HUMAN CAPACITY DEVELOPMENT FOR RESPONSE TO HIV

For presentation at the HIV Implementers Meeting Plenary session on Human Capacity Development

HIV Implementers Meeting
Plenary Session - Human Capacity Development
4th June 2008

Facilitation Associates responding to HIV
www.affirmfacilitators.org

The Constellation for AIDS Competence
www.aidscompetence.org

Interhealth Worldwide
www.interhealth.org.uk

Aids Education Programme,
University of Chiang Mai, Thailand
www.cmu.ac.th

The Salvation Army
www.salvationarmy.org/ihq

Kampala, Uganda
4th June 2008

Ian D Campbell
Affirm Facilitation Associates
www.affirmfacilitators.org
iancampbell11@aol.com

The HIV and AIDS epidemic is not finished; the volume and intensity of impact is growing, globally.

Whilst U.S. global AIDS spending is helping to prolong the lives of more than a million people and is widely seen as a foreign policy and humanitarian success, there are some seeds of a future crisis. Mead Over[1] notes that 'life-long treatment costs are increasing as those on treatment live longer, and the number of new HIV infections continues to outpace the number of people receiving treatment.' He challenges the creation of the expectation of full funding of permanent treatment entitlement, which will inevitably skew the distribution of health and development funding.

S2 

Historically, much of the response to HIV has been interventionist, with a structural provision-focused working culture, yet since the beginning of the epidemic, especially in the economically 'developing' world, the experience is that human beings in local relationships of family, friends, and neighbourhood can respond with genuine care, community belonging, capacity to change, to express leadership, and to hope.

Such human capacity, when affirmed and developed (HCD), motivates PLWAHA to respond in the interests of a shared future to which we are all connected.

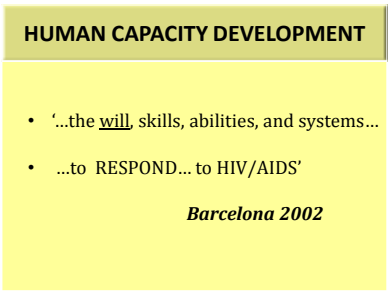
S3 

[1] Mead Over. *Prevention Failure: The Ballooning Entitlement Burden of U.S. Global AIDS Treatment Spending and What to Do About It*. 05/05/2008 http://www.cgdev.org/files/15973_file_Presidential_AIDS_Policy_FINAL.pdf

The essence of the community development process at the base of HCD, allows the participation of 'outsiders', yet strongly grounds response in local community ownership, affirming the right to commodities, and the right to initiate shared response.

I intend to

- illustrate and discuss some facets of HCD,
- propose some additional and connecting value of an HCD framework, and
- propose some practical steps which can be explored to more authentically understand and embed HCD into policy and practice.



S4

Defining Human Capacity Development (HCD)

At a satellite meeting of the Barcelona IAC in 2002, a working group convened by the Technical Network (TND) unit of UNAIDS concluded that HCD refers to the 'will, skills, abilities, and systems to respond to HIV'.

Since then, much emphasis has developed on 'Human Resources for Health', with systems being the subject, and training and retaining of health workers being the preoccupation. Capacity of human beings has been limited intellectually, emotionally, and strategically to keeping more numbers in the workplace, and to measuring for HCD mostly through HRD parameters.

For me, the 'will' of people is the subject. 'Human capacity development' therefore refers to the inclusive nurturing, refinement and application of the potential of people in local relationships, and partnerships, to respond to stress situations. It involves people coming together, face-to-face, in local situations of home, neighbourhood, and other community settings, to acknowledge challenges, conflicts, and human strengths and interweave care, treatment, support, prevention and transfer.

S5 

Example: Kithithuni, Kenya

In 2001, I was privileged, to visit a friend in Kithithuni who was one of the pastors in charge of the local Salvation Army church. S6

Scaling out Response – Kithithuni HCD

- 2001
  - a village response
- 2007
  - 70 local responses within 25 kms
- 2008
  - 72 primary, 15 secondary

She understood that HIV was for everyone and she formed a team from the neighbourhood. With support visits from the Salvation Army regional facilitation team and no external funds, 7 years later, there are 72 local responses directly stimulated by the original village team, and 15 secondary responses which have transferred directly from a primary response. S7

Scaling out Response – Kithithuni HCD

Number of team members for host community	Number of team members for 1st Generation Communities	Number of team members for the 2nd Generation Communities	Number of active community team members	Number of people (87 communities)	Average cost per year (USD) $
1+	72 +	15+	696+	53,500	$2,200

NB: + Due to organic expansion of the teams as a result of mentoring and inclusion of new team-mates.

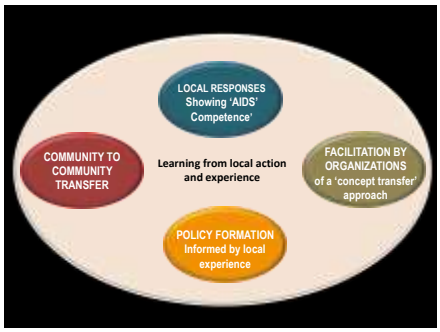
At a cost of $2200.00 per year, internally generated, about 700 community members sustain and document their action that engages 53000 people in care and prevention response.

S8 

The term Human Capacity Development for response[2] affirms

[2] Susan Lucas. *Human Capacity Development*. Paper prepared for a satellite meeting on Human Capacity Development for an effective response to HIV/AIDS. Barcelona, Spain: 4-5 July 2002.

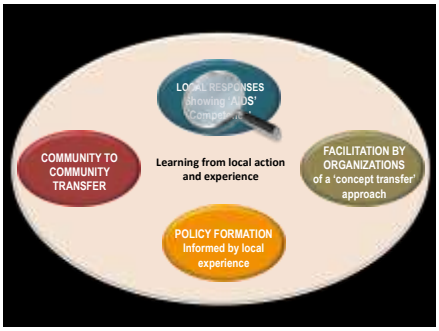
local community capacity to respond, and organisational capacity to adjust to that competence for response.



S9

There are at least four dimensions of human capacity development for response: local community (usually neighbourhood), transfer (from community to community), organisational (usually service provision), and policy – and all dimensions need to be synergistic for expanded outcomes and long-term impact.

We will look briefly at each dimension of response and examine the inter-connection fostered by learning from local action and experience.



S10

Dimensions of response

1. Local Response

HIV/AIDS is an epidemic that is disastrous in terms of impact on persons, families and communities, and even nations. It has an enormous tendency to divide, through stigma associated with perceptions of blame and 'wrongdoing'. Failure to acknowledge the accumulating loss, particularly in high prevalence communities, leads to suppression of hope and of community memory formation.

This pattern has been noticed in all areas of prevalence: from the time that HIV/AIDS was noted in Haiti and the United States in the early 1980s, in the rapidity of development in the mid to late 1980s in Sub-Saharan Africa, and in the emergence in India, China, other parts of Asia-Pacific, and Latin America throughout the 1990's.

The *local response* refers to the capacity of people in the living environment as well as the work place and local community based organisations, to acknowledge fragility, yet utilise the existing human strengths for responding to AIDS, and developing a sense of hope for the future[3].

International Salvation Army Response to HIV (2007)	
Total number of countries	41
Total number of programmes	183
Total number of focal points	510
Total number of responding communities	15,030
Community development coverage	3.5 million
Awareness raising coverage	?

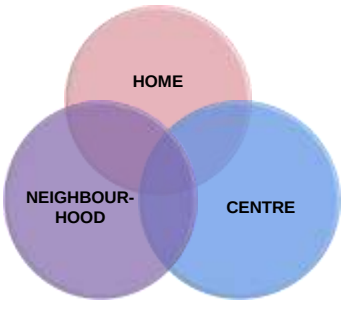
S11

From 25 years of responding to HIV/AIDS through building on community strengths for response, The Salvation Army has learned many lessons, consistent with research, concerning loss, grief and trauma. S12

TRANSFERABLE CONCEPTS

- Care
- Community
- Change
- Hope

It was in Zambia at Chikankata Hospital in 1987 that I, with colleagues, noticed that local people of the catchment population of 80,000 people can care, they can build community belonging, they can change behaviour, and they can hope with an energy that is passed on to others and stimulates transfer from neighbourhood to neighbourhood.

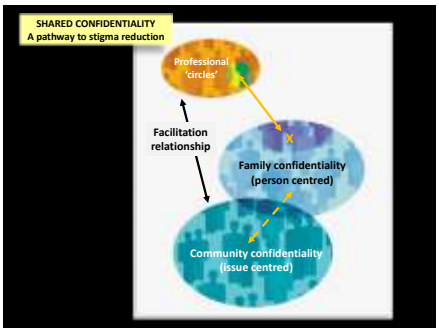


S13

Two strategic foundations to expansion of local response have been noticed:

[3] UNAIDS Local Response Unit. *Technical note 3*. Geneva: 2001.

One is *the link between home care and neighbourhood driven change*, and the other is

S14 

shared confidentiality. They are mutually interdependent. Secrecy harms by stigmatising, whilst the discovery that local families and neighbours in all cultures can choose to share knowledge on issues of common concern, and can do so safely and confidentially, is a liberating experience.

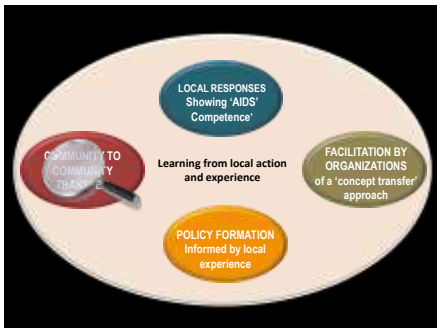
This is true not only for people living with HIV, but for the facilitation team members who watch astounded, as I have, for example, in PNG, India, China, Bolivia, and many other countries where local families, leaders, youth, children and old people declare that HIV is for everyone. It is not just for the truck driver known to have HIV going to Mumbai from Gujarat but for all the families of all the truck drivers doing the same thing – and in the village concerned not far from the town of Anand, 50% of men are truck drivers.

S15 

Community counselling happens as part of facilitated community discussions, which provide the opportunity for recognizing community issues, losses, feelings and the emotional dimensions of relationships such as intimacy, family life and future, and collective responsibilities and rights.

"*When communities assume responsibility for their health, they far surpass the efforts of health services and institutions in combating HIV.*"
(AIDS Competence programme. India: April 2008.)

S16



2. Transfer

Community to community transfer refers to the horizontal shift of vision and action for change and for care, from one community setting to another. In all areas of the world this has been observed to happen without any external organisational presence whatsoever – yet it can be greatly accelerated, and can be a critical learning ground locally and nationally, if support organisations intentionally foster a 'strengths-based approach' to community driven change.

S17

Community to Community Transfer	
Participatory Action Research 2001	
Number of countries (Zambia, Malawi, Kenya, Uganda)	4
Number of 1st generation (reference) communities (in 1 month)	12
Number of 2nd generation communities (in 2 months)	24
Number of local responses (in 3 months)	36
Number of facilitation team visits per country	2

Examples

In an action research process conducted in Zambia, Malawi, Uganda and Kenya in 2001, by The Salvation Army regional programme facilitation team for Africa, 12 'reference' communities each showed competence for deciding on change, and for measuring change, with respect to reducing the risk of HIV transmission within and around the local community.

Each of the 12 communities was asked to map their influence on surrounding communities, for HIV/AIDS response. At least two communities were identified over the next two months by each reference community; and either by invitation, or by an initiative from the reference community through a family or friendship linkage, a total of at least 36 local responses were observed and documented. The responses were characterised by local action for care, for behaviour change, for income generation, and for assertive exploration of material resources to help the community in its

response[4]. An expansion from 12 to 36 responses happened within a two-month period, at virtually no cost.

TRANSFER MAP
Mutandalike, Zambia

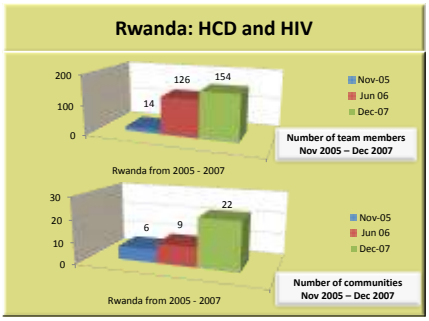
S18

One of the 12 communities was Mutandalike in Zambia, where in 4 years, it was documented that 10 different yet connected local communities responded, supporting between 10-15 orphans each and influencing the communities within a 40 km radius.

Rwanda: HCD and HIV

	November 2005		June 2006		December 2007	
COMMUNITY	No. in Team	No. of communities	No. in Team	No. of communities	No. in Team	No. of communities
Kigali	2	1	22	1	25	3
Bugoba	2	1	10	1	15	3
Bitare	2	1	14	1	17	2
Kayenzi	4	1	23	2	27	4
Runda	2	1	25	2	30	4
Rutobwe	0	0	15	1	20	3
Taba	2	1	17	1	20	3
TOTAL	14	6	126	9	154	22

S19 A recent example is Rwanda. Between June 2005 and December 2007, an initial group of 6 communities has expanded to 24 and the team members involved have increased from 14 to 154 people.



S20

The common factors for success are *facilitation* of the response via visits by a team that learns and mentors; and involvement *of local people as self-measurers* of progress.

When communities transfer vision and action to other communities, the result is not an inappropriate expectation on government resources by more communities – rather it is a vastly

[4] *Community Determined Measurement of Change and Transfer – an HIV/AIDS related community action research process to communities and policy makers.* A joint action by The Salvation Army Africa Regional Programme Facilitation Team for HIV/AIDS, Development and Mission with local implementing teams and communities of Kenya, Uganda, Zambia and Malawi: March – September 2001.

increased capacity for personal, family and neighbourhood responsibility for care, support and change; and an enhanced skill in accessing resources not only from government, but from many other sources as well.

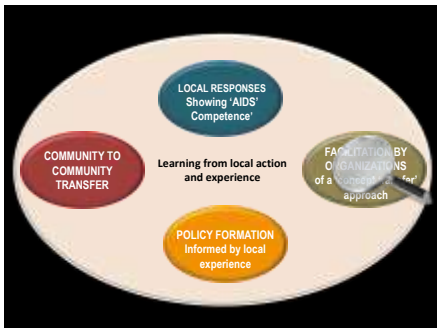
S21

3. Organisational response

'*It is now becoming clearer that NGOs, if not careful and vigilant, can undermine the public sector and even the health system as a whole, by diverting health workers, managers and leaders into privatized operations that create parallel structures to government and that tend to worsen the isolation of communities from formal health systems'*

(Preamble to *The NGO Code of Conduct for Health Systems Strengthening* April 23, 2008)

S22



We can probably agree that the challenge is for all of us who work with systems and interventions.

The contrast between an interventionist expertise-based approach and an experienced based facilitation approach is illustrated in the following table: [5]

[5] Jean-Louis Lamboray. *The shift in perspective*. UNAIDS/UNITARAIDS Competence Program, Geneva: 2002/

The shift in perspective		
Change in:	**From:**	**To:**
Institutional belief	We believe in our own expertise	We believe in people's strengths to respond
Institutional practice	We control a disease	We facilitate responses
Main message to clients, communities	You have a problem	Together, you and we have solutions
Interaction with implementers	We instruct, advise	We learn and share

S23

Perhaps one of the more subtle is the first – of course we know that expertise is needed, but without an invitation for support based on being genuinely respected as owners and actors, the intervention has no 'home'.

It is noteworthy that the Global Fund has proposed community systems strengthening as a priority for round 8. At the same time, The WHO partnership unit in the office of the Director General is forming a Participatory Action research/PHC renewal partnership to systematically capture learning from district wide demonstrations of ***scaling out*** *neighbourhood local responses*, supported by the formation of district facilitation teams.

Facilitation Team Development

S24

National Facilitation team approaches have developed in Zambia, Rwanda, India and Thailand, to name just few countries . Several organisations have experience in developing the facilitation team approach, including Affirm, The Salvation Army, the AIDS Education Programme from University of Chiang Mai in Thailand, and the Constellation for AIDS Competence.

The Gwembe DFT+ (Zambia)
(March 2008)

- 100,000 people
- 100 communities in 3 years
- 10 local facilitation teams /DFT/NFT/IFT
- $100,000 per year = $1/person/year

Examples S25

In the Gwembe and Monze districts of Zambia, a *District Facilitation Team* (DFT) has formed, in March 2008, mentored by Affirm Facilitation Associates. A precursor is the Zambia National Facilitation Team (NFT) formed in 2001 with the support of UNAIDS TND Unit, Geneva, and funded for a time by the Global Fund and Irish Aid.

For a unit cost of 1$ per person per year it is proposed that a massive turn around in local ownership for scaling out response can happen, which will drive scaled up supply of commodities

We know that a community can transfer optimism and action for response to at least two other communities within 12 months if a facilitation team is active.

In Rwanda (2002) and in Thailand (2004) NFT's were developed also, looking a little different in terms of host structures yet sharing a vision that all local communities can respond and that it is possible to learn from their experience.

SALT visits are a method for forming and sustaining groups of people who are available to mentor the quality and quantity of local response and multiply FT formation. SALT is a mnemonic for ***S****timulate,* ***A****ppreciate,* ***L****earn,* ***T****ransfer*. It is a disposition to be practised in the locality of home and neighbourhood, whatever the origin of the SALT team member, usually one of a team of 3-4 people.

The Aids Education Programme of the University of Chiang Mai, since 1995, has been documenting participatory learning from local action and experience. In February 2008, 360 SALT visits were facilitated by 44 team members, and the 960 participant learners came from three major religious traditions. Over 60 communities were visited and were stimulated, yet the focus was on the change potential within the religious leaders and workers.

S26

'*I have come to appreciate those SALT visits to the communities. It has really helped me to understand certain things about communities during my day-to-day work. That concept really works.'* (Matthew, District Health Planning Manager, Gwembe, Zambia).

The facilitation team approach for organisations establishes a learning culture. One result, for those involved, is a revitalisation of personal and organisational vision and commitment.

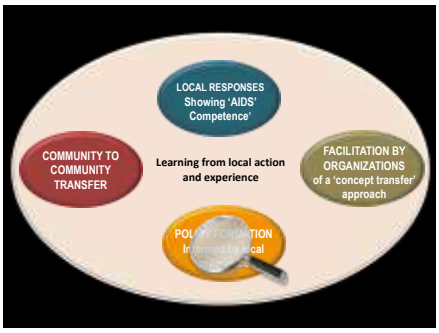
With all this in mind, what should be the culture of work for the growing number of global health initiatives?

'Every person, in every village, everywhere will have access to a skilled, motivated and facilitated health worker'. (Dr. Margaret Chan**,** Director-General, World Health Organization, preface to *The Kampala Declaration*, developed from the First Global Forum on Human Resources for Health. Kampala, Uganda: 2-7 March 2008.)

'*Countries will emphasize community and team-based training, along with other innovative approaches and linked to service delivery*.'

At the very least, human resources for health solutions will be found, said a global reference group, in local communities and through team culture.

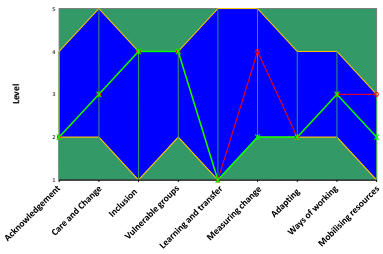
S27



4. Policy

A data gathering process is usually statistical and epidemiological data in nature, and naturally tends toward support for specific interventions that are targeted at risk factors.

The problem with this is that the forward progress of the HIV/AIDS epidemic is so fast and dynamic that policy, once formed, is usually several years out of date, at least in terms of acknowledging the human element involved in transmission, and the tension of worsening vulnerability, and capacity to make progress.



S28

Example: Self-assessment for HIV/AIDS Competence

In March 2003 the local community at Kithithuni hosted an international partnership team from UNAIDS/UNITAR AIDS Competence Unit, Geneva. Together they developed a self-assessment tool for HIV/AIDS competence that measures levels of response (basic is 1, advanced is 5) according to the ten elements shown [6]. The self-assessment tool is now being shared internationally by the Constellation for AIDS Competence, and others, and is influencing the policymakers who become involved.

S29

When policymakers actively and systematically learn from local action and experience by involving themselves in local responses, they are encouraged and sustained as they discover a realistic position for integrating local strengths with national or district interventions.

HCD – connecting for

- Rights, ethics and health
- Local health movements and systems
- Human resource development
- Partnership pathways
- Measurement
- Faith based response expansion

S30

[6] *Self-assessment of AIDS Competence – A human capacity development framework.* UNAIDS/UNITAR AIDS Competence Unit. May 2003. (www.unitar.org/acp)

HCD: the connector

I will briefly comment on some relevant connections or bridges built through an HCD framework. They suggest the added value of adopting an HCD approach.

1. Rights, ethics and health

If we remember that our emphasis is HCD *for response* we can see success, because the belief is that people can respond (care, change, build community of belonging, hope, lead, transfer) and the practice is that we make sure there is space for response (hence we are team, we facilitate, we are present, we respect rights and dignity for response).

In fact the right to shared response is at the heart of human dignity and respect.

"*Alongside the longing for justice, rights also generate a sense of belonging, since they point to our common identity as members of the human family . . .We could think of a 'global health system', not as an organizational entity, but rather as a structured set of relationships among actors that perform different functions . . . It is there, in our ability to care for each other, in our sense of solidarity, in our determination not to leave anybody behind, in our vision of health as a human right, where we may find the building blocks for a better world".*

(Julio Frenk. *Global Health and the UN*. Atlanta: 8 May 2008.)

HIV more than any other development issue, provokes us to see health as a social objective, grounded in ethics of universal human rights and human relationship.

2. Local health movements and health systems

The immense challenge for global health is to connect the potency and potential of local health movements with health systems. HCD for HIV response is informing the current discussion on renewing Primary Health Care.

HIV experience adds dimensions to Primary Health Care (PHC) including *transfer of local respon*se, and *facilitation team development* as a means of accompanying local and district health systems. *Participatory action research* can engage local community for their own future and strengthen their voices to engage outside supporters.

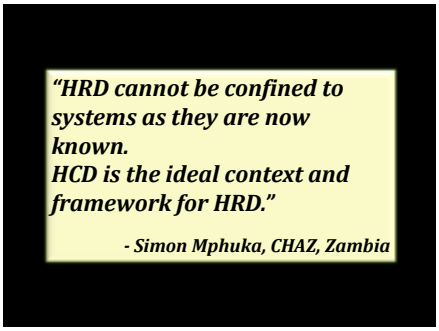
Scaling out of responses to HIV, TB, malaria, health of women and families, youth, neglected

tropical diseases, and other critical health issues, should complement the *scaling up* of systems and interventions.

3. Human Resource Development (HRD)

'I have remained amazed and overwhelmed at the reflections of the meeting last month. We will get in touch so I can share the experience of the DFT's and SALT visits in the next mail.'

(Ricky Mapulanga, Gwembe District AIDS Task Force Manager, Zambia, March 2008)



S31

Simon Mphuka of the Churches' Health Association of Zambia (CHAZ), has proposed the contrast and complementarity of HRD with HCD.

HRD and HCD-contrast and complementarity

HRD	HCD
1. Organisation & systems repair	**Country and community response**
2. Welfare to people	Stimulating people
3. Expertise	Experience
4. Transfer of expertise	**Transfer of capacity for response**
5. Skills training	Learn from local action & experience
6. Training institution	SALT teams, mentoring
7. Provision of service	Participation in response
8. Needs based	Concerns based
9. Financial incentives	Vision incentives
10. Replace & retain	**Team growth including community**

S32

Human capacity development embraces more than HRD. HCD necessitates a community driven relational approach, supported by commodities, channelled through organisations and interventions. It provides an environment for inspiration, and creative growth that guides everyday decision-making by health and other staff.

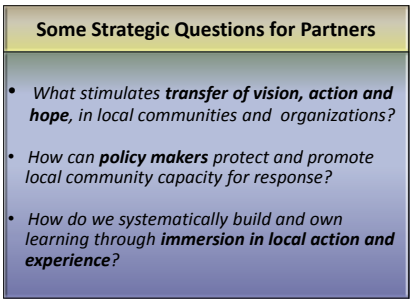
The values of commitment to family and community and national wellbeing are foundations that outlast incentives of salary increments, training, and housing. Given that a health worker or a religious leader or a policy maker or a community member has opportunity to experience human

renewal around a shared suffering and hope, the energy supply for initiatives and for sustaining and retaining people is also renewable.

4. Partnership pathways

The normative partnership framework is based in activities done through an intervention within a specific budget and time period. Assumptions are made that on the surface seem valid.

For example, '*This is needed now'* is the assumption, and often cultural and local capacity is not part of the immediate or even medium and long-term analysis. The opportunity and the numbers of people who can participate are usually very limited in comparison to the number of people, with their families and local neighbourhood community, who need their stories heard now so that they can understand and choose to respond.



S33

Some strategic questions for partnership

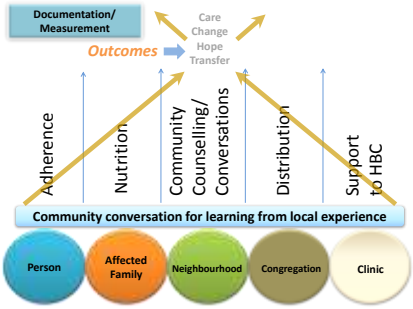
Amongst others, the following questions that focus on human capacity development for response need to complement questions relating to national and international interventions.

- *What stimulates transfer of vision, action and hope, in communities and in organizations ?*
- *How can policymakers protect and promote human capacity for response?*
- *How do we systematically build learning and reconciliation through immersion in local action and experience?*

In the process of exploring these questions, meaningful partnerships can form to bring about an integrated response.

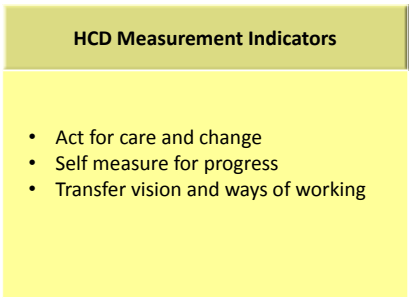
5. Measurement

'*Communities are competent when they learn from local responses to HIV, apply knowledge, measure their own progress, and share their knowledge'* (ACP, India)



S34

The graphic relates to community-led ART management and measurement. All participants are measuring, including families in homes, who play a part in nutrition and adherence and supply. Why not engage their knowledge and motivation?



S35

What we now see is that every participating cluster of people, be it a family, neighbourhood, NGO, or religious group or government unit should

- act for care and change
- self measure for progress and
- look for transfer of vision and direction, which is not the same as programme replication

When there are indications that these three responses are happening we can know that we are relevant, and competent.

For example, in Long Chuan County of Yunnan Province, China, local women of an ethnic community formed a guard over young men as they worked in the fields to ward off drug sellers. Their young people are met and welcomed home as they leave the drug detention centre. They know they are making progress, and now they sing again. The facilitation team that is accompanying them, a mix of government and NGO, is watching their progress by hosting SALT visits and encouraging transfer of methodology to other organisations, whilst helping to document the influences that affect local community to community transfer

What matters is that for every intervention there is an expanded pattern of response. Normative HRD indicators for health and other systems are part of the measurement story, complementing the human response indicators.

We learn through HCD about patterns of response, where the target which is a small part of the actual 'pie diagram', becomes an entry point into the response of affected others. We realise not only GIPA, but the Centrality of Affected People (CAP) (WHO publication on 'Decent Care in the midst of HIV/AIDS', March 2008).

6. Faith based response

Local faith communities were a focus for the UNAIDS strategy meeting on partnerships with FBO's in April 2008 and the consensus was definitely affirmative. Personal religious faith gives courage, integrity and hope.

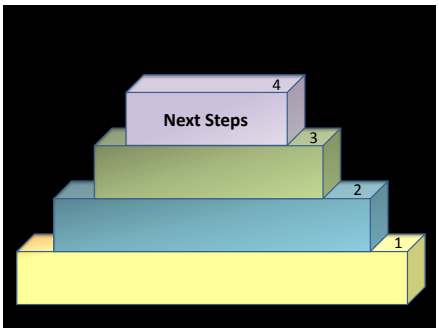
S36

Faith-based organizations are an asset[7] [8] and at the same time, members of faith-based organisations and faith leaders are human, and need to learn by experience to be relevant.
HCD offers a common foundation for faith and secular approaches – a shared commitment to learning from local response and adapting to it.

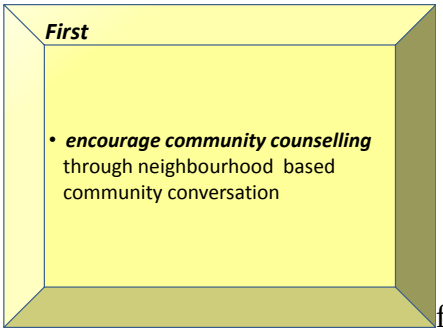
The Reverend Canon Ted Karpf of the Director General's department at WHO (Geneva) states *'Further examination of the nature of intangible (spiritual encouragement, knowledge and moral formation) health assets is needed to more fully document the full extent of possibilities for religious health assets."*[9]

---

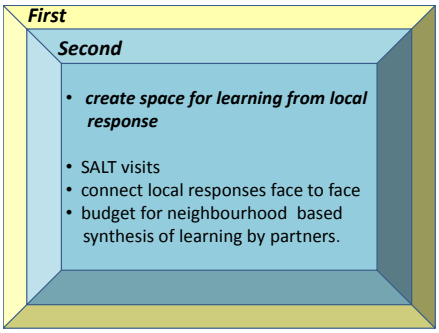
[7] "Faith based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa". Press release by the World Health Organisation. Washington, DC: 9 February 2007.
[8] *Faith in action: examining the role of Faith Based Organisations in addressing HIV/AIDS.* Report by Catholic Medical Mission Board and Global Health Council, published by the Global Health Council, 2005.
[9] *Global AIDS Link* No. 103 (May/June 2007): p.5.

S37 

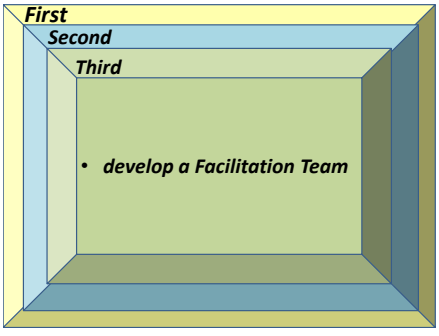
Some steps

Perhaps the *first step* S38 

for some is to remember that with any public health and community health initiative we should foster community counselling through neighbourhood -based conversation, in harmony with other initiatives, from the beginning of response.

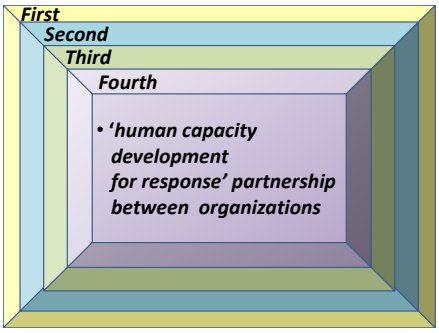
S39 

Second, can we create space for learning from local response and transfer from the beginning of an initiative? This implies that we need to visit to learn, connect local responses for transfer and expansion, and budget for field-based synthesis of learning by partners.

S40 

Third, can we prioritise the development of district and national facilitation teams, with the belief that every community counts and no neighbourhood need be left behind.

S41

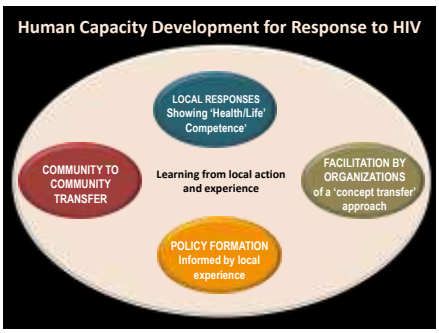


Fourth, can we foster 'human capacity development' partnerships between organizations that will, through an appreciative learning disposition, discern how international and national organizations can better link with local communities?

S42

Conclusion

S43



The dimensions of HCD form a connected framework for action learning and measurement that engages a shared response and includes people from the village to the World Health Assembly.

Ian Campbell
London, UK
Affirm Facilitation Associates
www.affirmfacilitators.org
ian.campbell@affirmfacilitators.org
30/5/08