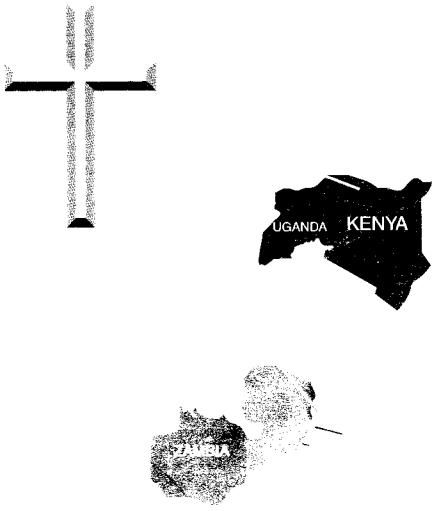
MOVING TOGETHER



MARCH-SEPTEMBER 2001

COMMUNITY DETERMINED MEASUREMENT OF CHANGE AND TRANSFER

An HIV/AIDS related community action research process to communities and policy makers

Action Research
Kenya, Uganda, Zambia and Malawi

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An HIV/AIDS related community action research process for communities and policy makers

A joint action by
The Salvation Army Africa Regional Programme Facilitation Team for HIV/AIDS, Health, Development and Mission
with local implementing teams and communities
of Kenya, Uganda, Zambia and Malawi

March – September 2001

Action Research
Kenya, Uganda, Zambia and Malawi

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Thanks to all the families that opened their homes and themselves for questions, discussions, and shared learning.

April J. Foster, Coordinator, The Salvation Army
Africa Regional Programme Facilitation Team

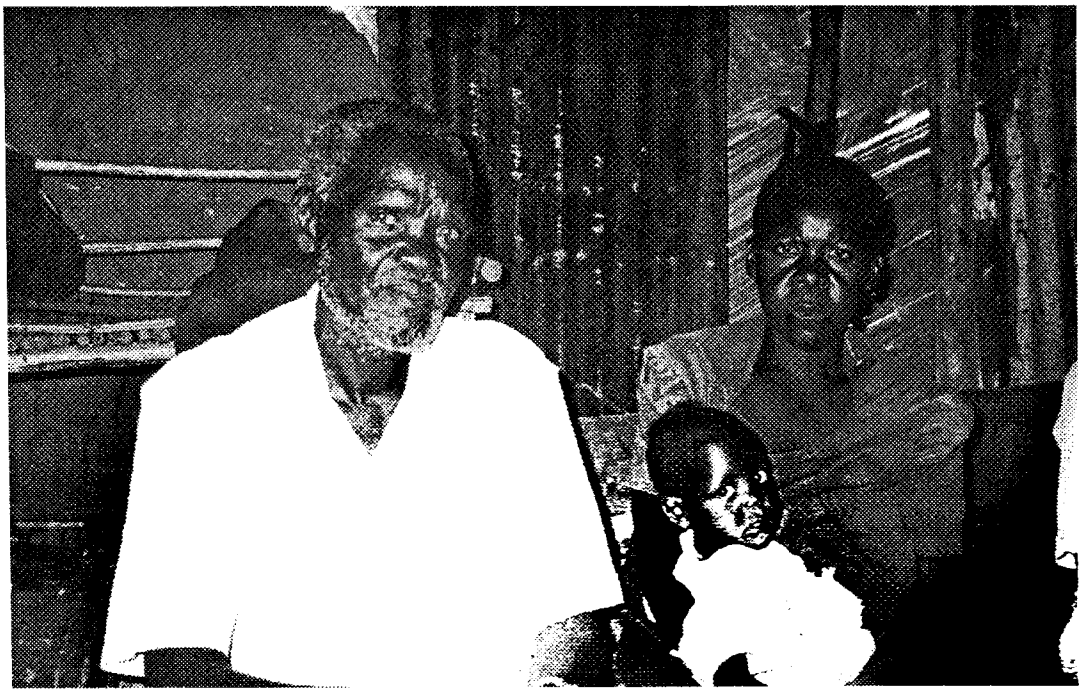


TABLE OF CONTENTS

Appendices

See also: *Transfer Maps booklet*

There are a number of data sources that were collected for the purposes of this research. These are listed below. They can be obtained by contacting the Health Services, The Salvation Army International Headquarters, 101 Queen Victoria Street, London EC4P 4EP : e-mail (Ian_Campbell@salvationarmy.org)

- *Theme grids, using verbatim reporting, of each protocol for each community that participated in the research*
- *Summary of protocols by theme*
- *Written report from each community location containing comparison of protocols by themes for within the community*
- *Analysis of transfer maps*

1. EXECUTIVE SUMMARY

The Salvation Army HIV/AIDS approach in Africa has expanded over the last 10 years with the help of participatory programme designs coordinated by a regional (inter-country) facilitation team. The team facilitates concept transfer rather than activity transfer, based on the belief in community capacity to determine its own response.

From March to September 2001, three communities in each of four countries (Kenya, Uganda, Zambia and Malawi) were involved in a participatory action research process. Each community was joined for four to five days by the research assistant. Alongside the local team (community based implementers), five groups within each community participated in discussions in order to give perspective on changes that have occurred in their community as a result of HIV/AIDS, and whether they had been able to identify and measure change within their own community. The five groups included local leaders, a community group, people living with HIV in the family context, neighbours and the local implementing team. Each response to the questions was examined by the local team and the research assistant, to determine whether it reflected any of eight pre-determined themes. Each theme was then summarised for patterns of responses across all countries.

The research process clearly indicated that change is occurring in communities, and that these changes are largely attributed to work by local teams in community. While negative changes were mentioned by all the groups (increased deaths, number of widows and orphans, and increased poverty), each group also believed that positive change could happen and they expressed hope about God's presence with them in this process.

Attitudes towards HIV/AIDS have changed in many communities, shown by increased caring for the sick within the community. In addition, general awareness of HIV/AIDS has increased as a result of sensitization, including demonstration of caring presence by local teams, which has helped to create an increasing openness in the discussion of HIV/AIDS issues by the community members, and within families.

These factors, particularly combined with an intensive community counselling approach, have contributed to alterations in traditional practices within each of the four countries. For example, all countries have altered the way in which circumcision is conducted in traditional ceremonies in order to reduce their risk.

Significantly, each of the 12 communities visited responded to the challenge of stimulating two neighbouring communities to undertake the action research process for themselves. Thirty-three community responses were documented within the research period. A few communities were activated to work together for the first time. Such an expansion of the research process reflects capacity for rapid yet effective community to community transfer of experience and learning.

At this stage of the epidemic, the local teams have been responding for a long time and need validation of the approach and way of working in the ongoing struggle for sustainable change. This action research process can be used to examine patterns of responses over selected countries. It can, in effect, strengthen the community and demonstrate that communities are moving in a positive direction in their response.

Through the action research, Salvation Army teams at all levels have learned, and are refreshed for the continuing journey. There are still many communities which have not had encouragement and stimulation to use what they know. The action research process has affirmed that every community matters. Organisations need to accompany communities without imposing on them, to share motivation, and help understanding develop of community to community transfer, and the contribution of local community responses to national scaling up strategies.

2. HISTORY, OBJECTIVES, METHODOLOGY AND PROCESS

(Note: see appendix 1 for full proposal)

History

The Salvation Army developed its internationally known home and community-based approach to HIV/AIDS care and prevention at Chikankata Hospital in Zambia in the late 1980's. From this experience, an International Health and HIV/AIDS Programme Facilitation Team was formed in 1990, to provide programme facilitation in the areas of design, support, monitoring and evaluation within the Salvation Army internationally.

At an evaluation of the International Facilitation Team in Ottawa in September 1992, and at a Regional Consultation on HIV/AIDS in Zambia in November 1993, field representatives from African programmes indicated that successful programme implementation and improved quality of programme response resulted from appropriate programme facilitation, particularly during the first period of programme work. It was felt that a Regional Team presence within Africa, complemented by the IHQ Team, would continue to facilitate quality programme design, while at the same time being more readily available to field programmes, and cost effective. Capacity development of field programme personnel to provide programme support to each other through programme to programme sharing, and programme to programme transfer of lessons learned, energy and hope within the region was seen as essential. This represents a process of ongoing learning of those involved in implementation, to also function as facilitators.

In February 1995, a full-time Co-ordinator for Regional Programme Facilitation started work, based in Nairobi, Kenya.

At the Regional Programme Facilitation Team evaluation in December 1996 (Harare, Zimbabwe), field programme personnel expressed the desire and capacity to use their experience to resource others in the region. Already, the potential for utilisation of local field people as facilitators had been seen, and several joined the IHQ and Regional Teams on occasion. Although this had been happening by including field programme people as part of the Regional and IHQ Teams, it was felt that for specific types of support and skills/programme development, 'regional resource teams' could be formed for short periods of work in a location, co-ordinated by the Regional Team and by agreement of the Salvation Army territories concerned. Demonstrations of these team formations began in 1998. They are one strategic expression of the broader regional programme facilitation process to strengthen community-based care and prevention of HIV/AIDS.

Increasingly, at this stage of the AIDS epidemic and experience, the need for documenting effective facilitation processes, and analysis of associated questions at community level is being felt within the region. Many lessons have been learned, and are being learned about the capacity of communities to change, and to name/measure their own indicators of change. Documentation at community level is happening, but needs further strengthening, and channels for sharing the stories of change and hope that are present in the face of an escalating epidemic are needed.

The Salvation Army regional process, within the context of regional programme facilitation and community based initiatives throughout Africa as described above, is well placed to contribute to this process of documentation. The action research process described in this document, is one

means of documenting and sharing lessons learned on community capacity to care, change, hope and transfer to others.

Objectives
The objectives of the action research process included:

1. To gather existing data, and to use key strategic questions to collect additional information about responses to HIV/AIDS and change in 4 country locations over a 6 month period.
2. To validate local community capacity to care, change, hope and expand the response, through community named indicators of these capacities.
3. To facilitate discussion, understanding and application of the processes involved in HIV/AIDS programme development (such as care linked to prevention, behaviour change and community agreement), and the relationship between HIV/AIDS, health, development and mission.
4. To influence policy at a national and regional level by interacting with other organizations on the findings of the research process.

Participants
Communities in Kenya, Uganda, Zambia and Malawi were selected based on the length of time they have been consciously involved in a facilitated change process, through Salvation Army responses at community level. Representatives from each country came to an initial workshop, then returned to their countries to select three locations for the main sites of study. In each location, five perspectives were sought: people living with HIV in a family context, neighbours, leaders, community discussion group, and the local team (community based implementers).

Methodology
The African Regional Co-ordinator, April Foster, supervised the implementation of the research project, as the key reference point for the research assistant. Within each country location, the research assistant joined the local team and together they carried out the research process.

The research process involved:

- Development and use of protocols (*see appendix 1*), to explore questions about community and organizational capacity around the themes of:
  - Care linked to change
  - Hope
  - Community-to-community transfer
  - Local partnerships
  - Capacity for shared confidentiality and community informed consent
  - Spiritual life
  - Community determined and documented indicators of change
  - Influence of the facilitation team approach (local team)
- Mapping
  *Community situation and concerns * Transfer from one community to others

Process
Over a 6-month period, in 4 country locations (3 community locations in each country), 2 field visits of approx. 2-3 weeks each were used for the research process. In-country work consisted of the following activities:

- Home visits to people and families living with HIV, and neighbours
- Participation in community discussions (focus group style)
- Visits to community leaders, and other local partners in each country

- Discussions with local teams of facilitators

Each field work visit, (to three communities in each country) was followed by a 1 week period of synthesis by the research assistant with support from members of the regional and international advisory group. The protocol for neighbours group was revised after the first country, to approach the discussion more directly. The protocol for local teams, especially in the questions regarding regional team influence, was not bringing clear responses, so a group was reconvened with representative members from each country, for further exploration of their responses.

A second visit was made to each country to meet with a working group for the purposes of feedback and application by the local team representatives. This visit included the research assistant and members of the country team, with support from the regional team and members of the international advisory group.

A final working group meeting took place to compile the report, with representatives from all the countries involved.

Comparative analysis between the selected communities has been used, to note similarities and differences, and lessons learned which could be transferred or shared with others. Open-ended questions were used, therefore many answers were possible. Answers were not led into predetermined choices, but were categorized according to themes. Each group (e.g. neighbours, local leaders, etc.), was asked different questions, according to their perspective, although there was overlap in the exploration of themes. The degree of quantification is based on patterns of similar responses.

3. THEME DEFINITIONS

Local programmes involved in the action research were designed in a participatory way with emphasis on concepts, reflecting existing strengths of communities. The themes have emerged from key questions based on a community capacity approach and community experience, over a 15 year period of work with communities and facilitators in the Africa region. Many of these themes are also present in the documented experience of groups such as UNAIDS, and others.

- **The linkage between care and change**
  Care is a supportive presence that accompanies people in their situation, for example, visiting a neighbour or community visits. It reflects mutual support between family, neighbours, community, and a relationship of being with and interacting with others. Care is often expressed and experienced as relational through presence in homes and neighbourhoods. Care has been translated in many languages as love in action.

  Caring relationship is an enabling environment and catalyst for *change.*

  Change occurs by the demonstration of care or the direct experience of care itself, which allows people to see the reality of HIV, and may result in a change in understanding and attitude. This may also occur in the person giving the care. Care helps to make change more likely to happen. Change does not happen simply in persons in isolation but when the care and change process is relational in nature, the change is expansive. It is a foundation for going to scale.

  The care to change linkage is also termed "care/prevention" linkage. It is a key strategic approach to expansion of circles of involvement in local community and organizational response to HIV/AIDS.

- **Hope**
  The belief that something positive can happen, that change can happen. Hope relates to past, present and future. It is intrinsic to formation of a community memory. It is not only a belief but also an experience that a situation can and will be better. It requires valuing of the past, belief in the future and action in the present. This is not necessarily tied to circumstance (i.e. it is not materially based), it is something inside people. Hope can be individual or collective, that is, in some situations it may not be individually owned but, be in connection to others.

- **Community to community transfer**
  This is also referred to sometimes as 'diffusion' - it refers to the sharing of meanings across boundaries, which include knowledge, experience and particularly concepts, or ideas such as care, community, change, leadership and hope. It also includes transfer of ways of thinking and approaching the situation such as teamwork and participation. It does not necessarily refer to the transfer of activities. Transfer may occur spontaneously, or reflect a level of development within a community that demonstrates that they see needs beyond their own community and actively seek to engage in the process of sharing. The process is an experience of shared learning, as well as a contributing influence to going to scale at a national level.

- **Local partnerships**
  Local partnerships involve collaboration for mutual learning and action, with a mutual accountability and transparency. It involves knowing what others are doing and working in

a complementary manner so that work is not duplicated unnecessarily, so that the local response can be strengthened.

- **Shared confidentiality**
  Shared confidentiality refers to the shared knowledge and understanding of meanings within a group/community context, that is respectful of intimacy within a group, and in which there is a sense of mutual accountability. Knowledge that is shared in this context is not a secret. The content and meanings are known within the group, even though there is not necessarily open conversation about the content and meanings. Some examples of this would be cultural practices, patterns of sexual behaviour, or observation that home visits are taking place. This strong capacity is the foundation for effective community counselling and for scaling up prevention response.

- **Community informed consent**
  Community informed consent is shared agreement within a local community that processes often considered private and personal can be understood as valid for the neighbourhood as a whole. It presumes a healthy relationship based on trust between the local community members and those who interact from situations such as hospitals or other institutions. In a sense, the community view is that if it is good for one it is good for all. Some examples would be testing, or reaching agreement on the time and purpose of community discussions, or renewing of invitations for a facilitation team to return. Another example would be the acceptance of an outreach team visit to specific homes, without the necessity of specific disclosure, yet with implied understanding that what is happening in specific homes affects the whole community.

- **Spiritual life**
  The belief that the spiritual dimension is a significant part of everyday life and physical well being. It is a belief in the continuity of life beyond the physical. This notion is an important part of a holistic view of people and responses.

- **Influence of the facilitation team approach**
  There is a distinction between implementing teams (teams located within the community), which need a participatory approach along with skills in facilitating, in contrast to a territorial (country-wide), regional or international facilitation team which refers to a programme support team derived from various levels of the organization (often multinational). The Africa regional programme facilitation team is an example of this type of multinational programme support team. This theme explores the specific influence of the Africa regional team (and in some cases territorial facilitation teams) in terms of the influence on implementing teams with regards to capacity development for stimulating and nurturing local community response.

- **Community determined change**
  Changes may be decided and implemented by a community forum, or may be action seen as a pattern across a community and chosen by members of that community. Therefore, actions may be formally decided, openly discussed, or mutually agreed either verbally or nonverbally.

4. RESEARCH LIMITATIONS AND CHALLENGES

There were several limitations and challenges experienced during the action research process.

The use of open questions in the protocols was intentional in order to allow a full range of response from the community's point of view. This created a natural limitation in categorizing some responses.

The protocol for neighbours was revised after the first country visit. The protocol for local team members influenced by or involved in the regional facilitation team process did not bring clear responses, so this was supplemented by a discussion with a composite group.

Document review was planned but not fully implemented due to time constraint and inaccessibility of records due to language differences.

The political environment in Uganda put some constraints on the process, as it meant that the researchers had to stay at a location averaging 40 km drive and 5-8 km walk away from the research sites. The rainy season caused some difficulties to the community members for participation.

The Africa regional team had a major transition of membership early in the year, which limited the involvement of the supervisor/ coordinator in the action research process. It was also difficult to involve other regional team members on a consistent basis as part of the process especially in Zambia and Malawi. In Zambia the research team formed from within the country, while in Malawi several of the Zambia team took part for some of the time. Members of the regional/international advisory group were able to give support, for debriefing and clarifying the process during the field visits, mainly by telephone, which was not always available.

5. KEY FINDINGS

(1) Country analyses - Kenya

A story from Kenya ....

Elizabeth – (Kenya)

Elizabeth is a widow who lives in Busingo-Butiti community. This woman's husband died in 1999 although she did not know the real cause of death. Later, she attended an HIV/AIDS programme in the community and listened to precautions, symptoms and so on. She flashed her mind back and saw the state her husband was in, and concluded that he died of AIDS.

This year in June, her daughter died of the infection, and the grandson has also died. Elizabeth has been very active in Busingo by telling the community that the disease is real, and she knows she is also infected. She states that "I know I'm living due to God's grace."

She is also helpful to the community because she advises women to be careful with whoever goes with them, for no one may know who has the virus and who does not have. She also says that since she knew her husband died of HIV/AIDS she has never met with any man, just to save the situation. (To avoid passing the virus to another person.)

Elizabeth has devoted herself to selling charcoal on behalf of the community and allows meetings to be held at her home. In taking care, she gives advice and a life example of how she attended to her husband, compared to how she attended to her daughter and the grandson. This has brought a lot of light in her life and the entire family. She is willing to tell people openly what she has experienced, and tries to influence people accordingly.

Elizabeth's story is an illustration of a person showing *care*, beyond herself and her own family, to other women, other caregivers, and the general community. As a result, she has become an influential person for *change* and a source of *hope* for others.

Background

The three communities in Kenya that participated in the research process were Matunda, Butiti and Kithituni. Butiti comprises a single traditional ethnic group which influences programming especially in terms of gender relations and issues, while Matunda is mainly cosmopolitan in nature with several ethnic groups in a rural setting.

In all three communities, partisan leaders can create conflict among community members regarding which public meetings to attend. The government has appointed and given power to political leaders leaving no strong custodian of the traditions and customs. This has eroded traditional leadership powers. The emerging multiple churches that bring conflicting facts about HIV/AIDS have contributed to the community members confusion in terms of a clear understanding of HIV/AIDS issues.

The majority of community members are subsistence farmers, while others depend on trading along the highway. Two of the communities (Matunda and Kithituni) are geographically located along the highway creating an avenue for commercial sex work and thereby fuelling the spread of HIV. Many men work away from home and come back infected, ill or dying, thereby strengthening the belief that HIV/AIDS is not necessarily a local problem but is being brought from outside the community. It is interesting to note that there is a lot of youth involvement in the team activities. Many women also participate in meetings and attend to community care activities.

Matunda - Each of the groups (local leaders, community group, local team, clients and neighbours) says awareness and acceptance of AIDS has increased in the community. Clients and the community also support the team's view that there has been a change in attitude towards the sick. These groups report that they are being taught how to care for the sick and open discussions are occurring more often. However, clients and neighbours hold conflicting views over the extent of support given. Clients claim neighbours are supportive and encouraging, and that they pray together, while neighbours talk about fearing the disease and the test. However, both leaders and the local team believe that people are capable of being more open-minded and that change is possible.

Butiti - Conflicting messages emerged from the discussions of the five groups. The local team, the community group and clients feel that change is happening in the community. They report that neighbours are visiting clients more often: there is a general change in behaviour and attitude of people towards the disease as awareness is increased through education. The community group and the local team report that exchanges of information are now occurring between various age groups – the old are teaching the young and the young are teaching the old. However, leaders and neighbours feel that no real change has occurred yet. The leaders assert that men and young people have not altered their attitudes towards the disease. Neighbours support and extend this view claiming that people are still not open about the disease. Both leaders and neighbours would like change, in that they want people to be more open, as they feel this would decrease the physical effects AIDS is having in the community – i.e. an increase in the number of deaths and orphans. Both groups recognize the role the local team is playing in working towards bringing about more openness in the community.

Kithituni - The local team asserts that change has happened in their community in the form of greater acceptance of AIDS, reflected in behaviour change, for example people now take care of the sick. This assertion is strongly supported by each of the other groups – local leaders, clients, neighbours and the community. They each confirm that the local team has influenced change in the community by increasing awareness about AIDS. The local leaders and clients in particular highlight the fact that behaviours such as prostitution and "free mixing" (multiple partners) have decreased, while caring for the sick, and increased communication between people, particularly between old and young people has occurred. Further, each group asserts that their hope is in God to provide strength, help solve their problems and heal.

Country analyses - Uganda

A story from Uganda . . .

Wekesa - (Uganda)

Wekesa was sick for a long time. He sold most of his property including his only piece of land to meet hospital bills. He was left with a temporary house and the roof was blown off. On hearing about the counselors, he developed interest to meet them with the hope that they might be able to bridge him to life because the programme was headed by an amusing lady. After meeting them, the story was different. Wekesa was counselled, helped and after some time, he developed interest to go for a blood test, which was positive. He came back home and disclosed his status to his wife and family at large. They were assisted both materially and spiritually by the team. For three consecutive months he moved with counselors from one community meeting to another, which he says played a very important role in reducing stress, fear and stigma and prepared him for coming out openly.

He has joined the local team in a strong campaign against AIDS by sharing or testifying about his status with other community members in each meeting. He volunteered to be the chairperson of People Living With AIDS, by doing visitation and comforting others infected and affected. He also reports to the local team about new cases.

Wekesa believes that accepting and sharing the experience with others helps others health to improve daily. He has re-assurance and hope to live even longer, and he has been transformed from a bony/skinny individual to a healthy and promising gentleman.

Wekesa's story demonstrates a number of themes. Hearing about the counselors gave him *hope* that there was help available to him. The *care* shown by the team resulted in Wakesa *changing* his attitude towards blood testing. His positive status resulted in him *confiding* in his wife and family. The team *influence and care* provided Wakesa with the support he needed to live. He was then *influenced* by the team to *share/transfer* his story to others. As a result of the teams' efforts, Wakesa now has *hope* that he will live longer.

Background

The communities in Uganda participating in the research process were Butemulani, Kongoli, and Buteteya. Each of these communities has a common language and culture. Community members are mainly subsistence farmers. Government appointed leaders are committed to the team activities and this has positively influenced the participation of other sectors. Local leaders facilitate problem solving at community level. Traditional practices have been adjusted in response to the HIV/AIDS epidemic with specific by-laws being put in place. It is the men who predominantly participate in group meetings while the women are involved in care activities. The men debrief family members on related issues discussed in the meetings. Salvation Army officers are committed to the team activities.

Butemulani

Each of the groups interviewed (local leaders, community group, clients, neighbours and the local team) believe changes have occurred in the community as a result of AIDS. These include an increased openness and willingness to share experiences by those infected and the community. Leaders and the community say death rates, the number of people being diagnosed with HIV/AIDS and suicide rate has decreased. Neighbours and leaders in particular refer to an increased sense of spirituality brought about by the team visiting people and working in the community. There is a sense of hope received from God and the belief that there is life after death. These factors have also resulted in an attitude change within the community with regards to AIDS. There is an increased acceptance and ownership of the AIDS problem within the community reflected in community member's willingness to be blood tested and no longer fearing the sick. Many of these changes are attributed to the local teams work.

Kongoli

All the groups indicate that there has been a change of attitude and behaviour towards HIV/AIDS in the community. The notion that people no longer fear the sick, that they care for the sick and are willing to have blood tests comes through strongly from each group. Furthermore, the groups each indicate that AIDS is seen as a community problem to be tackled by them. In addition, each group indicates that people are now more open about AIDS. Community members sit and talk, neighbours talk among themselves and with clients, parents are talking openly to their children about their sexual behaviour, something that was previously taboo. Clients are openly declaring their status and sharing their experiences with others. Spiritual changes are also mentioned. Neighbours say more people are now attending Church and being saved as a result of AIDS. Each of the groups refer to the influence the Salvation Army team is having on these changes they are seeing in the community, and that this information is being transferred between communities.

Buteteya

Each of the groups acknowledges that behaviour change has occurred in the community as a result of HIV/AIDS. These changes include increased openness among people, more people are turning to Christ and changes to traditional practices. The groups also report that there is increased care occurring in the community as a result of AIDS, and that transfer of information is occurring between communities. They report that other NGO's/communities have learnt from their community and have started similar work themselves.

Country analyses - Zambia

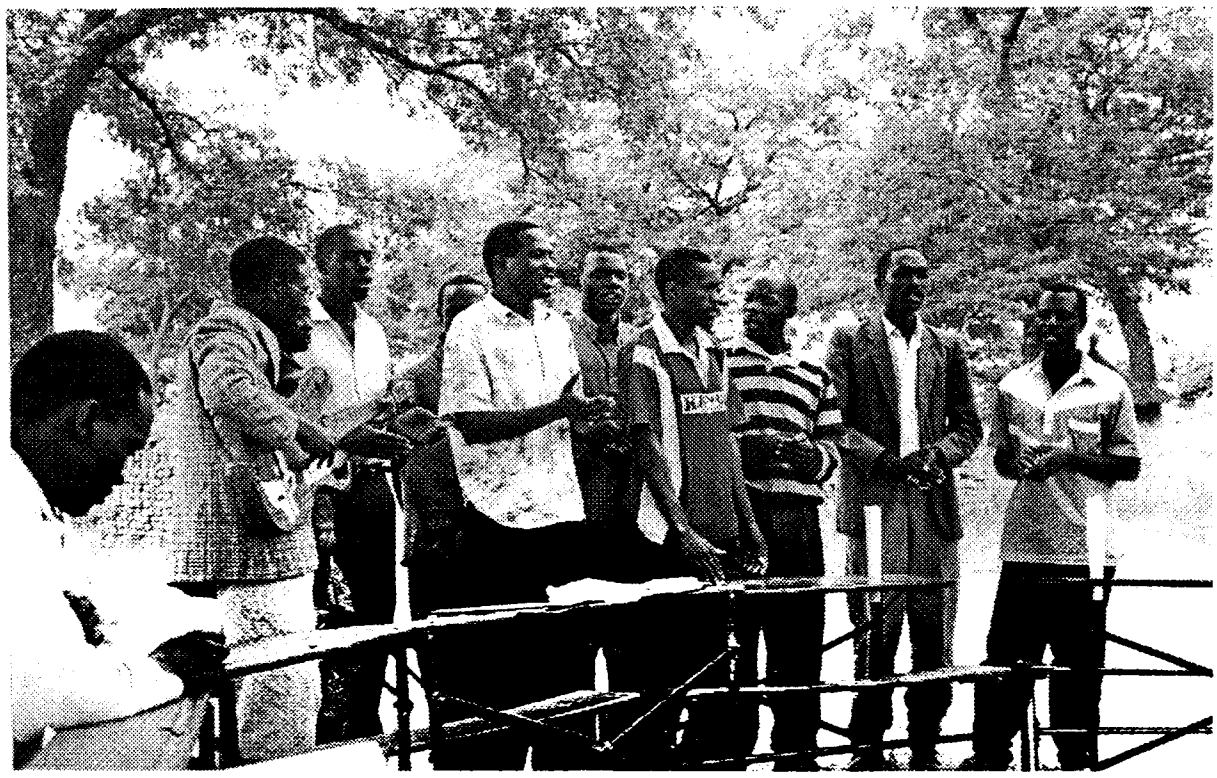
A story from Zambia . . .

Clever - (Zambia)

Clever is a community counsellor in the Mukwaela area of Chief Mwenda. In 1993 he attended a community counselling workshop at Chikankata at the request of his village headman. Upon returning home he made a meeting with the village headman and asked permission to go village by village to sensitise people about AIDS transmission and protection. This permission was granted and Mr. Dimba proceeded to educate people in his community, and continues to do so until the present time.

Clever comments that as a result of this counselling process by himself and others such as Chikankata, a number of changes have occurred in the community. He highlighted in particular the changes to traditional customs that were enforced by Chief Mwenda such as ceasing sexual cleansing. The Chief ruled that someone could be cleansed with the exchange money, and did not require the widow/er sleep with the brother/sister of their spouse.

Clever's story demonstrates a number of themes in operation. The headman's request that Clever attend the workshop reflects his concern or *care* for his community and his belief or *hope* that AIDS education could help them. The workshop at Chikankata allowed the *transfer* of community counselling skills and AIDS education to community members via volunteers such as Clever. This expression of *care* for the community then resulted in behaviour *change* in the form of alterations to the way traditional customs are performed.



Background

The communities in Zambia that participated in the research process were Chikanda, Mutandalike and Malala in Chikankata. In these rural communities, traditional leaders are still very influential. Community members are predominantly subsistence farmers. Some community leaders are active members of the local teams making it inevitable for them to support community activities such as group discussions, home visits, income generating projects, etc., while leaders are not that supportive. Community members participate in the activities mentioned above, and own the programme. Men are more active in team activities than are women. Women on the other hand are active in community care activities. Team members participation in the group activities varies. Members of community committees which have been formed to support HIV/AIDS work participate more, while geographical coverage is shared equally. Culture has had a negative impact in some communities and a positive impact in others. The counselling process and skills are used to solve problems and community leaders are called upon to facilitate when the need arises.

Mutandalike

Each of the groups refers to change as occurring in the community, even if this change is occurring slowly. The community, leaders, neighbours and the team say one of the greatest forces behind change is education. This has resulted in an increased sense of sharing among community members, for example; old people are now free to talk with younger members of the community about sexual behaviour. In addition, as a result of education sexual behaviours have been altered. For example, the community says traditional cleansing practices have been altered so they are not as sexual in nature and wife inheritance has ceased. Each of the groups also comments that as a result of AIDS people have been brought nearer to God - are attending Church and that this is largely due to fear.

Chikanda

Each of the groups identified change as occurring in the community. Common to all groups was reference to increased education about AIDS, which was raising general awareness about the disease. This education has been seen in many ways. Each group commented that the team is educating the community about AIDS. Neighbours, leaders and the community also refer to the fact that parents are now educating their children in the home, neighbours are educating each other and people are sharing more about AIDS in general. Leaders and the team also comment that education is now occurring at funerals. Much of this education is attributed to the local team.

Malala

Each of the groups (community group, leaders, local team, neighbours and clients) comment that there is an increased awareness about AIDS in the community and acknowledge that it is having a large impact. For example, leaders commented that it is from Malala to the Basin. This increased awareness is attributed in part to increased education and sharing about AIDS occurring in all aspects of the community. The groups also referred to alterations in traditional practices. This change occurred as a result of members of the hospital going to the Chief who then declared that sexual cleansing should be altered and money exchanged instead. Later, wife inheritance also ceased. Each of the groups believe the local teams are helping to influence these changes.

Country analyses - Malawi

A story from Malawi . . .

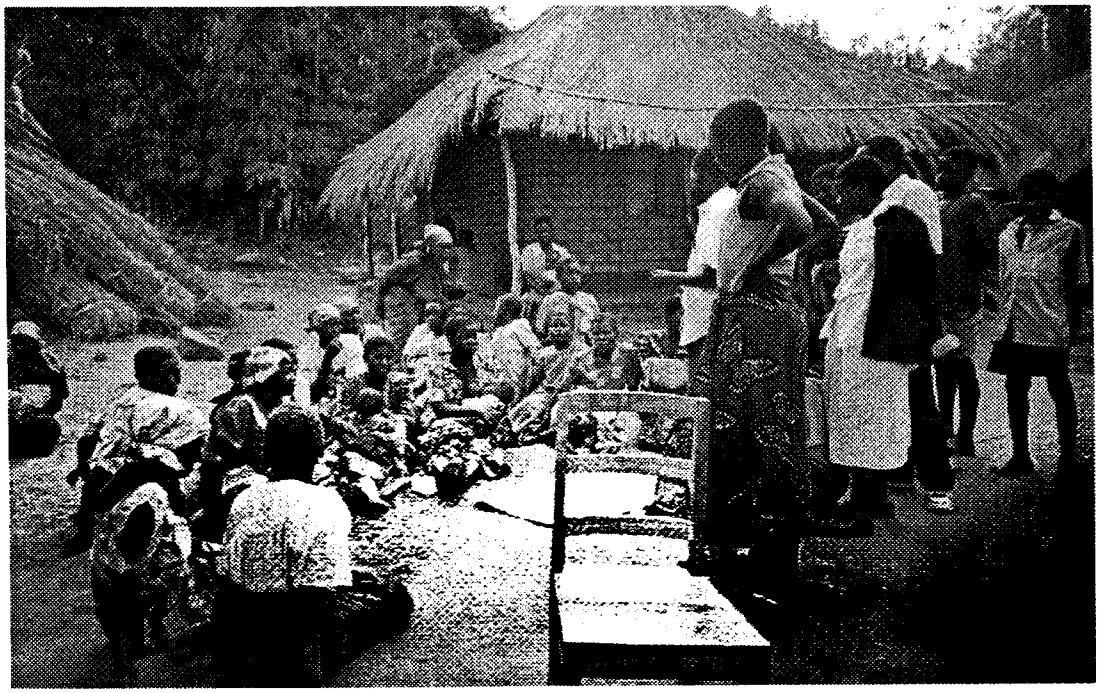
Joseph - (Malawi)

Joseph became concerned a few years ago when he realised his community did not have an HIV/AIDS project. He says he was a drunkard and a male prostitute (in the sense of sleeping with every female he could). However, all his friends who practiced such things have been buried and as a result he has changed his behaviour.

After witnessing the number of funerals increase he felt compelled to join the AIDS group when it began in late 1999 "I did not only want others to change, but wanted them to see how I could change". After gaining permission from the Chief to run the programme, it came to life and started sensitising people. Joseph and several other volunteers from the community attended a community-counselling workshop in Blantyre to be trained as community counsellors. The group has grown rapidly over the last few years.

Joseph believes he has total hope in the future, and is busy planning for it. He and the group are currently working with the Chief who has donated some land for the group to begin an IGA project. With this project, he believes the group and the community can have a self-sustaining future.

The story of Joseph demonstrates a number of themes. Witnessing the deaths of his friends created a sense of fear about AIDS and resulted in behaviour *change.* The Salvation Army offered a way for Joseph to demonstrate *care* for his community and work towards more *change.* The workshop in Blantyre, facilitated by The Salvation Army demonstrates how information can be *transferred* from one community to another. Those involved in the AIDS project are working with the local leaders in a mutually beneficial *partnership*, and are building *hope* for the future in the community by the creation of an income generating activity.



Background

The communities in Malawi that participated in the research process were Nguludi, Migowi and Chiringa. The Government of Malawi is actively involved in creating awareness about AIDS. They run health centres which distribute condoms and provide funds for other non-government organizations. The Government also actively works in each district through the health co-ordination committee which co-ordinates all HIV/AIDS programmes in the area through the district co-coordinator. Many traditional leaders are involved in creating awareness about HIV and AIDS in their communities in co-operation with the Government leaders who encourage them to discuss the issue in their communities. However, many leaders at local level expect NGOs working in their areas to give them money in order to have their support for the programme. As the Salvation Army does not engage in this practice this can sometimes create difficulties in working with the local leaders, although most leaders are very positive about the Salvation Army programmes. The communities themselves are also very active. They agree that there is HIV and AIDS in their midst and that they need to change. A number of communities have introduced anti -AIDS clubs and are changing positively. However, the local teams in each community felt there was a long way to go for real behaviour change to became evident.

Nguludi

Each of the groups (leaders, community group, local team/volunteers, clients and neighbours) felt that awareness/knowledge about AIDS among members of the community has increased. This is largely attributed to the work done by the local team. Other differences in opinion emerge from the groups. The team believes people are changing their behaviour as a result of increased awareness. However, while leaders agree awareness has increased they say that this has not translated into behaviour change. They emphasize that prostitution and immorality are still occurring, and that AIDS is creating many negative changes for example increased widows, orphans and poverty. It could be that these groups are focusing on changes they would like to see and not fully recognising the changes that have already occurred in their community. For example, each group mentions increased sharing among members of the community, which has also translated into increased levels of care in the community. Consequently, an attitude of ownership of HIV/AIDS as a community problem is expressed by the leaders, community and team, with leaders commenting, "We have to take action".

Migowi

Each of the groups spoken to (local team, local leaders, community group, clients and neighbours) acknowledges that AIDS is in the community and that people are aware. This awareness is accredited in part to witnessing many deaths occurring in the community. The community says that despite this awareness there has been very little behaviour change. They say it takes time to change behaviour and due to lack of resources people are not changing, for example, women engage in prostitution in order to have money for food. Leaders also say that few changes have occurred, but they accredit this to ignorance. Each of the groups do report some changes however, for example there is increased sharing of information about AIDS in the community, which has resulted in increased care being shown. These changes are attributed to the local team who are seen as working with others, for example they train local leaders in community counselling and were the first to bring the local leaders together. In addition, leaders say the team has challenged them to motivate their community.

Chiringa

Each of the groups (local team, local leaders, community group, clients and neighbours) acknowledges AIDS in the community. The team, community and neighbours in particular say people fear, and that this fear has resulted in a certain amount of behaviour change. These changes include, decreased drinking, increased Church attendance and increased sharing among members of the community. The team however, says that some people in the community still do not accept AIDS as a reality. Awareness has also increased. Each of the groups comment that this increased awareness is reflected in increased sharing.

(2) Thematic analysis

Over a 6-month period (March to August 2001), a participatory Action Research process took place in Kenya, Uganda, Zambia and Malawi. In three communities per country, various themes were explored from five perspectives, including local teams, local leaders, people infected and affected by HIV/AIDS, neighbours and community members (per country 15 responses are possible per theme, and a total number of 60 responses across all 4 countries). Local teams from each community then transferred this process to 2 additional communities, which were used to verify the outcomes. Information from these additional communities was not included in the analysis of each theme. The information below is a compilation of responses from 12 communities, across all 4 countries.

- ***Shared confidentiality and consent***

  This theme is primarily about awareness and knowledge or 'consciousness' of the issue of HIV/AIDS as active in the surrounding community. The consciousness may be maintained in silence or may lead to action, personally, or collectively. The discussion of this theme, rather than emphasizing action, is a glimpse of the stages of secrecy and openness in the development of the epidemic.

  Community consent is the agreement given to something, which may be given verbally or may be indicated by the response of the community. Acceptance of the team was named by 12 groups as an indicator of community consent. The community has consented to the action of the team, which includes discussion and home visits. The ongoing community meetings were another example given by 14 groups. The community agrees, or consents, to continue the dialogue.

  Indicators of shared confidentiality mentioned included willingness to care for the sick, mentioned by 18 groups. Openness to being tested was given by 18 groups. Confidentiality was specifically mentioned 16 times, in relation to families keeping confidential within the family, neighbours keeping confidentiality, special groups for the protection of confidentiality, and acknowledging without talking.

  Twenty-six groups said that people are sharing more openly in various ways, both corporately and more privately. Acknowledgement of the reality of HIV/AIDS was mentioned by 22 groups, saying that it is acknowledged but not spoken about. Fifteen groups associated acknowledgement with action taken by the community.

  The end of all the sharing, acknowledgement and action, is a mutually supportive environment. People living openly with HIV was mentioned by 4 groups as an indicator that the community could maintain an internal confidentiality. A few early stage indicators were mentioned, of fear of talking openly, self-isolation by a person living with HIV, and some unwillingness to care. These more typical reflections of stigma came from individuals within communities which had not been working together for long, through a facilitated community counselling approach.

  In practice, consent is linked to the idea of shared confidentiality, as often the communities consent to the action of the team begins to open up informal discussion within a community (based on the shared confidentiality within the community). Willingness to meet and discuss together is often stimulated as the team becomes aware of the talk arising from their presence and enters into dialogue with members of the community. There is increasing openness as more groups within a community begin to

speak about the issue, and people are increasingly able to live openly as both infected and affected by HIV.

- ***The influence of caring on change***

  Care expressed in the community, by a team, has influenced the acknowledgement that HIV is widespread, and an increasing openness about it in every community. This is linked to more healthy and inclusive attitudes and also to behaviour change.

  Many positive changes have developed, yet 20 groups also acknowledged the heavy burden of impact, and 12 groups expressed concern that some are not changing, or do not believe in change. There is an associated fear about the whole situation, as mentioned by 14 groups.

  Increased openness was mentioned by 25 groups, as a result of care being shown. The value of home visits for demonstration, encouragement, and a sense of well being was mentioned by 26 groups, while the value of the local team in working well and together with people was mentioned by 10.

  Care helps to reduce fear, mentioned by 5 groups, and cultivates an attitude of kindness and working together, mentioned by 18 groups. The practical action or change, based on this attitude, is looking after each other including care for the sick and orphans, according to 29 groups.

  Openness of communication as a way to influence was mentioned by 40 groups– in relation to children in particular, but also older people to younger people, and within various circles inside the community.

  The pattern of communication changing in the communities includes talking at funerals (15 groups) or at church (7 groups). Active participation of people living with HIV by sharing experience, encouraging others, and living openly, is part of the pattern according to 13 groups. Working together as a community is felt as a strength, said by 11 groups.

  Spiritual life is important as an influence for change, whether through church attendance, shared prayer, or personal faith including belief in life after death, according to 23 groups.

  Changes in behaviour were mentioned by 37 groups. For further detail about changes see the next section, on Community Determined Change.

  Attitudes and actions that express care, are directly linked to the potential and energy for change in a situation. Demonstration of normalcy and encouragement by a team in homes is experienced as an influence for positive change in the attitudes and actions of people surrounding the situation. Care reduces fear and opens up communication, enlarging the enabling environment for people to live openly with HIV and to contribute to each other's lives.

- ***Community determined change***

  Community determined change incorporates changes decided or implemented by a community forum, yet it also includes actions chosen by members of the community and seen as a pattern or trend.

Thirty-one groups mentioned changes in patterns of entertainment, such as discos or adjustments in how alcohol is used, with 20 of those groups mentioning changes in traditional practices.

The actions of members of the community within their own spheres of influence was mentioned by 8 groups, including examples such as parents becoming stricter with their children and youth reinforcing each other in safe practices.

Care for the sick was described by 20 groups as a decision made by the community, associated with a decision to stop fearing people with HIV. This decision may not have been declared in a community meeting, but it became the collective attitude and practice.

In 17 groups changes in sexual practice were named, including increased faithfulness, either in terms of decreased prostitution, greater love between husbands and wives, or less "moving with other partners" or condom use.

Openness to being tested was stated as a community determined change also in 13 groups, which was also linked to shared confidentiality (see above).

Openness in discussion, dialogue and mutual influence around the issue of HIV was discussed above, in the section on the influence of caring on change. Yet openness could also be placed here, as a community determined change. Ongoing community meetings were given by 10 groups as an example of the decision to be open,

Decisions about how to live as a community with HIV are happening, in patterns of entertainment and tradition, in strengthened bonds of care for each other, and in increasing commitment to openness by way of dialogue, testing, and care.

- ***Spiritual life and hope***

Spiritual life and *hope* were two of the themes explored during the research process. All communities and people spoken to demonstrated capacity for, and acknowledged the reality and influence of spiritual life and hope as part of living with the impact of HIV/AIDS.

The belief that we are not alone, that God is present – giving strength, hope and comfort, and that people rely on this as part of daily life was a dominant response mentioned 60 times. The presence of team members through visitation, and family/neighbours showing care and concern are practical expressions of what is often seen as spiritually motivated behaviour was mentioned 50 times. People acknowledge that we live in relationship, with each other and with God.

Although it was acknowledged only 2 times that HIV/AIDS could bring periods of doubt/ discouragement, and at times conflict mentioned 1 time, the over-riding emphasis was on a belief in the continuation of life-beyond death, mentioned 18 times, and a seeking after true wholeness and health in the present, mentioned 20 times. Some expressions of this can be seen in increased church involvement, 20 responses, and prayer, 10 responses, as well as sustained change of behaviour, mentioned 3 times. Also, knowing how to avoid HIV was seen as a source of hope, which was mentioned 23 times.

The belief that change is needed, mentioned 6 times, and possible, and seeing this change in others contributes to hopefulness in people and communities, mentioned 22 times. As with spiritual life, the source of hope is seen as coming from God, mentioned 14 times, but is practically expressed and felt through care, visitation and counseling by team members, families and neighbours. It was strongly affirmed that hope is within people, 7

responses, it is something that is found even in difficult circumstances, and is not dependent on external help or assistance, although these things can bring encouragement, and are needed.

Hope, as with spiritual life can be cyclical. There will be periods when hope is not felt, or when relatives or community members appear to have lost hope, but the reality of its potential and presence is still there. Although one (1) response indicated an unwillingness among church leaders to acknowledge HIV, the truthful acknowledgement of HIV among family members and communities, and knowing ones HIV status were seen as contributing to hope – 7 responses. Openness and sharing as setting an example for others, mentioned 9 times, and a positive attitude focused on having a long life, mentioned 2 times, were also seen as sources of hope.

Both spiritual life and hope are seen in a relational context across all of the communities/countries. They acknowledge our connectedness to each other and to God. They confirm that we are not alone, but live in families, neighbourhoods and communities where the present is seen as connected to the future through faith and hope. Ways of working through team, facilitation, visitation and counselling were seen as being spiritually motivated. Sustained change is strongly linked to support from others, as well as spiritual motivation and faith.

"We share hope and strengthen each other spiritually by gathering together, being with one another, and supporting each other."

In the midst of HIV/AIDS, both the infected and affected are expressing the same needs for 'presence': the acknowledgement that we are not alone, but together, and that together hope is released and shared, both in the present and for the future.

- ***Local partnerships***

In the 12 communities in Zambia, Uganda, Malawi and Kenya that were interviewed as part of the action research program, partnerships generally included churches and church leaders, NGOs, traditional leaders and healers, medical/health personnel, local community groups and teachers. This indicates a good cross section of participation, however, it is interesting to note that government was not more involved.

When looking at the types of partners the local program is working with, church leaders/other churches were mentioned in 26 of the 60 interactions (43%).

The second partners mentioned most often were NGOs, they were mentioned in 17 of the interactions (28%), from Malawi and Zambia, although Kenya did not mention NGOs at all.

Traditional leaders and traditional healers were mentioned in 16 discussions (27%). The Malawi communities by far mentioned traditional leaders the most – 11 (73%). Zambia was second with 5 (33%) and Uganda and Kenya only mentioned traditional healers in one of their discussions.

Medical personnel/health institutions were the next most mentioned local partner. It was mentioned in 12 interactions (20%).

Local task force/community groups and teachers were both mentioned in 11 interactions (18%). Other local partners mentioned to a much lesser degree include government, 7, trained community volunteers, 4, Salvation Army Territorial Headquarters, 4, women, 3, children, 2, police, 1, and relatives, 1.

- ***Influence of the local implementing team***

  There is a distinction between implementing teams which need a participatory approach along with skills in facilitating, as opposed to a facilitation team (territorial, regional, international) which refers to a programme support team. The findings below relate to the influence of the local implementing team on local community action.

  The influence mentioned most was that The Salvation Army has helped to get the community to discuss, out in the open, the subject of HIV/AIDS. This was mentioned in 32 of the 60 interactions (53%). The second major impact has been on helping to train people from the community to conduct care and prevention activities, which was mentioned in 21 of the 60 interactions (35%). The Salvation Army team has also helped in facilitating behaviour change, which was mentioned in 14 interactions, and provides hope and encouragement, which was mentioned in 13 interactions, and organizes community meetings which was mentioned in 9 interactions. Other influences mentioned were counselling, 6, encouraging the involvement of others, 5, helping to build relationships, 4, support in bringing about positive change in attitudes, 2, serving as an example, 2, and encouraging the involvement of other groups, 2.

  Salvation Army local implementing teams have had success in serving as a catalyst to get the subject of HIV/AIDS to be part of the community discussion. This is an important step in a community moving toward doing something about HIV/AIDS. Implementing teams have also been influential in supporting communities as they go from talking to doing something.

- ***Influence of the regional programme facilitation team***

  In the original design of the action research process, it was intended to explore the influence of the regional programme facilitation team (as distinct from territorial or local implementing teams) through focused group discussions with local implementing team members. The questions were not clearly understood, due to the nature of the regional teams work, which is seen as complimentary to territorial and local teams work. A supplementary discussion was held with 23 members of local implementing teams from the 4 countries. The group was asked to comment on whether and why there is need for the regional facilitation team, and if money could go direct to the community instead, would that be better.

  The questions brought a strong reaction from the group. The following reflections were shared regarding the influence of the regional programme facilitation team on local teams and community change processes.

  "If all money went direct to the communities there would still be need for facilitation support in order to develop the community's own strategy for response. Otherwise that money can be wasted."

  "The way of working of the facilitation team is not with a boss and the people 'down there'. This is something difficult to understand from the outside, because most people think and experience and even believe in the higher and the lower positions."

  "Facilitators need to remember where they come from. We are part of the community." (This was spoken by the team leader /coordinator for Kenya and Uganda, who has been working in his own home village area for years before taking on the intercountry role).

"We need to remain connected to the local community reality on a regular basis in order to be effective facilitators of others."

"We have to know that we are not alone or isolated, and that we are 'moving together'. "

"We draw strength from knowing that others are also concerned and confronting similar challenges in other places. "

"We put together the wisdom of each one of us. We keep learning. We need the ideas from those with more experience."

The presence of various forms of facilitation team support (territorial, regional and international) was clearly seen as a strength of the Salvation Army approach to capacity development for strengthened community responses to HIV/AIDS. Regular contact with facilitation teams that work through invitation, and in ways that respect local capacity was named as a catalyst for stimulating local action.

It should be noted that in some contexts, such as Kenya, very few organizations are working in the rural areas. Without facilitation, people still respond, but the community-wide effort is rare. The research process itself caused some communities to reflect together for the first time. For those communities that have been working together even for years, the ongoing presence of facilitation support helps them to weather the changes in the epidemic and to renew their strength.

Specific strategies of Salvation Army facilitation teams, such as programme exchange visits, were mentioned as increasing the pace of learning and enriching local programme action.

The presence of facilitation teams was seen as part of a strategy for sustained community change and transfer, and capacity development of territorial and local teams as well as community members.

"To produce and sustain anything of good quality, we need to go step by step in the process. All of us working together, sharing the load, will bring success. If any part is eliminated, we will have a gap that will weaken our work in communities."

(3) Community to community transfer

- **Methodology**
  The research assistant returned to each country after a six-week period to receive feedback on the work that was continued after the first visit to each community. The focus of this workshop was on the transfer of influence, experience and learning between communities. Using the data already gathered as a source, team members asked themselves, Where has transfer occurred? The responses were mapped in order to give a visual representation of transfer from each of the communities researched. In order to verify the maps produced during the second round workshop, each community was requested to return to their community and produce a transfer map with their community group (see the following pages for examples).

  Thirty-six communities were mapped altogether. The maps were then analyzed by the type of transfer and the result (*see appendices for this analysis*). The figures below represent the total number of instances each of the categories was mentioned in the 36 communities.

- **Findings**
  It is possible to begin to measure transfer of influence, experience, and learning between communities by looking at how transfer occurs and with what effect.

  - ***How does community to community transfer occur?***

    The most prominent channel of transfer mentioned is the local teams (78), through community counselling, education and sensitisation. This was followed by direct invitations (44) being received by the local team to conduct community counselling within a community. Home visits (8) by the team are also distinguished as facilitating transfer through 'being with' people living with HIV/AIDS.

    Theatre activities (8) such as drama, poems and songs, can also create a forum for transfer to occur. The communities highlighted public discussions (23) as also resulting in transfer. These discussions may have spontaneously occurred in market places and homes or have been organized.

    Other informal channels of transfer such as personal initiatives between friends, relatives, and private discussions were indicated as occurring, but would require additional research in order to discern more definitively.

    Local leaders (9) are also involved in the transfer of information about AIDS. This may occur through planned meetings, giving permission for AIDS work to occur within their communities and sharing information with leaders from other communities.

    Funerals (9) are also a forum for transfer due to the usual influx of relatives and friends from outside the immediate community. This may occur through announcing the cause of death, team members conducting sensitisation sessions or through private discussions with people who have attended the funeral. Churches (9) also transfer within and between congregations.

    Other categories which emerged as a means of transfer include the media (2) and partnership with others (1).

- ***What effect does the transfer have?***
  The forming of groups (71) which include AIDS clubs, women groups and youth groups appears to be the most prominent effect of community to community transfer. These groups have been established within the original community and in other communities. Requests are also frequent (43) from other communities for the local team to conduct community counselling meetings with them, and requests for the teams to train (26) additional volunteer counsellors within their own communities and others.

  It is interesting to note that the extension out to other communities can increase interest within the original community, as indicated by the frequent mention of community counselling (30) within the local team's own communities. Increased action in the home (5) and increased openness (2) were also mentioned.

  Transfer of the team influence has activated leaders (23) to respond to the AIDS problem within their communities by, for example, calling community meetings, and enforcing the alteration of traditional customs so they no longer present a great risk in the transmission of HIV/AIDS.

  The work load of the local teams has increased as a result of the transfer of their influence. Counselling operates in many schools (11) and additional visits to clients (11) were both highlighted. Yet the local groups which are forming, as mentioned at the beginning above, are part of an ongoing effort to share the load.

  It appears as though community to community transfer can occur in various ways including the influence of the local teams, direct invitations, churches or public discussions. This transfer of influence has resulted in further activity within the local team's own communities as well as in other communities.

  The informal transfer of energy for action from one community to another, by personal initiative, is a significant area for further exploration, as the transfer mentioned here is only the most visible.

- ***What was learned?***
  The teams that participated in the action research including this mapping exercise gave the following reflections:
  - Community counselling can effect behaviour change and transfer
  - Transfer is the oldest, cheapest and most effective method of acquisition of knowledge and goods among other things.
  - Communities tend to have confidence in other communities.
  - Communities and people interact continuously
  - Community members at grassroots level are capable to understand themselves better. People share positive responses

Maps were drawn by the local implementing teams who participated in the research process, and then they were checked with the local community. The first two maps following this page depict the transfer of action research processes from one community to two other communities. Verification maps were then drawn by the community and one example is included on the third page following. These examples are from Butiti, in Kenya

6. LESSONS AND IMPLICATIONS

(1) Lessons learned from the themes

- ***Shared confidentiality and consent***
  - Shared confidentiality and community consent is a sign of knowledge and interest by the community to learn more.
  - It contributes to willingness for education and change which leads to openness
  - There is need for community members to understand the difference between shared confidentiality and disclosure
  - Mapping by the community members enhances awareness of problems in their areas and is a catalyst for shared confidentiality to be a reality in a wider circle of the community.
  - It can strengthen community to community transfer

- ***Influence of caring on change***
  - Communities can change and can measure the change
  - Not all community members who claim to stop practicing some traditions actually practice and maintain the change.
  - Care within communities is an indicator of acceptance of HIV/AIDS; taking their own responsibility to find solutions and implement change.
  - The shift from care to change is a practical way to influence positive living.
  - Care can stimulate and strengthen spirituality in communities.
  - Care within communities can lead to fear as communities see the effects of HIV and/or AIDS. The experience of caring for the sick can facilitate change.
  - Change within the community encourages clients to have hope.

- ***Spiritual life and hope***
  - Many people in the communities derive comfort from spiritual life and have confidence and believe in life after death.
  - Communities have hope that transmission will stop and that there is a possibility for change.
  - HIV/AIDS has pushed people to seek God
  - Hope is a cycle. Local teams therefore need to sit alongside communities to share their pain and loss, which has the potential to accumulate. Hope has to be nurtured and sustained along the way.

- ***Community to community transfer***
  - Community counselling can effect behaviour change and transfer
  - Transfer is the oldest, cheapest and most effective method of acquisition of knowledge and goods among other things.
  - Communities tend to have confidence in other communities.
  - Communities and people interact continuously
  - Community members at grassroots level are capable to understand themselves better. People share positive responses

- ***Community determined change***
  - Change is a process and therefore some changes are long term
  - Action research has brought out positive attitudes among community members.
  - People can act on and follow up on agreement
  - Determination to change is provoked by the experience of pain at individual and community level.
  - Communities are committed to change
  - Openness and fear for further transmission strengthen determined change.
  - The latent power in communities has reawakened their capacity and determination to change

(2) **Lessons learned from the experience of the action research**

- ***Kenya***
  Matunda have recognised that the research is a continuous process in their work, and that it has opened avenues to working and forming new relationships with new communities.

  In Butiti the research has motivated and challenged the local teams and the community to extend the work.

  The research process in Kithituni has helped the community identify their own problems and motivated counsellors to extend their work.

- ***Uganda***
  Butemulani view the research as have helping them to identify that people are taking preventative measures in their community and have identified some of the dynamics of their community.

  In Kongoli the capacity of the community to recognise its own problems and take action/ownership has been identified through their research process.

  Buteteya recognise the need to continue counselling and sensitising in order to continue to save the lives of people in the community.

- ***Zambia***
  In Mutandalike the research was seen as helpful in identifying the need for strengthening partnerships with other organisations and extending the work in other communities.

  The research motivated the Chikanda team to extend their work in other communities.

  In Malala, the research process highlighted the community's motivation and ownership of the AIDS problem within their community.

- ***Malawi***
  In Nguludi, the research has enabled the team to develop a greater understanding of their community (culture/needs/dynamics) and helped develop the team's research skills.

The research has helped the Migowi team to realise they are helping change occur in their community e.g. night dances have stopped since they began working.

The research has helped the Chiringa team realise they still have much work to do in order to motivate their community.

- ***Regional team***
  The importance of documenting all community processes by the local teams should be reinforced in each community. This may require some additional training of the teams.

  - Action research is an ongoing process
  - Action research has motivated and challenged both the local teams and the communities they work in
  - The research has helped the local teams develop new skills
  - The research has enabled local teams to reach a new understanding of the communities they work in
  - As a result it has deepened community work and contributed to transfer
  - Generally people seem to want to:
    - Extend their work into new communities
    - Develop the capacity of the local teams and the community
    - Work more closely with other organizations

(3) **Current programme implications**

Local teams

- Increase allocation and empowerment of people to work on transfer of learnings between communities
- Work to increase community awareness of its own capacity to change without waiting for outside help
- Get agreement with community on community change indicators
- Ongoing regular documentation of the change process
- Develop a network of communities involved in change process for solidarity and fellowship
- Continue to reinforce and support community determined change
- Strengthen Salvation Army involvement in local partnerships at community level
- Explore indicators of effective local partnerships, including
  - Sharing lessons
  - Transparency
  - Sharing challenges

Regional team

- Integration of action research into more Salvation Army programmes through:
  - Transfer to one or two territories within the next year
  - Availability for methodology support to any ongoing action research by the teams involved in this study
  - Availability to support onsite one community per country in the next year with ongoing action research initiatives
  - Actively develop resource pool of people experience in action research

- Encourage and support action research by local teams to strengthen response to the following issues:

- Shared confidentiality and disclosure of serostatus by PLWH/A
- Expression of spirituality and sustainability as well as generation of hope
- Types of care and effective sustainable community change process
- Strengthening and sustaining shared confidentiality in communities
- Community counselling and cross gender/generation communication

- Support the development of tools for consistent measurement of community to community transfer
- Help to draw out guidelines from the experience for community to community transfer, in order to accelerate local responses.

7. KEY QUESTIONS AND PATHWAYS FOR ACTION RESEARCH IN THE FUTURE

- **Spiritual life and hope:**
  - What expressions of spiritual life generate and sustain hope?
  - How is hope shared from community to community?
  - What factors contribute to the cycles of hope?

- **Shared confidentiality and consent**
  - What is the link between shared confidentiality and disclosure?
  - What are the inhibiting factors in shared confidentiality in the community?

- **Care linked to change**
  - How can or does a community counselling process enable cross-gender and cross-generational communication?
  - How is caring sustained?
  - What type of care is most effective for change to happen?

- **Community determined change**
  - What is the impact of community decisions (who is affected by them, how will future generations be affected)?
  - Who are the influential people to lead their communities into sustainable change?
  - Is community determined change sustainable even without a local team or other motivators? How?

- **Local partnerships**
  - What challenges are faced in local partnerships?
  - What are the limits of partnerships?
  - How to convince and bring together different churches and faiths to work together towards a common goal against HIV?

- **Transfer**
  - How do we identify and measure the effectiveness of community to community transfer?
  - Who are the people involved in transfer as it continues to expand?
  - What method can be used to sustain the spirit of originality in each community as transfer takes place?

8. POLICY IMPLICATIONS

The patterns of response within this action research confirmed accumulating evidence from many sources, that technical, financial and facilitation support for local community capacity development is essential.

Community capacity development works – and can expand impact 'horizontally' because of the enormous potential for transfer of initiative from community to community.

Going to scale with response to HIV/AIDS is dependent on this recognition of the capacity for local response. It equally depends on a working culture of facilitation by support organizations. This policy implication is relevant to NGOs and UN partners, as well as to the Church, for whom the facilitation working culture can be a practical expression of incarnational living.

Standing alongside and learning from communities can be a shared journey into hope.

APPENDICES

APPENDIX 1
Action Research Proposal
The Salvation Army - Africa Regional Programme Facilitation Team (HIV/AIDS, Health & Development

NEED DEFINITION

Increasingly, the need for documenting effective facilitation processes, and analysis of associated questions at community level is being felt within the region. Many lessons have been learned, and are being learned about the capacity of communities to change, and to name/measure their own indicators of change. Documentation at community level is happening, but needs further strengthening, and channels for sharing the stories of change & hope that are present in the face of an escalating epidemic.

The Salvation Army Regional Process, within the context of regional facilitation & community-based initiatives throughout Africa as described above, is well placed to contribute to this process of documentation.

The purpose of this proposal is to provide resource support, and channels for sharing information about community change & hope through the documentation of the link between care and prevention in several locations in each of four countries. There will be a synthesis of patterns of response by communities that reflect their capacity for care and change, and which will explore the response of the Africa regional facilitation team.

BACKGROUND

The Salvation Army developed its internationally known home and community-based approach to HIV/AIDS Care & Prevention at Chikankata Hospital in Zambia in the late 1980's. From this experience, the International Health & HIV/AIDS Programme Facilitation Team was formed in 1990, to provide programme facilitation in the areas of design, support, monitoring and evaluation within The Salvation Army internationally.

The Africa programme facilitation team exists to support programme development at the local level in 12 countries in Africa where the Salvation Army has a presence. It is also available to partner with other organizations. Capacity development of field programme personnel to provide programme support to each other through programme-to-programme sharing, and programme-to-programme transfer of lessons learned, energy & hope within the region was seen as essential. This represents a process of ongoing learning of those involved in implementation, to also function as facilitators.

GOALS/VISION

The overall goal of the action research proposal is to demonstrate community capacity to initiate, measure and sustain change with reference to attitudes, behaviours beliefs, and the environment, in the context of integrated care and prevention. In addition, the impact of spirituality on people's behaviour is an integral part of the research proposal. Partnerships with other organizations seeking to nurture local response will also be examined, as a contributing factor in long term sustained change.

OBJECTIVES (specifically related to documentation/research)

To gather existing data (e.g. Community documentation, process records, etc), and to use key strategic questions to collect additional information about responses to HIV/AIDS and changes happening in 4 country locations.

To validate local community capacity to care, change, hope, and expand the response, through community named indicators of thee capacities.

To facilitate discussion, understanding & application of the processes involved in HIV/AIDS programme development (such as care linked to prevention, behaviour change and community agreement), and the relationship between HIV/AIDS, health, development and mission.

To influence policy at a national and regional level by interacting with other organizations.

The goals or vision of regional programme facilitation include, stimulation of programme implementers in the emergence of programmes which show:

★ *Increased community capacity to cope & take responsibility* for HIV/AIDS and the subsequent effects on health & development,

★ *Increased quality of life* for individuals, family & community members

★ Organisational *capacity development* through the sharing of lessons learned, transfer of ideas and linkage with other organizations (in persons involved in implementation, in facilitation teams, in communities, in The Salvation Army, and in other government & non-governmental organizations, especially with reference to participatory capacity at field level and facilitation of team capacity with respect to inter-country/regional programme support.)

★ Increased facilitation "pool" of regional & international resource people from within field programmes with experience in community health, community development, and commitment to the faith movement.

★ Enhanced mission impact of programme activity, shown through local responsibility, sensitivity and relational growth showing evidence of holistic change.

METHODOLOGY

- The African regional co-ordinator, April Foster, will supervise the implementation of the research project, and is the key reference point for the research assistant. Within each country location, the research assistant will join the local team and together they will carry out the research process.

- Bramwell Bailey who is part of the Salvation Army World Service Office, Washington DC, Dr. Ian Campbell and Alison Rader who are part of The Salvation Army International Health Services Programme Facilitation Team, and Tamara Kwartang of the MacFarlane Burnet Centre for Medical Research, Melbourne, Australia are part of an international advisory group for the research process. Other advisors will be identified within each country

- Review of existing community & regional team documentation of community conversations, process analysis, participatory evaluations, etc.

- Development and use of protocols (see attached), as well as existing tools such as community counselling, community mapping, stories, focused group discussions, to explore themes of:
  - care linked to change
  - hope
  - community-to-community transfer
  - local partnerships
  - capacity for shared confidentiality & community informed consent
  - spiritual life
  - community determined & documented indicators of change
  - influence of the facilitation team approach (local team)

- Over a 6-month period, in 4 country locations (3 community locations in each country), 2 field visits of approx. 2-3 weeks each will be used for the research process. In country work will consist of the following activities:
  - home visits
  - focused group discussions with community groups, using experienced field facilitators
  - participation in community counselling discussions
  - visits to community leaders, and other local partners in each country
  - Discussions with local teams of facilitators

Each field work visit, will be followed by a 1 week period of synthesis by the research team, made up of the regional co-ordinators, several regional team members, and the research assistant.

Communities will be selected for length of time they have been consciously involved in the change process (proposed country locations include: Kenya, Uganda, Zambia and Malawi)

Working with comparative analysis between the selected communities, to notice similarities, differences, and lessons learned which can be transferred/shared with others using **key strategic questions** such as:

For the local community

- ★ Since you first saw HIV, what changes (negative and positive) have you seen in your community?
- ★ How have changes that have occurred in this community influenced neighbouring communities or other groups?
- ★ How does care link to expansion of change?

For facilitation teams/local partners and organisations:

- ★ What do we believe about community capacity for care, change, hope and transfer?
- ★ What are the characteristics of the facilitation team approach used?
- ★ What participatory methodologies do we use, to help ourselves and communities to reflect and make decisions for change?
- ★ What is the basis of mutual learning as opposed to reliance on provision of external knowledge - expertise?
- ★ How are we developing our capacity for analysis of the process and meanings of our own and community change?

EXPECTED OUTCOMES

- ★ Documentation (written & visual), of the community change process in 4 locations within the Africa region over a 1 year period
- ★ Sharing of the experience of community process analysis & documentation at regional & international levels through UNAIDS channels & other forum
- ★ Increased skills development in documentation & process analysis of approx. 20 resource people in the 4 locations
- ★ Strengthened communities which can name and document their own change process, and share this with others

BUDGET

1 full time operational researcher for a 6 month period @ $2,500 per month (accommodation/food/local expenses)	USD$15,000
Travel/local expenses in 4 locations x 2-3 weeks x 2 visits over a 6 month period @ $6,000 per location x 4 locations (air-fares/accommodation/food/local expenses)	USD$ 24,000
In-country participatory workshops with community representatives on the documentation process @ $1,500 per country x 4 locations	USD$ 6,000
Regional team members participation with researcher (2 per country location: travel/accommodation/local expenses)	USD$ 5,000
Research Adviser (air-fare/local expenses for 2 week period during research process)	USD$ 5,000
Documentation/Materials/Administration	USD$ 4,000
Communication (tel/fax)	USD$ 1,000
TOTAL	USD$ 60,000

SAWSO contribution being requested: USD$25,000

RESEARCH PROTOCOLS

HOME VISITS

Objectives:

- Develop and use a protocol to describe the home visit process, and its linkage to other activities such as the community counseling.
- Develop and use a protocol that will describe the impact of care and change in the family and community as a result of the home visit process.

HOME VISIT TO CLIENT:

1. How did it happen that you started to receive home visits?
2. Do you feel that what is shared during home visits is valuable? How?
3. What changes have happened as a result of the visits? (Including, Talking; Concern for our families; Visiting others; Behavior change)
    a. in your family
    b. in your neighbourhood
    c. in the community
4. How do your relatives/friends/neighbours encourage you?
5. What gives you hope?
6. How do you contribute hope to others?

Re: Testing

(the following questions will be used in homes of clients known to the local team)

1. Have you thought about being tested? (No – Why, then question 2; Yes – go to questions 2)
2. If you have been tested, what difference has it made to you, your family?
3. Has being tested caused any change in your life?
4. Do you think other people in this community would want to be tested? Why?

HOME VISITS TO NEIGHBOURS:

1. Introduce by acknowledging that HIV is around. What do you think about it?

(For the next two questions we can share an experience of someone we know who has been tested if it will help)

2. What do you think about testing?
3. What do people say about testing?

4. Personally, I'm affected by this problem of HIV and I'm concerned about it. How do you feel that neighbours shoul respond when this kind of situation comes up?

Would you want to talk more about these things (Local team can offer to visit them at home, and invite them to the community discussions)

HOME VISITS TO NEIGHBOURS PROTOCOL

1. Introduce by acknowledging that AIDS is around. Ask how the interviewee feels about AIDS in the community
2. Since you first saw HIV/AIDS what changes have you seen in your community?
3. Who is involved in the change processes within this community?
4. Who is involved in showing care in the community?
5. Do you think the Salvation Army is contributing to this process?
6. What role is the Salvation Army playing?
7. How have you contributed to change?
8. How have these changes affected you and others
9. What motivates you to make positive change – to make a difference in the community
10. Do you think that the changes that have occurred are sustainable? How?
11. What gives you hope/keeps you going?

COMMUNITY CONVERSATION/COUNSELING

Objectives:

- Develop and use a protocol that will clarify the perception of the group on community change processes involving community members
- Develop and use a protocol that will give the communities perception of the Salvation Army facilitation process on change in the community

MAPPING OF CONCERNS AND HOW THE COMMUNITY IS RESPONDING

1 Define the area
2 Divide into four groups, each looking for one type of home

3 Look for:
Homes with orphans
Homes headed by children
Homes headed by single women/ widows?
Homes where someone sick is being cared for

4 Report back and explore themes:
Care: which homes are receiving visits
Who is visiting (neighbours or other groups)
Local partnerships: who is involved in showing care in the community
Transfer: Is care in one place helping care to happen in any other place?

5 Combine map into one

6 End meeting with the following questions:

- How has this been useful?
- What did we learn?
- How can we use this in our ongoing work?

QUESTIONS FOR COMMUNITY CONVERSATION

(If the community has done a timeline before, it can be used for this discussion)

1. When did you first see HIV/AIDS in this community?
2. Is HIV/AIDS a widespread problem in your community?
3. Since you first saw HIV, what changes (negative, positive) have you seen in your community?
4. What decisions have we made to protect ourselves and the community?

5. How is the community active in the change process? Who has been most active? Why?
6. What other groups and organizations are involved in the change process?
7. Do you think what the Salvation Army is doing is contributing to this change?
8. What role is the Salvation Army playing?
9. What has been the role/ influence of people living with HIV and their families in the changes that have occurred in the community?
10. How do people feel these days about getting tested?

Split into groups for the following questions (Men/Women/Young people)

11. How have we ourselves contributed to change? (Positive/negative)
12. How have these changes affected us/others
13. What motivates us as men/women/young people in the community to make positive change/ to make a difference? (Answer according to the group you are in)

Return to the full community group

14. How have changes that have occurred in this community influenced neighbouring communities or other groups?
15. Do you think the changes in the community are sustainable? How?
16. Has the impact of HIV/AIDS caused people to seek faith or churches?
17. What gives you hope/ keeps you going?

LOCAL TEAMS

Objectives:

- Develop and use a protocol that will explore influence on local teams of the facilitation team approach (both locally and regionally)
- Develop and use a protocol that will explore the major themes of the research, from the perspective of the local team

Questions:

1. How have you seen the community express:
   Taking care/love for each other
   Change/positive response to the challenge, to change themselves
   Hope
   Sharing of experience/ what they know with others
2. Do we believe people in the community can TAKE CARE of each other?
   Do we believe people can change in a positive way?
   Do we believe people can have hope, even without outside help?
   Do we believe people can share what they know with others?
   Why?
3. What do we do as a team, to help ourselves and the community to reflect/think together and make decisions for change?
4. In the community now, families are taking care of each other, neighbours help each other, the team is also supporting. How does all this (care going on) help positive change to happen in the community?
5. We find that people are aware of HIV, of neighbours who are infected or affected (although may not talk about it). Are people in the community becoming more open, shown by their action or word? (revise if necessary)
6. How do we learn together as a team with the community and others?
7. Who do we link up with in this work?
8. How have the work and the community response influenced others? (Have other communities or churches or groups begun to work after seeing what we are doing?)
9. How does our work with HIV effect/influence/change our spiritual life?

LOCAL TEAM MEMBERS EXPOSED TO THE REGIONAL PROCESS

This may be done during group meetings for synthesis

1. How has the regional process influenced your capacity for analysis?
2. What has been the influence of a facilitation team approach to your own team development and action in the community?
3. How has the regional program facilitation team process affected and influenced community change processes (directly by involvement of one of the coordinators or regional team members from outside the local team, or indirectly through training and experiences of their local team members outside the area which then came back to them)

LOCAL LEADERS (and people of influence)

Objectives:

- Develop and use a protocol to explore the perspective of local leaders/ people of influence/other organizations/Salvation Army leadership on the impact of the participation process in the community (especially facilitation of community conversation through a counseling approach), as well as the part played by the regional programme facilitation team on local team and community response.
- Develop and use a protocol that helps describe the involvement of local leaders/people of influence/other organizations in the community change process in relation to HIV/AIDS.

1. Do you see HIV/AIDS as a problem in your community?
2. Has the impact of AIDS increased or decreased over the last five years in your area?
3. What changes have you seen in the community in relation to HIV/AIDS? (positive and negative)
4. What factors have contributed to these changes?
5. How long have these changes been going on?
6. Where do you see the Salvation Army team as having its greatest impact in the community?
7. What challenges do you face as leaders in working with the Salvation Army and others? (Give examples)

8. How have the changes in this community influenced neighbouring communities?
9. Do you think that more change is possible in the community in the future with regards to HIV/AIDS? (How? What changes would you like to see?)
10. How does our work with HIV effect/influence/change our spiritual life?

THEME DEFINITIONS

The themes are a way of showing individual and community capacity.

THEME: CARE TO CHANGE

Care

A supportive presence that accompanies people in their situation, for example, visiting a neighbour or a community visit. It reflects mutual support between family, neighbours, community, and a relationship of being with and interacting with others.

Change

Change occurs by seeing care (or experiencing care itself), which allows people to see the reality of HIV, and may result in a change in understanding and attitude. This may also occur in the person giving the care. Care helps to make change more likely to happen. Change does not happen simply in persons in isolation but when the care and change process is relational in nature, the change is expansive. It is a foundation for going to scale. (This should hopefully be demonstrated through examples which come out of the research process).

Link between care and change

The link between care and change is relational. If there is not a relationship, it is something different to what we are doing. If people are not engaging in developing relationships, then the intervention will probably not be sustained (i.e. only handing out condoms).

The care to change linkage is also termed "care/prevention" linkage. It is a key strategic approach to expansion of circles of involvement in local community and organizational response to HIV/AIDS.

THEME: HOPE

The belief that something positive can happen, that change can happen. Hope relates to both present and future. It is intrinsic to formation of a community memory. It is not only a belief but an experience that the situations can and will be better. It requires valuing of the past, belief in the future and action in the present. This is not necessarily tied to circumstance (i.e. it is not materially based), it is something inside people, . Hope can be individual or collective, that is, in some situations it may not be individually owned but, be in connection to others.

THEME: COMMUNITY TO COMMUNITY TRANSFER

This is also referred to sometimes as 'diffusion' - it refers to the sharing of meanings across boundaries which include knowledge, experience and particularly concepts or ideas such as care, community, change, leadership and hope. It also include transfer of ways of thinking and approaching the situation such as team work and participation. It does not necessarily refer to the transfer of activities. This may occur spontaneously, or reflect a level of development within a community that demonstrates that they see needs beyond their own community and actively seek to engage in the process of sharing. The process is an experience of shared learning.

THEME: LOCAL PARTNERSHIPS

Local partnerships involve collaboration for mutual learning and action, with a mutual accountability and transparency. It involves knowing what others are doing and working in a complimentary manner so that work is not duplicated unnecessarily.

THEME: SHARED CONFIDENTIALITY

Shared knowledge and understanding of meanings within a context of respectful intimacy within a group in which there is a sense of mutual accountability. Knowledge that is shared in this context is not a secret, however, the content and meanings are known within the group, even though there is not necessarily open conversation about the content and meanings. It is strong capacity, which is the foundation for effective community counseling and for scaling up prevention response.

Community informed consent

Community informed consent is shared agreement within a local community that processes often considered private and personal can be agreed as valid for the neighbourhood as a whole. It presumes a healthy relationship based on trust between the local community members and those who interact from situations such as hospitals or other institutions. In a sense the community view is that of it is good for one it is good for all. An example can be testing, or reaching agreement on the time and purpose of community discussions, renewing of invitations to return, and accepting the meaning of an outreach team visit to specific homes as applying to the whole community in terms of relational meaning with the necessity of specific disclosure.

THEME: SPIRITUAL LIFE

The belief that spiritual dimension is a very important part of everyday life/physical well being. It is a belief in the continuity of life beyond the physical. This notion is a very important part of the holistic approach.

THEME: INFLUENCE OF THE FACILITATION TEAM APPROACH

There is a distinction between implementing teams which need a participatory approach along with skills in facilitating contrast to a facilitation team which refers to a more distant programme support team derived from other levels of the organization often multinational. The Africa regional programme facilitation team is an example. This theme explores the specific influence of the Africa regional team and in some cases national facilitation teams in terms of the influence on implementing teams with regards to capacity development for stimulating and nurturing local community response.

THEME: COMMUNITY DETERMINED CHANGE

Where the community has made a decision, taken action and measures its own progress.

ACTION RESEARCH PROCESS

- Preparation of protocols by core team
- Field work in 3 communities per country by local team with research assistant (1 week per community)
- Fieldwork by local team in 2 additional communities by local team. Synthesis of information into themes chart.
- Second visit by Research Assistant to each country for feedback and looking at additional information – country meeting – 1 week
- Final meeting of core group to look at analysis, findings, results.

ROLES/RESPONSIBILITIES

Research Assistant and team

(Working together with teams and regional team mates)

- Gather documentation from field work
- Synthesize information
- Analyze information
- Feedback to teams
- Prepare final document
- Copies of local maps, photos, verbatim reports

Local Team leaders

- Organize local field meetings (community, local leaders, home visits, local team)
- Prepare local team (e.g. protocols, translation)
- Arrange transport/accommodation for research team (Claire/Patrick)
- Manage local budget and prepare finance reports to be given to Research Assistant by the end of each visit
- Communicate with local Salvation Army leadership (e.g. DC's)
- Participate in field work
- Participate in end of research core group meeting

TYPES/NUMBER OF MEETINGS PER COMMUNITY

Community conversations – 1 community 2-3 times (meet with the same community)

Home Visits – minimum 8-10 times (including neighbours)

Local leaders – minimum 5-10, 1-2 meetings

Examples:

Headmen – Assistant chief
Health workers
Self help group leaders
Social workers
Church leaders
Headmaster/teacher
Local herbalist/healer
Initiators
NGO's
Councilors
Local politician

Local team – volunteers/resource team

BUDGET

MAXIMUM – US$1000 per site (e.g. community)

- Local transport – local team / research team
- Food – Patrick
- Accommodation for Patrick
- Local expenses: materials (paper, markers etc)
- Other?

TIME-TABLE FOR RESEARCH

KENYA

1. Matunda
   - Dates : 11-18 March
   - Transport: local
   - Accommodation: home

2. Butiti
   - Dates: 18-25 March
   - Transport: local
   - Accommodation: home – DHQ

BREAK: March 26-31

3. Kithituni
   - Dates: 1-7 April
   - Transport: local
   - Accommodation: home – DHQ

BREAK: April 8-15

UGANDA

1. Butemulani Corps
   - Dates: 17 – 23 April
   - Transport: car hire
   - Accommodation: guest house

2. Kongoli Corps
   - Dates: 25 April – 2 May
   - Transport: car hire
   - Accommodation: guest house

3. Buteteya Corps
   - Dates: 3-10 May
   - Transport: car hire
   - Accommodation: guest house

BREAK: May 11-18

ZAMBIA

1. Mutandalike (Zambia Southern District)
   - Dates: 21-27 May
   - Transport: Project vehicle
   - Accommodation: school

2. Chikanda (Lusaka Northwest District)
   - Dates: 28 May – 3 June
   - Transport: project vehicle
   - Accommodation: CO's (2 nights at local hotel)

3. Kawama (Copperbelt or Chikankata)
   - Dates: 4-10 June
   - Transport: project vehicle
   - Accommodation: DO's

BREAK: June 11-16

MALAWI

Travel to Malawi on 16th June

Second visit dates to be determined

APPENDIX 2 : EXAMPLE OF COMPARISON OF PROTOCOLS BY THEME

Protocol Summary - Butemulani

1. Care to Change

Community Conversation

- Increased sharing and openness among the community/clients
- Counselling process (SA team) is producing change
- Spiritually now believe in life after death
- Testing reassures couples of status and people are encouraged by the results
- Death rate is influencing awareness and resulting in behaviour change
- Parents educate their children about AIDS

Local team

- People no longer fear AIDS - just another disease
- People have taken ownership of, and accept the problem so action now being taken e.g. no longer go out and infect others; traditional change - fear wife inheritance; accept the sick
- People are more open about AIDS e.g. infected are sharing their experiences; community sit and share experiences/discuss
- People accept and follow education about how to live
- Community and team work together

Local leaders

- As a result of counselling deaths have decreased, AIDS itself has decreased, drinking habits and sexual immorality has decreased
- There are still high numbers of widows, orphans and poverty
- Team are providing education, counselling and support
- Other communities are now learning from this community
- Believing in Christ can live longer, give help, no longer commit suicide

Home visits to Clients

- People are encouraged to attend counselling meetings
- Feeling free to talk about AIDS - clients, friends, relatives, neighbours
- Clients themselves are sharing their experiences
- Spiritual influence of the team and Christians helps change in attitude/acceptance of AIDS

Home visits to neighbours

- AIDS is a problem, it is dangerous and it is real
- Individuals and others are willing to be tested as a result of the teams work, but the distance of the test is a problem
- Neighbours are providing assistance and support to the infected and affected e.g. spiritual and material

2. Hope

Local team

- Hope for eternal life
- Hope for the future
- See change in others gives hope
- Education can increase length of lie
- People have hope within them, even without the team

Local leaders

- Hope for accessible blood tests
- Hope for sustained change - receive hope from counselling
- Hope for enhanced partnership with other Churches
- Continuation of life through Christ

- Increased material support

Home visits to clients

- Visits give hope/courage/ strength
- Spiritual sharing gives hope reassures client that there is life after death and for the future
- Receive hope from family/neighbours/ counsellors

Home visit to neighbours

- Neighbours give hope o their neighbours who are affected through telling them to be free, spiritually and willingness to be involved

Community conversation

- Hope that there is life after death
- Hope that drunkenness will reduce
- Salvation army team is giving people hope through counselling and visits
- Believe behaviour change can be sustained as a result of facilitation
- Hope through God - turning to the Lord

3. Community to community transfer

Local team

- Clients and the community are sharing what they have experienced and heard on their own and after community meetings
- Other groups have started after seeing the salvation army team

Local leaders

- Information transferred from community to community and Church to Church

Home visits to clients

Home visits to neighbours

Community conversation

- Other communities are doing as we are doing - they have learnt from us

4. Local partnerships

Local team

- Salvation army have been asked to go and educated/help other groups
- Work with other groups e.g. regional team, TASO, Government, other Churches

Local leaders

- Others (not the SA) are not wanting to work with the local leaders

Home visits to clients

Home visits to neighbours

Community conversation

- TASO, PHC, Uganda Women Concerned Ministries, other NGO's

5. shared confidentiality and community informed consent

Local team

- People feel able to share openly about AIDS e.g. announce openly at funerals the cause of death; Families share

- Accept the sick and care for them
- People accept being tested

Local leaders

- Good relationship built between community counsellors, the client an the community - people no longer fear those who are sic because they know AIDS is a disease like any other
- Sharing is occurring between one community and another

Home visits to clients

- Clients are open and share experience with others
- Community are now free and accept

Home visits to neighbours

- Willingness to be tested, know status, assist others spiritually and materially and be open

Community conversation

- People talk openly to each other about AIDS; increased communication among families e.g. seminars
- Faithfulness to one another by decreasing immorality
- Acceptance of testing to know status of couples - open
- People allow the salvation army to conduct community counselling meetings
- The community have become more active in the community counselling process

6. Spiritual life

Local team

- Believe life is Gods will I.e. if repent will live longer
- Hope for eternal life
- People have changed spiritually

Local leaders

- More people are now going to Church and being saved - believe live longer

Home visits to clients

- Sharing with others spiritually
- Belief in life after death
- Team enable spiritual growth
- Spiritual aspect - prayers have an important impact - friends, family, neighbours - God gives hope

Home visits to neighbours

- Neighbours preach to and strengthen clients spiritually

Community conversation

- People dedicating themselves to God - spiritual strength, life after death, testifying
- Belief in life after death

7. Community determined change

Local team

- Decided to announce at funeral whether individual died from AIDS
- Decided to change traditional practices e.g. wife inheritance, circumcision - trained by local team

Local leaders

- Decided to alter traditional practices e.g. circumcision, TBA, herbalist

Home visits to clients

Home visits to neighbours

- As a result of counselling community has decided to assist clients whenever it is needed

Community conversation

- Community have decided to reduce immoral practices
- Decided to be tested before marriage
- Polygamy (not considered immoral) has stopped

8. Influence of the facilitation team approach

Local team

- Organize community counselling groups
- Are an example to the community
- Educated traditional practitioners on safety

Local leaders

- Counsellors of the local team have facilitated change in behaviour e.g. drunkenness; change in attitude towards the sick
- Empowered the community with education and skills for prevention e.g. traditional practitioners
- Need for expansion of the local team

Home visits to clients

- Counsellors give clients encouragement through prayer, HIV, counselling, which influence friends/neighbours to care, share and increase openness

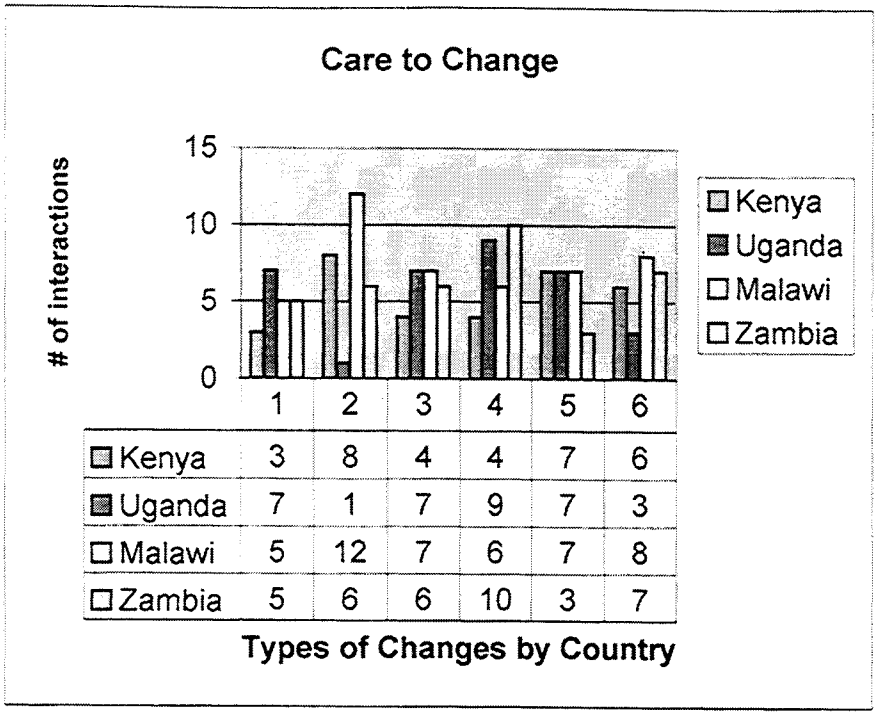
Home visits to neighbours

- Influence through teaching I.e. willing to be tested, and now care for clients

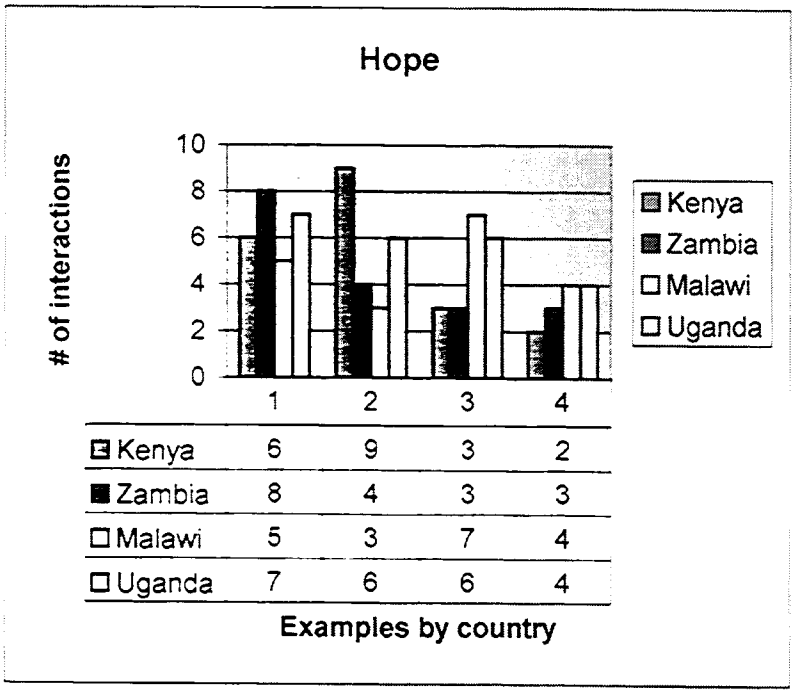
Community conversation

- People follow the teaching of the facilitation team (increased awareness) through teaching
- Team are active and influencing the community to become more active
- Team are accepted by the community
- Giving strength/hope to the infected and affected

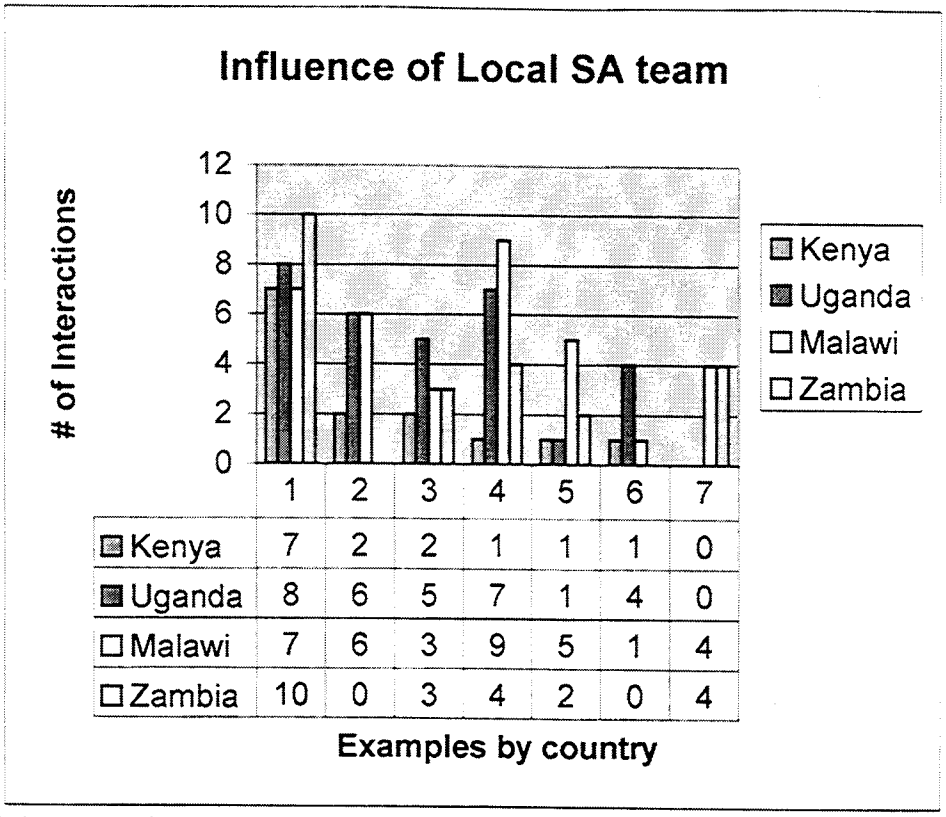
APPENDIX 3 - GRAPHIC ANALYSIS OF THEMES



1. Talking to each other
2. Home visits and wellness encouragement
3. Awareness of HIV as being widespread
4. Changed-behavior
5. Looking after each other
6. Negative changes

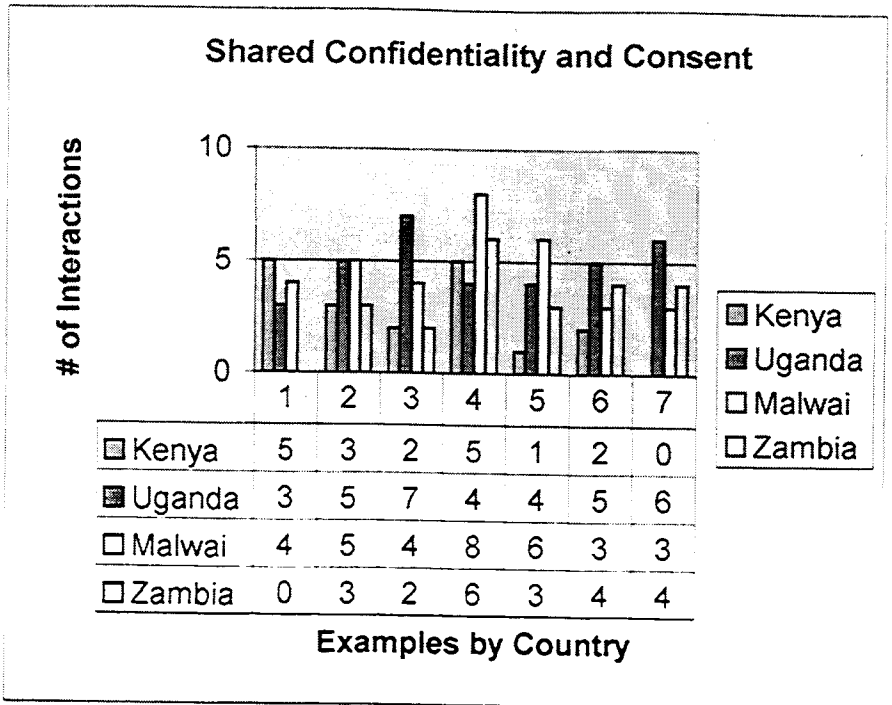


1. Belief that God can solve problems
2. Belief that change is possible, ie. Attitudes
3. Receive encouragement from team members
4. Receive encouragement from visits by friends, neighbors and families



	1	2	3	4	5	6	7
Kenya	7	2	2	1	1	1	0
Uganda	8	6	5	7	1	4	0
Malawi	7	6	3	9	5	1	4
Zambia	10	0	3	4	2	0	4

1. Increase discussion on HIV (Awareness)
2. Change in Behavior
3. Provide hope and encouragement
4. Train community members to do HIV awareness and care for sick
5. Organized community meetings, community couseling
6. Counseling
7. Help in the support of orphans and vulnerable children

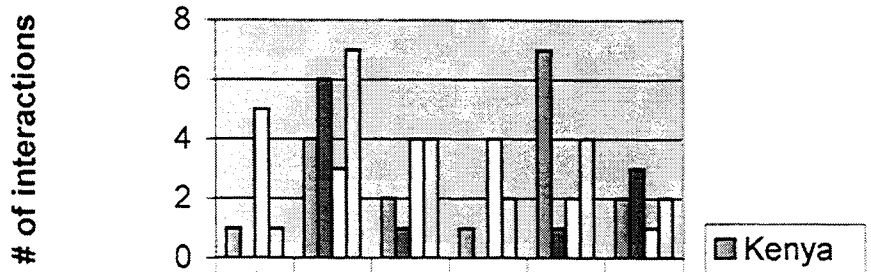


	1	2	3	4	5	6	7
Kenya	5	3	2	5	1	2	0
Uganda	3	5	7	4	4	5	6
Malwai	4	5	4	8	6	3	3
Zambia	0	3	2	6	3	4	4

KEY:

1. Allow SA team in
2. Community knows
3. Action taken
4. Open discussion ie parents & Kids, young and old
5. Holding meeting to discuss issues important to community
6. People willing ot care
7. Individuals willing to be tested

Spirituality

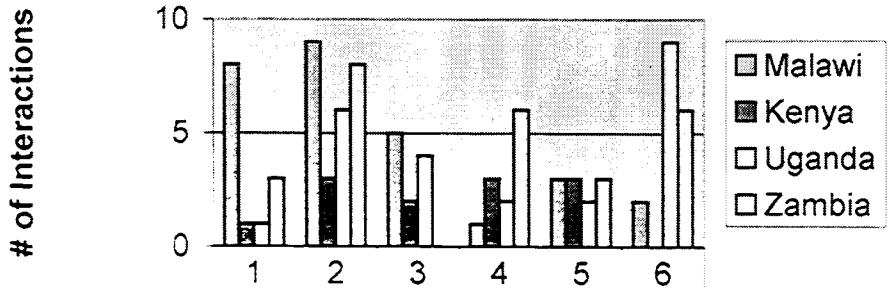


	1	2	3	4	5	6
Kenya	1	4	2	1	7	2
Malawi	0	6	1	0	1	3
Uganda	5	3	4	4	2	1
Zambia	1	7	4	2	4	2

Examples by Country

1. Belief in life after death
2. Increase in church activities, attendance
3. Surrender to God
4. Influence and prayer with/by neighbors, friends and relatives
5. God is hope
6. Prayer provides support

Local Partners



	1	2	3	4	5	6
Malawi	8	9	5	1	3	2
Kenya	1	3	2	3	3	0
Uganda	1	6	4	2	2	9
Zambia	3	8	0	6	3	6

Examples by Country

1. Traditional leaders
2. Church leaders/ other churches
3. Local task force/community groups/ clubs
4. Medical Personel/ health institutions
5. Teachers
6. NGOs