Rapid Appraisal

of the

Community Capacity Empowerment Programme
and
Leadership Development for Results

components of the

Enhancing an Integrated Response to HIV, AIDS and Poverty Programme

UNDP
Pretoria

OCTOBER 2004

CONTENTS

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral Treatment
CBO	Community-based organisation
CC	Community Conversation
CCEP	Community Capacity Empowerment Programme
CSO	Civil Society Organisation
DOTS	Directly Observed Treatment Short-course
FBO	Faith-based organisation
IDP	Integrated Development Plan
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
KZN	KwaZulu-Natal
LDR	Leadership Development for Results
NGO	Non-Governmental Organisation
PLWHA	People Living With HIV and AIDS
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing

ACKNOWLEDGEMENTS

This rapid appraisal was carried out by the Social Aspects of HIV/AIDS and Health programme of the Human Sciences Research Council during September and October 2004. We would like to thank the staff of the UNDP, Social Development and HIV and AIDS Unit: Aloma Foster, Mothomang Diaho, Shivaji Bhattacharya, Thebisa Chaava, Dolly Mphuthi, Gift Buthelezi, Dumisani Magadlela, Isaac Chivore, Florans Siya, Enerst Maigurira, Singh Bhandari, Nompumelelo Mnconywa, Thabo Thobejane, Maria Mesomola, Ntombizanele Mazwi, Mbulelo Kutu, Nomzamo Landingwe and Joseph Legae for facilitating the appraisal process and cooperating with the research team.

We would also like to thank all the individuals who participated in the study, including facilitators, NGO leaders (KwaZulu-Natal CBO Coalition and National Progressive Primary Health Care Network) and government officials in KwaZulu-Natal (Department of Health), Eastern Cape (Department of Health) and Limpopo (Department of Health and Welfare, and Musina Municipality).

Authors: Tsiliso Tamasane, MA and John Seager, PhD, October 2004

The UNDP, Social Development and HIV and AIDS Unit funded this appraisal. However the findings, interpretations and conclusions expressed in this paper are entirely those of the authors and should not be attributed to the UNDP, which does not guarantee their accuracy and can accept no responsibility for any consequences of their use.

EXECUTIVE SUMMARY

Introduction

The Enhancing an Integrated Response to HIV, AIDS and Poverty Programme aims to reduce the impact of HIV infection, AIDS and poverty on human development by addressing their interrelationships. The programme operates at community, municipal, and provincial levels.

The Programme comprises various elements but this report cover only the Community Capacity Enhancement Programme (CCEP) and the Leadership Development for Results (LDR) initiative. CCEP helps communities to create local level responses and LDR trains leaders in multi-sectoral responses to HIV, AIDS and poverty.

The rapid appraisal utilised document reviews, individual and group interviews, of both beneficiaries and other stakeholders, plus observation at selected pilot sites in three provinces. The emphasis of the appraisal was on previously selected "successful" sites in order to describe positive impacts and, owing to time constraints, did not assess any of the less successful sites.

Impact of the Community Capacity Enhancement Programme

CCEP has introduced participatory-, change- and action-oriented tools to the communities investigated. The programme facilitated active participation of communities in combating the spread of HIV and AIDS, providing care and support, fighting poverty and identifying cultural practices that may increase risk of HIV infection and/or discrimination on grounds of gender, economic or health status.

Through 'Community Conversations', CCEP provides a platform where people can engage in open discussions about sensitive issues in their community. People were able to identify and explore concerns and myths, catalogue resources available within the community and agree on areas where external support was needed.

A notable strength of the methodology lies in its ability to facilitate intergenerational dialogue, which is particularly valuable in the case of HIV and AIDS, where risks and impacts differ markedly for different age groups. The Programme has had a profound impact in creating partnerships for addressing HIV, AIDS and poverty and such partnerships are a critical component of sustainability.

A majority of facilitators interviewed reported change in their own sexual behaviours as well as a change in attitude towards PLWHA. They also stated that their understanding of the relationship between HIV, AIDS, poverty and culture had improved. Whilst not a specific objective of CCEP, this process should be regarded as an important first step in community empowerment. Several facilitators identified with being 'role models' in their communities.

Members of the community gained valuable skills such as public speaking, facilitation, minutes recording and development of business plans. The level of awareness of essential services was raised, and CCEP has helped to facilitate access to these services. Communities within the project pilot sites have also undertook income-generating projects.

Basic understanding of HIV and AIDS improved and there was wider awareness of the advantages of voluntary counselling and testing (VCT). A marked increase in requests for VCT was reported in some areas. Community conversations also provided a platform for dealing with misconceptions about HIV and AIDS, and to review those cultural practices that may fuel or curb HIV and AIDS.

Lessons for best practice for CCEP

- The use of participatory tools has a profound impact.
- Partnership approaches cultivate stakeholders' "buy-in".
- Community conversations facilitate dialogue on sensitive issues such as sex and sexuality, HIV, AIDS, poverty, culture, stigma and access to services and resources in the communities.
- CCEP develops vital capacity at the community level.

Impact of the Leadership Development for Results programme

The establishment of Action/Task Groups has facilitated the application of theory by encouraging participants to identify and implement HIV-, AIDS- and poverty-related projects.

LDR has contributed to development of social capital. It has also enhanced leaders' understanding of the impact of HIV and AIDS on affected and infected individuals and improved their empathy towards PLWHA.

Because of their participation in LDR, leaders were better equipped to influence the direction of their organisations, as well as groups within the community.

Two hundred and thirty-five leaders from local and provincial government, the private sector and civil society have participated in this programme.

Lessons for best practice for LDR

- Involvement of leaders at all levels helps to ensure buy-in for development initiatives.
- Leaders were empowered and more willing to engage in the process once they were better informed about the relationships between HIV, AIDS and poverty.
- Future initiatives should seek ways to improve participation of senior leaders since they are key role players, especially regarding the allocation of personnel and other resources.

RAPID APPRAISAL OF THE COMMUNITY CAPACITY EMPOWERMENT PROGRAMME AND LEADERSHIP DEVELOPMENT FOR RESULTS COMPONENTS OF THE ENHANCING AN INTEGRATED RESPONSE TO HIV, AIDS AND POVERTY PROGRAMME

1 INTRODUCTION

Since the beginning of the epidemic, an estimated 60 million people worldwide have become infected with HIV (UNAIDS, 2003). AIDS claimed about 3 million lives in 2003 and an estimated 5 million people were newly infected with the virus, bringing to 40 million the number of people living with HIV and AIDS (PLWHA) in the world (UNAIDS, 2003).

Developing countries are worst affected by the epidemic, with an estimated 95% of the global total cases (World Bank, 1999). Africa is by far the most hard-hit by HIV and AIDS. Presently, two-thirds of the world's epidemic is in Africa (World Bank 1999; UNAIDS 2002a; Barnett and Whiteside, 2002) and in 2001 alone, the disease killed more than 1.5 million people (UNAIDS 2002). The sub-Saharan Africa region is leading other parts of the world with HIV and AIDS incidence (Barnett and Whiteside 2002,White and Robinson 2000). It estimated that the sub-region hosts almost 71% of HIV-positive people and 80% of infected children in the world (UNAIDS 2002b).

Table 1 Regional HIV and AIDS statistics and features, end of 2003 (UNAIDS, 2004)

Region	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult & child deaths due to AIDS
Sub-Saharan Africa	25.0 – 28.2 million	3.0 – 3.4 million	7.5 – 8.5	2.2 – 2.4 million
North Africa & Middle East	470 000 – 730 000	43 000 – 67 000	0.2 – 0.4	35 000 – 50 000
South & South-East Asia	4.6 – 8.2 million	610 000 – 1.1 million	0.4 – 0.8	330 000 – 590 000
East Asia & Pacific	700 000 – 1.3 million	150 000 – 270 000	0.1 – 0.1	32 000 – 58 000
Latin America	1.3 – 1.9 million	120 000 – 180 000	0.5 – 0.7	49 000 – 70 000
Caribbean	350 000 – 590 000	45 000 – 80 000	1.9 – 3.1	30 000 – 50 000
Eastern Europe & Central Asia	1.2 – 1.8 million	180 000 – 280 000	0.5 – 0.9	23 000 – 37 000
Western Europe	520 000 – 680 000	30 000 – 40 000	0.3 – 0.3	2 600 – 3 400
North America	790 000 – 1.2 million	36 000 – 54 000	0.5 – 0.7	12 000 – 18 000
Australia & New Zealand	12 000 – 18 000	700 – 1 000	0.1 – 0.1	<100
TOTAL	**40 million (34 – 46 million)**	**5 million (4.2 – 5.8 million)**	**1.1% (0.9 – 1.3%)**	**3 million (2.5 – 3.5 million)**

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2003, using 2003 population numbers.

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. These ranges are more precise than those of previous years, and work is under way to increase even further the precision of the estimates that will be published mid-2004.

The southern African sub-region has the highest prevalence of HIV and AIDS in the Sub-Saharan Region (White and Robinson 2000). The table above (UNAIDS, 2004) demonstrates the massive scale of HIV and AIDS in Sub-Saharan Africa when compared to other regions of the world. Not only is the prevalence of infection highest in Africa, but the likelihood of poor people dying from AIDS is much greater than their wealthier counterparts in developed countries.

Along with its neighbours, Botswana, Lesotho, Swaziland and Zimbabwe, South Africa is ranked in the top ten countries with the highest adult HIV prevalence rate (Pelzer in van Rensburg, et al. 2002). It is estimated that by the end of 2003, more than 5 million South Africans were living with HIV (Department of Health, 2004). Its devastating impacts can be felt at various levels of society: individual, household, community, government and even internationally.

Early interventions to combat the spread and mitigate the impacts of HIV and AIDS have concentrated on behavioural change through awareness-raising and the treatment of sexually transmitted infections and other opportunistic infections (Campbell, 2003). However, there is growing recognition that HIV and AIDS is not just a health problem, but it is also a behavioural, cultural, societal and development problem (these issues will be highlighted throughout the report). Bio-medical interventions should therefore be complemented with interventions that confront these issues at the root-cause. Given limited capacities of governments in countries ravaged by the epidemic, partnerships with civil society and international communities are crucial.

The UNDP Project Document for "Enhancing an Integrated Response to HIV, AIDS and Poverty Programme" notes that in South Africa the debate has progressively moved from considering HIV and AIDS in purely bio-medical terms to contextualising it in the wider social and economic forces prevalent in the country. The Document further argues that the South African government has been in the forefront of the debate and government policies are increasingly reflective of this current thinking.

"One important challenge that remains is to move the process from mere policy statements to actual plans and programmes that would make a difference to the population and the institutions through which people access services", the report notes.

It is against this background that the UNDP, in partnership with the South African Government, is implementing the "Enhancing an Integrated Response to HIV, AIDS and Poverty Programme." The programme aims to contribute towards the reduction of the incidence of HIV, AIDS and poverty and reverse the vicious cycle of their impact on human development by enhancing an integrated and concerted response dealing with the interrelationships between HIV, AIDS and poverty at all levels.

This partnership approach includes various stakeholders such as provincial, district, and local government, national and local NGOs, community-based

organisations, faith-based organisations, and traditional leadership structures. The UNDP works as an implementing agent during the pilot phase, but it is envisaged that local NGOs, CBOs, and Local Municipalities will implement the programme once the approach has been properly tested. In this regard, the UNPD is presently training a number of NGOs in preparation for the 'hand-over' stage.

2 THE "ENHANCING AN INTEGRATED RESPONSE TO HIV, AIDS AND POVERTY PROGRAMME"

2.1 Background to the Programme

The Programme, which is funded by the Government of Denmark, seeks to tackle HIV and AIDS in a multi-disciplinary way. It is being implemented in three of the nine provinces, namely KwaZulu-Natal, Eastern Cape and Limpopo. Table 2 indicates the Programme sites. The programme aims to strengthen capacity at the National, Provincial, District, Local government and the community level.

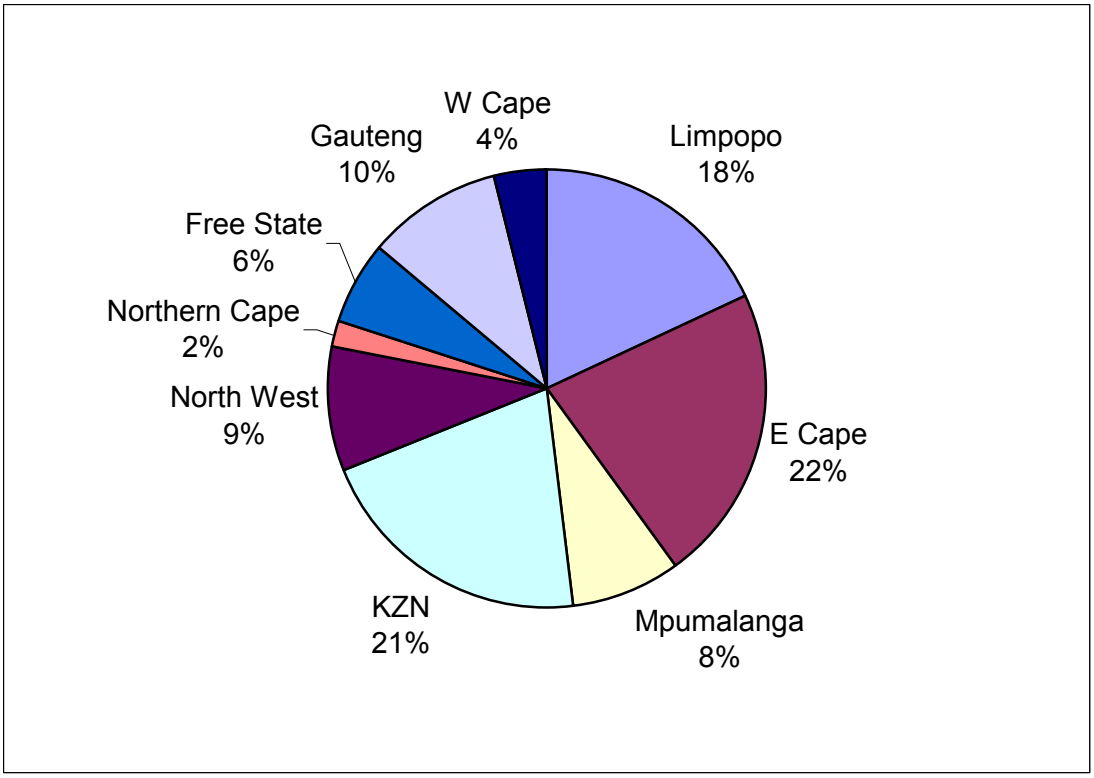
Table 2 Province, District and Local Municipalities where the Programme is being implemented

Province	District Municipality	Local Municipality
KwaZulu-Natal	Sisonke	Ingwe
		Kwa-Sani
	Umgungundlovu	Mpofana
		Mpendle
	Ugu	Hibiscus Coast
		Umdoni
	Umzinyathi	Nquthu
		Endumeni
Eastern Cape	Ukhahlamba	Senqu
		Elundini
	O.R. Tambo	Mbizana
		Nyandeni
	Alfred Nzo	Umzimvubu
		Umzimkhulu
	Chris Hani	Engcobo
		Inkwanca
Limpopo	Vhembe	Musina
		Mutale
	Bohlabela	Bushbuck Ridge
		Maruleng
	Sekhukhune	Groblersdal
		Tubatse
	Waterberg	Bela-Bela
		Mogalakwena

Limpopo, KwaZulu-Natal and the Eastern Cape provinces were identified as having the direst need because of their profile established by Presidential Nodal Points. The three provinces also have high levels of unemployment, large rural populations, and acute development challenges, migrant labour abounds and the levels of literacy are the lowest in South Africa. Figure 1 shows the provincial share of the poverty gap in South Africa. Prioritising the

three provinces, therefore, also recognises the poverty-environment-growth nexus, which shows strong links between unemployment, HIV, AIDS and poverty.

Figure 1 Provincial shares of poverty gap (Whiteside & van Seventer, 1999)



2.2 The goal of the Programme

The Programme is aimed at contributing towards the reduction of the incidence of HIV, AIDS and poverty and reversing the vicious circle of their impact on human development by enhancing an integrated and concerted response dealing with the interrelationships between HIV, AIDS and poverty.

It supports policy dialogue aimed at increasing understanding and awareness of the interactions between HIV, AIDS and poverty, and facilitates the development of concrete strategies and plans to deal with the challenges. Furthermore, the programme aims to strengthen critical capacities of key government departments, civil and private institutions at the community, municipal, and provincial levels and to develop, implement and monitor plans aimed at reducing HIV, AIDS and poverty in a holistic manner.

2.3 Activities of the Programme

The programme utilises several different tools and strategies to deliver the expected results. Specifically, this report focuses on the **Community Capacity Enhancement Programme (CCEP) and the Leadership Development for Results (LDR) programme.**

2.3.1 Community Capacity Enhancement Programme

The Community Capacity Enhancement Programme (CCEP) is aimed at the community level and utilises participatory methodologies such as community conversations and social mobilisation using rights-based and sustainable livelihoods approaches to enhance the capacity of households to mitigate the impact of HIV and AIDS, to provide safe environments and address the fear, stigma and silence that continues to fuel the epidemic, as well as to empower communities to create their own effective response. CCEP utilises participatory methodologies at a community level and its objectives are to:

- Reinforce the capacity within individuals and communities to better understand the nature of the epidemic, to reflect and to initiate changes to respond effectively;
- Explore community perspectives concerning how to live with and respect PLWHA and their involvement in community response to the epidemic;
- Strengthen the capacity of individuals and organisations to facilitate local community responses to HIV and AIDS that integrate care with prevention, keeping in mind other priority concerns such as coping strategies, orphans and vulnerable children, health and development, etc.;
- Sustain local action by increasing the capacity to care, change and find hope within individuals, families and the community;
- Strengthen individual and organisational reflection on their approach and ways of working with communities; and
- Facilitate the transfer of lessons learned and change between individuals, from organisation to organisation and from community to community.

2.3.2 The Leadership Development for Results Programme

The Leadership Development for Results Programme (LDR) is part of UNDP support, response and intervention to generating an unprecedented multi-sectoral response to HIV, AIDS and poverty with commitment to action and results. The first phase of the initiative was launched in 2002, not only to generate leadership for results, but also mobilise the energy and commitment of all partners required to produce results for an integrated response to Poverty, HIV and AIDS.

The programme further enhances and promotes the creation of an enabling environment for other key interventions envisaged. Objectives of the LDR Programme are to:

- Mobilise social and political action across all sectors to promote a deep transformation leading to effective responses;
- Develop leadership capacity at all levels;
- Identify South African specific social, economic, cultural and emotional dimensions fuelling the epidemic;
- Provide space and time for dialogue, learning, creativity and transformation; and

- Align the leaders' complex understanding with focus on solutions and continuously cultivate a commitment for sustained action.

3 A RAPID APPRAISAL OF CCEP and LDR

3.1 Background to the study

Through CCEP and LDR activities, the Programme has begun to make significant 'breakthroughs' in the pilot sites. The UNDP Office in Pretoria required these achievements to be documented and for the challenges and opportunities for improvement to be identified. Specific objectives of the study were to:

- Assess those activities which were carried out;
- Assess the achievements of the CCEP and LDR initiatives and how they are meeting the intended results, as well as responding to the emerging needs;
- Identify constraints, if any, which have affected the implementation of the initiatives and assess corrective actions taken to deal with them;
- Document the actual impact, as well as perceived impact, by the beneficiaries, and the role so far played by relevant partners in the achievement of the development objectives;
- Evaluate the effectiveness of the internal processes and management arrangements in the implementation of the initiatives; and
- Based on the above, draw lessons that may help in future design, implementation and management as well as propose options and make recommendations for future sustainability.

For detailed Terms of Reference, please see Annexure 1.

3.2 The methodology of the research study

The study employed a combination of research techniques: document reviews, group and individual interviews, and observation. These are discussed in detail below. The researcher, accompanied by the provincial programme staff, visited selected pilot sites in all three provinces to conduct interviews with programme stakeholders and beneficiaries.

3.2.1 Study sites/sample

The appraisal was carried out in Musina, Tafelkop, and Mkhuhlu, in Limpopo Province; Sibongile Township and Ixopo in KwaZulu-Natal (interviews were also held with representatives from KZN CBO Coalition and National Progressive Primary Health Care Network); and Ntlabeni, Mbizana, and Mount Fletcher in the Eastern Cape. Table 3 indicates the research activities that were undertaken in each area.

Table 3 Research activities

Province	Village/Township	Research activities
Limpopo	Musina	Interviews with facilitators, home-based care worker, Corridors of Hope, Health and Welfare officials, police, community development services manager.
	Tafelkop	Interviews with facilitators, Municipal councillor, traditional leaders, group of men and PLWHA.
	Mkhuhlu	Facilitators, groups of women, men, youth and PLWHA.
KwaZulu-Natal	Sibongile	Observation of community conversation, facilitators, 2 females, 1 male, 1 religious leader.
	Ixopo	Observation of community conversation, interviews with facilitators, group of youth and a woman.
Eastern Cape	Ntlabeni	Observation of community conversation, interviews with facilitators, traditional leader (1), government official (1).
	Mbizana	Observation of community conversation, interviews with facilitators, teachers (1), municipal officials (2).
	Mount Fletcher	Observation of community conversation, interviews with facilitators, traditional leaders and councillor.

The research study's aim was to determine the perceived impact of the programme on individuals, communities and organisations. Only those who had been exposed to the Programme were contacted, including facilitators, CBO leaders and government officials. Owing to time constraints and because the study aimed to investigate current impacts the researcher was taken to communities that project staff identified as being most likely to have demonstrable progress.

Clearly, it would have been useful to interview members of the community who had decided not to participate in CCEP, and to ascertain why. Likewise, useful information could be gathered from areas where implementation or progress had been slow but, given the time constraints for the appraisal, this was not possible.

3.2.2 Research tools/methods used

a) Documents review

In order to get an in-depth understanding of the background of the Programmes, and to keep track of past and present activities, we reviewed project documents, monthly and quarterly reports as well as minutes of community meetings. Literature on sustainable livelihoods and rights-based approaches, HIV, AIDS and Poverty, HIV, AIDS and culture and community-based HIV and AIDS intervention, was also consulted as a background context to the Programme.

b) Semi-structured interviews

In order to measure the impact of the Programme at the individual and community levels, interviews were conducted with individual females, males, youth, leaders of community-based organisations and government departments. Interviews focused on the perceived impact of the programme on individual respondents, their organisations and the broader community,

and were conducted with people who had been directly exposed to the Programme.

Interview questions focussed on skills gained; knowledge about HIV and AIDS (causes, mode of transmission, prevention, care and treatment); attitudes regarding voluntary counselling and testing; relationship between HIV, AIDS and poverty, the relationship between HIV, AIDS and culture, as well as the extent of respondents' or community commitment to change. These were directed to both facilitators and individual members of the community. For examples of types of questions for all stakeholders that were consulted, please refer to Annexures 2, 3, 4, 5, and 6.[a] Table 4 illustrates the types and the numbers of stakeholders that were interviewed.

Table 4 Research activities and the total number of people interviewed

Respondents	Number
Facilitators – individual interviews	15
Facilitators – focus groups	33 (6 groups)
Members of the community – individual interviews	15
Members of the community – focus groups	120 (8 groups, 15 per group)
Government officials – individual interviews	11
NGO/CBO representatives – individual interviews	11

c) Group interviews

Group interviews constitute a valuable tool of investigation, allowing the researcher to focus upon group norms and dynamics around issues that they wish to investigate. In order to measure the impact of the Programme at the individual and community levels, separate focus group interviews were conducted with groups of women, men and youth.

d) Key informant interviews

In order to corroborate information gathered from interviews with focus groups, individuals and community leaders, interviews were conducted with key informants, such as provincial, district and local government officials, especially in the departments of Health, Welfare and Development Services (at Local Municipality levels).

e) Observations

The researcher attended community conversations as an observer. The experience provided an opportunity to learn about the facilitator's and community's understanding and use of the methodological framework (this will be discussed below). Each community conversation visited was at a different stage of the methodology framework. This allowed the researcher to observe

[a] Whilst questionnaires were developed for the interviews, time constraints meant that they could not be fully utilised. Consequently, selected questions were only used as guidelines for interviews.

execution of each stage, although different communities executed different stages. A total of 5 community conversations were visited.

3.2.3 Research limitations

A limitation of the methodology is that the appraisal was biased in favour of 'best performing' villages (as defined by UNDP personnel). This approach is limited in that it could only document challenges that have been successfully overcome, as opposed to those which may have impeded or even prevented implementation in other sites. Secondly, claimed 'breakthroughs' could not be compared against any data, since no baseline study was conducted prior to the inception of the programme. Thirdly, due to time constraints, the interviews focussed mainly on individual members of the community who attend community conversations regularly. This made it impractical to compare their knowledge with the 'non-regulars'.

Box 1 Methodological framework of CCEP

Relationship building: It is important to build relationship with communities so there will be mutual trust, understanding and respect. How do we build good relationships with people/communities?

Identification of community concerns: Community concerns are general issues that worry or disturb the communities, from these they extract their needs, which are more specific. Communities are capable of identifying their own concerns and needs, the facilitator guides them using strategic questioning.

Exploration of community concerns: Having identified their concern or problem, together with the community you explore the concern.

Decision-making: Communities have the capacity to make their own decisions, based on their identified concerns and based on findings of their exploration, known also as the planning phase

Action (Implementation): Decisions taken are plans that have to be implemented for the desired change to occur. It has to involve as many community members as possible, so they can take ownership and ensure its sustainability

Reflection and Review: Reflection and review rather than evaluation should be participatory, based on the respect of the capacity of communities to identify their own changes, and indicators of change.

4 IMPACT OF CCEP

This appraisal, addresses the impact that the Programme has had on the ground.

4.1 Approach/process

This section reflects on the impact of methodologies/tools used, and the partnership approach that was adopted by the programme.

4.1.1 Methodology/tools

The methodological framework for CCEP uses participatory, change and action-oriented tools. Stages of the methodological framework are listed in Box 1. Key tools that were found to have profound impact in the community are discussed below, and their impacts will be demonstrated – the CCEP Facilitators Manual provides detailed description of the tools.

The CCEP methodological framework is based on the vision and recognition that communities have capacities to care, change and sustain hope in the

midst of the HIV/AIDS epidemic. It further recognises that local responses to the epidemic need to be based in the reality of existing social dynamics/relationships, and the concerns of local communities. This approach recognises community's strengths and leverages on them.

Community mobilisation and active participation to combat the spread of HIV and AIDS, providing care and support, fighting poverty and overcoming cultural practices that facilitate the oppression of one group by another on the basis of their gender, economic or health status has been the prime motive and drive.

Central to the CCEP methodology is the notion of Community Conversations. Community Conversations are facilitated sessions where people in the village or area can meet, engage in open discussions about issues in their community, identify and explore concerns and myths, catalogue resources available within the community and agree on areas where they need external support. Tools such as the transect walk, mapping and story telling are used during the identification and exploration as well as taking stock of available resources. Box 2 discusses some of the approaches, methods and tools used.

In Community Conversations, the priorities for external support, determined by the community, are incorporated into simplified strategic plans for supporting these needs. As could be deduced from the Facilitators Manual, the material used is inexpensive and environmentally friendly. For example, participants use grass, stones, and flip charts.

These methodologies have profoundly impacted on the lives of facilitators, individual members of the community, the broader community and the stakeholders, such as community and traditional leaders, government officials and municipal councillors. This will be illustrated in 4.2 below.

The strength of the methodology lies in its success to bring people from all walks of life - youth, men, women, disabled persons or PLWHA - together to discuss common livelihoods threats and challenges, and to jointly seek solutions. However, attendance records of conversations' indicate that fewer men attend these gatherings and men were said to lack interest in attending. Facilitators suspect that men identify the activity with home-based care that is regarded as women's work. Feminists see such negative perceptions as potentially being perpetuated by the domestic division of labour, unequal power relationships and caring activities within families and households (Gavron, 1966; Giddens, 2001).

- Box 2 Approaches, methods and tools of CCEP

- **Community conversations** are facilitated sessions where people in the village or area can meet, engage in open discussions about issues in their community, identify and explore concerns and myths, catalogue resources available within the community and agree on areas where they need external support.
- **The Transect Walk** is a tool that allows community members to explore and thereby rediscover familiar surroundings. This activity allows people to focus attention on community realities that are usually overlooked or taken for granted, leading them on a process of self-reflection and collective exploration. Participants are requested to specifically look out for community resources, strengths, weaknesses, and for a possible entry point for HIV and AIDS.
- **The Likert model** is used to explain the stages of organisational development and the kind of leadership predominant in each stage. These stages are not static: individuals, organisations and communities move fluidly from one stage to the other, having a little bit of the characteristic of each stage, including the strengths and weaknesses. Moving higher up on the levels of the model does not necessarily equal improvement for all community organisations but that instead each community can identify the stage best suited for its needs in a given situation. The Likert model can be a useful tool in relationship building, problem identification, and problem exploration and in reflection and review.
- **Historical timeline**. Societies and groups live inspired by major events and challenges, by tragedies and crises that have been overcome, and by movement and difficult times in their communal lives. Social change also has a profound affect. People mobilise themselves into communities in order to face difficult ordeals, the perceptiveness of a leader, large harvests, or droughts, or even the management of a past epidemic. From these experience lessons are learned, which are often used as points of reference.
- **Ken Wilber's four quadrants** represent an analytical tool, which can be used to explore the relationship between intentions and values on one hand, and actions on the other hand, at both individual and collective level and the transformation that occurs within these. Furthermore, a profound understanding is possible through identifying, analysing and reviewing the causes and origins of actions. In addition, the responsibilities can be situated in the quadrant, according to their nature, and thus the fields that are less filled can be pointed out and a reflection on their reasons is possible.
- **Social mapping** can be used to visualise community strengths and concerns and other observations made. The visual representation of people's familiar surroundings allows them, including those that are illiterate, to increase their awareness about their current activities in relation to it as well as their understanding of the current reality.
- **Story telling** helps people reflect on the social dynamic of their community; on their values, attitudes and behaviour. To help people talk about these topics, based on their experiences and emotions using the personal pronouns 'I' and 'my' rather then 'they', and to think about and discuss why change is needed. Stories are about people and what they do. They are ways of understanding social life, its dynamics, its influences and its impact.

This limits opportunities for improving gender relationships such as those that make it difficult for women to negotiate for safer sex with their male partners. Effort should be made to encourage men to participate in these conversations, and perhaps increase their role by recruiting more male facilitators. Presently, the majority of facilitators are female and most of the male ones are youths.

Participation of PLWHA in community conversations helped to enhance the level of awareness of their (PLWHA) plight. For example, in Musina, people interviewed spoke sympathetically about a woman who disclosed her status in one of the community conversations, and pleaded for the community's empathy for people who are in her condition. One woman said:

> "…. Thandeka (not her real name) touched many of us when she revealed her status in the presence of everybody who attended the community conversation that day. She told us how badly people had treated her in the past and how she got help, and strength to remain this strong and healthy (she has been living with the virus for more than 8 years). She encouraged everybody to check their status so they can get help before it is too late…. Many people were encouraged. She soon got employed by the regional office of the South African Police Services to promote awareness campaigns among members of the Police Service…"

Judging by the above statement, the noticeable presence of a PLWHA in community conversations has the potential of raising the level of community's awareness of the presence of the disease and the needs of affected and infected people.

4.1.2 Partnership approach as adopted by the Programme

The debates on sustainable livelihood approaches emphasise the principle of a partnership approach to interventions as being key to their sustainability. Partnerships should be established with all key stakeholders: individuals, community, local, provincial, and national governments and the international community where possible – since HIV and AIDS represents a global challenge. In her book 'Letting them die: why HIV and AIDS prevention programmes fail', Campbell (2003) notes that the success of partnerships depends on first, the strength and quality of partnerships formed by project stakeholder representatives. Secondly, the extent to which potential grassroots beneficiaries regard the project as relevant to their needs and interests is fundamental.

For CCEP to maximise its impact in combating the spread of HIV and AIDS, partnerships should be formed with both the powerful partners and the less powerful ones. CCEP has made a moderate impact in this regard.

For instance, at the national level, the government of South Africa has entered into an agreement with the UNDP to implement this Programme. At the provincial level, the programme is housed within the Department of Health and/or Welfare offices. At the District level, CCEP facilitators interact with local staff of the municipal community services, municipal managers, mayors and traditional leadership.

In addition, staff from the above-mentioned Departments, including local government officials, attend community conversations to render assistance, such as expert advice on matters that relate to their different spheres of work. At the local government level, facilitators are allowed to use facilities such as community halls, faxes, telephones and photocopiers. Some municipalities

assist with transport during community conversation activities and provide refreshments.

Furthermore, the Programme has trained members of the community as facilitators. These community-based facilitators are the drivers of the Programme at the community level, with assistance of national and provincial staff of the UNDP. The programme has had an impressive impact on both community facilitators and members of the community (see below). Partnerships have been formed with community-based organisations such as home-based carers and faith-based organisations. UNDP proposes to eventually hand-over the implementation role of the Programme to local NGOs, CBOs and Municipalities.

4.2 Impact of the Programme

This section reflects on the impact of the programme on the facilitators, individual members of the community (who participate regularly in community conversations), and the impact of the programme at the broader community level. Reference will also be made to the impact that the programme has had on other stakeholders in government and non-government organisations.

4.2.1 Impact of the CCEP on the facilitators

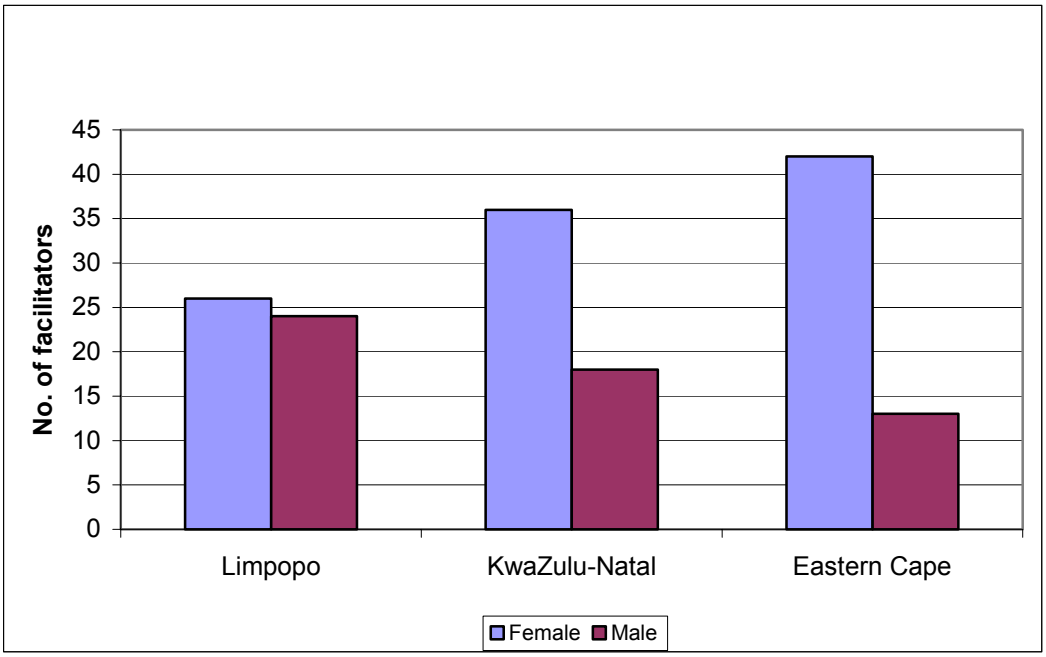
The profile of facilitators indicates that many of them were already active in the community in different capacities, including work on HIV and AIDS. For example, some have been involved in activities that are aimed at raising HIV and AIDS awareness among youth, such as the Love Life campaign, others in home-based care initiatives, Directly Observed Treatment Short-course for TB patients, and with some serving as lay-counsellors at local VCT centres. Annex 8 provides a brief profile of facilitators from Limpopo Province, to indicate their line of interest, training and background.

However, discussions with the facilitators reveal that through participation in CCEP, they have gained new skills, including change in their own behaviour. Furthermore, their participation in the Programme has enhanced their understanding of the relationship between HIV, AIDS, poverty and culture.

a) Personal gains and behavioural change

The CCEP programme held training workshops for facilitators. Approximately, 161 facilitators are actively involving in driving the process on the ground in KwaZulu-Natal , Eastern Cape and Limpopo provinces. Figure 2 indicates the number of facilitators per province and the gender ratio.

Figure 2 Number of facilitators per province



Through intensive training, facilitators acquired new skills such as facilitation, public speaking, self-confidence and planning for community development. One male facilitator remarked:

> "Before I participated in CCEP I was not confident enough to address masses of people and facilitate discussions. The CCEP training provided me valuable tips for self-confidence, public speaking and facilitation. Facilitation of group discussions created an opportunity for me to apply what I had learnt in the training sessions. I also learned that as a facilitator, one should not enforce one's point of view on others, but rather listen first. This taught me that people have knowledge, even though they may not have gone to school or have more money".

In the Eastern Cape, a 21 years old facilitator stated:

> "I never imagined that I could stand in front of the masses of people and facilitate discussions. I think the training made it easy for some of us, because as a facilitator you are not 'Mrs Know It All', rather you are encouraged to allow people to express themselves the way they may be comfortable. Through my involvement in this programme as a facilitator, I gained valuable facilitation skills and the courage. I also learned how take minutes and prepare a plan of action."

Moreover, many facilitators said CCEP has also reinforced basic facts about HIV and AIDS, especially the implication of living with HIV and AIDS, and thus the need for change of attitude towards the illness in general and PLWHA in particular. A woman facilitator said:

> "CCEP training has really enlightened me about HIV and AIDS. To me HIV and AIDS were one and the same thing. If one has tested HIV positive, to me he/she had AIDS, and it meant one thing: a slow and painful death. But, I now

> understand the distinction between HIV and AIDS. That is, being HIV positive does not necessarily mean that one has AIDS. By adopting healthy lifestyle habits, such as eating balanced diet, avoiding certain drinks and practicing safer sex, one can prolong one's life and lead a productive life. To me being HIV and AIDS positive meant one thing: death. CCEP training changed my view of the illness".

Such comments were generally common among adult facilitators. This could be an indication of how current conventional awareness-raising campaigns (that take a form of a once-off event or radio programme that have limited interaction) have perhaps not reached everybody, especially women living in rural parts of the country. Judging by the above, CCEP initiatives appear to be making a breakthrough of reaching people in remote areas with little access to conventional means of raising awareness on health issues such as HIV, AIDS and poverty.

Some facilitators' reported change in attitudes towards voluntary counselling and testing for HIV and AIDS, and disclosure. A female facilitator in Eastern Cape stated:

> "Before I became a CCEP facilitator, I was very scared of going for an AIDS test. I used to think: What would my husband say? What would my family and relatives say? What will my neighbours say? What would happen to my children when I die? I was not aware of the importance of testing for AIDS. But through CCEP training I gained valuable information regarding the importance of undergoing an AIDS test, and got the courage to do it…I went for a test and encouraged my husband too. He also went for it. This has brought us closer than ever before. I also wanted to test so I can set an example for the community".

There was an indication of a change of attitude towards PLWHA. Many of them had friends, relatives or neighbours who were living with HIV and AIDS, and mentioned that they have good relations with them and provide assistance where necessary. Being the 'drivers' of the Programme at the community level, facilitators often come into contact with PLWHA, thus deepening their understanding of the illness and the challenges that PLWHA endure constantly. Discussions with them revealed changes in their attitude.

For example, in Limpopo, community facilitators have helped to facilitate the establishment of a support group for PLWHA. The support group has more than 20 members who meet regularly, and some of the facilitators are members of the group. Some members of the support group (that consists of some CCEP community facilitators) visit local clinics and schools to raise awareness about the disease, encourage members of the community to take HIV and AIDS tests, to be more open about their status and accept PLWHA in order to reverse the stigma attached to HIV and AIDS.

It is therefore, not surprising that most facilitators mentioned that they would like to receive training in counselling. One facilitator said:

> "We really need counselling skills. Many people come to us looking for help, and most of the time we are not in a best position to help them, especially with the psychological problems, especially after they have been to VCT centres".

Another facilitator added:

> "When we do an exercise like 'counting-your-losses', people get deeply touched to a point where they need counselling…. With role-playing, some people take it so seriously that they end-up needing counselling. Very few us can provide this service and our local clinics are understaffed".

It is therefore highly recommendable that the Programme should introduce counselling training for the facilitators and interested members of the broader community, especially home-based caregivers.

Despite some problems related to payment dates and 'Contract' procedures, many facilitators spoke appreciatively about the allowances they get from the UNDP. Although much of the money goes to pay for travelling and telephone expenses, with some saying nearly half of the stipend is spent on the above-mentioned expenses, many are now better able to feed members of their households, which is often a challenge in these rural parts of South Africa where unemployment and related problems of poverty are endemic.

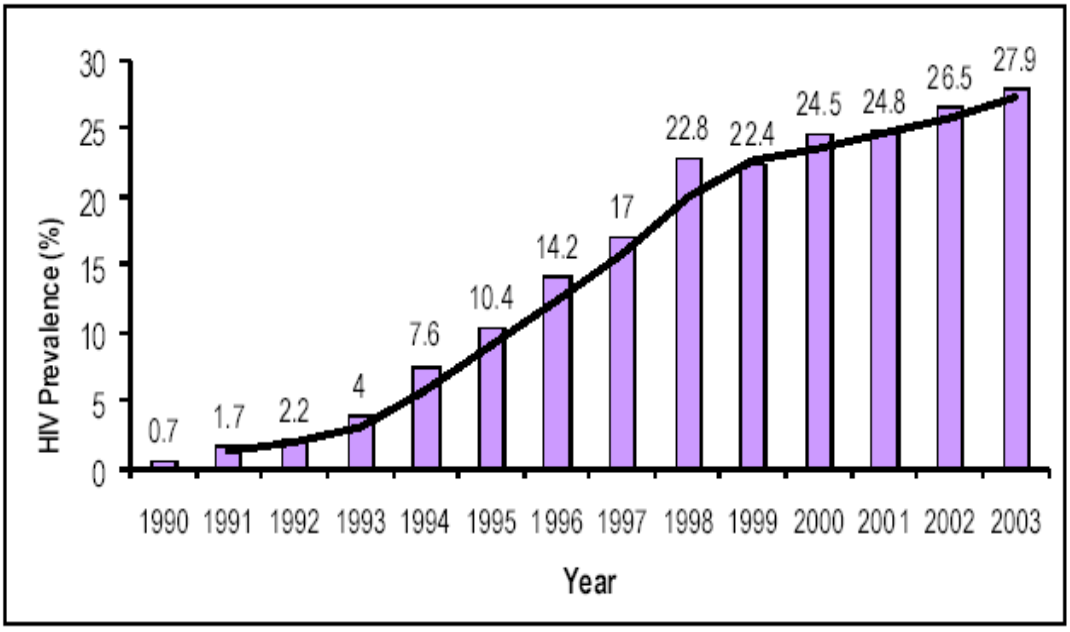
b) Change of sexual behaviour and commitment to change

Generally, research studies indicate that although many people are now aware of the dangers of contracting HIV and AIDS, and are familiar with methods of transmission as well as possible prevention measures, this does not necessarily translate into change of behaviour, particularly sexual behaviour. For example, according to the South African Department of Health report on the 'National HIV and Syphilis Antenatal sero-prevalence survey in South Africa', HIV prevalence is still rising. Figure 3 overleaf indicates an increase from 24.8% in 2000 to 27.9 % by 2003 (Department of Health, 2004).

All community conversation facilitators who were interviewed stated that their sexual behaviours have changed and that this was in order to lead by example. For example, a young male facilitator in KwaZulu-Natal mentioned:

> "Although I practiced safer sex by using condoms every time I have sex, I used to have many partners. Through participation in CCEP, I realised that I lived a risky life, nevertheless. I have since reduced the number of my partners to one. I confessed this to my current partner and the two of us went for VCT. We are now clear about our status. I also felt that I needed to lead by example. I command a lot of respect from the community and young people. It would do a lot damage to my reputation to be found to have more than one partner".

Figure 3 Prevalence of HIV among antenatal care attendees in South Africa, 1990- 2003 (Source: Dept of Health, 2004)



Some, mostly female facilitators, have opted to walk out of relationships 'until they find understanding partners'. One young woman said:

> "I know my boyfriend is not a faithful person, yet he refuses to use condoms when we have sex. I tried hard enough without success to convince him that we should use condoms, but he is still not willing to do so. I had no choice, but to break up with him. I still love him though".

Another young woman added:

> "When I came back from CCEP training in Mbizana in the Eastern Cape I shared what I learned with my partner and urged him that we should practice safe sex, visit VCT centres for more information or even, checking our status, he was not impressed at all, and was totally against the idea of using condoms. We eventually broke up…."

Such attitudes towards sexual relationships were very common among unmarried facilitators – with many "choosing to be alone rather than risk their lives by engaging in unsafe sex". For example, 3 out 5 unmarried female facilitators said that their relationships with their boyfriends have ended as a result of their stance in relation to safe sex.

As highlighted by the young man from KwaZulu-Natal above, facilitators felt that they needed to set good examples to members of the community. In addition, they mentioned that this is the type of message that was emphasised during the training.

Another conspicuous impact of the programme on facilitators was the level of commitment to making a difference in the community and the vulnerable

members of the community. Many spoke about their CCEP work with passion and eagerness. A middle-aged female facilitator in Eastern Cape said:

> "I have always had the passion for getting involved in community development and empowerment initiatives, and will continue to do for as long as I can…. What matters to me is to see change in communities' health, livelihoods and living conditions, especially, the poor, ill, elderly and orphaned children" (the same woman is part of a group of women who are running a 'Drop-in Centre' in Sibongile Township, Dundee in KwaZulu-Natal).

Furthermore, in Limpopo, some facilitators, who are members of the local PLWHA organisation, belong to a community group that has vegetable gardens in the area. A member of PLWHA organisation said;

> "Members of the community, including PLWHA are constantly encouraged to eat healthily and start vegetable gardens in order to reduce costs related to maintaining a healthy diet. I decided to join this group in order to encourage others, and also because I do not have a permanent job and I am therefore unable to afford to buy food for myself and my children".

c) Awareness of the relationship between HIV, AIDS and poverty

Literature indicates that the relationship between HIV, AIDS and poverty is symmetrical. Just as HIV and AIDS exacerbate poverty and inequality, poverty and inequality facilitate the transmission of HIV. For example, the absolute level of poverty is often correlated with poor access to health facilities and HIV prevention programmes. In situations where the disparity between 'rich' and 'poor' is particularly great, there are also data to suggest that the poor and socially most disadvantaged are more vulnerable to HIV infection (see for example, Allen & Thomas, 2000; Barnnet & Whiteside, 2002; Cohen, 2002; Baylies, 2000) and more rapid progress of AIDS among infected person.

Two sets of issues provide a solid link between HIV, AIDS and poverty: (a) the combined effect of poverty and inequality creates a vulnerable environment through which HIV transmission is facilitated and (b) HIV infection and AIDS causes or exacerbates poverty. It is crucial that facilitators are made aware of this phenomenon and that they are able to raise the community's awareness, and are motivated enough to encourage communities to mobilise and take collective actions to meet the challenges.

Facilitators spoke convincingly about the relationship between HIV, AIDS and poverty. A woman facilitator aged 20-25 said:

> "There is a definite link between HIV, AIDS and poverty. I am a living proof of this sad case. I did not go out with the father of my child because I loved or liked him. It was for what he could give me, which is money to clothe myself, and buy food for my family, since both my parents are not working and we have no source of income. My dependence on him made it difficult for me to negotiate the use of condoms during sexual intercourse. If any one of us had the HIV virus, we would have infected each other. But now I am aware that I could have handled the situation differently – insisted on the use of condoms

> or walk out of the relationship. It is sad that I already have a child with him, and having a fatherless child is almost exacerbating the hardships. However, my parents are very supportive, and always encourage me to look at the brighter side of life".

Community facilitators in all the provinces encourage communities to start their own income-generating projects or to participate in those that already exist. This is done in order to encourage communities to create job opportunities and secure 'improved' livelihoods. Communities are also encouraged to participate in or start their own vegetable gardens in order to fight malnutrition and ensure that the sick do not take their treatment on empty stomachs.

The youth are encouraged to participate in income-generating projects and vegetable gardens in order to give them something constructive to do and to discourage them from risky behaviours such as prostitution and criminal behaviour. One female facilitator said:

> "You see we encourage youth of this township to be involved in income-generating projects so they can make money for themselves. It achieves no purpose to say to young people should refrain from illegal activities and prostitution without providing them with an alternative. Many of the young girls become prostitutes in order to earn money. This puts their lives in a serious danger of contracting HIV. Young men, too, get themselves involved in criminal activities in order to earn money. We have seen many of them coming out of prisons seriously ill with HIV and AIDS, due to risky sexual practices in our prisons. Our prisons are death-traps".

A consequence of economic crisis, for women in particular, is frequently multiple partner strategies or the practice of "transactional sex". Often, sexual activity is not pursued purely on pleasure-seeking grounds but is a means of gaining access to as many resources as possible, but this may mean risking one's life. This vulnerability manifests itself nowhere more strongly than in the usage and refusal of condoms. It is therefore crucial that in addition to raising awareness about this danger, that women need to be empowered, socially and economically, in order to help avoid HIV infection.

4.2.2 Impact of the CCEP on individuals

Interviews and discussions with members of the community focussed on their basic knowledge of HIV, AIDS and its relationship with poverty and culture, levels of awareness of services and their rights, and their commitment to change.

a) Empowerment through skills improvement

Members of the community that were interviewed said that through their participation in community conversations, they gained valuable skills such as public speaking, facilitation, minutes recording and development of business plans.

- In Ixopo, facilitators, in collaboration with the local Progressive Primary Health Care organisation, organised computer and life skills training for the community. The training costs were covered by Umsobhomvu Youth Development organisation.

- The community of Sibongile Township in KwaZulu-Natal worked together to develop business plans for their income-generating projects.

It would undoubtedly be a good move to extend the training in CCEP methodologies and framework to the broader community. A lot of these tools are applicable in day-to-day lives. It would be an empowering gesture to train as many willing people as possible. This is an achievable objective, given the fact that a cadre of 'Trainers of Facilitators' has been trained. It is therefore likely to come at the lowest cost, as it will not be necessary to engage the services of external facilitators.

b) Basic understanding of HIV and AIDS

Eight out of 15 individual members of the community that were interviewed appeared to have mastered a basic understanding of HIV and AIDS. A member of the community said:

> "HIV is a virus that attacks the immune system of the person in order to reduce the ability of the body to fight diseases, thus leaving the body vulnerable to any other disease, making it difficult to cure, and ending eventually with the death of the person who has the virus".

Regarding modes of transmission, a traditional healer said:

> "We have always known (unprotected) sexual intercourse as primarily responsible for the transmission of HIV. However, we are now aware that certain practices that are related to traditional healing such as scarification and surgery involving contact with fresh blood have the potential of exposing both traditional healers and patients to infection with HIV."

Another man, who previously worked in the mines, said:

> "It is sickening to see the type of risk that we put our lives in, and those of our family members, when we were in the mines. We ignorantly used to handle blood with bare hands during accidents, especially underground. Even though the employers had provided latex gloves, we used to help colleagues with bare hands, either because there was no time to put-on gloves or because of ignorance. I want to know how many mine workers still do this".

c) Voluntary counselling and testing for HIV and AIDS, and disclosure

Testing and disclosure are key factors in prevention and treatment for HIV and AIDS in terms of health care and prevention but can have negative consequences for individuals in a highly stigmatising environment. Existing South African research on testing and disclosure suggests that people only test or disclose if they perceive stigma to be at acceptable levels or that going

through the process of testing and disclosure may reduce people's perceptions of community stigma (Etiebet et al 2004, Kalichman & Simbayi 2003).

Locally, however, levels of disclosure are very low. A survey of 726 HIV positive patients at two sites in KwaZulu-Natal found that 65% and 92%, respectively, had not told anyone of their status (Pawinski & Laloo 2001). Other South African studies have also found relatively low rates of disclosure.

However, it appears that community conversations are making a breakthrough in this area. Interviews with local health officials in all three provinces (Musina, Tafelkop, Mkhuhlu, Sibongile Township, and Ntlabeni) revealed that there is an increased awareness of VCT centres among the populace.

All CCEP participants that were interviewed said that it is very important for people to go for voluntary counselling and testing. Reasons cited for this argument were that:

- If a person knows his or her status early enough, it is possible to change lifestyle to avoid infecting others and/or re-infecting him/herself with the virus, especially if they are HIV positive;
- If positive, one would be able to ask for help earlier and gain access to ARVs, multi-vitamins and counselling through PLWHA support-groups; and
- If one is positive, one can prepare for one's death and reduce the emotional and psychological strains on family members and relatives.

A man from Sibongile Township in Dundee, took the researchers through the VCT process, and gave a short lecture on when one can start treatment. Highlighting the fact that it is dangerous to take any medication without the supervision of a Medical practitioner, and the role of the CD4 count in determining the timing and type of treatment.

More than half the participants interviewed individually (9 out of 15 members of the community) said they would consider having an HIV test, 4 of these 9 said they had already had an HIV test. They said they did so after they had been to community conversations and learned about the importance of knowing one's status.

In some areas, officials said there has been a noticeable increase in the number of people visiting the Centres, either to find out about the services offered or to undergo HIV tests. A Health official in Musina mentioned:

> "It amazed me to see the growing number of visitors to our VCT centre. We truly felt happy to see so many people coming forward. It would appear people realised that undergoing AIDS testing has more positives than negatives. People were taught that it is helpful for one to find out about their status, because one could get immune boosting medication from the clinic or

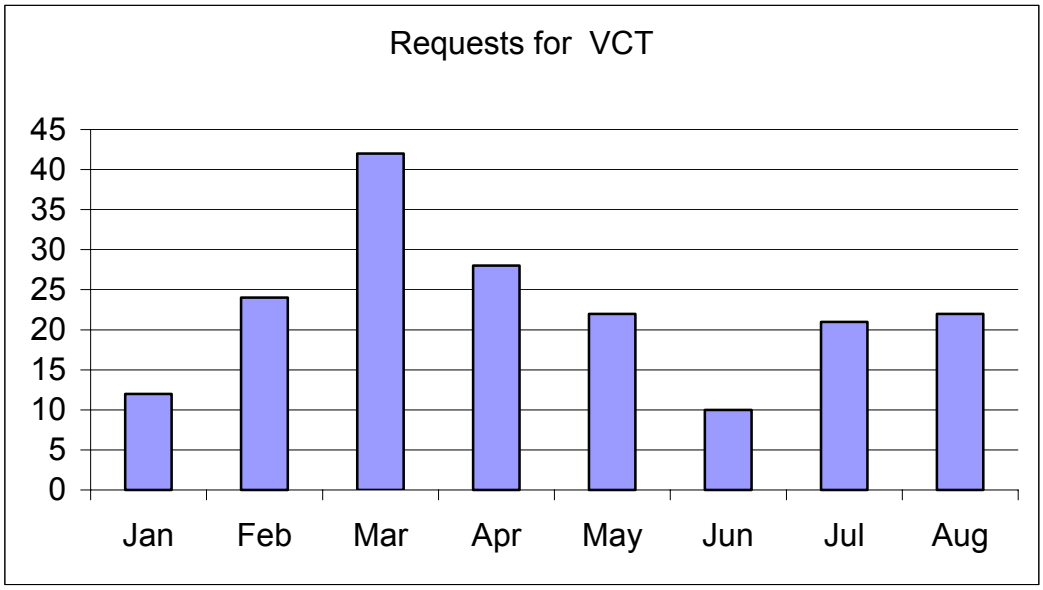
ARV's for those, whose CD4 count is below 400. They also realised that people who are at this stage are eligible for the State's disability grant".

Another health official in Tafelkop in Limpopo added that:

"Through awareness campaigns we conducted during community conversations, the number of visitors to our VCT as increased. The campaign is truly bearing results".

Health officials are invited to community conversations to provide an expert opinion on HIV and AIDS and other health related matters. All officials spoke highly about this approach and said they have seen a lot of change of attitudes in the people that they are serving.

Figure 4 VCT requests January to August 2004 (Tafelkop)



The programme started in Tafelkop in October 2003 and the data shown in Figure 4 shows that there was an increase in requests for VCT a few months later. However, without baseline data, it not possible to confirm whether this was directly related to the programme. The subsequent fall off in attendance may be to a higher level than before the intervention but again this was not possible to assess from the data provided.

d) Awareness of services and rights, and ability to access them

It has been argued above that one of the strengths of the Programme has been its partnership approach. The Programme works with and through government and non-government stakeholders. Involvement of government officials has provided an opportunity for them to learn first-hand the challenges facing the communities that they serve. But is has also raised the communities' awareness of the type of services offered and by whom. An elderly woman in Musina in Limpopo stated:

> "What I like most about these community conversations is the fact that nurses from the local clinic, the police, officials from the Department of Welfare, Health and Home Affairs come to these meetings to address us and tell us more about their work and what to expect from them and the challenges that face them, like shortage of personnel, funds or facilities. These initiatives enabled people to understand their government better and its shortcomings. I have seen many of our youth volunteering their time in police stations and offices of the Department of Health and Welfare. It is really good".

Another woman in the Eastern Cape said:

> "I am really thankful to our local facilitators. Through community conversation I gained more knowledge about services offered in our area. I also know where to go for what. I have also gained confidence to speak to the police, nurses and welfare officials. I used to be so scared to approach them when I had problems. But since they have been attending community conversations, they have been speaking to us in a friendly and humble manner. That truly gave me courage to approach them. I live with my late sister's two children, and they both do not have birth certificates. I was able to talk to welfare department officials who helped me to fill-out appropriate forms. Both children received their birth certificates. Through their assistance, I applied for foster care grants…."

As a result of the complaints raised at a community conversation gathering, the local clinic in Mkhuhlu put-up a suggestions box in the premises and members of the community were asked to make submissions. Complaints ranged from the poor quality of service to bad treatment by nurses. Feedback was given in the community conversations sessions that followed.

4.2.3 Impact of the CCEP at the community level

Many commentators have observed that early in the HIV epidemic, it was often assumed that sexual behaviour was shaped by conscious decision of rational individuals. The assumption was that if only one could reach HIV-vulnerable people and tell them about the dangers of HIV and how to prevent it, they would quickly take care to safeguard their behaviour. Many felt that it was as easy as A, B, C (Abstain, Be faithful or Condomise). However, there is much evidence, based on research, to suggest that despite increased knowledge, the HIV and AIDS prevalence rate continues to climb.

Moreover, it has become common-knowledge that the forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual information about health risks, and the availability of medical services. Social context (as well as political and economic contexts) plays a key role in enabling and supporting health-enhancing behaviour change, particularly in marginalized communities, in less affluent settings, where people often have even less choice about their behaviour than their more privileged counterparts. CCEP, has sought to address this through community conversations.

a) Misconceptions about HIV and AIDS

Many communities are still in denial about the causes of AIDS and misconceptions abound. Discussions with members of the community and facilitators revealed the following misconceptions:

- Having sex with a virgin will cure you of AIDS;
- Having sex with a widow/widower gives you "*Magoma*" (meaning venereal disease, which is seen as synonymous with AIDS);
- You can be cured by following traditional practices such as *ukucima* (using an enema);
- *Oomarhosha* (commercial sex workers) sleeping with immigrants are the ones who brought HIV;
- Condoms spread AIDS (because they have some fluids within them); and
- Foreigners are responsible for the spread of AIDS in South Africa, because they sleep with monkeys.

Box 3 Cultural practices that communities think are likely to help curb the spread of AIDS.

- **Ukuphehlwa:** This is a surgical process, which aims to remove certain 'impurities' in the clitoris to delay sexual desires. Now that this is no longer practiced, older participants voiced the concern that children become sexually active at an earlier age.
- **Ukuhlolwa:** This is virginity testing. Zulu people take pride in this practice as it helps to reduce pre-marital sex, especially penetrative sex.
- **Ukusoma:** This refers to sex without vaginal penetration. It was intended to protect girls from losing their virginity before marriage. Maintaining virginity is a very important custom for Zulus.
- **"Koma":** Young men are prepared for manhood.
- **"Komba':** This is a ceremony to check the virginity of the newly-wed on the first night with her husband by putting a white sheet on their bedding.

Facilitators stated that with the assistance of local nurses who attend community conversations, communities are allowed to discuss the validity of these belief systems.

b) Review of cultural practices that fuel or curb HIV, AIDS and poverty

Box 3 lists some traditional practices identified in community conversations in many communities in KwaZulu-Natal and the Eastern Cape as ways, which if reintroduced and observed, could contribute to a reduction in the spread of HIV. Conversely, Box 4 lists some traditional practices that may exacerbate the epidemic.

Notably, there is a remarkable desire to revive and strengthen the custom of virginity testing. A leader of a local community-based organisation who spoke favourably about virginity testing said:

> "…. A culture and youth development organisation in Pietermaritzburg revives cultural dances, games, and music events across the province on a regular

basis. The organisation conducts virginity testing as well. We have taken it upon ourselves to revive our cultural practices that to a large extent upheld moral values in our communities. Church organisations discouraged a lot of good cultural practices without providing an alternative, especially when it comes to issues of sex and sexuality. In our culture we provide sex education to young women and men at the stages of their development. For example we teach young girls how to clean their bodies at puberty and also how to behave in a marriage relationship when they reach adulthood. Sadly, the church is not able to cater for these teachings".

Although many communities regarded virginity testing as a desirable practice, there are concerns that it is both a violation of human rights (Amnesty International, 2000) and may have specific implications in the context of 'blaming' women for the propagation of the epidemic (Leclerc-Madala, 2001:533). Neverthelss, many communities in KwaZulu-Natal, Limpopo and the Eastern Cape are reviving the ancient tradition of abstinence, hoping that it will contribute to curbing the spread of HIV/AIDS (refer to Box 5 for examples).

Box 4 Cultural practices that communities think are likely to exacerbate the spread of HIV and AIDS

- **"Seantlo":** A practice in which a widower takes his wife's sister to perpetuate his family name.
- **"Tlhatsoa-li-rope":** This is the practice in which an infertile man's wife is encouraged secretly to sleep with her husband's brother to bear children for the family.
- **"Sethepu"** (polygamy). This is the practice where usually a man marries more than one woman. The absence of practicing safer sex may put lives of partners at risk.

While some young women are uncomfortable with the procedure of virginity testing, there appeared to be a general acceptance of the practice among respondents. Reasons included the desire to uphold culture and the status associated with being a virgin. Young women argued that they gain self-confidence and respect from the community if they remain virgins until they get married. However, some felt uncomfortable with the procedure. One woman said:

"The uncomfortable part about this practice is when someone you are not familiar with opens your legs to conduct the examination. You feel like your privacy has been invaded. It would feel a lot better if only my mother or close relatives were the ones to examine my status".

c) Traditional healing practices

Research studies note that there is considerable evidence that scarification involving shared instruments is probably the commonest practice among African societies who value specific forms of bodily mutilations as a mark of membership to a particular cultural group (Helman, 2000; Marck, 1997). Moreover, it is widely recognised that scarification could lead to considerable bleeding, and that group scarification has implications for HIV transmission especially when a single instrument is used (Orubuloye, Caldwell & Caldwell, 1995).

All the communities that were visited and interviewed commented about the traditional healing practices and initiation rites. They noted that traditional

healers' surgery and scarification procedures have the potential of exposing both patients and traditional healers/surgeons to the risk of infection with HIV. For example, they argued that if one instrument is used to perform scarification or surgery to all patients without proper sterilisation, the virus could easily be transmitted from one patient to the other. They also noted that if traditional healers and surgeons handle patients with bare hands, especially when they have wounds, they face the risk of being infected with the virus.

Box 5 Community initatives to revive virginity testing

- In Sibongile Township, the community has taken a decision to revive virginity testing as a way of discouraging pre-marital sex between young women and young men. Elderly women who would be trained to conduct such tests have been identified and their trainer has been identified. The community, together with the provincial programme team are mobilising resources for transporting the identified trainer into the area.

- In Ixopo, local women have strengthened the abstinence campaigns among young women, both to preserve culture and to curb the spread of HIV and AIDS among this vulnerable section of the community, through virginity testing.

- In Ntlabeni and Bizana villages of Transkei, communities have revived virginity testing as a way of discouraging youth from engaging in sexual activities outside marriage. These events are usually attended by traditional, political and community leaders as well as political office-bearers. For example it is reported that Mrs Winnie Madikizela-Mandela and the local Chief attended a recently held-function where they handed out certificates.

- In Gomane village, in Mpendle in KwaZulu-Natal, the community has also established a team of elderly women to conduct virginity testing and encourage young women to protect themselves from men who demand sex. The fear of being found to have lost one's virginity is said to keep girls from having sex. Through Community Conversations, villagers are now openly calling for these practices to be revisited because they regard their abolition as fuelling the spread of HIV and AIDS.

- In Stepmore, the community has established a group of elderly women to perform Virginity Testing, which they see as a way to teach young women 'responsible sexual behaviour' by delaying the first sexual encounter until marriage.

One woman in Musina said:

> "Community conversations have raised awareness among traditional healers of the importance of sterilising surgery instruments when they are re-used. This protects thousands of people who consult them from contracting HIV, including our boys who attend initiation rites".

The communities also stated that certain initiation rites, especially male circumcision, expose young males to the risk of infection with HIV. However, communities are aware of the South African government's campaigns amongst traditional healers/surgeons and community leaders that conduct circumcision ceremonies.

Traditional healers/surgeons, as well community leaders that are responsible for circumcision ceremonies, confirmed this point. They all said they either

use one instrument per patient or sterilise them before they are used again. A traditional leader that has been tasked with the responsibility of overseeing circumcision schools in Ntlabeni village, in the Eastern Cape, stated that their policy is that young men should undergo medical examination, including HIV testing before they are admitted to any circumcision schools.

d) Dealing with the stigma attached to HIV and AIDS

The HIV and AIDS epidemic in black townships and villages is likely to stimulate suspicions of sorcery, fear of witchcraft, and a general sense of spiritual insecurity, as more and more people die at an early age of painful, debilitating, and incurable infections that resonate with indigenous categories of interpretation broadly subsumed under the rubric "witchcraft"' (Ashforth 2001:18, Stadler 2003).

Interviews with PLWHA during the study revealed shocking humiliation of PLWHA. Others complained that people call them with derogatory names such as "Z3" (a fast BMW), "10111" (the police emergency response number) "amagama-amathatho" (meaning three words). Some complained that their families, relatives and neighbours avoid them, and their children are prevented from playing with their neighbours' children for fear that they are infected and would therefore infect them.

Box 6 Community actions to address a health-promoting environment

- In Musina, Limpopo, communities identified '*shebeens*' (unlicensed bars) that were operating "all–day–and night", allegedly making noise and attracting school-going children, as contributing to crime in the community and the tendency of many youth to drop out of school before they complete their school leaving certificates. With the help of the police, such '*shebeens*' were closed down. Moreover, the community noted that the truck stop that was right in the middle of town attracted young women to become involved in transactional sex. Again, with the help of the local traffic police and the municipality, the truck stop was removed from the centre of town.
- The community of Mkhuhlu, in Limpopo, took a similar stand against unlicensed '*shebeens*' that were identified as contributing to anti-social behaviour by making noise and selling liquor to minors. One facilitator remembered that:

  > "Many parents shed their tears when we were conducting the social mapping exercise. Many imagined how their children got raped, injured or even killed in these places. For many, the pain was just too much to bear, and broke down with tears. Those who sympathised with them cried with them. One woman said to me that she felt better now that she could do something about the place that lured her son to his death, after the community had taken a decision to request the police to shut-down such '*shebeens*'".

- The community of Tafelkop, in Limpopo, identified abandoned, ruined, old housing structures as hiding places for criminals in the area. The community took a collective decision to demolish the ruins completely.

There is a definite need to address the stigma attached to HIV and AIDS and Community Conversations provide a platform for such debates. Community conversations address these issues through story telling and role-playing.

Facilitators said that they found these tools very helpful and both stimulating and helpful in directing the discussions. A facilitator explained:

> "When we talk to communities about stigma, we start by telling a story. We then ask them to put themselves in both situations (of being infected and affected) and say how they would feel or react. For example, we would say: 'after a long illness her doctor advised Thandi that she was HIV positive. She went home, told her parents and partner about her status. If you were her parents or partner how would you react?' The community would then come up with all sorts of responses and we would allow them debate the merits and de-merits of each point of view".

Box 7 Community initiatives to look after the vulnerable sections of the population

- In Sibongile Township, KwaZulu-Natal, the community has established a "Drop-in Centre" for orphans and vulnerable children. These children receive one meal on Mondays, Wednesdays and Fridays every week, due to limited funds. The "Centre" is also providing Directly Observed Treatment Short-course (DOTS) for TB patients. TB patients are also given meals before they take their treatment
- A group of home-based caregivers in Musina, Limpopo, has opened a day care centre for vulnerable children. Vulnerable children come to the centre after school or crèche hours to get meals, toys to play with and books to read. They are also assisted with school homework. Furthermore, these women are helping with birth registration of children in distress, and are also assisting them to access social grants.
- In the village of Ixopo, in KwaZulu-Natal, women have volunteered time to assist at a 'Soup Kitchen'. The 'Soup Kitchen' will provide meals to children in distress, three times a day. The local Chief has made one his homesteads available to serve as a kitchen. The local branch of the Red Cross is helping out with soup and maize meal.

Another tool that the facilitators use to stimulate empathy and compassion with PLWHA is the 'counting your losses' exercise. Participants are asked to count the number of people they know who have died (or they suspect have died) due to HIV and AIDS related illnesses, what these people meant to them, what is it that they did not do which they could have done to assist them.

e) Community mobilisation for action

It has been argued above that the mobilisation of local people is necessary not only as a strategy for limiting the destruction of lives and families by limiting HIV-transmission, but also as a part of how communities negotiate their response to the epidemic. Local community mobilisation is not only a strategy for the prevention of further spread of HIV, it is also a key piece of the complex puzzle of how survivors of decimated communities can live through the epidemic, and come out of the other end of it as part of better, stronger societies.

The CCEP aims to mobilise communities and enhance the capacity of households to mitigate the impact of HIV and AIDS, to address the fear, stigma and silence that continues to fuel the epidemic as well as to empower communities to create their own effective response. The Programme defines

social/ community mobilisation as a set of actions aimed at raising awareness throughout the broader society on critical social issues and soliciting their active support and participation in addressing them.

The Programme, working together with other stakeholders such as home-based caregivers, faith-based organisations and other non-governmental organisations such as Progressive Primary Health Care, KwaZulu-Natal CBO Coalition and the Red Cross, is beginning to bear fruits.

Using the social mapping and the transect walk, the communities of Musina, Tafelkop and Mkhuhlu, in Limpopo, identified "hot spots" for crimes and anti-social behaviours and took a joint stand to get rid of them. Box 6 gives examples.

f) Care for vulnerable sections of the population

There seems to be a general feeling that children in distress should be provided with the necessary support from their families or home, rather than putting them in institutions. Families are considered more appropriate because they provide a homely environment, identity and maintain kinship ties. One of the provincial leaders of an organisation that facilitates capacity building and access to resources for community-based organisations argued:

> "It is much, much better if children in distress are cared for within their homely environment. And this is also the view of my organisation. Placing vulnerable children in a homely environment is likely to alleviate the problem of having to learn social/community norms and values at a late stage of their development. Remaining in the community gives children in distress a sense of identity. They are being called by their family names (*seboko/sibongo*). This gives them an idea of who they are and where they come from. By interacting with members of the community they get to know better about their late parents. Take me for example: I lost my father when I was 9 years old, so I never got to know him that well. But through interaction with his friends and colleagues, I hear a lot of positive stories about him. I now have an idea of the type of person my Dad was. I don't think I would have had the privilege of knowing this if I lived in an orphan centre".

Box 7 provides evidence of community initiatives to look after the vulnerable section of the population.

g) Effective community networks of support/social capital

Social capital refers to the internal social and cultural coherence of society, the norms and values that govern interactions among people and the institutions in which they are embedded. Social capital is the 'glue' that holds individuals, communities and society together.

In the face of a phenomenon so intricately linked into the fabric of a society and as personally and professionally threatening as the HIV epidemic, it may be that only programmes that penetrate the soul of a community, organisation or nations will be effective (Campbell, 1997). Central to this is the belief that

community norms, values and practices shape group and individual behaviours. The kind and the extent of linkages and relationships within a community are critical determinants of the spread and impact of the epidemic.

For example, in Tafelkop, CCEP has facilitated the establishment of a support group for PLWHA. A group of nearly 40 women and men have formed a consortium that will engage in agricultural activities. The local farmer has availed his entire farm for this purpose. He is also a part of this consortium.

h) Participation in activities aimed at improving household livelihoods

It has been argued that the forces responsible for the spread of HIV are social, political and economic in nature. Ideally, the most important aspect of slowing down the spread of sexually transmitted infections, including HIV, in communities would be to alter the broader social and material conditions that encourage high-risk sexual practices (Campbell, 2003). These would include measures such as an end to rural poverty.

The backbone of rural economies is agriculture, whether commercial or subsistence. Many communities within the project pilot sites have engaged themselves in agricultural activities. While some gained inspiration from community conversations, others had already started and had their morale boosted by increasing interest by fellow citizens. Box 8 lists some of the community driven income-generating projects.

Visits to project sites revealed a high level of enthusiasm among members of the community for becoming involved in livelihood projects. However, limited resources to meet these levels of interest reportedly caused community members to get discouraged and become increasingly sceptical of any intervention. Communities said many similar projects in the area collapsed due to poor management and lack of funds.

Box 8 Examples of income-generating projects

- In Mkhuhlu village, of Bohlabela District in Limpopo Province, a group of women started a vegetable garden. A group of nearly 40 women and men have formed a partnership with a local farmer to start operating on his farm. The farmer is a local resident and regular CCEP participant. The decision to start this initiative was taken in one of the community conversations.
- A group of youth have started a vegetable garden in Musina, Limpopo. During the field trip to the area, the youth concerned had gone for training on project management in the nearby Thohoyandou.
- In Ntlabeni, in Eastern Cape, communities have organised themselves into groups and are pursuing various income-generating activities, such as poultry, piglet and other livestock rearing and vegetable gardens. The local municipality is fully behind the initiatives and has provided some groups with fencing material and seeds.

i) Intergenerational Discourse

An additional benefit of the concept of community conversation is the fostering of intergenerational discourse. One elderly man remarked:

> "The fact that these meetings combine elders and the youth in

one joint discussion is a huge advantage. It helps us understand each other better than we have done before. Now we can help our children cope better…"

A young facilitator made this observation with excitement:

"As a Community Facilitator, I have learnt how to listen to others, and how to gain good knowledge from the elders that can help us to work better especially in this area. One of the best outcomes from Community Conversations has been the breakdown of the age barriers between elders and the youth on sexuality issues. Now we are able to engage each other better than ever before. Our community has hope now that things will change, especially to link the community with their Local Municipalities…"

4.3 Lessons for best practice

4.3.1 Participatory tools

The participatory tools used proved to be highly accessible to the targeted communities and reinforced learning amongst them. Members of the community could relate to them and often referred to them in our discussions. Essentially, at the centre of the participatory methodologies is the recognition that communities have the assets and the potential to realise their dreams, but may do better with additional ones. This is precisely the approach which the Programme adopted.

4.3.2 Partnership approach

The horizontal and vertical partnership approach adopted by the UNDP has cultivated a lot of stakeholders' buy-in that is probably strong enough to promote the sustainability of the Programme. To illustrate, international (Denmark) and local (SA) governments are involved in various ways. Provincial, District and Local government are also involved, as well as individual members (facilitators), and civil society (CBOs and FBOs). Furthermore, the UNDP is in the process of handing-over the Programme to local NGOs as implementing agents. Facilitators are to be drawn from Local Government's Social Development Facilitators' staff roll.

4.3.3 Community conversations

Community conversations have facilitated dialogue on sensitive issues such as sex and sexuality, HIV, AIDS, poverty, culture, stigma and access to services and resources in the pilot sites. It has also facilitated the mobilisation of communities to effect change in their neighbourhoods and to participate in livelihoods projects. Furthermore, community conversations facilitated the emergence and strengthening of social capital at the community level.

4.3.4 Linking HIV, AIDS, poverty and culture

Campbell (2003) notes that the declining level of participation of targeted groups is primarily answerable for failure of many HIV and AIDS prevention programmes. Declining participation over time is often due to the lack of

variety in topics discussed at peer-driven information sessions, where peer educators repeat the same messages, such as 'Abstain, Be faithful, Condomise', over-and-over again. CCEP introduces a variety of topics for discussion at community conversations that are aimed at raising awareness about HIV and AIDS and the link between HIV and AIDS, poverty and culture. Communities are also expected to identify strategies for addressing these issues.

4.3.5 Strengthen capacity at the community level

Approximately, 161 community-based facilitators have been trained in CCEP methodology and are actively involved in driving the process on the ground in KwaZulu-Natal (55), Eastern Cape (56) and Limpopo provinces (50). Leaders from home-based care, faith-based, and traditional leadership organisations have been trained in these methodologies.

4.4 Constraints

Constraints relate to less coordination among the many Programme activities than is optimal, lack of facilities and support staff at the inception stage, and huge rural wards and an inability to meet urgent needs of communities.

4.4.1 Coordination among the Programme activities

Programme staff felt that there appeared to be little coordination among activities such as "Mainstreaming of HIV, AIDS and poverty into IDP" and CCEP. While targeted at different stakeholders, there is little collaboration amongst these Programmes. If programme beneficiaries had a more complete picture of the Programme they would be better able to appreciate how different activities compliment one another.

4.4.2 Facilities and support staff

The project's inception has been hampered by lack of facilities, such as office space, faxes and photocopiers in some pilot sites. Delay in the appointment of additional support staff, further affected the implementation. Moreover, newly appointed staff need training in the methodologies and processes.

4.4.3 Rural wards

In many rural areas the wards, which are the chosen level of intervention, are very large, with villages widely spread. This makes it difficult for people to attend community conversations regularly and potentially excludes entire villages from participation.

4.5 Recommendations for CCEP

The results of the appraisal imply that the Programme should:

- Investigate and address the issues that relate to the limited participation of men;
- Train as many people as possible in the use of CCEP methodologies, especially CBO members;
- Introduce counselling courses for facilitators and CBO members; and
- Conduct a baseline study in new sites for the purposes of monitoring, evaluation and impact assessment.

5 THE IMPACT OF THE LDR

5.1 Introduction

The Leadership Development for Results Programme is intended to promote continued dialogue on South African-specific issues that are reinforcing the continued spread of the HIV epidemic. It aims to support the development of appropriate policy measures, develop capacity at all levels and generate an extraordinary nationwide multi-sectoral response to the epidemic.

The LDR has been designed to enhance the capacities of existing programmes in order to broaden their scope to embrace a multi-sectoral approach. It recognises current efforts being made by different role players and aims to bring to the fore the synergistic interaction between individual and institutional leadership and between the bio-medical and socio-economic frameworks.

Further, the LDR recognises the need to develop leadership capacity at individual, community, institutional and societal levels where everyone takes responsibility for a part of the complex HIV and AIDS challenge and is empowered to act. Box 9 discusses the Programme's principles.

5.2 Expected outcomes of the LDR programme

The LDR programme aims to produce the following outcomes:

- Capacity developed, with equal representation by women and men, at the local level through participation in this programme;
- Civil Society Leadership strengthened, in equal numbers of women and men, in their support of the need for response to HIV and AIDS at the local level; and
- Strengthened capacity for local level planning and implementation.

5.3 Programme activities

The programme has put together some tools, techniques and processes with the aim of creating a multi-faceted approach towards building capacity for the new type leadership required for the various sectors in the country (Box 9). Two of the main techniques are discussed below.

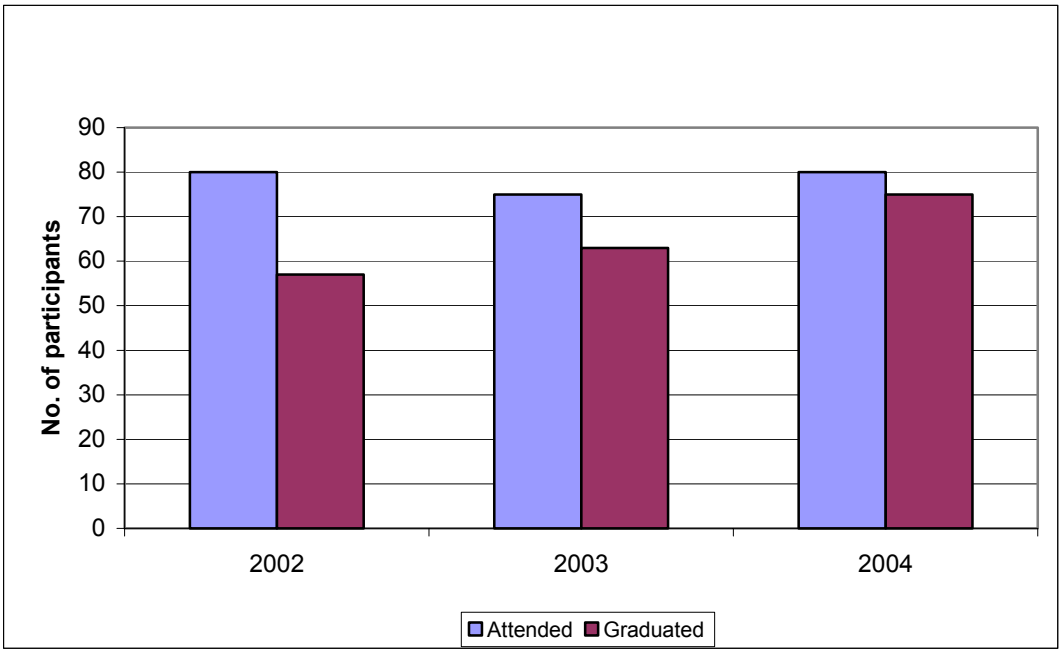
Box 9 Principles that are applied to the design of the leadership development process

1. **It must mobilise the emotional energy needed to change**. Without a compelling personal goal there is little emotional energy for change, and lasting change is minimal. To that end, people must understand why they should change, what they should change, how it will benefit both them and the institution, as well as how their individual change directly impacts results.
2. **It must offer the opportunity, stimulus, space, and time for change**. Time, attention, and resistance are major barriers to change. Participants must be given the mental and emotional space to consider, plan for, and ultimately accept the opportunities for change.
3. **It must provide accurate feedback and ongoing support**. People successfully change only when they know in what direction and how far they must go to achieve their goals, and what progress they are making. To that end, coaching, mentoring, and possibly 360-degree feedback are needed for ongoing calibration, reality checking, and support.
4. **It must provide carefully calibrated development**. Leadership development is not about rebuilding. It's about refining and evolving. To be effective, it must address the gaps, while maintaining the strengths. We believe this is best done through coaching that facilitates the participants' ability to contextualise the feedback and customize the data to support their personal development.
5. **It must be research-based, but "dialogue driven."** Adults learn best when they can 'wrestle', with challenges, process well-researched-based concepts through small group dialogue and discussion, and experiment with new behaviours while getting feedback from trusted peers.
6. **It must be ongoing, reality-based, and nurturing**. Behavioural change takes time. It cannot be rushed. It must be practiced and nurtured over time in the real world, far from the classroom.
7. **It must involve memorable 'events'**—Something that marks a moment in time when a change process began. This may be achieved by a particularly stimulating location, a challenging process, a shared group experience – something that is "out of the box" for the participants. The aim is to focus their attention and to create an orienting emotional memory that will support ongoing change when the times are difficult.

5.3.1 The total learning community.

This is a space where all participants come together for dialogue and some experiential learning. To this end, 235 leaders form government at all levels, the private sector and civil society have participated in this programme. In 2002, nearly 80 leaders participated in the programme. For 2003 and 2004 the numbers were 75 and 80 respectively. Figure 5 provides a breakdown of participants and graduated over the 3 years. Worthy of note is the fact that more participants graduated, compared to the previous two years.

Figure 5 Numbers of leadership development for results participants, 2002-2004



5.3.2 Action Learning (AL) Groups.

The Emotional Intelligence and Action Learning groups were formed to provide a forum for Programme participants to explore their individual leadership and personal development issues. There were groups of 10 participants. Groups were constructed with participants from Limpopo, Eastern Cape, KwaZulu-Natal, and a national group.

Each Action Learning Group was asked to identify and scope out a high impact/leveraging HIV and AIDS project so that they could apply their dynamic inquiry leadership learning to go beyond current responses to the issue. Table 6 lists the groups and provides a brief description of the groups' activities. To demonstrate leadership for results, the action learning project groups were required to establish new strategic partnerships and networks through which they could achieve a noticeable impact. Participants (groups) were given a vehicle for learning new techniques and taking action on HIV and AIDS.

Overall, the Groups did well and fostered a great deal of learning. One of the ex-members of the Action Group stated:

> "My participation in the Action Group helped me to 1) put into practice what I have learned, which is transformation leadership, and 2) helped me to come face-to-face with the reality of HIV, AIDS and poverty. My Action Group dealt with PLWHA. I was deeply touched by the experience".

This strategy is being repeated with the 2004 group of LDR participants.

5.4 Programme impact on leaders

It has been argued that there is a need to develop leadership capacity at individual, community, institutional and societal levels where everyone takes responsibility for a part of the complex HIV and AIDS challenge and is empowered to act. Interviews were conducted with available LDR participants to determine the impact of the Programme on them at these three levels. Given the short time we had to conduct the study, it was impossible to draw a representative sample and execute a full survey with structured questionnaires. Besides, as the participants were senior leaders from different sectors, it was impossible to gain access to people with busy schedules at short notice.

As a result, we interviewed a 'convenience' sample of participants who were available during the time we were in each pilot site. Twenty-four participants were interviewed using semi-structured questionnaires. The questionnaire is attached in Annexure 6. The questions focussed on the perceived impact of the programme on them as individuals and how this in turn had impacted on their communities and organisations.

Table 5 Description of the activities undertaken by selected Change Groups during 2003

Name of Group	Description of the Project
Akanani Change Group	The group decided on an initiative to enhance the capacity of an HIV and AIDS Economic Development NGO in resource mobilisation. The Tubatse Economic Development Organisation (TEDO) is an NGO led by PLWHA. The group identified the organisation for their work in the community and the enthusiasm shown by their members. There are about fifty people that are members of the group. There are two development projects that are income-generating; a car wash and food garden project.
Letaba Change Group	The group investigated prevailing opinions and experiences on issues of disclosure of HIV status by members of the Provincial Legislature in Limpopo. This was meant to create understanding of the behaviour and attitudes related to disclosure as well as understanding what will help identify relevant intervention measures. Leaders were encouraged to lead by example in matters relating to HIV and AIDS.
Kenako Change Group	To raise HIV and AIDS awareness in Limpopo, communities using a stage drama with a script drafted by members of the change group. The play was staged twice for Limpopo communities, and was also staged for the LDR participants and guests at the graduation ceremony.
Vhempol Change Group	The group decided to investigate the role of gender relations in marriages and its impact on HIV and AIDS in selected households in Vhembe district of the Limpopo Province, looking specifically at: gender dominance in marriages; dominant attributes in marriages and the complex state of sexuality within marriage.
Impact Change Group	The group identified a Life-skills development project at Sehlaku High School (grades 8 and 9) in the Sekhukhune District, Greater Tubatse Municipality. Meetings were held with parents (67) and scholars and there were also three separate workshops for parents.
African Gladiators	This group decided to investigate the possibility of providing capacity for home-based caregivers. Twenty-three home-based care givers from Mkhuhlu were trained in home-based care, stress management, project management and financial management. Dynamic inquiry interviews were conducted at Mkhuhlu and Ha-Musha communities.
Mvelaphanda Change Group	To create awareness on HIV and AIDS at an Ethiopian Church, Seshego, The project targeted Church Youth using participatory focus Group discussions. The project provided basic information on HIV and AIDS, positive living and relationships.
Magoni Change Group	To raise awareness of HIV AIDS among the leadership of Faith-Based

Name of Group	Description of the Project
	Organisations and Traditional Healers in Limpopo. At a meeting with both groups they acknowledged the following: they know and believe HIV and AIDS is a reality, is killing multitudes and is incurable; they are aware poverty contributes to HIV and AIDS; they agree sexual intercourse is the main transmitter of the pandemic; they realise HIV and AIDS affects life expectancy and population growth and there is a high rate of deaths amongst the youth and the economically active groups.
Tswelopele Change Group	To start a community garden and transfer basic skills to contribute to the improvement of the nutritional status of PLWHA. The group targeted a youth group at Masakaneng in Seshego as well as the emerging farmers' groups.
Shona Khona	The group conducted dynamic interviews to find out how integration is perceived and interpreted among others and the challenges thereof. Participants from the following organisations in Gauteng, KwaZulu and Limpopo were targeted for interviews: UN Agencies; Government Departments; NGOs and CBOs

5.4.1 Individual level

a) Empathy for PLWHA

Participants (leaders/mangers) said the Programme made them more sympathetic towards PLWHA. A very senior person stated:

> "Interacting with PLWHA made me realise the reality of HIV/AIDS and its devastating impact on PLWHA and members of their family and relatives. I was deeply touched by the experience".

Another CBO leader mentioned;

> "…. I felt like I was a University graduate. It taught me to have feelings for other people, especially PLWHA. It helped me to organise myself better. I have been able to impart my knowledge to other women of my organisation – 45 of them. We took a collective decision to do HIV tests. We wanted to experience what PLWHA are going through so we could become more empathetic. Four of our members tested positive. This brought us closer to each other than ever before".

b) Better organised and make better informed decisions

Managers and leaders said the programme helped to organise and manage their time.

A senior manager stated:

> "The training helped me to value the importance of time, and finishing assignments on time. And learned how best to communicate deadlines with other colleagues".

Another one added:

> "The decision-making exercise was very helpful for me. I hold a highly responsible position where I often have to make key decisions at the spur of the moment. Since that exercise, I am better at prioritising issues".

c) Better relationships with family/relatives

Managers/leaders mentioned that the Programme helped them to resolve their personal and marital problems. One participant mentioned:

> "My marriage was at the brink of collapse. We had gone through counselling with our Priests and had tried everything possible to save our marriage. The training taught me that change starts with me. I took this approach to my marriage problem and became very humble in a way that changed my spouse too. It was amazing indeed. I can recommend this to any person".

d) Appreciation of link between HIV, AIDS and poverty

The Programme facilitated learning about the link between HIV, AIDS, poverty and culture. One manager mentioned:

> "I managed an organisation that looked after the interests of people with disabilities, and never imagined there could be any link. Through the training I managed to include HIV, AIDS and poverty dimension into the organisation".

e) Learning is fun

Leaders and managers enjoyed learning by having fun. An elderly woman stated:

> "I learned to learn by playing. I thought I was old enough and had no time to play around (in referring to 'energisers'). I felt differently by the end of the first session".

Another manager mentioned:

"The playing part made me realise that I still belong here with people".

5.4.2 Organisational level

a) Influence others/colleagues and organisation direction

LDR aimed to influence leaders to be able to influence colleagues and potentially the direction of their respective organisations. Programme participants that were interviewed demonstrated their ability to influence others/colleagues and the direction of their organisations. To illustrate, a leader of a home-based organisation mentioned:

> "Our organisation was doing home-based care and doing it very well, with passion, but there was no awareness-raising component. We have since included awareness in our activities. We have earned a lot of respect as a result. Many people come to us for advice. They even ask us to conduct training for them. We told them we were not qualified to do so and instead referred them to the contact person in the Provincial Department of Health and Welfare".

5.4.3 Community level

a) Influence others

Some mentioned that participation in the programme influenced them to help shape the direction of community initiatives in their neighbourhoods. A former manager of an NGO stated:

> "I managed to encourage people with disability to form an NGO in Seshego. The NGO has any income-generation component".

Another manager stated:

> "Upon my return from the first session, I shared what I learned with my wife, who was never really interested in the matters of health. She gradually developed interest in my work and has been able to help many of her colleagues, who were infected with the virus. She encouraged local women to start a home-based care programme and assisted them with training".

Box 10 Areas that LDR participants felt could be improved upon

- Allow more time for training. Many said it was a bit congested with only three days per contact session.
- Training should be timed in such a way that it allows the involvement of other people. For example, it has been difficult to get senior people involved due to scheduling.
- Allow more time for change groups. Many, said one year does not allow sufficient time for successful completion of projects.
- Localise content. One participant argued; *"We should localise the content. We should include examples from Africa and developing countries. This will enhance the universal flair of the Programme. It will dispel the myths that America or other nations are superior to others"*.
- Use other languages such as isiZulu, isiXhosa, and Sepedi. Many felt that exclusive use of English has the potential of excluding some leaders, especially leaders of local NGOs and CBOs.
- Another concern that was raised was that groups were too large (70) to allow for a meaningful contribution by everyone.
- Some maintained that there was too little entertainment and social activities.
- Many felt that catering during training sessions should be provided by black economic empowerment groups.
- Some felt that the criteria for choosing programme participants should be given more thought. *"Find out first from people if they are interested in the course. I was merely told to attend. Afterwards, I felt that there are people who were better suited to attend this programme other than me"*.
- Others felt that there was more theory than practice. For example one participant stated: *"Facilitators should bring PLWHA, for example, so trainees could engage with real issues"*.
- Some would prefer to have the course accredited with the South African Qualifications Authority (SAQA).

5.4.4 Social network of support

For many the programme facilitated the establishment of social capital. An NGO leader mentioned:

> "Through the Change Group, I learned to work with people of different cultural and language backgrounds. We worked together as a team. The process facilitated the emergence of networks of support. I now know who to call when I need any help".

5.5 Lessons for best practice

- LDR focuses on leaders and change at the leadership level is crucial, because this is where key decisions are taken.
- Involvement of leaders at all levels helps to ensure buy-in for development initiatives.
- Successful implementation of development initiatives depends greatly on the attitude of leaders. Leaders were empowered and more willing to engage in the process once they were better informed about the relationships between HIV, AIDS and poverty.
- Future initiatives should seek ways to improve participation of senior leaders since they are key role players and frequently control the allocation of personnel and other resources.

5.6 Constraints for LDR

Implementation of LDR is affected by the fact that most leaders, especially senior leaders, are unable to attend training sessions due to their hectic schedules.

Exclusive use of English as the language of instruction is likely to exclude local community leaders who, although not necessarily well educated, have enormous influence at community level and access to extensive indigenous knowledge.

5.7 Recommendations

Although the overall assessment of LDR is positive, Box 10 lists a range of recommendations emanating from the participants. Clearly, the training has encouraged participants to critically review their work, and that of others, and they are therefore well placed to make suggestions for improvements in the implementation of LDR. As with many training programmes, participants wanted more time to learn, and more practical experience. Also, changing complex systems takes time and some participants felt that expecting significant changes within one year was overly optimistic.

6 CONCLUDING REMARKS

This rapid appraisal has been able to provide a primarily qualitative assessment of the activities undertaken by CCEP and LDR and their impacts

at various levels. Future phases of the Enhancing an Integrated Response to HIV, AIDS and Poverty Programme would benefit from a more formal evaluation, utilising baseline surveys prior to interventions, in order to more accurately assess the specific impacts of the various components of the Programme.

BIBLIOGRAPHY

Allen, T & Thomas, A (Eds). 2000. *Poverty and Development into the 21st Century*. Milton Keynes: Open University and Oxford University Press.

Ashforth, A. 2001. *AIDS, Witchcraft, and the Problem of Public Power in Post-Apartheid South Afric*', paper delivered at the *AIDS in Context* Conference, University of the Witwatersrand, 4-7 April 2001. Also available at http://www.sss.ias.edu/home/papers.html

Barret, T & Whiteside, A. 2002. *AIDS in the Twenty-First Century: Disease and globalisation*. New York: Palgrave Macmillan.

Baylies, C. 2000. Overview: HIV/AIDS in Africa: Global & Local Inequalities & Responsibilities. *Review of African Political Economy* 86:487-500.

Baylies, C. 2002. The impact of AIDS on Rural Households in Africa: A shock like no other? *Development and Change*. 33 (4): 611-632.

Campbell, C., Wood, R. & Kelly, M. 1999. *Social Capital and health*. London: Health Education Authority.

Campbell, C. 2003. Letting them die: Why HIV/AIDS prevention programmes fail. *African Issues*. Oxford: International African Institute

Etiebet, M.A., Fransman, D., Forsyth, B., Coetzee, N. and Hussey, G. 2004. Integrating prevention of mother-to-child HIV transmission into antenatal care: learning from the experiences of women in South Africa., *AIDS Care* 16(1): 37-46.

Giddens, A. 2001. *Sociology* (4th ed). Polity Press: Cambridge.

Gavron, H. 1966. *The Captive Wife: Conflicts of housebound mothers*. London: Routledge and Kegan Paul.

Jackson. H., Kerkhoven. R., Lindsey. D., Mutanadura, G. & Nhata, F. 2000. *HIV/AIDS in Southern Africa: The threat to development*. Harare: SAfAIDS.

Nattrass, N. 2002. *AIDS and Human security in Southern Africa*. Centre for Social Science Research, University of Cape Town. Working Paper No. 18.

Kalichman, S. C. & Simbayi, L. 2004. Traditional beliefs about the cause of AIDS and AIDS-related stigma in South Africa, *AIDS Care* 16(5): 572-580.

Kalichman, S. C. & Simbayi, L. C. 2003. HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa. *Sexually Transmitted Infections* 79 (6):442-447.

Leclerc-Madlala, S. 1997. Infect one, infect all: Zulu youth response to the AIDS epidemic in South Africa, *Med Anthropol.* 17(4): 363-380.

Leclerc-Madlala, S. 2001. Virginity testing: managing sexuality in a maturing HIV/AIDS epidemic, *Med Anthropol.Q.* 15(4): 533-552.

Leclerc-Madlala, S. 2002. On the virgin cleansing myth: gendered bodies, AIDS and ethnomedicine, *African Journal of AIDS Research* 1(2): 87–95.

Loevinsohn, M & Gillespie, S. 2003. *HIV/AIDS, food security and rural livelihoods: understanding and responding*. Renewal Working Paper No. 2, 12 May 2003.

Helman, C.G. 2000. Culture, *Health and Illness*. London: Butterworth-Heinemann.

May, T. 1993. *Social research: issues, methods and process*. Open University Press: Buckingham & Philadelphia.

Marck, J. 1997. Aspects of male circumcision in sub-equatorial African culture history. *Health Transition Review*. 7:337.

Orubuloye I.O, Caldwell P., & Caldwell J.C. 1995. A note on suspect practices during the AIDS epidemic: vaginal drying and scarification in southwest Nigeria. *Health Transition Review*, Supplement to Volume 5, 161-165.

HSRC 2002 *Nelson Mandela/HSRC Study of HIV/AIDS: South African National HIV prevalence, behavioural risks and mass media household survey*, HSRC, Cape Town, p82.

UNAIDS 2002a. *Report on the global HIV/AIDS epidemic*. July 2002. UNIADS Geneva, Switzerland. http://www.unaids.org.

UNAIDS. 2002. *South Africa: Epidemiological Fact Sheets*. Available: http://unaids,org.

UNAIDS. 2003. *AIDS epidemic update: 2003*. Geneva: UNAIDS.

Van Rensburg D, Friedman I, 2002. *Strengthening local government and civic response to the HIV/AIDS epidemic in South Africa*. Bloemfontein: Centre for Health Systems Research & Development (University of the Free State).

ANNEXURE 1: Terms of Reference for a consultancy to conduct a rapid appraisal of the enhancing an integrated response to HIV, AIDS and poverty programme

Background

The government of South Africa now considers HIV and AIDS one of the most significant development challenges of its times. National debates have progressively moved from considering HIV and AID in purely bio-medical terms to conceptualising it in the wider social and economic forces obtaining in the country. Government continues to advocate for an integrated and coordinated response to HIV, AIDS and Poverty. However, capacity to translate this realisation into action has proven to be difficult. Government further acknowledges that developing capacity to mount a sustained effort as well as mobilising and scaling up the community response is one of the key challenges.

The "Enhancing an Integrated Response to HIV, AIDS and Poverty to reduce the Impact on Human Development in KwaZulu-Natal, Eastern Cape and Limpopo provinces" Programme is aimed at contributing towards the reduction of the prevalence of HIV, AIDS and poverty and reversing the vicious circle of their impact on human development by enhancing an integrated and concerted response dealing with the interrelationships between HIV, AIDS and poverty at all levels in KwaZulu-Natal, Eastern Cape and Limpopo Provinces. The programme supports policy dialogue aimed at increasing understanding and awareness of the interactions between HIV, AIDS and poverty, and facilitates the development of concrete strategies and plans to deal with the challenges. Furthermore, the programme aims to strengthen critical capacities of key government departments, civil and private institutions at the community, municipal, district and provincial levels to develop, implement and monitor plans aimed at reducing HIV, AIDS and poverty in a holistic manner.

The programme utilises several different tools and strategies to deliver the expected results. Specifically the scope of this consultancy will focus on the Community Capacity Enhancement Programme (CCEP) and the Leadership Development for Results Programme (LDR).

CCEP is aimed at the community level and utilises participatory programmes such as community conversations and social mobilisation using rights based and sustainable livelihoods approaches to enhance the capacity of households to mitigate the impact of HIV and AIDS, to address the fear, stigma and silence that continues to fuel the epidemic as well as to empower communities to create their own effective response. CCEP programme utilises participatory methodologies at a community level.

The Leadership Development for Results Programme (LDR) is part of UNDP support, response and intervention to generating an unprecedented multi-sectoral response to HIV, AIDS and poverty with commitment to action and results. The first phase of the initiative was launched in 2002 – 3, not only to generate leadership for results, but also mobilize the energy and commitment

of all partners required to produce results for an integrated response to Poverty, HIV and AIDS. The programme further enhances and promotes the creation of an enabling environment for other key interventions envisaged.

Aim of the work
To design and conduct a rapid appraisal of the CCEP and LDR programmes and to produce a qualitative and quantitative report highlighting impact achieved, challenges, opportunities and lessons learnt.
The appraisal team will include the following experts:

- Researcher – responsible for conducting and analysing the research and production of substantive report based on the research findings (these ToRs refer)
- Writer - responsible for producing the final report – the writer to subcontract a photographer to capture relevant pictures etc. (separate ToRs – please see attached)

Objectives of the work
The appraisal should cover an assessment of the project outcomes, relevance, performance and sustainability. Specifically, it should:

- Assess those activities which were carried out;
- Assess the achievements of the CCEP and LDR initiatives and how they are meeting the intended results, as well as responding to the emerging needs;
- Identify constraints, if any, which have affected the implementation of the initiatives and assess corrective actions taken to deal with them;
- Document the actual impact, as well as perceived impact, by the beneficiaries and the role so far played by relevant partners in the achievement of the development objectives;
- Evaluate the effectiveness of the internal processes and management arrangements in the implementation of the initiatives; and
- Based on the above, draw lessons that may help in future design, implementation and management as well as propose options and make recommendations for future sustainability.

Expected Outputs
- Two research instruments designed to assess a) LDR and b) CCEP
- A substantive report with qualitative and quantitative data on the impact, challenges and opportunities of CCEP and LDR initiatives.
- A powerpoint presentation based on the findings

Specific Activities
The consultant will be required to:
2. Attend a briefing meeting on 25 August with key UNDP officials and contracted writer
Please note that a relevant % of daily rate will be given to Task 1

3. Undertake a desktop review of al available documentation

The information that is collected needs to be read, analysed and documented. The desktop report should reflect a summary of the common trends, gaps, challenges and recommendations from this data. This report must be presented to the UNDP before commencing task 2.
Please note that a maximum of 5 days will be given to Task 2.

4. Develop/design two research instruments to assess the different initiatives – CCEP and LDR
Please note that a maximum of 3 days will be given to Task3.

5. Consult with key stakeholders. The list of key stakeholders, particularly local government and communities will be developed in consultation with Programme Manager of the HIV, AIDS and Poverty Programme.
Please note that a maximum of 12 days will be given to Task 4

6. Analyse data and prepare of a substantive report and powerpoint presentation based on the findings of the appraisal. Draft report to be submitted for feedback
Please note a maximum of 5 days will be given to Task 5

7. Present the findings of the research to UNDP and relevant stakeholders
Please note that a maximum of 1 day will be given to Task 6.

Timelines
The final report should be presented to the UNDP on or before the 8 October 2004 [subsequently revised].

Intellectual property
Guidelines and reports may not be reproduced or made available to any unauthorized person or institution or sold for profit without prior written consent from the United Nations Development Programme.
On termination or completion of the agreement, all information, materials and products developed by the consultant in the execution of the contract must be handed over to the United Nations Development Programme who will therefore hold copyright.

Accountability and reporting
Day to day management of the consultants will be by the HIV and Poverty Programme Manager.
The approval process will be through the relevant UNDP officials and procedures.

The service provider will work in close partnership with the contracted writer.

ANNEXURE 2: Interview schedule for facilitators

Section A: Biographical information

1. Village _____
2. Gender _____
3. Age _____
4. Highest standard passed _____
5. Post-matric training _____

Section B: Human development

6. What personal changes have you made in your life since your involvement in CCEP, mention at least two lessons you have learnt (*A general question, could refer to new skills acquired or personal changes*)
    a. _____
    b. _____
7. By participating in CCEP which new skills have you acquired and how important are these skills to you? What are you now able to do which you could not do before you were trained as facilitator?
    a) _____
    b) _____
    c) _____
8. What other skills would you have liked to learn which CCEP could not provide? (Give explanation on the relevancy of the skills for your work or life in general)
    a) _____
    b) _____
9. How have your personal circumstances changed since you became a CCE facilitator? (You now have a job. How has this changed your livelihood?)
10. How have changes in your personal circumstances affected how community members relate to you, what are some of community views about you and the work you done? (There is apparent bitterness among certain sections of the community about the stipend that community facilitators get).

Section C: Personal change

11. How has your participation in CCEP changed your views about life generally? (*Looking at senses of self-worth and self-fulfilment*)
12. Since your involvement in CCEP would you say you are now committed to change for service delivery and community mobilisation?
13. Would you say that you are now more committed to responding to challenges of HIV and AIDS and poverty?

Section D: HIV, AIDS and poverty

14. Since your participation in CCEP how has your views about HIV, AIDS and poverty changed
15. What is your understanding of:
    a. What causes HIV and AIDS

    _____

b. Modes of transmission

_____

c. Stages of the disease

_____

d. Treatment

_____

e. Care

_____

f. Prevention

_____

16. How has your attitude or behaviour changed as a result of this understanding (*For example do you now practice safe sex, regularly?*)
17. What is your understanding of the relationship with HIV and AIDS and socio-cultural issues (*which cultural believes or practices are likely to fuel or combat the spread of HIV and AIDS*)
18. What is your understanding of the relationship between HIV, AIDS and poverty? (*Which economic factors fuel the spread of HIV and AIDS?*)
19. How has your work as facilitator affected your attitude & conduct towards PLWHA ?
20. What are your views and attitude voluntary counselling & testing for HIV and AIDS?
21. What do you know about ARVs (*efficacy, regimen*)?
22. What support can you give a person who wants to start ARVs or a person who is on treatment?
23. What are your views on the stigma attached to HIV and AIDS and the potential discrimination of PLWHA as a result thereof?
24. How can HIV and AIDS related stigma be reversed in communities?

Section E: Rights and service issues

25. Since your participation in CCEP would you say you are more informed about your rights, obligations and responsibilities in addressing HIV and AIDS and poverty?
26. Would you say that you are now better informed about available related services for addressing the challenges of HIV and AIDS and poverty
27. Do you feel confident enough to demand for services due to you?

Section F: Change at the community level

28. Social cohesion and integration. Would you say that community conversations have brought community together?
29. Social capital. In your view have community conversations strengthened or weakened social networks of support?
30. How have the community conversations identified and used social networks in addressing HIV and AIDS and poverty?
31. Would you say communities are more mobilised for active response to HIV and AIDS as result of their participation in CCEP? (*e.g., more support groups, more home-based carers*)?
32. Would you say members of the community are more aware about their rights and available services as result of CCEP? (*Services such as food parcels, ARVs, social grants, ID, birth registration, housing, water*).

33. Would you say that the municipality takes decisions taken in the community seriously? (*Probe for examples to illustrate*).
34. What have communities defined as issues for HIV, AIDS and poverty? (*E.g., care for children in distress and PLWHA, ensuring access to nutrition*).

Section G: Impact of community conversations

35. In you view, have community conversation addressed issues of stigma and discrimination?
36. What action and decision have they taken to address stigma and discrimination
37. In your view how have community conversations facilitated review of indigenous practices that fuel HIV and AIDS and poverty? (*They include Ukuphehlwa, Ukuhlolwa, Ukusoma, Seantlo, Tlhatsoa-li-rope, Komba, koma*).
38. VCT and disclosure of HIV and AIDS status. How has CCEP helped or hindered people in going for VCT and disclose their status in their communities?
39. How have communities responded to disclosure of HIV+ status during conversations?
40. How have community conversations addressed issues of awareness of the scale and needs of children under distress?
41. Are children affected by HIV and AIDS treated differently from other children in distress?
42. How have community conversations addressed issues of power relations and gender inequalities? (*Which of the power relations have been addressed in your community relationships between male and female in control of the spread of the epidemic, and the adjustment of social contracts between the rich and the poor, youth and adults,*).

Section H: Service providers

43. How service delivery improved in this area since the introduction of CCEP and LDR?

a) Do you find government officials more efficient?
b) Do you find government officials friendlier and helpful?
c) Would you say there is noticeable change in the attitudes of government officials?
d) Do you find CBO and NGO leaders more efficient?
e) Do you find CBO and NGO leaders more knowledgeable?
f) Would you say there is a change of attitudes among traditional leaders towards HIV, AIDS and poverty? (*Including socio-cultural aspects of HIV, AIDS and poverty*).
g) Would you say there is a change of attitudes among religious leaders towards HIV, AIDS and poverty? (*Including socio-cultural aspects of HIV, AIDS and poverty*).

Section I: General comments

44. Any other comments regarding CEEP and, or LDR? (Which areas do you think the UNDP need to focus on?)

_____

ANNEXURE 3: Interview schedule for members of the community

Section A: Biographical information

1. Village _____
2. Gender_____
3. Age _____
4. Highest standard passed _____
5. Post-matric training
6. Employment status
7. When did you start to attend community conversations?
8. How regularly have you been attending community conversations?

Section B: Human development

9. By participating in CCEP which new skills have you acquired and how important are these skills to you? That is, what are you now able to do which you could not do before you were exposed to community conversations? (*These may include public speech or facilitation*).
    c. _____
    d. _____
    e. _____
10. What other skills would you have liked to learn which CCEP did not provide? (*Probe for explanation on relevancy of the skills for the participant's work or life in general*)
    a) _____
    b) _____

Section C: Personal change

11. How has your participation in CCEP changed your views about life generally? (*Looking at senses of self-worth and self-fulfilment*)
12. Since your involvement in CCEP would you say you are now committed to change for service delivery and participation in community structures? (*Ask for examples of community structures the interviewee is participating in*).
13. Would you say that you are now more committed to responding to challenges of HIV, AIDS and poverty?

Section D: HIV, AIDS and poverty

14. Since your participation in CCEP how has your views about HIV, AIDS and poverty changed
15. What is your understanding of:
    g. What causes HIV/AIDS
    h. Modes of transmission
    i. Stages of the disease
    j. Treatment
    k. Care
    l. Prevention
16. How has your attitude or behaviour changed as a result of this understanding? (*For example, do you now practice safe sex, regularly?*)

17. What is your understanding of the relationship between HIV and AIDS and socio-cultural issues (*which cultural believes or practices are likely to fuel or combat the spread of HIV and AIDS*)
18. What is your understanding of the relationship between HIV, AIDS and poverty? (*Which economic factors fuel the spread of HIV and AIDS?*)
19. How has your attitude and conduct towards PLWHA changed? (Do you now empathise with PLWHA? Can you kiss, hug or share a meal with them?)
20. What are your views and attitude about voluntary counselling and testing for HIV and AIDS? (*Would you consider testing for HIV?*)
21. What do you know about ARVs (*efficacy, regimen*)?
22. What support can you give a person who wants to start ARVs or a person who is on treatment?
23. What are your views on the stigma attached to HIV and AIDS and the potential discrimination of PLWHA as a result thereof?
24. How can HIV and AIDS related stigma be reversed in communities?

Section E: Rights and service issues

25. Since your participation in CCEP would you say you are more informed about your rights, obligations and responsibilities in addressing HIV and AIDS and poverty?
26. Would you say that you are now better informed about available related services for addressing the challenges of HIV and AIDS and poverty
27. Do you feel confident enough to demand for services due to you?

Section F: Change at the community level

28. Social cohesion and integration. Would you say that community conversations have championed justice for all, including discrimination of PLWHA, women and young girls?
29. Social capital. In your view have community conversations brought you closer to your neighbourhood? (That is, are you now part of burial, savings schemes, cultural, religious organisations, home-based carers and women/men groupings).
30. How have the community conversations identified and used social networks in addressing HIV and AIDS and poverty?
31. Would you say communities are more mobilised for active response to HIV and AIDS as result of their participation in CCEP? (*e.g., more support groups, more home-based carers*)?
32. Would you say members of the community are more awaren about their rights and available services as result of CCEP? (*Services such as food parcels, ARVs, social grants, ID, birth registration, housing, water*).
33. Would you say that the municipality takes decisions taken in the community seriously? (*Probe for examples to illustrate*).
34. What have communities defined as issues for HIV, AIDS and poverty? (E.g., care for children in distress and PLWHA, ensuring access to nutrition).

Section G: Impact of community conversations

35. In you view, have community conversation addressed issues of stigma and discrimination?

36. What action and decision have they taken to address stigma and discrimination
37. In your view how have community conversations facilitated review of indigenous practices that fuel HIV and AIDS and poverty? (*They include Ukuphehlwa, Ukuhlolwa, Ukusoma, Seantlo, Tlhatsoa-li-rope, Komba, koma*).
38. VCT and disclosure of HIV and AIDS status. How has CCEP helped or hindered people in going for VCT and disclose their status in their communities?
39. How have communities responded to disclosure of HIV+ status during conversations?
40. How have community conversations addressed issues of awareness of the scale and needs of children under distress?
41. Are children affected by HIV and AIDS treated differently from other children in distress?
42. How have community conversations addressed issues of power relations and gender inequalities? (*Which of the power relations have been addressed in your community relationships between male and female in control of the spread of the epidemic, and the adjustment of social contracts between the rich and the poor, youth and adults.*)

Section H: Service providers

43. How service delivery improved in this area since the introduction of CCEP and LDR?
44. Do you find government officials more efficient?
45. Do you find government officials friendlier and helpful?
46. Would you say there is noticeable change in the attitudes of government officials?
47. Do you find CBO and NGO leaders more efficient?
48. Do you find CBO and NGO leaders more knowledgeable?
49. Would you say there is a change of attitudes among traditional leaders towards HIV, AIDS and poverty? (*Including socio-cultural aspects of HIV, AIDS and poverty*).
50. Would you say there is a change of attitudes among religious leaders towards HIV, AIDS and poverty? (*Including socio-cultural aspects of HIV, AIDS and poverty*).

Section I: General comments

51. Any other comments regarding CEEP and, or LDR? (Which areas do you think the UNDP need to focus on?)

ANNEXURE 4: Interview schedule for focus group discussions

Section A: Human development

1. How did you got to be involved CCEP and, or LDR?
2. By participating in CCEP which new skills have you acquired and how important are these skills to you? That is, what are you now able to do which you could not do before you were exposed to community conversations? (*These may include public speech or facilitation*).
3. What other skills would you have liked to learn which CCEP did not provide? (*Probe for explanation on relevancy of the skills for the participant's work or life in general*)

Section B: Personal change

4. How has your participation in CCEP changed your views about life generally? (*Looking at senses of self-worth and self-fulfilment*)
5. Since your involvement in CCEP would you say you are now committed to change for service delivery and participation in community structures? (*Ask for examples of community structures the interviewee is participating in*).
6. Would you say that you are now more committed to responding to challenges of HIV, AIDS and poverty?

Section C: HIV, AIDS and poverty

7. Since your participation in CCEP how has your views about HIV, AIDS and poverty changed

   _____

8. What is your understanding of:

a) What causes HIV and AIDS

   _____

b) Modes of transmission

   _____

c) Stages of the disease

   _____

d) Treatment

   _____

e) Care

   _____

f) Prevention

   _____

9. How has your attitude or behaviour changed as a result of this understanding? (*For example, do you now practice safe sex, regularly?*)
10. What is your understanding of the relationship between HIV and AIDS and socio-cultural issues (*which cultural believes or practices are likely to fuel or combat the spread of HIV and AIDS*)
11. What is your understanding of the relationship between HIV, AIDS and poverty? (*Which economic factors fuel the spread of HIV and AIDS?*)

12. How has your attitude and conduct towards PLWHA changed? (*Do you now empathise with PLWHA? Can you kiss, hug or share a meal with them?*)
13. What are your views and attitude about voluntary counselling and testing for HIV and AIDS? (*Would you consider testing for HIV?*)
14. What do you know about ARVs (*efficacy, regimen*)?
15. What support can you give a person who wants to start ARVs or a person who is on treatment?
16. What are your views on the stigma attached to HIV/AIDS and the potential discrimination of PLWHA as a result thereof?
17. How can HIV and AIDS related stigma be reversed in communities?

Section D: Rights and service issues

18. Since your participation in CCEP would you say you are more informed about your rights, obligations and responsibilities in addressing HIV amd AIDS and poverty?
19. Would you say that you are now better informed about available related services for addressing the challenges of HIV and AIDS and poverty
20. Do you feel confident enough to demand for services due to you?

Section E: Change at the community level

21. Social cohesion and integration. Would you say that community conversations have championed justice for all, including discrimination of PLWHA, women and young girls?
22. Social capital. In your view have community conversations brought you closer to your neighbourhood? (*That is, are you now part of burial, savings schemes, cultural, religious organisations, home-based carers and women/men groupings*).
23. How have the community conversations identified and used social networks in addressing HIV and AIDS and poverty?
24. Would you say communities are more mobilised for active response to HIV and AIDS as result of their participation in CCEP? (*e.g., more support groups, more home-based carers*)?
25. Would you say members of the community are more aware about their rights and available services as result of CCEP? (*Services such as food parcels, ARVs, social grants, ID, birth registration, housing, water*).
26. Would you say that the municipality takes decisions taken in the community seriously? (*Probe for examples to illustrate*).
27. What have communities defined as issues for HIV, AIDS and poverty? (E.g., care for children in distress and PLWHA, ensuring access to nutrition).

Section F: Impact of community conversations

28. In you view, have community conversation addressed issues of stigma and discrimination?
29. What action and decision have they taken to address stigma and discrimination

30. In your view how have community conversations facilitated review of indigenous practices that fuel HIV/AIDS and poverty? (*They include Ukuphehlwa, Ukuhlolwa, Ukusoma, Seantlo, Tlhatsoa-li-rope, Komba, koma*).
31. VCT and disclosure of HIV and AIDS status. How has CCEP helped or hindered people in going for VCT and disclose their status in their communities?
32. How have communities responded to disclosure of HIV+ status during conversations?
33. How have community conversations addressed issues of awareness of the scale and needs of children under distress?
34. Are children affected by HIV and AIDS treated differently from other children in distress?
35. How have community conversations addressed issues of power relations and gender inequalities? (*Which of the power relations have been addressed in your community relationships between male and female in control of the spread of the epidemic, and the adjustment of social contracts between the rich and the poor, youth and adults.*)

Section G: Service providers

36. How service delivery improved in this area since the introduction of CCEP and LDR?
37. Do you find government officials more efficient?
38. Do you find government officials friendlier and helpful?
39. Would you say there is noticeable change in the attitudes of government officials?
40. Do you find CBO and NGO leaders more efficient?
41. Do you find CBO and NGO leaders more knowledgeable?
42. Would you say there is a change of attitudes among traditional leaders towards HIV, AIDS and poverty? (*Including socio-cultural aspects of HIV, AIDS and poverty*).
43. Would you say there is a change of attitudes among religious leaders towards HIV, AIDS and poverty? (*Including socio-cultural aspects of HIV, AIDS and poverty*).

Section H: General comments

44. Any other comments regarding CEEP and, or LDR? (Which areas do you think the UNDP need to focus on?)

ANNEXURE 5: Interview schedule for government officials

SECTION A: Biographical information

1. Gender _____
2. Age _____
3. Highest standard passed _____
4. Post-matric training _____
5. Province _____
6. District _____
7. Local government _____
8. Department _____
9. Position _____

SECTION B: Personal change

10. How has your involvement in CEEP changed your views about life generally? (*Looking at senses of self-worth and self-fulfilment, serving the community*)
11. Would you say that you are now more committed to responding to challenges of HIV, AIDS and poverty?

Section C: HIV, AIDS and poverty

12. Since your department's involvement in CCEP would you say your (organisation) views about HIV, AIDS and poverty have changed?
13. What is your organisation's understanding of the relationship between HIV and AIDS and socio-cultural issues (*which cultural believes or practices are likely to fuel or combat the spread of HIV and AIDS*).
14. What is your organisation's understanding of the relationship between HIV, AIDS and poverty? (*Which economic factors fuel the spread of HIV and AIDS?*).
15. How has your department's attitude and conduct towards PLWA changed? (*Do you now empathise with PLWA? Can you kiss, hug or share a meal with them?*).
16. What are your organisation's views and attitude about voluntary counselling and testing for HIV and AIDS? (*Would you consider testing for HIV?*)
17. What does your organisation know about ARVs (*efficacy, regimen, access*)? How can your department intervene?
18. What support can your department give a person who wants to start ARVs or a person who is on treatment?
19. What are your department's views on the stigma attached to HIV and AIDS and the potential discrimination of PLWA as a result thereof?
20. How can HIV and AIDS related stigma be reversed in communities?

Section D: Rights and service issues

21. Since your involvement in CCEP would you say your department is able to inform the community about their rights, obligations and responsibilities, and services? (*Services such as food parcels, ARVs, social grants, ID, birth registration, housing, water*).

Section E: Change at the community level

22. Social cohesion and integration. Would you say that community conversations have championed justice for all, including discrimination of PLWA, women and young girls?
23. Social capital. In your view have community conversations brought communities together? (*That is, are communities now able to speak in one voice?*).
24. Would you say communities are more mobilised for active response to HIV and AIDS as result of their participation in CCEP? (*e.g., more support groups, more home-based carers*)? And what is your department doing to assist?
25. Would you say that your department takes decisions taken in the community seriously? (*Probe for examples to illustrate*).
26. How does your department address issues of stigma and discrimination? (*What action and decision have they taken to address stigma and discrimination*)
27. How does your department facilitate community review of indigenous practices that fuel HIV and AIDS and poverty? (*They include Ukuphehlwa, Ukuhlolwa, Ukusoma, Seantlo, Tlhatsoa-li-rope, Komba, koma*).
28. VCT and disclosure of HIV and AIDS status. How does your department help or hinder people in going for VCT and disclose their status in their communities?
29. How does your department addressed issues of awareness of the scale and needs of children under distress?
30. Are children affected by HIV and AIDS treated differently from other children in distress?
31. How does your department address issues of power relations and gender inequalities? (Which of the power relations have been addressed in your community relationships between male and female in control of the spread of the epidemic, and the adjustment of social contracts between the rich and the poor, youth and adults.)

ANNEXURE 6: Interview schedule for non-government leaders

Section A: Biographical information

1. Gender _____
2. Highest standard passed _____
3. Post-metric training _____
4. Organisation (*FBO, NGO*)

Section B: Personal change

5. How has your involvement in CCEP changed your views about life generally? (*Looking at senses of self-worth and self-fulfilment, serving the community*)
6. Would you say that you are now more committed to responding to challenges of HIV, AIDS and poverty?

Section C: HIV, AIDS and poverty

7. Since your organisation's involvement in CCEP would you say your (organisation) views about HIV, AIDS and poverty have changed?
8. What is your organisation's understanding of the relationship between HIV and AIDS and socio-cultural issues (*which cultural believes or practices are likely to fuel or combat the spread of HIV and AIDS*).
9. What is your organisation's understanding of the relationship between HIV, AIDS and poverty? (*Which economic factors fuel the spread of HIV and AIDS?*).
10. How has your organisation's attitude and conduct towards PLWHA changed? (*Do you now empathise with PLWHA? Can you kiss, hug or share a meal with them?*).
11. What are your organisation's views and attitude about voluntary counselling and testing for HIV and AIDS? (*Would you consider testing for HIV?*)
12. What does your organisation know about ARVs (*efficacy, regimen, access*)? How can your organisation intervene?
13. What support can your organisation give a person who wants to start ARVs or a person who is on treatment?
14. What are your organisation's views on the stigma attached to HIV and AIDS and the potential discrimination of PLWHA as a result thereof?
15. How can HIV and AIDS related stigma be reversed in communities?

Section D: Rights and service issues

16. Since your involvement in CCEP would you say your organisation is able to inform the community about their rights, obligations and responsibilities, and services? (*Services such as food parcels, ARVs, social grants, ID, birth registration, housing, water*).

Section E: Change at the community level

17. Social cohesion and integration. Would you say that community conversations have championed justice for all, including discrimination of PLWHA, women and young girls?

18. Social capital. In your view have community conversations brought communities together? (*That is, are communities now able to speak in one voice?*).
19. Would you say communities are more mobilised for active response to HIV and AIDS as result of their participation in CCEP? (*e.g., more support groups, more home-based carers*)? And what is your organisation doing to assist?
20. Would you say that your organisation takes decisions taken in the community seriously? (*Probe for examples to illustrate*).
21. How does your organisation address issues of stigma and discrimination? (*What action and decision have they taken to address stigma and discrimination*)
22. How does your organisation facilitate community review of indigenous practices that fuel HIV and AIDS and poverty? (*They include Ukuphehlwa, Ukuhlolwa, Ukusoma, Seantlo, Tlhatsoa-li-rope, Komba, koma*).
23. VCT and disclosure of HIV and AIDS status. How does your organisation help or hinder people in going for VCT and disclose their status in their communities?
24. How does your organisation addressed issues of awareness of the scale and needs of children under distress?
25. Are children affected by HIV and AIDS treated differently from other children in distress?
26. How does your organisation address issues of power relations and gender inequalities? (*Which of the power relations have been addressed in your community relationships between male and female in control of the spread of the epidemic, and the adjustment of social contracts between the rich and the poor, youth and adults.*)

ANNEXURE 7: Interview guide for Leadership Development for Results

Section A: Biographical information

1. Gender _____
2. Age _____
3. Province _____
4. Organisation _____
5. If government, state the level (e.g., national, provincial, district or local)
6. Position at your work _____
7. Position in the community _____

Section B: Training

8. List types of leadership programmes that you attended, and the duration
9. List at least three most valuable lessons that you learnt from the LDR training sessions (*For examples, social transformation, relationship between HIV, AIDS and poverty, importance of mainstreaming HIV, AIDS, poverty and gender in all programmes*).
10. How can the programme be improved?

Section C: Impact of the programme

11. How have these lessons benefited you at the individual level? (*For example, more committed to change at the individual level, family, and social transformation*).
12. How have these lessons benefited your organisation or individuals (*What difference have your lessons made to your organisation, what changes have you brought into your organisation*)?
13. How have your client benefited from your participation in LDR (*How has your attitude towards your client changed*)?
14. How has the community that you are serving benefited from your participation in LDR (*What role are you playing in the community as a result of your participation in LDR*)?
15. Would you say there is a link between socio-cultural practices, HIV and AIDS? (*That is, socio-cultural factors that fuel or curb factors associated with HIV, AIDS and poverty*).
16. Some people have an attitude towards PLWHA. What is your response to this notion and how can it be effectively addressed?
17. Some people have an attitude towards households that are affected by HIV and AIDS. What is your response to this notion and how can it be effectively addressed?
18. Some people have an attitude towards children in distress. What is your response and how can this be addressed?
19. What do you think should be done to improve on the LDR programme to address some of the issues? *(That is, point to areas of improvement).*
20. Which organisation were you working for during your participation in the leadership development programme?
21. Are you still in the same organisation and position?
22. If promoted or have moved to another organisation, was it as a result of your participation in LDR?

ANNEXURE 8: Skills mapping for Limpopo facilitators

Name	Gender	Age	Std/Educ	Skills obtained	Org	Other/needs	Service provider
R.E Langa	F	47	Matric	HBC	Bakenberg clinic	HBC/HIV	DOH-2003
T.S Lesu	M	22	Matric/NQF level 4 facilitator	Peer ED Trainer	PPASA Mahwelereng	HBC/HIV	PPASA –2003
A.N. Mothoa	F	36	Matric/Dev studies	Train HIV/AIDS	Dira-Anti AIDS Club	HBC/HIV	DOH – 2001 Dira –O-Direle 2000-2003
V.H. Khota	M	29	Attemped matric peer education HIV/AIDS	HBC	Mapela community H.C	HBC/HIV	Mapela community HC PPL
R.S.Mashisi	F	36	Diploma	Life skills HIV/HBC		HBC/HIV	JHB Metropolitan DOH
M.M Mahlako	F	42		First aid		HBC/HIV	
N.G. Molapo	F	26	Matric	HBC	Maruleng HBC	Caunselling VCT PMCT&HIV/AIDS	DOH Maruleng HBC – 2003
M.M Raganya	F	23			Maruleng HBC	DOT HIV/AIDS	Maruleng HBC
M.L.Mashilane	M	36	Matric		Choice	HBC/HIV counselling	CHOKE
G.S. Mtheza	M	27	Matric		Municipality	HBC/HIV/AIDS Counselling skills	
P.P.F Mokgakala	M	27	Matric	-	Municipality	HBC/HIV	DOH-2003
S.V. Sobopha	M	32	Matric	-	-	HBC/HIV	PPASA –2003
F.L. Maimela	F	30	Matric	-	HIV/AIDS Care Dev	HBC/HIV	DOH – 2001 Dira –O-Direle 2000-2003
M.B. Marape	F	35	Matric	-	PPSA	HBC/HIV	Mapela community HC PPL
M.F. Mzimba	M	22	Diploma	-	DOH	HBC/HIV	JHB Metropolitan DOH
S.T. Ntuli	F	21		DOT HIV/AIDS awareness	Tafelkop HBC	HBC/HIV	
M.M.	F	27	Attempted Matric	HIV/AIDS	Tafelkop	Caunselling VCT	DOH Maruleng HBC –

Name	Gender	Age	Std/Educ	Skills obtained	Org	Other/needs	Service provider
MOSOTHO				awareness DOT	HBC	PMCT&HIV/AIDS	2003
J.W. Mohlala	M	42	Attempted matric		Home affair Tafelkop HBC	DOT HIV/AIDS	Maruleng HBC
M.Z. Motlafi	F	38	Matric	Matric	Tafelkop HBC	HBC/HIV counselling	CHOKE
M.L. Phala	F	27	Matric	Matric	Tafelkop	HBC/HIV/AIDS Counselling skills	
R.J Molekwa	M	33	Diploma	-	Municipality	HBC/HIV/AIDS & Counselling	-
N.H Mokone	M	43	Attempted matric	-	-	HBC/HIV/AIDS & Counselling	-
B.T Malebye	M	27	Tertiary	Cost acc. Project management	-	HBC/HIV/AIDS & Counselling	Wits Technicon
R.C Mabuselo	F	33	Diploma	Awareness building basic HIV/AIDS	HIV/AIDS prevention group	HBC/HIV/AIDS & Counselling	Prevention group
E.Chimbiza	F	33	Tertiary	ABET facilitation skills	-	HBC/HIV/AIDS & Counselling	University of North
R.S. Lebogo	M	42	Certificate	Clerical skills	DOH	HBC/HIV/AIDS & Counselling	-
M.M. Luthara	M	50	Std 10	Clerk	DPSA	HBC/HIV/AIDS & Counselling	-
T.M. Phalandwa	F	25	Certificate	-	-	HBC/HIV/AIDS & Counselling	-
H.R. Nyatheli	M	25	Diploma	-	Goundo Company	HBC/HIV/AIDS & Counselling	-
M.M Ratshilumela	F	27	Certificate	-	-	HBC/HIV/AIDS & Counselling	-
L.N. Netshisaulu	F	26	Diploma	Clerical	Justice department	HBC/HIV/AIDS & Counselling	-

Name	Gender	Age	Std/Educ	Skills obtained	Org	Other/needs	Service provider
K.K. Mukeya	M	26	Diploma	Sales	Score Retail	HBC/HIV/AIDS & Counselling	Wits Technicon
J.J. Ngobeni	F	41	Certificate	Teacher	HBC HIV/AIDS & Counselling	HBC/HIV/AIDS & Counselling	Prevention group
I. Mukwevho	M	30	Diploma	Ass. tutor	HBC HIV/AIDS & Counselling	HBC/HIV/AIDS & Counselling	University of North
P.M. Chauke	M	27	Matric	Clerical work	HBC HIV/AIDS & Counselling	HBC/HIV/AIDS & Counselling	-
P.Khorombi	M	22	Matric	Communication Journalism	HBC HIV/AIDS & Counselling	HBC/HIV/AIDS & Counselling	-