Source: Campbell 2003)

monitor and evaluate programs. Figure 1 illustrates the elements of the human capacity development approach.

## KEY ELEMENTS OF A HUMAN CAPACITY DEVELOPMENT APPROACH

The four key elements of the human capacity development approach include local response, organizational change, policy, and knowledge transfer based in learning from local action and experience. Human capacity development is transferable and makes scale-up possible. The human capacity development approach is not dependent on replicating activities, nor dependent on establishing pilot projects elsewhere. Communities are involved through contact with

other communities that have already established a response or through deliberate outreach by the facilitation teams. There is no model program to be implemented; there is, instead, a process through which a local response, based in the local context but drawing on the accumulated experience of others, can be catalyzed.

**A Working Culture of Facilitation.** Most HIV/AIDS projects depend on a culture of expertise. In contrast, a human capacity development approach, such as the one taken by The Salvation Army, takes the lead from communities. This approach creates a process through which the community learns about HIV, and develops and articulates its own response. Community counseling and "community

conversations," facilitated by a team that includes local community members, lay the foundation for change: through understanding the existence of HIV and exploring the impact it can have in their particular situations, communities take the lead, make their own decisions, and decide their own actions. The process requires support in the form of accompaniment—encouragement, recognition, and affirmation of progress.

So who does the "facilitation" and how do they do it? A series of teams, whose foundation is in participation in community response, have been formed at local, national, regional, and international levels. A strong characteristic of these teams is the support they give each other, both within and across teams. Members of different teams can overlap, with people working at different levels from time to time. Teams are not seen—nor do they see themselves—as experts. They take on a role of facilitating change by learning from others and sharing this learning. Teams at all levels facilitate such learning experiences and share what they have learned, which leads to action and change on the part of the communities involved. The focus of all the teams, at each level, remains the same: action that leads to change within a community.

Originally developed in Thailand, these "Support and Learning Teams" (SALTs) have become known in The Salvation Army as "Support, Appreciation Learning, and Transfer" teams. Examples are The Salvation Army teams, National

Facilitation Teams in Rwanda and Zambia, and teams brought together by the Promoting Participatory Learning from Local Responses Project,[2] of the AIDS Education Programme at Chiang Mai University in Thailand.

**Local Action and Response: Core Concepts.** Community, care, change, and hope are four core concepts around which the response to HIV is built.

*Care* is used in a broad sense, and it includes but is not restricted to treatment. Care incorporates accompaniment, in the sense of being with a person in need of support; protection, especially for those who are vulnerable; and the sharing of painful experiences. Caring includes the willingness to break through taboos and social barriers, and, in this sense, implies the inclusion of people who are marginalized. Caring, therefore, addresses stigma and discrimination.

A sense of *community* embodies the idea of belonging with others and sharing a vision of what might be with others. Where a sense of community exists, it is evident through an ability to act together, a shared background, and a sense of accountability to each other and to the group. Communities can be strengthened, and can develop these characteristics, through coming together in the face of an external threat such as HIV.

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[2] The Promoting Participatory Learning from Local Responses program has been conducted in 22 communities in four regions of Thailand during the past two and a half years. A human capacity development network currently is emerging in Thailand, whereby the program's Support and Learning Teams are spearheading the introduction of human capacity development to other HIV/AIDS activists (including those that will work on the Global Fund to Fight AIDS, Tuberculosis and Malaria project in Thailand), while also demonstrating the strengths of the Support and Learning Team concept and practice.

*Change* implies transformation from within rather than change imposed from outside. It can be a personal transformation, an organizational transformation, or a change in a community's understanding. Change requires openness to learning from local community experiences and an understanding of a need to adapt old values to new circumstances. Communities can and do change themselves in response to new learning; outside stimulation may not be necessary.

*Hope* represents anticipation of a future and seeing a way to shape this future. The intense burden of death and grief that is now affecting communities in southern Africa—the difficulties of coping with the increasing numbers of orphans in stressed families, and the fear that comes with inadequate knowledge about HIV—all create a paralyzing sense of hopelessness about the future. Seeing change happen fosters hope and the sense that a community can change the future for the better. Hope also makes change possible.

**Knowledge Transfer.** Communities interact with each other through mobile individuals who transfer their knowledge to others. HIV, however, spreads faster than knowledge. A human capacity development approach aims to facilitate the transfer of knowledge and action from one community to another through the process of learning together from local responses. A facilitation team not only helps to make transfer a reality, but is also able to accompany communities (or other teams in the various environments) as they start the process of learning-reflection-action-learning.

## SELF-MEASUREMENT

Change needs to be measured so that the community sees the results of its action and incorporates both successes and failures into its learning. A new approach to monitoring and evaluation is needed to measure human capacity development in a manner that is supportive rather than critical. Communities—and organizations—can measure their effectiveness in responding to HIV through developing their own indicators to monitor change. Self-assessment to gauge the quality of a response is also a tool for communities and organizations to judge their progress.

## RELATIONSHIPS, APPROACHES, AND VALUES

Accompaniment and affirmation of community action are a vital part of the team facilitation process. While change comes from within communities and must be initiated by community members, it is more likely to be sustained if support and affirmation are a regular part of a facilitated process. Most NGOs and other organizations work through a structure of international, regional, and local teams that are, to some extent, hierarchical, with supervision from above and external visits for monitoring and evaluation. In contrast, The Salvation Army team approach focuses on affirmation and support. Team visits from outside are by invitation from the local team and are meant for reflection, learning together, participatory monitoring, and measuring change and transfer. While this support and affirmation method has been documented in various fields, including guidelines for community counseling (The Salvation Army 1998),

psychosocial support for children (UNAIDS 2001a), and community capacity building (UNAIDS 2001b), there remains limited understanding of the profound difference between this relationship and one based on supervision and external evaluation.

Building on the strengths of individuals, families, and communities is also in contrast with the much-accepted practice of emphasizing needs assessment as a main element of community mobilization. Identification of needs means concentrating on the weaknesses and, thus, disempowering communities rather than valuing their strengths. While communities without support cannot address all aspects of HIV, and an assessment of needs as well as strengths is a part of any community action, communities can also recognize their strengths, the ways in which they are already responding, and the ways in which to build on this existing response. Without a community-led foundation, technical solutions and external interventions are not likely to be sustained beyond the short period of active implementation.

To identify a community's strengths, it is necessary to respect and value its people. HIV is fostered by dysfunctional relationships within couples, families, and communities. The Salvation Army approach is centered on people and their relationships with each other and with God, and on their capacity to repair and value these relation-ships. This people-centered method is at the heart of The Salvation Army mission and vision, and it drives the organization's response to poverty and

other social issues. It is an integral part of any work with the marginalized and disadvantaged, including people infected or affected by HIV, drug users, sex workers, and other minority groups.

Reaching out to people where they live and work is a part of a people-centered method and a central element of a human capacity development approach. In practice, this means visiting people in their homes and communities, and home visits are included in all team visits. Valuing people as the program's source of strength and main resource is also a distinct characteristic. Creating opportunities for people to become engaged, mentoring those who want to be an active part of the response, and continuing to support them are core elements of the growth of this work on HIV. Table 1 contrasts the behavior and mentality of normative, supervisory organization with that of a human capacity development organization.

## LINKS TO POLICY FORMATION

Ultimately, sustainability of community responses depends on wider recognition and support. As with the change process, communities need to be at the center of a policy change. Community leadership implies not only that communities change themselves, but also that they influence others to change. Technologies to address HIV will be effective only if the people for whom they are intended determine the way that technologies are introduced and used. The concept of learning from local responses thus applies to policymakers and governments, as well as to other communities. Senior leaders and policymakers are encouraged

Table 1. Contrast of Organizational Approaches to Communities

| Normative, Service Provision Approach | Alternative, Human Capacity Development Approach |
|---|---|
| **Belief and concept**<br>The people need help<br>The organization has capacity | **Belief and concept**<br>The people have capacity to respond through care, community, change, and hope |
| **Behavior and practice**<br>People come to us<br>We know what to do<br>We provide | **Behavior and practice**<br>We go out to people:<br>• To stimulate and facilitate local response<br>• To learn<br>• To transfer<br>We participate |
| **Organizational approach**<br>Organizations supervise | **Organizational approach**<br>Organizations support, learn, facilitate, and transfer |
| **Communities and families affected by HIV are characterized by**<br>Broken relationships<br>Distrust | **Communities and families affected by HIV are characterized by**<br>Reconciliation<br>Trust<br>Action<br>Self-measurement<br>Expansion |

to join team visits, and in the course of these, to visit the homes of people affected by HIV. By observing how individuals, families, and communities are responding to HIV, organizations and institutions, including governments, understand better how to make technologies effective and, therefore, change the way they operate. This tactic is a contrast to an approach in which organizations analyze the problem, reach a conclusion, and implement it in the community.

# THE SALVATION ARMY FACILITATION TEAMS

*Probably, the facilitation teams are the most dynamic example we have at the moment for crossing boundaries.*

Israel Gaither, Chief of Staff, The Salvation Army International Headquarters

The Salvation Army's regional facilitation teams are currently active in Africa, Latin America, Southeast Asia, and India. Their purpose is to create continuity between the international

headquarters and the international facilitation team, and between the community and the community facilitation teams. Regional facilitation teams are not a channel for authority, funding, or supervision; instead, they carry out a support function in both directions by contributing to local responses in the communities in which they work, as well as by influencing policy development and being a part of the joint learning of international teams within Salvation Army territories (usually countries) and locally. The regional facilitation teams also support Salvation Army territorial and local teams in such areas as assessment, program development, participatory evaluation, documentation, and measurement of progress. Regional facilitation teams also visit countries at the invitation of The Salvation Army territorial teams or the local and community teams. Learning from local actions is always incorporated via reflection and action into all the teams' practices, and the regional facilitation team transfers the concepts to other teams and communities, as well as to The Salvation Army leadership.

As the other teams, the regional team is composed of people who have become actively involved in HIV work in their communities, that is, those whose approach links naturally with the way of working outlined above. Team members are self-selected. They are people who are concerned about HIV/AIDS and how it affects their communities. Those who show a willingness to learn from local experiences are included in team activities and supported through visits.

The African regional team has existed since 1995, and includes members from facilitation teams in all African countries where The Salvation Army has a presence. It includes young people, people living with and affected by HIV, and those with both international and local experiences. The coordinator of a core team of five full-time members is currently based in Zimbabwe, but for visits and support activities, the regional team includes members from a pool of more than 100 facilitators from across Africa. People join the team for specific activities or for longer-term attachments, and through their association with the team, people offer and gain experience.

In Zambia, there have been close links between The Salvation Army territorial facilitation team and members of the regional and the international facilitation teams. These links have included team visits in both directions and participation in workshops, program-to-program visits, skills development, facilitation team attachments, and action research.

## THE SALVATION ARMY STRUCTURE

*If The Salvation Army in Africa has AIDS, then The Salvation Army has AIDS.*

A call from Africa participants at the 2000 Interregional Program Facilitation Team Consultation

Internationally, The Salvation Army organizational structure is based on a military model established soon after the Army was founded by William Booth in 1865, and is deliberately hierarchical. The Salvation Army is present in 109 countries.

Salvation Army officers are the spiritual leaders at all levels: Corps Officers or pastors lead the local churches at the community level, reporting to the District Officers, who in turn are responsible to the Territorial Commander. While territories are accountable to the General, each has autonomy and is responsible for its own administration and activities within the overall direction of the international leadership and policy. The Salvation Army has emphasized the relief of poverty since its inception. The Army's major work in developing countries currently includes both long-term development and disaster relief, often in partnership with other development agencies, the United Nations, and governments. International work funded by the U.S. Agency for International Development is supported by The Salvation Army World Service Office (SAWSO), which is based in Alexandria, Virginia.

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**SAWSO Mission and Vision**

**Mission Statement**

Support and strengthen The Salvation Army's efforts to work hand-in-hand with communities to improve the health, economics, and spiritual conditions of the poor throughout the world.

**Vision Statement**

Create a world where people live in safe and sustainable communities in which differences are celebrated, basic needs are met, and all enjoy opportunities to learn, work, and worship freely.

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# THE CASE STUDY—PUTTING IDEAS INTO PRACTICE

The Salvation Army has had a presence in Zambia for more than 80 years and now has at least 22,0000 members in the country. Zambia constitutes a territory, headed by the territorial commander based in Lusaka. The use of facilitation teams described in this case study is based on more than 15 years of involvement with HIV/AIDS and its issues, starting with the home-care program developed in Chikankata Hospital in the mid-1980s. The cycle of learning, reflection, action, change, and learning from change indicates that the work is continually evolving.

## LUSAKA CHANGE PROGRAMME

The Lusaka Change Programme, which started in Lusaka about 1999, is the focus of this case study. Although the program title has not changed, the program's work reaches far beyond Lusaka.

The program began as the result of one woman's realization of the significance of the HIV epidemic for herself and her community. It continued because of her determination and leadership, supported by the existing structure for response to HIV within The Salvation Army. The story of the program is based in people's strengths and their relationships with each other. The Lusaka Change Programme has spread quickly, operating now in two Salvation Army districts (Ndola in Copperbelt Province and Choma in Southern Province); in two divisions, Lusaka South East (Libala and Ching'ang'auka) and Lusaka North West (Chikanda and Mumbwa); and in 14 communities in these areas. The work in communities has been performed with minimal resources: those that come from the community. A small grant from the Canadian International Development Agency has helped with administrative and transport expenses.

## WAYS OF WORKING

The Lusaka Change Programme illustrates how the regional and international facilitation teams interact with people, communities, The Salvation Army, and other organizations with which it works on a partnership basis. The values that guide the way relationships develop include a participatory, inclusive, and nonjudgmental approach that encourages leadership from the community people involved. In many organizations, visits to the field are mainly for evaluation and to supervise and ensure that field staff are carrying out organizational policy correctly. In contrast, visits to the field by The Salvation Army teams are designed to learn from local responses rather than to judge and control activities.

A faith-based organization such as The Salvation Army has special links to communities: church congregation members may understand the needs of their local community better than those who are

in "community-based" organizations that are not of the community. Church members who become involved in a community issue start from the same point as their fellow community members. A response to a community problem, thus, starts from the community.

> *The facilitators are from within; they are the same community. These people were born here and grew up here; they know the dos and don'ts. The community has accepted them without lobbying, and they are talking to their own fathers, brothers, and sisters. The community knows them as individuals and has known them since childhood. It is important for us as facilitators that when we go to the next village or community, we spot the next facilitators, from within that group.*
>
> —Betty Muleya, Coordinator, Lusaka Change Programme

The Salvation Army is, of course, not the only church in a community. Rivalry between churches does happen, but, in most cases, other congregations share their concerns and responses. Open discussion is effective when church leaders give their support. Yet even when support is weak, one or two people within a congregation can start a community response. Although people who are not members of a church can initiate a response, a community that shares a vision, values, and aspirations can make a response spread quickly.

## WORKING WITH PEOPLE

Placing people at the center of the response to HIV is fundamental to human capacity development. This people-centered approach is illustrated by the Lusaka Change Programme on two levels: first, by the way in which people who take part in the process are identified, encouraged,



*Sue Lucas*

"Mbuya" with some of the local team at Mutandalike

**Box 1**

**Fostering Response: From "Betty" to "Mbuya"**

Betty Muleya, who is known as "Mbuya," or grandmother, first began to understand the gravity of the HIV epidemic and the need to respond in 1995, when she was working with The Salvation Army as coordinator of child sponsorship and food relief. Her journey from the realization that HIV is a threat to all communities to her current work as coordinator of the Lusaka Change Programme in Zambia illustrates the power of fostering people's existing strengths.

While attending a meeting on HIV with the Catholic congregation in her area, Betty realized that The Salvation Army should be responding more actively in her area, Libala. With the backing of her supervisor, John Allott, who had worked at Chikankata, Betty set out to read all she could find about HIV. In the course of this study, Betty realized that, like every family in Zambia, her own family had already been touched by HIV. In 1998, with encouragement from within the organization, she started to give HIV education talks to The Salvation Army corps, the community-level unit of the Army structure. People were the key part of her strategy and she started in three locations: her own corps and two where she knew people would back her effort.

This first stage was to provide basic education and awareness about HIV to The Salvation Army corps. One of the first places she did so was Kanyama, and the response that started there has grown. By 2001, the team was visiting about 1,000 clients. A team of 11 people is now working across the country with Betty, and district teams are active in five regions. They all reach out to communities within their area. The territorial team, which holds workshops to train potential facilitators, youth leaders, and others, reaches at least 200 people directly each year; the numbers the community teams reach, however, are much greater. The Salvation Army regional facilitation team learns from and supports this work in Zambia, and the Zambia territorial team has learned from and shared its experience with teams in Kenya, Uganda, and Zimbabwe. In Zambia, Betty—Mbuya—is a well-known and respected figure in the communities where the program is active. This recognition is illustrated by the village headman's response to a request to call a community meeting for this case study: "Is Mbuya coming? Then we will come."

and supported; and second, by the way people affected by HIV are supported and included.

The narrative of Betty Muleya's work (Box 1) shows the essential role that individuals play in responding to a crisis such as HIV. But even with the support of key people within The Salvation Army, it is obvious that this kind of response cannot be generated and sustained by one person. Betty created a territorial facilitation team by fostering people who have emerged as potential leaders within The Salvation Army community. The same pattern of fostering was recreated at the community level to sustain local teams. Eleven

men and women are now fully involved in working with their communities to sustain the response, and they have become part of the territorial facilitation team. The number of community teams facilitating local responses is constantly growing. In two years, a local team in Choma expanded to include 17 villages that are mentored by the territorial team members.

## SHARED CONFIDENTIALITY

The Salvation Army's response has recognized the importance of reconciliation within families and communities as a first step in addressing HIV, and the need to include families rather than to isolate individuals. The inclusion of families has meant developing an approach to confidentiality that respects an individual's right to privacy but includes the family and community in the overall response. The person living with HIV always determines whether to share confidentiality, which may be nonverbal, by acknowledging HIV in the family. Responding to HIV first means acknowledging it. Community members may recognize the presence of HIV and know of people and families within their community who are affected, but they may not be able to speak openly about it. In communities where there is no open response, there is often suspicion that families are affected, but community members do not know how to react, and without facilitation of acknowledgment and acceptance, stigma and discrimination may be the result. The same can happen within families, especially if HIV is not discussed, which leads to fear of people who are affected. Facilitating an open acceptance of this hidden knowledge is a central part of a constructive response. Openness does not mean informing other people of

individuals who are affected; rather it means enabling a community or family to come to terms with HIV in its midst rather than denying it. In Ching'ang'auka, for example, one of the three active volunteers has noted a significant change: "The headman gave us time to go around the community. Before, people said there was this disease and they could not talk about it. Now, many people have accepted and are talking about it." The community also requested that testing be made available through The Salvation Army team. (See Box 6 on page 30.)

Home care is integral to the community facilitation approach and is based on the philosophy of reaching out to people in their own environment. For the Lusaka Change Programme, home visits are integral to community acknowledgment and are therefore an essential part of community development. The aim of home visits is to help people change their behavior to prevent the further spread of HIV and to cope with the consequences. Home visits link people affected by HIV to the wider community through their inclusion in community conversations or in community counseling meetings. In communities that do not have access to drugs and treatment, home visits may not include material goods, but a community-run project often has food available for those who need it. Accompaniment and spiritual support are valued even if nothing else is available. The Libala community garden (Box 2), cultivated land donated by the local Salvation Army corps, provided the local team with vegetables to take on their home visits to people affected by HIV and to others in need of support. Home visits also create a platform for treatment when it becomes

available and a support network for orphans and children whose parents are sick. Home visits help families to be more open about HIV.

## WORKING WITH COMMUNITIES

In 1998, Betty Muleya was working primarily by herself, visiting different areas and holding workshops at the invitation of corps officers. It was evident that many people coming to these meetings did not know what HIV was, and that the awareness-raising and information were essential. It was also clear that raising awareness was not enough, and that the response needed to be both broadened and deepened. The next step was an HIV education workshop in a new area and for a broader group of people, including other church-based groups. This step was the beginning of the community-team development process.

Betty was unaware of the interest of Ching'ang'auka Corps. An invitation to hold a workshop there was a new venture. The local corps officer announced the workshop over several Sundays and invited the participation of other churches, including the Seventh-Day Adventist Church and the Roman Catholic Church. About 25 people attended, and from this first workshop, three people emerged as potential facilitators and leaders for the local community. Other participants were emerging in other areas. Back in Libala, the corps officer invited volunteers, specifying the need for retired nurses and teachers, but making sure that all with an interest knew they were welcomed. By bringing together this smaller group of motivated community members, Betty hoped to find more people to work as facilitators. Four came forward, and they are now working with the facilitation teams.

The 22 orphans (Box 2) may seem a small number, given the million orphans now estimated to be in Zambia, but this is one small community among thousands. With the community's backing of the people who emerge through this type of process, this response—which is dependent on community strengths rather than on external funding—could be a reality throughout the country.

A community counseling and educational workshop was held in Mumbwa, with a

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**Box 2**

**Dialess' Story**

*We never thought of doing it, but through Betty we learned about HIV. After the first workshop we forgot, but she came back again, asking, "What are you doing?" So for a while, if she came round, we would go the other way and pretend not to see her. Then there was another workshop, and we saw friends doing something in the villages. We reported back to our Corps Officer and asked for a piece of land. We started a small garden. Then we learned there were orphans and people who were being neglected. Now we are helping 15 orphans in Grades 1 to 7 and seven in secondary school. The little money we make from the garden goes to pay the school fees.*

Libala local team

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T.K. and Flackson: Territorial and District Teams

co-facilitator from Chikankata. At the time, famine was prevalent in the area, and more than 35 people came to the meeting; some people came for the food that was distributed. Three people stood out as possible facilitators, and when Betty left, she asked them to continue the sensitization process in her absence. A year later, one person had withdrawn, but the other two joined people from around the country at a workshop specifically for facilitators. All the communities from which they come are now actively responding to HIV, and these facilitators have participated in and hosted program-to-program visits across the country.

The facilitators work with The Salvation Army on the one hand and with their communities on the other, melding ideas from both, but always taking their lead from the community. The Mutandalike area has seven villages within 12 kilometers of Choma Town. These villages have projects to raise funds and grow crops for HIV-affected families and orphans. A community facilitator from Mutandalike describes the community response and transfer process as follows:

*It all depends on the vision at the local level. After the education session to share what AIDS is, T.K. (a retired teacher now working with the territorial facilitation team in Choma) sensitized others. Betty visited all the communities, and when we sat down to discuss [her visits], the issue of orphans came up. Betty picked out people to spearhead the work after the workshop ended. We discussed what we could do next and came up with the idea of a garden….[3]*

T.K. explains how the facilitation process works from the viewpoint of the territorial facilitation team:

*We heard the initial concern from the community discussions, then there was a*

[3] From a group discussion with community facilitators at Mutandalike, March 17, 2003.

A LESSONS LEARNED CASE STUDY:

The Salvation Army Team

Community conversation in Ndola

*brainstorm session with the territorial HQ, then with the central committee [of the seven communities involved, made up of the community facilitators], then local facilitators held a community meeting with each of the seven communities. The brainstorming gives the team one voice with which to go back to the community, but we don't go to say, "We want you to do gardening." We pose the question, "This HIV, what problems has it brought you? Who has this problem?" and we ended up with the orphans as a concern. The brainstorms come up with many suggestions, but because the facilitators have already discussed this with other communities and have learned from other places, so they can bring the ideas that work. Then community-to-community visits show how the gardens have started and what ways work best.*

The facilitation team describes the circle of learning it developed: starting with the two separate but linked concerns about HIV and the orphans in the community, the process brings together income generation, material needs, and spiritual needs. "When this all comes together," says T.K., "it is very powerful."

## WORKING WITH THE SALVATION ARMY

The Lusaka Change Programme works with the rest of The Salvation Army organization in several ways. First, the program reports to and is managed within the organization, but it is also an agent of change within the organization in Zambia. Corps officers and pastors in communities where the program is active have become involved with the facilitation process, and the response to HIV has

become a part of the congregation's activity. The facilitation teams cut across the vertical structure, and team members have been able to work directly with different levels of management and leadership, particularly, by bringing leaders at various levels directly to communities to experience home visits. This process helps people in administrative posts not only to understand the effect of the epidemic and the way people cope with it, but also to understand directly the suffering it causes, which links to and reinforces The Salvation Army mission to work with the poorest and most marginalized.

A change also emerges in the way people who are involved in the local facilitation teams relate to—and see themselves in relation to—the local church structure. When a local pastor changes, official local church support to the teams can change, too, becoming either more or less supportive. One group recently experienced a change of local leadership and reduced its support to the local facilitation team. The result was that some of the land being used for a garden might be needed for other church use. The group's response has been to seek the support they need through other community partnerships. Thus, the strength developed through the response to HIV builds other strengths.

## WORKING WITH PARTNER ORGANIZATIONS

Churches often work together to ensure that as many people as possible within a community are included in a response to HIV. Many community facilitators are not Salvationists, and the teams make no distinction between clients or team members based on faith or religious affiliation. Inclusiveness avoids duplication. When other denominations prefer not to be part of a joint approach, the facilitation team respects this decision.

The Lusaka Change Programme appreciates its particular skills and strengths, but other organizations that have different strengths are needed to enhance the program's overall effectiveness. In the Choma District, an active branch of the Kara Counselling Trust brings together people who are open about their HIV infection and provides voluntary testing and counseling in Choma Town. People who are open about their HIV status are invaluable for raising awareness and promoting counseling; therefore, counselors from Kara Counselling Trust are included in community meetings on HIV. The Mutandalike community requested that The Salvation Army make testing available to its residents. Although The Salvation Army teams had helped the community achieve this level of acknowledgment of HIV, the Kara Counselling Trust was an essential partner in providing accessible counseling and testing to the community in its own surroundings.

In Ching'ang'auka, where the work of The Salvation Army teams also resulted in a community-initiated demand for testing, all churches in the area participated in notifying the community when and where the testing would be available. When The Salvation Army brought in testing equipment and trained counselors from its John Laing Clinic in Lusaka, the demand was so great that another nurse had to quickly complete a

government-approved training course in order to help with the testing program (see Box 6 on page 30).

## KEY CONCEPTS IN PRACTICE

The key concepts of care, change, community, hope, and leadership, as well as the transfer of these concepts between communities, are illustrated through a variety of strategies that are central to The Salvation Army's work in Zambia.

### FINDING THE RIGHT PEOPLE: CARE, HOPE, CHANGE, AND TRANSFER

The process of finding motivated people to sustain the response involves care for these local leaders

also illustrate the concept of hope: the mentoring and affirmative support help people to value what they are doing and to recognize the change that is happening. Recognizing their contribution to change helps people to realize they can influence their own futures.

### FOLLOWING THE COMMUNITY LEAD: LEADERSHIP AND CHANGE

At a community meeting in Mutandalike in March 2003, 25 to 30 local men and women, including the village headman and three local facilitators, gathered to provide material for this case study and to build on the results of the action research carried out the previous year on community-to-community transfer. This community conversation

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*When I came back from Masiye Camp\*, I told friends and others not already in the program to come [and find out about it]. One man, Michael, said, "I hear you are going to open a camp. The next time you go to Masiye, I want to go." I realized that these were the people I should teach. Michael has already shown an interest. He can do training as a leader for the Kids' Clubs. We have not yet started the program. I visit him to discuss it, and when it starts, he will be able to do it.*

\* See section on psychosocial support for children

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in the form of mentoring and supporting them. At all levels, people involved in the leadership of the response need to be included in the wider sphere, as well as in their own particular sphere. The Salvation Army territorial facilitation team occasionally visits the facilitators working in the community. Such visits are not for evaluation or supervision. They are designed to observe the work being done, to share ideas from other communities, and to affirm actions. These visits

helped to illustrate the ways in which communities work together, initiate change, and influence others.

The facilitators' role was clear to the community members: "They tell us what they learn at the workshops, and come back and teach us. What we learn at such meetings we go back and teach this to those who were not at the meetings." The community vision also gave the facilitators a

**Box 3**

**Community Leadership and Change in Mutandalike**

Asked what their current concerns were, the villagers wanted continued support from the facilitators and education for prevention, treatment, and spiritual support. They asked about the role of condoms and sought behavioral change intervention for both adults and young people. They wanted to include condoms and access to them in the choices they had available. They were concerned about the increasing numbers of orphans and believed that this issue was causing behavior change. This community had achieved some changes: sexual cleansing of widows had stopped; children and young people no longer stayed out overnight without adult supervision; drinking sprees were fewer; and because of a stricter drug law, the community had reduced drug use among young people. Challenged with how they would maintain these changes, the villagers developed several strategies:

- Using examples from within the community to encourage others to change
- Having elders counsel other elders to change their behavior
- Maintaining change to safeguard the future and recognizing the effects of death on children
- Recognizing the numbers of orphans and the need to care for them

central role: "…teaching each other, expanding the groups. If we stop, HIV will come back. Education should go ahead, and we need to increase the number of facilitators, especially within the churches. There needs to be one in each church, because people don't come if we call them to a meeting, but they do go to the churches. If there is no medication, education is the way forward."

## KNOWING THAT ACTION MAKES A DIFFERENCE: CARE, HOPE, CHANGE, MEASUREMENT, AND TRANSFER

Community action alone is not enough. People need to know they are achieving something, if they are to build on their actions. Traditionally, measurement of progress involves an evaluation,

usually by an external evaluator, who judges the success of the project by external criteria. This kind of evaluation is often unhelpful to the people involved in the project. A balance needs to be drawn between judgmental, "impartial" evaluation and uncritical support. One way to achieve this balance is by self-measurement. Communities can measure their progress and report their successes and failures.

Ching'ang'auka has benefited from an active community response since the first workshop was held in 1999. Ching'ang'auka now has three community facilitators and a committed Corps Officer. The community has been involved in an action research process, measuring its own progress and examining the transfer of concepts

and action. Ching'ang'auka is at the junction of the main roads to Lusaka from Zimbabwe and Botswana, and is close to a major abattoir and a source of river sand, which is one of the main components for the building industry. It is a transport center where many truck drivers stop.

Asked about change in the community, the local team described the following:

• Families no longer send young women to sell beer at the taverns, which has led to a change in their behavior. Many young women have died, and the community has understood the risks.

• Information is shared within the community to teach each other.

• Village headmen have become involved and have backed the local team's efforts. One village headman donated land to raise crops to support the orphans.

• The Salvation Army has also experienced change. Church leaders have become involved in community action.

• More people are requesting HIV tests, and testing is now available in the community. (Villagers nearby heard about HIV testing in Ching'ang'auka and asked how to arrange for it.)

The action research conducted in 2001–2002 in four African and two Asian countries helped communities recognize their own progress and gain the skills to develop indicators and to measure progress.[4] In different communities, the indicators of change may be different, depending on the local circumstances that increase the chances of becoming HIV infected, and on how

the community chooses to address these factors. The community is involved in developing indicators that are specific to their circumstances and in choosing the ways to respond to HIV.

Though communities are able to recognize the change happening in their communities and to draw hope from this evidence of control over their lives, there must be a way for the progress reflecting this kind of change to be measured externally. Outcomes and indicators that are being developed recognize not only the quantifiable changes—such as numbers of people reached, condoms distributed, or meetings held—but also the qualitative change in the community. The indicators for success in working this way are intended to measure change in communities rather than to measure what the implementing organization has done. (See the Appendix.)

## MONITORING

Both monitoring and quality control issues need to be addressed. In addition to the self-measurement that communities can carry out with facilitators, how is the performance of the facilitators maintained? Betty Muleya describes a few ways this happens:

*We encourage short reports, and (when there are funds) follow-up visits to meet both the counselors/facilitators and the people in the community. These visits are not (for the purpose of) going out to criticize, but to be with people and to discuss what they are doing.*

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[4] Moving Together, March–September 2001: Action Research in Kenya, Uganda, Zambia, and Malawi, The Salvation Army.

*The continuity is there because you let the community decide, rather than say what they should do. That will never take off because it would be Mbuya's program, not theirs. If we think the community can't manage something, we think it through with them, and sometimes communities change their minds. For example, we might ask, "Where is the water? Can you water a garden here?" In one case, they joined hands with the next village, which is nearer [to] the stream.*

The facilitators' performance is managed within the teams, whose aim is to create a critical, supportive relationship for each other. An effective team shares leadership, holds each other account-able through creative criticism, and maintains continual briefing and debriefing. Members are open to learning from others and are willing to share. When a member of one district team stopped being involved, the committee released him: "One counselor is not now with us. He didn't carry out his duties." Thus, the way the team operates is in itself a tool for monitoring, and external structures become inappropriate. Accountability is to the team, the community, and the ways of working, rather than to an organization or supervisor.[5]

## COMMUNITY ACTIONS

Thus far, this case study has examined the concepts and principles behind the work. But what are the activities? What actually happens in these communities, and how does it help to address the effects of HIV? In some ways, the description of activities is the least important part of the story of The Salvation Army response. The concepts and values are the key issues in starting and stimulating a response. The actual activity—which is based on the concern identified by communities and which varies from one community to another—is less important than the process through which the response is started and sustained. The ways in which communities in Zambia have responded show diversity and how communities learn from each other through the facilitation teams.

The facilitation approach is not a process for replicating activities. Similar ideas transfer successfully between communities or countries and are adapted and changed to meet different needs in different settings. The transfer of concepts and ways of working, rather than activities or models, encourages community action to happen successfully.

## INCOME GENERATION: SUPPORTING AND SUSTAINING CARE

In much of southern African now, and certainly in Zambia, a main concern of communities is orphans and inadequately supported children, particularly children in child-headed households. In situations of great poverty, which are often linked to drought and lack of food security, it is hard to realize how communities that struggle for the basics of life can also support children when their parents die. There are many stories about

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[5] The Salvation Army teams have developed guidelines for mentoring, a checklist for facilitators, a developments planning framework, and other tools to guide the approach and to help facilitation teams to maintain this Human Capacity Development Approach.

**Box 4**

## Local Responses

Five local women, including a retired nurse and teacher, and the local corps officer, who had participated in a workshop for potential facilitators and who had been identified in the educational workshops, were leading the response in Libala. There had been a setback in 2000 when clients from other churches rejected the team's home visits because they came empty-handed. As in other communities, the local facilitators had called meetings and discussed local concerns. And here, as elsewhere, the concern about orphans and the sick emerged, and ideas for income generation and small projects were discussed. The home visits continued with the clients from The Salvation Army congregation, and the team began to think about what else they could provide from the resources available to them. They turned to The Salvation Army, and the pastor gave them a small piece of land that belonged to the church. They started a garden and produced crops that they took with them on home visits so they would no longer go empty-handed. A chicken project worked for a time, and sales of eggs provided funds for books for the children. But the project was impossible to sustain when the chickens stopped laying eggs. For a while, a remarkable collaboration between different teams and the church created an innovative project: the church in Libala needed to build a new hall, so the facilitation team realized that brick-making would bring them income. They then realized they could buy the sand they needed from the community in Ching'ang'auka, which was using that local resource, in this case sand, to support their efforts for orphans. So the church hall was built in a way that supported two communities' efforts to look after orphans.

the exploitation of these children and about their desperate situations, but there is little documentation of examples of community solidarity in which people have sought and found ways to support orphans without relying on external interventions.

The story in Box 4 illustrates the ways in which communities can help each other and in which churches can cement these efforts through productive use of community capacity and through support for intercommunity communication and learning. Individual projects are not static,

however, and they are not necessarily long-lasting or "sustainable." It is the motivation and action of the facilitators and, through them, the communities which are sustainable, though they need support to maintain motivation, and accompaniment to affirm the value of their actions.

In other areas, different projects are selected. The Mutandalike area is suitable for gardens because a reliable stream supplies water, and a market is within reach.

The process relies on voluntary contributions from community members. There is as much discussion about this within the teams as there is in many volunteer projects in southern Africa and elsewhere. Volunteers are already working to sustain their own families and may have been touched by the epidemic either directly or indirectly. Is this exploitation? And can voluntary service be sustained? Some volunteers drop out at an early stage when they learn there is no allowance, but others have been fully engaged for several years.

T.K. is responsible for seven orphans, and the community responses and discussions have helped him. By growing vegetables, he and his family were able to provide school uniforms for all seven children. As he says, "The knowledge I learn is the same as the knowledge I take home." By being involved in a community response, individuals can also benefit. This interdependence of the community and the individual may not compensate for the lack of an allowance for volunteers, but it does explain some of the strength of communities—if they are receiving support—to identify and address their concerns themselves.

In one school, 12 people met weekly at one stage, and of the 12, six now remain. These six individuals started their own income-generating project; through the village headman, they set up community counseling meetings. The facilitators say that when money is provided to communities, there may not be a strong community consensus about how to use it, and the money is less likely to reach those for whom it is intended. By starting with concerns, working through community volunteers

and relying on community resources, communities can count on an end result that provides more support for the orphans, and lessens the likelihood of misused funds and a disillusioned community group. As one member of the Mutandalike team says, "With the gardens, there is a sense of ownership. It is not someone else's money."

Through the community counseling process, people become accountable to each other, and the control is community-based rather than project-based. Some help for volunteers is available, such as bicycles for transportation. So far, the Lusaka Change Programme has received very little in terms of external resources.

## HOME CARE AND THE LINKS TO PREVENTION

The first step in addressing HIV is to acknowledge that it is present, and that it is both a personal and a community issue. The combination of community counseling or community conversations where facilitators lead the discussion on identification of concerns and visions and hope for the future, accurate information about HIV, and sustained visits to the homes of people who are affected—even if there is no medication to treat them—creates the environment in which people see a way to influence their own future and that of their children, and to see a way to act on this. This is illustrated by what happened in both Mutandalike and Ching'ang'auka, where a partnership between The Salvation Army and the community led to a request for testing and counseling (see Box 6 on page 30).

**Box 5**

**Mutandalike: A Story of Community Transfer**

In April 1999, there was no team and no response to HIV in the Mutandalike community. Betty, in an attempt to reach beyond Lusaka, visited the district headquarters in Choma as part of her strategy to involve The Salvation Army leadership in HIV issues. Among the others at the workshop (which was attended by both Salvationists and non-Salvationists) was T.K., a Salvationist and retired schoolteacher. T.K. attended a workshop in Livingstone to share his experiences from Ndola and Lusaka. On his return, he met the next team member, Richard, who joined him for a workshop in Ndola. By this time, one orphan project had just begun, and on their return from the Ndola workshop, T.K. and Richard together went to several villages to talk about what could be done about HIV. A third person, Flackson, joined the team. The communities were now sharing the information they were learning. A year later, five communities had started projects with land donated by the village headman or by individuals, and people were asking for the team to visit more villages. In 2001, the villages were grouped into smaller units; each unit included one of the team members or community counselors. In 2002, a different management structure for the projects was set up: a representative from each smaller group attended a central committee meeting. The central committee meets monthly or twice monthly, but projects are run locally. The projects are still expanding, and there is now a plan to split into two main committees. While the gardens do not always meet all the needs of the orphans, they do provide food. Sometimes there is surplus produce, which is sold in Choma. Community members take turns to cycle or walk the 12 kilometers to the market. Income generated from the sale of surplus produce is used to pay for school fees, uniforms, books, and pens for the children. Occasionally, when there is surplus over and above this, the central committee uses such funds to support projects that have not yet generated income. This activity has been achieved by using local capacity. There has been no funding for the projects, and the community counselors are volunteers.

In addition to the gardens, the teams are continuing with community counseling and education, reaching out to other villages as requested. Learning about HIV has led to a demand for voluntary testing and counseling. In partnership with another locally based organization, Kara Counselling Trust, testing was provided in the village setting. People living with HIV have joined The Salvation Army teams in the community counseling sessions, and Women for Change and the other churches in the area have also been part of the response.

*The Salvation Army Team*

Orphans working in their garden.



*The Salvation Army Team*

Volunteer gardeners taking produce to market.

The story in Box 6 is very different from the experiences of several projects aiming to address mother-to-child transmission in Zambia, those in which women do not seek testing or do not return for their test results. These community counseling sessions and home visits for those affected, combined with available technology provided in ways that follow the community's lead, could be powerful. Even without technology, the desire to understand one's own status and to seek support to cope with it leads to steps to prevent the further spread of HIV and to actions to reduce one's vulnerability. Communities already responding in these ways will be ready to participate in the introduction of antiretroviral treatment as it becomes available in rural areas.

## PSYCHOSOCIAL SUPPORT FOR CHILDREN

Children need more than education and food, especially children who have experienced the trauma of losing one or both parents and have taken on early responsibilities for caring for sick adults, and, often, the responsibility for younger siblings. The Salvation Army has undertaken innovative work with orphans and children affected by HIV. In Masiye Camp, in Zimbabwe, The Salvation Army pioneered the provision of psychosocial support for children in their communities and in camps that offer physical challenges and psychological support (UNAIDS 2001a). As part of the program-to-program exchanges, team members from Zambia visited Masiye Camp in 2002 for training in psychosocial skills, running a camp, and encouraging the involvement of children.

**Kids' Clubs**. Following this experience, the teams started "Kids' Clubs" in Zambia, which provide space for orphans and other neighborhood children to play games, explore spiritual issues, and share their concerns and ideas for response to HIV/AIDS. The first step was to invite 18 youth peer educators from the Community Development Department to a workshop on psychosocial support in Zambia. The regional team supported the idea and sent two young counselors from Masiye Camp to be part of the facilitation team for this workshop. The result was the development of Kids' Clubs in Libala and Kanyama, and a growing engagement with young people in other districts. The clubs meet on Saturdays, and for those meetings, young leaders and the facilitation teams volunteer their time.

**Youth Camps**. Later in 2002, T.K. and Richard, of the Mutandalike team, and Betty, attended a second workshop in Masiye. As a result of T.K.'s request on his return to Zambia, a village headman in the Mutandalike area donated land for another camp. A workshop is planned in the Choma area to bring together young people who will be future camp leaders. A few young people in the village have cleared the donated land, and they are already holding meetings there. Grass shelters will be erected so they will be able to hold weekend activity camps and retreats for the children. They hope to have tents for these activities in the future, if funds can be raised. A camp with similar activities for community children has also been set up on donated land in Ching'ang'auka.

**Box 6**
**Community-based Testing and Counseling: Care to Prevention Interlinked**

In Ching'ang'auka, the community moved from denial and rejection of people living with HIV to acknowledgment and recognition of the role of testing and knowing one's status. The community counselors talked about the changes: "The headmen give us time to go round the community. Before this, people said there is this disease but we cannot sit as a family to talk [about it]. Now, many people have accepted it and are talking about it." The role of the headman has been crucial. He has been supportive, given land for a children's camp, and has allowed facilitators to speak at burials and funerals. The team's work led to a request from the community to have testing made available.

A lot of thought and preparation went into the response to the request. For several Sundays, The Salvation Army and other churches announced when and where the testing would occur. A trained nurse from a Salvation Army clinic was brought in and five counselors from the teams were involved. The first session was planned for the afternoon to fit in with farming duties.

Meanwhile, the local team continued to talk to the community. "We told people, 'If you come for testing, you will know [whether you have HIV], and with counseling, you will know what to eat and so on. Then we can see how best to live.' "

The response still took the team by surprise. "Many people from five villages came for testing, and they are still coming." A second session was organized two weeks later, this time in the morning. For this session, a second nurse was needed. One of the Libala facilitation team members, a qualified nurse, went at short notice to a government-recognized training session to earn the qualifications needed to carry out testing for HIV. In total, 85 people were tested, mostly women and a few couples.

At the time of the case-study visit to Ching'ang'auka, follow-up visits were still being worked out, but the team said that nearly all those who tested positive requested the team to visit and support them. And a second village, 10 kilometers away, heard about the testing and asked the team to do the same in their community.

## TRANSFER OF ACTION AND LEARNING

An underlying assumption in The Salvation Army response is that knowledge, learning, and action are transferred from one community to another (see Figure 2), and although this happens sponta-neously, it can also be encouraged to speed up the local, national, and global responses to HIV. The Lusaka Change Programme offers many instances of how this transfer has happened practically, and in what ways the transfer has been built into the process and deliberately fostered. At a regional level, the exchange between teams in Zambia and Zimbabwe, which led to the rapid start of psychosocial support activities, is described above. In the early stages, key people such as Betty, T.K., and Dialess also learned by seeing work in action in Kenya and Uganda. At the national and local levels, opportunities for enhancing transfer of action and concepts have also been developed. Two of the processes through which communities learn from each other and transfer concepts and ways of responding are program-to-program visits and community-to-community knowledge transfers.

**Program-to-Program Visits**. In 2000, the first program-to-program visit took place in Ndola. The local district officer, Major Irene Hachamba, had moved to Ndola after becoming involved in the earliest activities in Libala. Two volunteer counselors each from Mutandalike, Libala, Mumbwa, and Ching'ang'auka (and sometimes a community member) saw the home-based care visits in action, joined counselors at the clinic where the Ndola counselors were working, and shared their own work with the others. During 2000 and 2001, this pattern of exchange was repeated in Libala, Mumbwa, and Mutandalike, where local partner Kara Counselling Trust supported the exchange and an openly HIV-positive member of Kara Counselling joined the meeting. These exchanges require some external resources; on this occasion The Salvation Army International Health Program provided assistance. The experience of learning from local actions, from seeing what can be done in practice, and from brainstorming together about what has and has not worked has been valuable for all the local teams. Betty sees this exchange as one of the most important processes in developing the identity of the national territorial facilitation team. With no available money for this type of activity, however, it has not been repeated.

**Community-to-Community Transfer.** The community members in Mutandalike described how they influence other communities: "The information travels from community to communi-ty. If there is a funeral in another village, people talk about it at the funeral, and from there it expands. Those who teach us also go to other villages, and so the circle of information expands. When other villages learn we had such a meeting, they want to know what happened, and we tell them. Then we ask their headman if we can talk to his people, and we send two or three people." The story about the chain of community gardens to support orphans in Mutandalike (see Box 5 on page 27) has been repeated in other areas of Zambia and globally. It is described in an action research report produced by The Salvation Army

Africa Regional Program Facilitation Team, and by local implementing teams and communities in four countries in Africa (The Salvation Army 2002). For the action research process, communities mapped the transfer within their regions. Figure 2 shows the map drawn by the community group in Mutandalike.

The research in the four countries identified ways in which the knowledge was transferred, and these ways show how the concept of knowledge transfer is interlinked with the different activities that make up the community response. The most frequently mentioned channel of transfer was the local teams, through community counseling, education, and sensitization. Direct invitations to the team and home visits were also prominent means of community-to-community learning. In Muntandalike, visits were arranged between villages so that the villagers could learn what had worked in their gardens. These visits also provided affirmation and encouragement, and led to healthy competition.

These processes stimulate a community response through the sharing of concepts and skills. Sharing specific ideas for small projects and real experiences in how and why activities did or did not work for others makes communities realize that they have a realistic means of responding and creating hope and fostering action.

## INFLUENCING OTHERS
### CHANGES IN THE SALVATION ARMY

The local work on HIV in districts and within the leadership in Zambia has raised the collective consciousness of The Salvation Army. Officers



*Sue Lucas*

T.K., the local team, and village headman study the transfer maps originally created by the community

A LESSONS LEARNED CASE STUDY:

# ZAMBIA



**KEY**

- —— Village Boundaries
- ∿∿ Munzuma River
- ——▶ Before the Research
- - - ▶ After the Research
- [IGA] Income Generating Activities
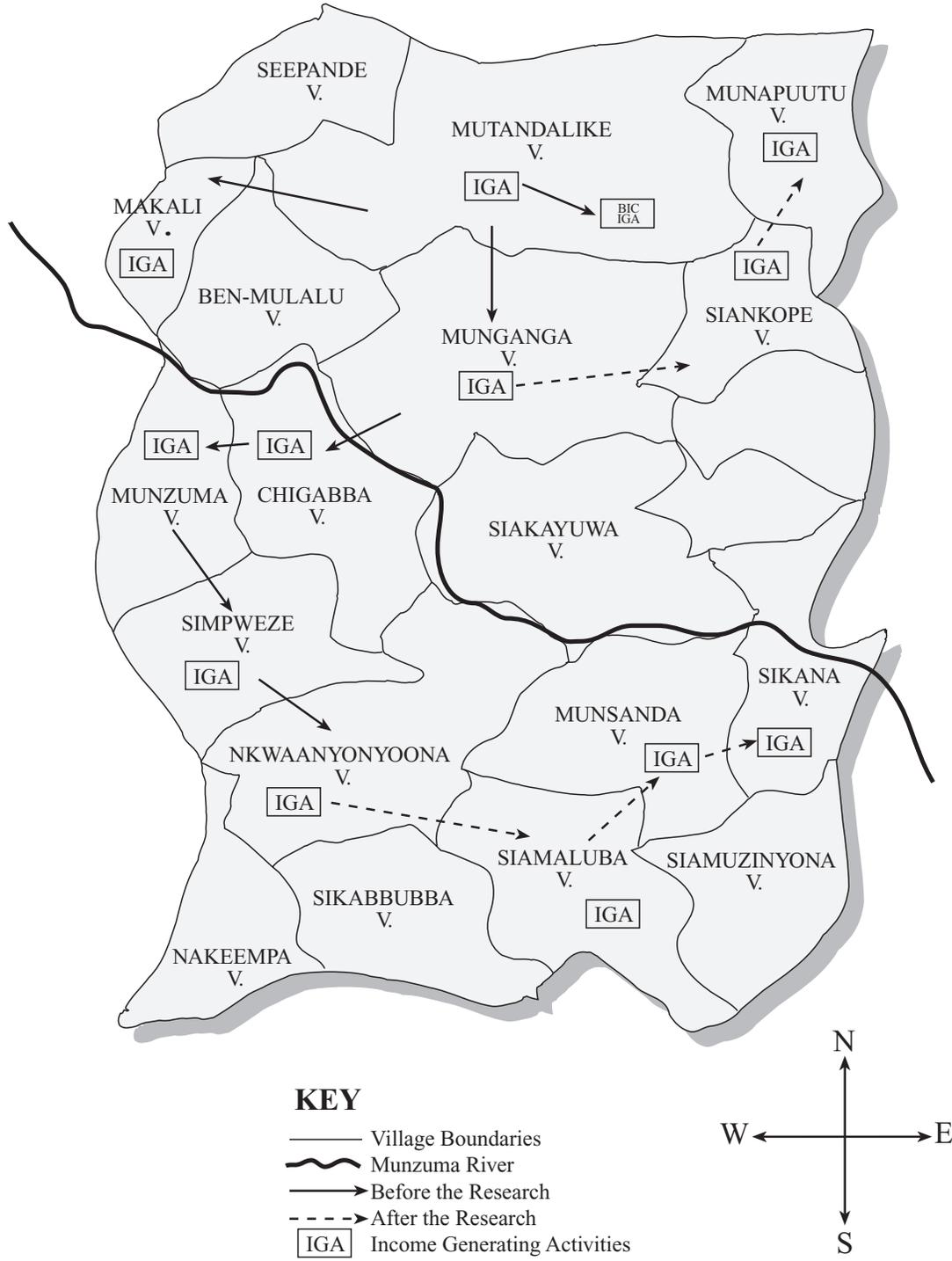
Figure 2: Map Showing Community-to-Community transfer and Community-Determined Change

at all levels have become personally involved, and the leadership is supportive of both the work and methods used to stem the HIV epidemic in Zambia. There is still a way to go, however. HIV is not yet a crosscutting issue in everything The Salvation Army does in Zambia, but it is becoming a part of the ministry. Where the teams are active, HIV is likely to be included in a variety of issues addressed through church activities, as well as through the teams.

The facilitation teams and the way they work have cut across The Salvation Army hierarchy. First, by bringing leaders to experience and learn from community actions, the facilitation teams have reinforced The Salvation Army's identification with the poor and its understanding of the lives of the people with whom it works. The facilitation teams have demonstrated that HIV intensifies poverty, exclusion, and deprivation, and that it intensifies the vision and mission of The Salvation Army as well. Second, members of the facilitation teams have begun to change the hierarchy and have gained direct access to senior leadership. The need to address HIV has proved the need for greater flexibility.

## CHANGES IN LOCAL LEADERSHIP

At the local level, the facilitation-team approach has led to greater response to HIV and greater community capacity for leadership and for coping with the effects of HIV. This increased capacity is rooted in change by individuals who can influence community responses within The Salvation Army and the secular community structures.

Increased capacity was demonstrated by the ways that communities: organized themselves, such as the committees in Mutandalike; maintained a response and found new approaches when they faced setbacks, such as the income-generating schemes; and initiated new responses, such as the request for HIV testing on the community's terms, and not on the terms of the service providers.

Community counselors (facilitators) in Mutandalike and Ching'ang'auka commented on the value of gaining the village leader's support, which was dependent on the way the local teams approached the leader and sought his or her support. Gaining support was difficult in some places, particularly where the facilitators were young women, who traditionally find it difficult to influence the predominantly male community leaders. In a rare failure, the team was unable to gain the support of the headman, reportedly because he thought that by bringing up the question of HIV, "These young people have insulted me." But these occurrences were rare, and the headman's support for the teams in nearly all villages led to freedom to call meetings and to donations of land.

The cooperation of different churches is not a new development, but the coordination of the response has been striking. The Salvation Army does not restrict its care to only Salvation Army church members. In several villages, churches of all denominations supported their own members, but they coordinated calls to meetings by sharing information at Sunday services. For workshops

in new communities, invitations are sent to all churches in the community.

National- and community-level partnerships are also based on the idea of learning together and on the recognition that coping with HIV requires many skills, resources, and services, and that these need to be brought together. Partnerships with local organizations bring in technical capacity (for example, for testing), and lead to broader participation.

## INFLUENCE AT THE NATIONAL LEVEL

At the national level, the experience of The Salvation Army in Zambia has greatly contributed to the formation of the National Facilitation Team, a national group of people from government; international, national, and local NGOs; communities; and service providers, who met and created a national team in 2001 to facilitate a national response. This team uses the Support and Learning Team approach by reaching out to communities and facilitating the transfer of action and experience across the country.

# CONCLUSIONS

It is clear the communities that have facilitation teams have changed. HIV is acknowledged and is being addressed. The experiences in Mutandalike and Ching'ang'auka illustrate how orphans can be integrated into the community and how attitudes can change toward people with HIV. This change is also happening in several other districts in Zambia, and the success of communities is being shared with others.

In addition to changes in the communities, there has also been a gradual change within The Salvation Army organization and leadership. Together, the changes represent the recapturing of hope and confidence in the face of HIV.

## THE VALUE OF PEOPLE

Any approach to the HIV epidemic has strengths and weaknesses, but the success and sustainability of an approach depend on a balance between them. These strengths and weaknesses are often mirror images of each other. In The Salvation Army approach, a main strength is the central role of people as individuals and team members in their communities. Overdependence on a few individuals can also be a weakness. A key strategy in the team approach, however, is that people are always being sought out, and there is room for individual development, mentoring, and encouragement. Backed by the faith environment and the

emphasis of The Salvation Army on valuing people and fostering healthy relationships between people, reliance on people and their commitment is strength rather than weakness.

## SUCCESSES AND CHALLENGES

Supporting a response entirely through community resources, with little external input, is both a remarkable success and a challenge. It is a remarkable success in that it shows how much can be done with so little, and it unveils the strength and capacity of communities to foster change and to find their own answers to problems. There is a tangible sense of hope and energy in these communities.

The challenge is the extent to which communities can respond without outside help, especially in countries such as Zambia, which has limited resources. The current debate on how to scale up services has illustrated, however, that external aid alone is not sufficient. The challenge is to find ways to support communities and to bring in external resources, while ensuring respect for the their priorities and capacity to find solutions. In the Lusaka Change Programme, this dilemma is presented in a local form: how to ensure that volunteer community counselors/facilitators have sufficient material resources to carry out the duties—without raising expectations that external

help can solve their problems or without creating a distinction between the community and its response—by making the teams accountable to the organization rather than the community. The team members are well aware of these questions, and they and the community members with whom they work recognize the advantages and disadvantages of bringing in external resources, and the value of their own response. For the global response to HIV, the success of work without external resources should raise significant questions about how to deliver the technical solutions without compromising the human and community capacity for change and hope. The need to combine the two is urgent.

## SCALING UP

Scale-up has been the catchphrase in HIV work for the past few years. How do we make small-scale, successful models work on national, regional, and international scales? The emphasis on horizontal transfer of concepts and action in The Salvation Army approach is one answer. Passing on the lesson of how other communities or teams operate, rather than what they did, means that responses are flexible and designed for local contexts. This method presents challenges for

monitoring and evaluation that are being addressed, but they demand a fresh approach. The Salvation Army approach also presents challenges for donors. While building on community strengths implies that much can be done with very little, resources are nevertheless required. If a large-scale response is to take off, substantial resources are needed to support essential elements such as program-to-program visits and the creation of opportunities for shared learning. These elements need to take place alongside the provision of services and technical interventions, which also require resources. Funding is needed for facilitation teams, program-to-program exchanges, local learning experiences, and action research. Such financial support may require the development of different funding mechanisms if existing funding frameworks are limited by rigid monitoring and evaluation regulations and by short-term time constraints. Human capacity development approaches must be taken as seriously as technical interventions if there is to be a long-term and sustainable impact on the HIV epidemic. This action requires a change in institutions as urgently as it requires a change in communities.

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# APPENDIX

## EVALUATION OF HUMAN CAPACITY DEVELOPMENT APPROACHES

Human capacity development, carried out through facilitation approaches and horizontal learning, is a dynamic, long-term process that aims to increase community responses and encourage organizational change. This approach requires the creative development of new frameworks of indicators related to community behaviors, changes in patterns of care, and changes in organizational approaches, as well as evidence of individual behavior change. The traditional indicators for HIV programs—such as changes in knowledge, attitude, and behavior—are not the only ones to show whether changes in communities and organizations have happened. For example, measurement of success in human capacity development includes a community's capacity to measure its own change and to develop its own indicators, and measurement of organizational change includes indicators of how organizations have applied what they have learned from local responses.

During the past few years, The Salvation Army has worked to develop a draft "Framework for Evaluation" and "Toolkit for Documentation and Measurement."[1] In partnership with The Salvation Army, the Joint United Nations Programme on HIV/AIDS, the United Nations Institute for Training and Research AIDS Competence Program, and the multinational oil company BP have developed a "Self-Assessment Framework for AIDS Competence."[2] The use of these tools adds to available conventional indicators of impact and contributes to program development and community capacity.

While some indicators will be relevant to all situations, specific indicators need to be developed with the participation of communities, organizations, or districts to reflect the local context. For example, a common indicator of HIV/AIDS competence is that communities care for affected people. Since the way such care is demonstrated (e.g., the caregiver and level of care given) may vary according to the local context and the stage of the epidemic, such care needs to be developed by communities themselves.

Communities are able to assess their progress by measuring indicators such as the numbers of people actively involved in caring for the sick, orphans being supported by community responses, young people who are no longer exposed to risky situations, people having come forward for testing and counseling, and, in the future, people

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[1] Contact April Foster, The Salvation Army Regional Facilitation Team, P.O. Box 40575, Nairobi, Kenya, arfsareg@maf.or.ke
[2] "Self-Assessment Framework for AIDS Competence" is available at www.unitar.org/acp

receiving and adhering to antiretroviral therapy. The communities can provide documentation of these changes. Communities can also measure and document how concepts and experiences are transferred to others.

It is also important to be able to measure the effect of facilitation teams. One clear indicator is the increase in local responses. Such responses include, for example, income-generation activities, numbers of local care and prevention teams established, and provision of voluntary testing and counseling services at the request of communities. Active team members in the national, territorial, and local levels also indicate a growing response.

The evaluation framework[3] that is currently in development is illustrated in Appendix Table 1. The framework allows progress to be measured for four key elements that contribute to achieving HIV/AIDS competence: development of local responses, formation of a culture of facilitation, achievement of community-to-community transfer, and development of policy based on learning from local responses.

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[3] Contact Dr. Ian Campbell, International Health Programme, The Salvation Army International Headquarters, 4, Queen Victoria Street, London EC4 4EP

Appendix Table 1. Evaluation Framework for Human Capacity Development Approaches: Assessment of Key Components

| Spheres of Action<br>Key Human Capacity Development Outcomes | Community, Family, Individual<br>(Community Level) | Service Providers/Workplace<br>(Organizational, District, National Levels) | Policymakers and Resource Allocators<br>(Organizational, National Levels) |
|---|---|---|---|
| **Expansion of Local Responses** | • Action demonstrating community and family acknowledgment of the existence and importance of HIV<br>• Demonstration of care by families<br>• Communities measuring their own change<br>• Development of local partnerships | **Organizational Level**<br>• Inclusion of people living with HIV/AIDS<br>• Evidence of learning from the local response<br>• Changes in services and service delivery reflecting learning from local responses<br><br>**District Level**<br>• Systematic participation in local learning experiences<br>• Inclusion of people living with HIV/AIDS<br>• Development of local partnerships<br><br>**National Level**<br>• Systematic participation in learning from local responses of national service providers and organizations | **Organizational Level**<br>• Provisions for ensuring that all employees understand HIV in relation to work and personal life<br>• Organizational human capacity development policy in place<br><br>**National Level**<br>• Systematic participation in learning from local action for policymakers<br>• Increasing numbers of local responses<br>• Increasing invitations to the national facilitation team from communities |
| **Culture of Facilitation** | **Community Level**<br>• Community members involved in district facilitation network<br>• Invitations sent from community to district and national facilitation teams | **Organizational Level**<br>• Development of SALT team within organization<br>• Involvement of staff, with organization backing, in national, district, and local facilitation teams<br><br>**District Level**<br>• Participation from multiple sectors in district facilitation team<br><br>**National Level**<br>• Formation of a national facilitation team<br>• Increasing number of invitations to national facilitation team | **Organizational Level**<br>• Formation of Support and Learning Teams<br>• Funding for staff participation in Support and Learning Teams outside organization and national facilitation teams<br><br>**National Level**<br>• Government funding for a national facilitation team<br>• Participation from multiple sectors in national facilitation teams |

| | | | |
|---|---|---|---|
| **Community-to-Community Transfer** | • Community members connecting with and to other communities<br>• Change within the community as a result of contact with other communities | **Organizational Level**<br>• Organizational commitment to sharing learning through local visits<br><br>**District Level**<br>• District facilitation team responding to community invitations<br>• Inclusion of community members in district facilitation team visits to other communities<br><br>**National Level**<br>• Government funding for exchange visits between communities or districts | **Organizational level**<br>• Participation of staff in visits to other organizations and communities<br><br>**National level**<br>• Participation in transfer between countries of learning from local action and experience |
| **Policy Development for Human Capacity Development Based on Learning from Local Responses** | • Local policy within communities and community-based organizations reflects learning from local responses<br><br>• Communities participate in wider policy development (that is, their voices are heard nationally) | • Change approach to one that integrates human capacity development and service provision<br>• Change ways of working to reflect learning from local action | **Organizational Level**<br>• Inclusion of people with HIV; action on care for people with HIV<br>• Change in approach from a dominant policy toward human capacity development away from external and technical interventions |

Appendix Table 2 offers examples of indicators to measure the success of local responses by district or national facilitation teams in changing approaches and fostering a culture of facilitation. Successful teams will enable changes in communities, organizations, and overall approaches toward health services. For example, successful teams will enhance the capacity of communities to transfer their learning to other communities and to learn from and act on other responses. Indicators need to reflect these processes.

Appendix Table 2. Indicators for Evaluation of Facilitation Teams

| Local and District Teams | National Facilitation Team |
|---|---|
| Increase in local responses | Increase in quantity and quality of local responses and in district facilitation teams |
| More local organizations involved in HIV responses | More national and district organizations involved in responding to HIV |
| Progress toward AIDS competence in the community (as measured above) | Implementation of systematic learning from the local response facilitated through district and local teams |
| Participating organizations demonstrate a shift toward a culture of facilitation (as measured above) | National policy becoming supportive of facilitation teams (for example, funding for national facilitation team) |
| | Evidence of participatory responses across all sectors of government |

Synergy Project case studies review programming models that demonstrate "good or promising practice" in the response to HIV/AIDS in resource-poor settings. The case studies describe the specific challenge addressed, the successes achieved, and the lessons learned in the process of implementing a model in one setting. Such documentation and dissemination to others who design and manage programs in the field are essential tasks contributing to an effective global response. If the goals set by The President's Emergency Plan for AIDS Relief and the World Health Organization 3x5 Initiative, and the United Nations Millennium Goals are to be achieved, program planners and managers need to replicate and bring to scale successful models to avoid known pitfalls and to build on the solid foundation of achievements in existing programs and projects.

Good or promising practice in this context refers to knowledge about what is and is not working, or to what appears to hold promise in the fight against HIV/AIDS in resource-poor settings. The ability to learn from the experiences of others and to improve and adapt those experiences to different field situations is essential for building the capacity to implement national programs. It is not only documenting and disseminating lessons learned, but also the ongoing process of feedback, reflection, and analysis that allow continued improvements to occur.

This case study documents a successful model for facilitating a strong community response to HIV/AIDS. The Salvation Army Change Program in Ndola and Choma Districts in Zambia illustrates the facilitation process stimulating an appropriate local response to HIV/AIDS, an essential component of human capacity development. "Human capacity development means developing the will, skills, capacities and systems for an effective response to HIV."