

Catherine Campbell, Kerry Scott, Mercy N. Nhamo, Kate Morley, Constance Nyamukapa, Claudius Madanhire, Morten Skovdal, Lorraine Sherr and Simon Gregson
Social capital and AIDS competent communities: evidence from eastern Zimbabwe

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Social capital and AIDS competent communities:

Evidence from eastern Zimbabwe

Catherine Campbell, Kerry Scott, Mercy Nhamo, Kate Morley
(London School of Economics)

Constance Nyamukapa, Claudius Madanhire (Biomedical
Research and Training Institute, Harare)

Morten Skovdal (University of Bergen)

Lorraine Sherr (University College, London)

Simon Gregson (Imperial College, London)

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Technical report 2

**Church responses to HIV in
Zimbabwe:**

**To what extent are the Anglican, Apostolic and Catholic
churches supportive of HIV care, treatment and
prevention?**

Nhamo, M,
Scott, K,
Campbell, C,
Madanhire, C,
Nyamukapa, C,
& Gregson, S.

Prepared August 2011 for the World Bank

Abstract

Background: Churches are one of the most popular social organizations in sub-Saharan Africa, exerting a strong influence on social and behavioural norms. This paper examines how churches in eastern Zimbabwe are responding to the challenges of HIV.

Method: We conducted 21 focus groups with 120 members of Anglican, Apostolic and Catholic churches between 2008 and 2009, exploring how members of these congregations understood their churches to support—or not support—HIV care, treatment and prevention.

Analysis: Interviews were analyzed quantitatively and qualitatively. Quantitatively, we counted the frequency at which members of the churches mentioned supportive and non-supportive responses to HIV and determined the proportion of comments that were supportive versus non-supportive. Qualitatively, we explored the data using thematic network analysis to outline the types of church support provided and the ways in which churches failed to support member uptake of HIV-related care, treatment and prevention.

Findings: We found far more references to supportive church responses to HIV than un-supportive ones. However, Apostolics made significantly fewer references to supportive church responses compared to Anglicans or Catholics (64% of Apostolic comments were supportive versus 83% of Catholic and 85% of Anglican comments; χ^2 23.71, 2 df, $p < 0.001$). Our thematic analysis found that, overall, all three churches play a strong role in promoting care-giving and kindness towards the sick. Church members are encouraged to access biomedical testing and treatment (except amongst certain Apostolic sects) and protect themselves from infection through 'behaving well' (all three church groups) and using condoms (Anglican only). Some Apostolic sects encouraged faith healing instead of biomedical care and polygamy while others supported faith healing and forbade polygamy. Silence and stigma surrounding HIV however were prevalent in all three church groups. Members of Apostolic and Anglican churches in particular reported that many people continue to hide the HIV-positive status of family members from their church. Although churches sometimes discussed HIV in terms of sin and punishment and strongly condemned extra- and pre-marital sex, most church members did not seem to find these messages at odds with exhibiting kindness and compassion towards people living with HIV.

Conclusion: The Anglican, Apostolic and Catholic churches in Zimbabwe all play a strong role in emotionally and spiritually supporting members to cope with high rates of illness in their families and communities. In most cases these congregations also encourage members to access biomedical support available in their communities. Nonetheless, moralistic and negative attitudes towards extra- and pre-marital sex and condoms appear closely linked to remaining high levels of HIV-related stigma among church members.

Key words: HIV competence, faith based organizations, churches, Zimbabwe

Introduction

There is a growing policy emphasis in the field of international public health on the need for community involvement in health programmes (Wouters, *et al.*, 2009; Campbell, *et al.*, 2009). Increased community mobilization is the fifth pillar of UNAIDS' five-pillar 'treatment 2.0 platform' (2010), which outlines the way forward in HIV treatment and prevention. UNAIDS states that "Community-based approaches to build trust, protect human rights and provide opportunities for socialization directly improve the ability of people to use HIV services and to benefit from antiretroviral therapy and prevent new infections."

UNICEF (2010) emphasizes the need for community involvement when considering the needs of AIDS affected children, stating that "strengthening families caring for AIDS affected children will not be possible without significant investment in social welfare systems and communities."

The World Bank has also focused on community mobilization to improve programme ownership and sustainability: "Community mobilization aims to organize and improve community participation. Motivating all members of a community provides the opportunity to utilize a variety of skills and abilities, which improves ownership and increases sustainability" (World Bank 2011). Working with churches and faith based organizations is considered a vital mechanism through which international health organizations can bolster community mobilization efforts.

The WHO has argued that greater efforts are required to increase collaboration between public health agencies and faith based organizations in order to meet global HIV prevention, care and treatment goals. In the African Religious Health Assets Program's 2006 report for the WHO *Appreciating assets: the contribution of religion to universal access in Africa*, they estimate that between 30% and 70% of the health infrastructure in Africa is currently owned by faith-based organizations, yet there is often little cooperation between these organizations and mainstream public health programmes. The WHO has pointed out that faith based organizations are a vital part of civil society, yet have generally not been adequately recognized by international agencies (WHO 2007).

In the year 2000 there were an estimated 390 million Christians in Africa, a number which is estimated to increase to 640 million by 2025 (Walker, 2008). There is great need for further research into the best ways for public health agencies to engage with faith based organizations in the context of HIV. This is imperative for two reasons: (1) churches are one of the most popular formal social organizations in sub-Saharan African communities, having great potential to engage large numbers of people with HIV-related messages and services and (2) religious messages and teaching have great salience throughout Africa with church responses to HIV having great influence on local attitudes and behaviours (Chiu, *et al.* 2008, Prince, Denis, van Dijk 2009; Dilger 2009). South African

theologian and academic Steve De Gruchy (2006) described religion in Africa as follows:

Though often hidden from Western view, religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives.

However little is known about the different mechanisms through which churches are responding to the specific challenges of HIV. Moreover, discussion of churches and HIV tend to overlook the major differences between different denominations. Determining how to maximize the positive role that churches can play in reducing the spread of HIV and improving support for people living with HIV/AIDS (PLWHA) necessitates understanding the current range of responses. From this research it will then be possible to determine how best to engage churches in improving or sustaining their approaches. To this end, this study examines the extent to which the Anglican, Apostolic and Catholic churches in Manicaland, eastern Zimbabwe are supporting HIV care, treatment and prevention service uptake.

Literature review

Churches play a complex and contradictory role in relation to optimizing HIV prevention, care and treatment in Africa. Research on the association of religious group and HIV related knowledge and behaviour has begun to suggest that different churches have different effects on their congregations and that different groups (men versus women) are influenced by church messages and norms in different ways. For instance, a recent study of youth in Mozambique found that religiously affiliated males did not differ from non-religious males on sexual activity, condom usage, and multiple partnerships. However, they were more likely than non-religious males to know when a condom should be used, respond correctly to HIV transmission questions and respond with less stigma to HIV-related scenarios. The authors speculate that this difference in knowledge may be linked to the greater educational opportunities afforded by religious-affiliated schools. In addition, non-religious male youth were more likely to have visited sex workers—a higher risk behaviour. Female responses and behaviour did not differ between religious and non religious youth (Noden, Gomes and Ferreira 2010).

In their review of literature on HIV stigma and churches, Campbell, Skovdal and Gibbs (in press) found that in many cases churches perpetuate HIV/AIDS-related stigma through i) moralistic attitudes often leading to the denial of AIDS in public church settings and ii) the reinforcement of conservative gender ideologies which militate against women exercising control over their sexual health, particularly within marriage. Married women in Africa remain at a high risk of HIV infection (Dunkle, *et al.* 2008; UNAIDS, World Bank 2008, De Walque 2007). However,

counter to this trend, there are also churches that have managed to move towards action that makes a more positive contribution to HIV/AIDS management. This can be evidenced in: iii) promoting various forms of social control for HIV prevention, iv) encouraging the care and support of the AIDS-affected and v) providing social spaces for discussions that challenge stigmatising ideas and practices.

There is a dearth of information on how Anglican, Apostolic and Catholic churches differ in their responses to HIV. These three denominations were chosen because they have high membership levels across sub-Saharan Africa. Moreover, few studies have explored church members' attitudes towards HIV and their perceptions of their church's response to HIV.

Theoretical framework

This paper examines churches as a social group with the potential to contribute to the creation of 'HIV competent communities' in Africa. Campbell, Nair, and Maimane (2007) and Campbell, Nair, Maimane, and Sibiyi (2008), characterise an HIV/AIDS-competent community as a context in which local people work together to contribute to the challenges of promoting behaviour change, stigma reduction, the support of AIDS patients and carers, and the appropriate accessing and optimal use of existing sources of health and welfare support.

Churches, as popular social institutions, have the capacity to provide opportunities for local people to access the six psycho-social preconditions to HIV competence: HIV/AIDS knowledge, social spaces for dialogue, a sense of solidarity, confidence in local capacities, collective sense of ownership of problems, and links with external social and economic resources through support and welfare agencies. Briefly, we will present the theory underlying our interest in how churches can help (or hinder) the development of such HIV competent communities.

Local people must have basic HIV/AIDS related knowledge and skills, such as an understanding of how HIV spreads, how to care for and assist someone living with HIV and how to access the health and welfare system. Churches, because of their extensive social reach have the potential to publicize and spread HIV/AIDS related messages. However, access and exposure to knowledge and skills are not enough. People have very few opportunities to translate HIV-related information into relevant and useful strategies for change. What people need is access to 'safe social spaces' (Campbell, Skovdal and Gibbs, 2011) in which they feel comfortable critically discussing their understandings of HIV. Safe social spaces enable people to collectively examine ways in which they might use the HIV-related information they have received and to renegotiate social norms that undermine their own and others' health and well-being (Campbell, Nair, Maimane 2007; Campbell, *et al.* 2009). Social spaces for informal peer-to-peer interaction and discussion have been highlighted by Low-Beer and Stoneburner (2004) as a key social precondition for sexual behaviour change to reduce HIV risk. Our

theoretical interest in churches examines the extent to which they build a community's sense of collective agency, confidence in existing local strengths, and solidarity by encouraging problem solving and active engagement with HIV prevention and care.

Context: HIV and churches in Zimbabwe and Manicaland

Manicaland is a province in eastern Zimbabwe with the second highest HIV prevalence rate in the country at approximately 20% (Gregson, *et al.*, 2010). The country-wide rate was 13.7% in 2009 (ZMoHFW, 2009). Residents of the region are primarily subsistence farmers or workers for mining companies, large commercial forestry enterprises, or tea estates. Most live in rural homesteads (compounds with several mud and thatch houses, a pit-latrine and animal pens), often without electricity. Many families have absent members working in major cities, some of whom send money back to the rural areas. Poverty is a major challenge and many local people were receiving food aid from international organizations during our period of research, in the late 2000s. Zimbabwe has experienced several recent crises, most significantly economic upset following agricultural land redistribution from white Zimbabweans to black in the early 2000s, hyperinflation in the late 2000s, and intermittent political unrest for the past two decades, particularly in 2008.

The Zimbabwean Council of Churches (2009) reports that 68% of Zimbabweans are Christian, with 14% Protestant, 8% Catholic, 7% Apostolic, 3% Anglican and 37% independent Christian. In Manicaland, the eastern Zimbabwean province where this research takes place, Christian mission churches are the most popular (primarily Roman Catholic, Baptist, Anglican and Methodist) with approximately 50% membership and spirit-type Christian churches are second most popular (primarily Apostolic and Zionist) with approximately 25% membership. The remaining quarter of the population identify their religion as traditional or other (Gregson, Zhuwau, Anderson, & Chandiwana, 1999). This study focuses on members of the Anglican, Apostolic and Roman Catholic churches because these are among the highest membership in the region. In addition they represent the most popular spirit-type church (Apostolic) and two large mission churches that have different teachings on condoms (Anglican accepting condom use and Catholic prohibiting).

While both mission and spirit-type churches now have black Zimbabwean leadership at the national and local level, mission churches maintain links to and align teachings with centralized Europe-based bodies. Spirit-type churches, which include various types of Apostolic churches represented in this research, are either separatist movements that have broken from mainstream colonial mission churches or are completely new entities founded by charismatic bishops or prophets (Gregson, Zhuwau, Anderson, & Chandiwana, 1999). Spirit type churches generally ban alcohol consumption and tend to encourage spiritual healing rather than biomedicine, some churches to the extent of refusing to vaccinate their children (dealt with by the state through forcible vaccination

following a severe measles outbreak in the 1980s) (Turner, 1967; Gregson, Zhuwau, Anderson, & Chandiwana, 1999).

Mission churches are closely linked with Western education and biomedicine and are frequently associated with schools and hospitals. While mission churches prohibit polygamy, spirit-type churches take a range of stances on this issue, from banning it to tolerating or encouraging it. Many spirit-type churches discourage unnatural birth control (condoms and other medical forms), as does the Catholic church. Mission and spirit-type churches both discourage pre-marital and extra-marital sex and the some popular Apostolic churches prohibit divorce.

Methodology

The focus group discussions

We analyzed 21 focus group discussion transcripts with a total of 120 participants to explore participant conceptions of church support for HIV treatment, care and prevention. Ethical approval for the study was granted by the Research Council of Zimbabwe and the Applied and Qualitative Research Ethics Committee at Oxford University (UK). These focus groups with members of the Anglican, Apostolic and Catholic churches in Manicaland were conducted in batches as follows: six in May 2008 (2 each with Anglicans, Apostolics and Catholics), three in September 2008 (one for each church affiliation), and the remaining 12 in January and February 2009 (four for each church affiliation). The 10 month time spread over which the focus groups were conducted was necessary because of the political and economic situation in Zimbabwe and also enabled an exploration of changing attitudes over time, particularly as ART became increasingly accessible from 2008 to 2009. We ensured that the focus groups were conducted with each of the three church affiliations the same number of times, over the same duration of time to avoid bias. A detailed description of the 21 focus groups is presented in table 1, below.

Table 1: Description of dataset

Church affiliation	Location code	Participants	Date
Anglican	1 Nyanga	8 (4 male, 4 female)	Jan 2009
	2 Nyazura1	7 (4 male, 4 female)	May 2008
	3 Nyazura3	7 (3 male, 4 female) [3 new]	Feb 2009
	4 St Killins	8 (4 male, 4 female)	Jan 2009
	5 St Theresa1	7 (3 male, 4 female)	May 2008
	6 St Theresa2	7 (2 male, 5 female) [4 new]	Sept 2008
	7 St Theresa3	9 (4 male, female) [2 new]	Feb 2009
Apostolic	8 Nyanga	7 (3 male, 4 female)	Jan 2009
	9 Nyazura1	7 (4 male, 3 female)	May 2008
	10 Nyazura3	6 (4 male, 2 female) [2 new]	Feb 2009
	11 St Killins	8 (4 male, 4 female)	Jan 2009
	12 St Theresa1	9 (5 male, 4 female)	May 2008

	13	St Theresa2	8 (3 male, 5 female) [4 new]	Sept 2008
	14	St Theresa3	9 (3 male, 6 female) [1 new]	Feb 2009
Catholic	15	Nyanga	7 (3 male, 4 female)	Jan 2009
	16	Nyazura1	6 (2 male, 4 female)	May 2008
	17	Nyazura3	7 (3 male, 4 female) [7 new]	Feb 2009
	18	St Killins	8 (3 male, 5 female)	Jan 2009
	19	St Theresa1	6 (4 male, 2 female)	May 2008
	20	St Theresa22	8 (4 male, 4 female) [4 new]	Sept 2008
	21	St Theresa3R	8 (4 male, 4 female) [5 new]	Feb 2009
Total	120 different people (56 male, 44 female)			

Catholic and Anglican focus group participants shared similar faith beliefs within their denominations, however the Apostolic participants included members of several sects, representing a wide variation in views on biomedicine and polygamy. All participants were given a large block of soap as a token of gratitude for their time.

Church members were sought from Anglican, Apostolic and Catholic denominations in each of four locations in Manicaland: Nyanga, Nyazura, St Killians and St Theresa. Details about these locations are presented in table 2, below.

Table 2: Salient characteristics of focus group sites

Location in Manicaland	Characteristics
Nyanga	A small rural area with a primary school, mostly farmers
Nyazura	A small township with a high rate of migration and informal work (small scale selling of goods at the roadside, unregulated diamond panning), meaning fewer long terms relations between residents.
St Killians	A larger rural town with a large clinic and school
St Theresa	A rural area with high levels of deeply rooted community relationships. Most residents farm their own land.

The focus group discussions, which lasted between 50 minutes and two hours, with an average length of 1.5 hours, involved asking the same questions of each religious group. These questions sought to elicit information on how participants perceived their church to be responding to issues surrounding care for PLWHA, HIV-related stigma, prevention and support for appropriate accessing of biomedical services (i.e. HIV testing, PMTCT and, in the later batches when it became available, ART). Questions included: "What are you and fellow church members doing to support PLWHA?" "How are PLWHA treated here?" "What organizations are working on HIV issues in the community?" "Imagine that you are HIV positive. Who would you tell? How would your family, friends, neighbours

and other church members respond if you disclosed to them?” When participants responded that there was some HIV stigma, the facilitator asked “What are you doing as church members to reduce stigma?” The interviews were recorded and conducted in Shona by two trained qualitative researchers and then transcribed into English. A random sample of interviews was back-translated into English on an on-going basis by the third author to ensure accuracy.

Coding

We analyzed the transcripts to determine the quantity and nature of discussion, focusing on responses to HIV that were supportive or unsupportive of stigma reduction and biomedical treatment, care and prevention. Text segments were coded into one of five thematic categories in line with the study’s aims: (1) supportive church response; (2) non-supportive church response; (3) general positive response by focus group participant (not specific to church); (4) general negative church response (not specific to church); and (5) ambiguous response. Within the five thematic categories, sub-codes were developed based on ideas and meanings arising from the transcripts. For instance, within the theme “supportive church response,” 13 codes arose from the transcripts, including: church encourages members to use biomedical services, church provides members with HIV-related bridging support, church educates people on HIV, church encourages kindness towards and assistance for PLWHA, and church welcomes and accepts HIV-positive members.

Sub-codes in each of the five thematic categories were developed through pilot coding of three transcripts (one from each of the three church affiliations). Once the final list of codes had been developed, the 21 transcripts were read and relevant text segments were coded. Segments were sometimes designated more than one code. For example, the text segment “*There was a person who we never thought would survive to see the next month, but I talked to the person and encouraged them to consider going for HIV tests and seeing the doctor*” was coded as both (i) ‘I encouraged safe behaviour/VCT/clinic visit’ as well as (ii) ‘I am kind to PLWHA’. VCT stands for voluntary counselling and testing. When one participant brought up the same point repeatedly it was only coded once. Similarly, when a participant’s comment was broken by an interviewer or other participant but continued again on the same theme it was only coded once. Table 3, below, outlines the coding framework.

Table 3: Coding framework

Thematic category	Code
(1) supportive church response	<ul style="list-style-type: none"> • Church encourages use of biomedical services • Church facilitates HIV-related bridging support (links to other support organisations) • Church educates people on HIV • Church encourages kindness towards and assistance for PLWHA (NB: not a text segment describing kindness and assistance, just discussion of the church encouraging kindness and assistance)

	<ul style="list-style-type: none"> • Church welcomes and accepts HIV-positive members • Church gives HIV+ members positions in the church/ensures they can keep positions • Church leaders model good/kind behaviour (i.e. leader acts as role model, is faithful, is nice to PLWHA) • Church leaders speak positively about HIV (ex. leader talks about being kind to PLWHA, brings up positive messages about HIV treatment, care and prevention) • Church members become kinder towards PLWHA • Church groups help PLWA (specifically action in an organized church group) • Church members discuss HIV at church/with other church members outside of church • Other discussion of church support for positive responses to HIV (ex. church encourages openness; proud of our hospital, etc)
(2) non-supportive church response	<ul style="list-style-type: none"> • Church 'isn't doing enough' • Church lacks links with helpful outside groups • Cruelty to PLWHA in the church • Do not talk about HIV in church • Discourage biomedicine/condoms in church, encourage impractical solutions (i.e. just pray and hope you do not get HIV) • False belief that church's HIV rates are low or that all members are sexually monogamous • Church belief that HIV is God's punishment, must repent • We/my church send HIV+ people to be healed • HIV positive people hide their status from the church • Church encourages polygamy
(3) generalised references to positive responses (not church specific)	<ul style="list-style-type: none"> • I/we encouraged safe behaviour/VCT/clinic visit • I encouraged others to help PLWHA • I am kind to PLWHA • I gave material assistance (food, money) • I helped (labour, visiting, cleaning, conversation) • I/we received help from outside • I stuck up for PLWHA and challenged stigma • Story of role model or positive change • Things are getting better • We do good things because of love, neighbourliness • Other positive things: People will accept me, I intend to do something good, expression of correct knowledge
(4) generalised reference to negative responses (not church specific)	<ul style="list-style-type: none"> • Blame women, focus on women's clothes • Hard to raise money/organize because of political situation • Hard to help because of material resource shortages • Lack of help from outside (bridging) or asking for help • Impractical solutions • Misinformation • Others are or will be cruel to PLWHA • People hide HIV status (of themselves or family) • PLWHA are difficult, cheeky • PLWHA feel embarrassed, inferior • I/we didn't visit or help much • Other
(5) ambiguous	<ul style="list-style-type: none"> • Church emphasizes 'being good' • Faith healing as supplement to biomed

response	<ul style="list-style-type: none"> • I converted/tried to convert HIV+ people • I/we preached/encouraged someone to stop sinning • Members try to 'reform' prostitutes • I told parents to be strict with kids about sexual behaviour • I warned someone about an HIV+ potential partner • Other (discuss male restraint versus female luring) • Youth, abstain, stop sleeping around
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The transcripts were read and coded in NVivo qualitative analysis software by a trained researcher. Three transcripts (one from each church affiliation) were read and coded by a different researcher. They were compared for inter-coder reliability and found to achieve 90%.

Analysis

The analysis took two forms: First we conducted a chi-square analysis of the relative frequency of supportive and non-supportive responses referred to by focus group participants. Second, a qualitative analysis explored the differences in responses reported by Anglican, Apostolic and Catholic respondents. The qualitative component explored all five of the thematic categories (not just the first two as in the quantitative) and paid particular attention to ambiguous responses and differences between church responses.

Findings and discussion

In all three churches, supportive responses were reported significantly more often than non-supportive, making up 76% of total coded responses. However chi-square tests suggest the frequency of coded comments for both supportive and non supported church responses were significantly different between the different church groups, as shown in table 4, below.

Table 4: Frequency of comments about church support for HIV prevention, care and treatment

Thematic category	Total	Anglican N (%)	Apostolic N (%)	Catholic N (%)
Comments coded as church being supportive of HIV prevention, care and treatment	331 (76%)	128 (85%)	119 (64%)	84 (83%)
Comments coded as church not being supportive of HIV prevention, care and treatment	107 (24%)	23 (15%)	67 (36%)	17 (17%)
Total comments	438	151	186	101

The difference between the church responses were found to be highly significant (chi-square test statistic of 23.71, 2 df, $p < 0.001$). The magnitude of the test statistic is mainly driven by the Apostolics, as they give fewer supportive responses and more unsupportive responses than Anglicans and Catholics.

Supportive church responses

The Anglican and Catholic focus groups exhibited significantly higher percentages of supportive comments in relation to HIV prevention, care and treatment than the Apostolic focus groups (Anglican 85%, Catholic 83%, Apostolic 64%, $p < 0.001$). This section details the most predominant ways in which churches were reported to be supporting HIV treatment, care and testing: (i) church encouragement to help and be kind to the sick; (ii) church members and leaders discussing and educating people on HIV, (iii) church welcoming and accepting HIV positive people, (iv) church members organizing in groups to help the sick, (v) church encouraging biomedicine, and (vi) church facilitating outside support.

Church encourages helping and being kind to the sick

Helping and being kind to the sick was the most prevalent form of supportive response to HIV found among church members in Manicaland at similar levels (Anglican 17%, Apostolic 24%, Catholic 25%). Members of all three groups described their churches as major sources of encouragement and inspiration to extend care for the sick. Church group members acknowledged that those they were helping were mainly PLWHA, although, in line with more widespread taboos about talking about AIDS in the community group members tended to talk about caring for 'the sick' than specifying that the sickness was AIDS. Participants also spoke of drawing strength from Christian and biblical teachings of compassion and caring for those in need, as the following quotations illustrate:

It is also in line with our Christian values that we managed to help other people because the Bible encourages us to do so. (AN, female, Anglican, St Theresa1)

The spirit of God is the one that leads us....The Bible talks of Paul who really did anything for the ill and those who did not know God (JO, male, Apostolic, St Theresa1)

Christianity is a way of life that requires us to be kind and soft with HIV/AIDS sufferers and all patients in general. We are advised to be gentle with HIV/AIDS sufferers and to avoid being rough or rude with these patients, in doing this one would be fulfilling what we are advised to do at church. We do this so that the patient doesn't feel neglected which may make them feel down. We try to do this so that these patients can feel loved. (CE, male, Apostolic, St Theresa3)

I also did what I did [helped someone with AIDS] because the Bible commands us to help and be kind to all people without considering whether the person is related to us or not, therefore everyone is a relative because we were all created in the image of God. Therefore we should treat everyone like they were our relatives. (GR, female, Catholic, Nyazura2)

It will also be in fulfilment of what Christ requires of us as Christians, as Christ says in the Bible, "You saw me when I was sick and you did not help" (PE, male, Catholic, St Theresa1)

Focus group participants provided hundreds of examples of helping the sick; the great extent of assistance offered is particularly inspiring considering the focus group discussions took place during the period of political upheaval and hyperinflation. Church members worked individually or organized in groups to: (a) provide money for PLWHA to buy food or other goods, get transportation to the hospital and pay medical fees; (b) physically care for PLWHA (washing, cooking, carrying inside or outside, applying lotion to skin infections); (c) donate labour in the form of ploughing fields or fetching things (such as medicines); (d) care for families of PLWHA (bathing and feeding the children of PLWHA) and (d) praying for PLWHA. The following quotations are examples of the range of assistance offered by church members.

I managed to assist my neighbour who is suffering from HIV/AIDS. This person has a young child, she was bedridden for some time but now she is recovering very well but she still needs assistance with cooking and bathing her kid, so I bath the child every morning and also give the child the food. At one time she did not have the money to go to hospital so I had some little money but I am mainly helping her with her household chores including doing her laundry. Some people in this group have also been very supportive; together with some members here we visit and pray for her. We also visited a number of other HIV sufferers and prayed for them and this is something that we are still doing at least once every week. (CA, female, Anglican, Nyazura2)

In our church, which is the Saturday Johane Masowe Apostolic sect, we help right from things like working in fields of those patients. We also help with food items. Some people even make an appeal for food assistance so we brace ourselves and help. We have an uncle who is ill and people go there and do their prayers and I passed through some days ago and left some money. Some people help in other ways. As Christian we will not tire from helping because the Bible calls us to help. (MI, male, Apostolic, St Theresa1)

We have also managed to visit a local person who was living in town and came here after the harvesting season so she didn't have anything from the fields. We took our own food and gave it to her as well as our monetary contributions. We also went there and did prayers for her. (AA, female, Catholic, St Theresa 2)

Several respondents discussed the challenges of helping people in the later stages of AIDS, when they lack the strength to use the toilet and are suffering from sores. The following long quotation describes, in detail, the caring for someone with advanced AIDS:

I went there but I was greeted by an unpleasant smell and a swarm of flies. The problem was that this patient had no close relative looking after him. There was the wife who was also ill. So on getting in the house together with my friend from church and we saw the patient was wrapped in blankets undressed. We asked what was the problem and the wife said the whole body was aching, and the guy also said this is what you are seeing and I don't have anyone to look

after me my wife is tired of the chores. We then tried to unwrap the blankets, only to see that the guy has been soiling himself for some time and the wife was just wrapping it on him. It was all faeces around.

We were three when we went there but the third guy left when he saw that. I asked the wife for a dish and water. We carried the patient together with the mat he was sleeping on. It was so dirty and there were already some maggots. We took the patient in his mat and blankets outside and took him to the toilet. We sat him on the bench. We poured water over him so that mess can soften a bit. It was just an eye sore. God helped and we encouraged each other with my colleague and we bathed the patient and we went on to clean the house and the place where he was sleeping. We put out all the dirty clothes outside and soaked. (TE, male, Apostolic, Nyazura 2)

The stories told during the focus groups, of which the above is an example, highlight the extreme challenges of caring for people living with AIDS. People drew heavily from church and biblical teachings that encouraged them to persevere in their efforts to help the sick.

Discussing and educating people about HIV

Anglicans in particular referred frequently to the church actively discussing and educating people about HIV (13% versus 2% for Apostolics and 5% for Catholics). For example, JA, from the Anglican group in Nyanga, explains:

The church has identified that gap in information so they set up an AIDS committee to disseminate HIV/AIDS information... We are not focusing on having people disclose their status but just empower people with information that is accurate and may eventually help reduce stigma. (JA, male, Anglican, Nyanga)

Anglicans from several other groups reinforced the systematic integration of HIV discussion and education into their church programmes:

At every church service we have managed to create time to talk about HIV/AIDS. This also helps us to educate our youths to avoid behaviours that may put them at risk of getting HIV/AIDS. However such HIV/AIDS talks are given in the church where everyone will be there. So everyone will be able to hear for themselves. (RE, male, Anglican, St Theresa 3)

Apostolic and Catholic participants also referred to discussions of HIV within the church. However it appeared that most focussed either on warning youth or caring for PLWHA rather than congregation-wide education and discussion.

Welcoming and accepting HIV positive people

Anglicans showed the most frequent references to the church welcoming and accepting HIV-positive people (12% versus 8% for Apostolics and 6% for Catholics). Members emphasized that HIV positive people who wanted to join the

church were welcomed and that members who disclosed their HIV-positive status were treated with love and acceptance. CH, an Anglican, explains:

There were even HIV/AIDS sufferers who fell seriously sick and decided to join our church in order to access help. But our priest... encouraged us to accept these people as any of our members. The Priest baptized them but some passed away just after baptism. (CH, male, Anglican, Nyazura 2)

The notion of HIV positive members having to repent, with the tacit assumption that they have sinned, underlay many of the discussions on welcoming HIV positive people into the various churches. However, an overwhelming attitude of support and acceptance for HIV positive people was clear. An Apostolic reports: "We don't talk about their illness in a negative way even if they join our church when they are already ill" (ON, Apostolic, Nyazura 2). Members of all three churches told stories of welcoming new members who were already clearly ill and extending care to them. People also talked about church members who disclosed their status and were not discriminated against and even given posts in the church:

They are treated like any other member and they are sometimes given positions in the church so that they can work together with others. We treat them like any other church member. (LA, female, Catholic St Theresa 3)

This welcoming approach by churches focuses on reducing stigma and encouraging HIV disclosure. However the notion of repentance that accompanied some churches' acceptance was likely to deter disclosure and contribute to the shame and stigma surrounding HIV.

Church members organizing in groups to help the sick

As discussed earlier, a central way in which churches respond in positively to HIV is through supportive care of PLWHA. Beyond encouraging members in general to help and be kind to the sick, respondents reported that their churches organized members into groups to extend care to the sick. This response was common across all three church groups but most common for Catholics (Anglican 15%, Apostolic 15% and Catholic 28%). Pre-existing church groups (such as women's, youth and men's groups) added support for the sick to their activity range, as the following quotations discuss:

The men in the church also have their association where we also try to address some issues to do with the roles of a father at home as a husband and father of the family. I am sure the same is also done with the women in the church. It is within these groups that we would organize and visit those suffering from HIV/AIDS. (JO male, Anglican, St Killins)

Some churches also created special care-giver groups to cope with the high burden of illness in the congregation. It is noteworthy that many respondents

mentioned the church groups' willingness to help any sick people, regardless of which church they attend. However, it appears the majority of caring work was done within each congregation.

Encouraging biomedicine and condoms

Respondents from all three churches—with the notable exception of some Apostolic sects, discussed next—reported that biomedicine (in the form of HIV testing and treatment) was actively encouraged by church leadership and among members. However, the majority of promotion of biomedical interventions was focused at those church members who respondents called 'patients', i.e. people already suspected to be or open about being HIV-positive, as the following example illustrates: "We encourage these AIDS patients to go to the hospital to have blood tests and get the proper medication" (DO, female, Anglican, St Theresa 1). There were few instances of all members being encouraged to seek testing. In this way it appears church members did not recognize a sense of personal vulnerability and instead focused on advising PLWHA.

Apostolics were generally enthusiastic to note that many of their sects encourage biomedical interventions and discourage polygamy.

Sure, as a church we teach people about HIV/AIDS, we even give people information on HIV/AIDS. We even encourage people to go HIV/AIDS tests when they get sick. We also pray for people who will be ill. We also give care and support to the HIV/AIDS (PE, male, Apostolic Nyazura 1)

Many HIV/AIDS sufferers will come to the apostolic churches seeking to be healed and they don't want to go to the hospital to be tested for HIV/AIDS, but now even in the apostolic churches we are telling them to go and get tested so that we can also pray for them while they get the right treatments. That's what we try to do as a church. (CE, male, Apostolic, St Theresa 3)

Apostolic sects vary widely and the uptake of biomedicine among most sects did not necessarily mean all had abandoned faith healing. Although at times presented as a viable alternative to biomedical care, there seemed to be instances where faith healing was reframed by Apostolics as a facilitator of biomedicine and as a way to boost the effectiveness of HIV treatment:

Some have been told they had TB and they go to Murambinda for their monthly treatments, so we thought we can also aid the process if we send them for faith healing as well. We were trying to also include the power of God in their recovery process. We are told some even react to these AIDS drugs but with the power of God things like that won't happen. The one we send for faith healing is now fit. He has also given his testimony about the marked improvement in his health. (TE, male, Apostolic Nyazura 2)

The Anglican Church was exceptional in its clear promotion of condoms. The following quotation by an Anglican priest exemplifies the pragmatic and open approach taken by Anglican leadership:

As a church we also encourage our people to be practical. At times I also encourage people to use condoms because they have failed to stick to one partner. This might surprise some church members because they will wonder 'why is a priest encouraging condom use?' But people are only able to come to church when they are fit and healthy, so although we want to emphasize chastity and being faithful to one partner, experience has shown that people are failing to do that. Therefore I think until people learn to be faithful it's better to encourage them to use condoms until they have grown spiritually to a level where they can be faithful to one partner. I would think it's better to advise people to use condoms instead of pretending to be chaste when people in the church are dying of AIDS. (MA, Anglican, St Theresa 2)

Catholic and Apostolic respondents expressed greater ambiguity and variety in their acceptance of condoms. Many respondents from all churches recognized condoms as a way to stop the spread of HIV but some Catholics and Apostolics also suggested that condoms were against the moral teachings of their churches.

...We had a case of one young man who was caught with condoms, so the issue was brought to us, the church elders. We wanted that young man to explain why he wanted those condoms and what he wanted to use them for. The older men quizzed this young man because that was not expected of him and he said he had been advised to carry them in case of emergency so we also wanted to know who had advised him that. We later realized that those NGOs that were giving food relief aid were the ones who were also dishing out these condoms. That is a problem and for us we thought it was the devil's work to encourage the youths to indulge in premarital sex under the protection of the condom. (MI, male, Apostolic, St Theresa 1)

Let me say those who use condoms in the church are doing it secretly because the church encourages faithfulness to one partner and abstinence for the youths. If these values are observed surely there is no need for a condom. I am sure all that was done so that people can at least keep the sixth commandment in the Bible. So if people observe the teachings there is no need of condoms, but from my own view I think people in the church are using condoms though they would not confirm it openly. (LU, female, Catholic, Nyazura 1)

Overall, it appears that all three churches (except some Apostolic sects, discussed in more detail in the next section "Non-supportive church responses") encouraged HIV testing and treatment but only the Anglican church encouraged condom use among members.

Facilitating outside support

'Bridging social capital' in the form of networking between socially heterogeneous groups (Putnam, 2000) is thought to be a key means of enabling resource-poor people to access the networks, skill-sets and investments needed to break the cycle of poverty (Campbell, Williams, & Gilgen, 2002; Howe, 2000). Churches in Zimbabwe can provide a means for local people to access this 'bridging social capital' through partnering with sources of support outside the local church. We found that Catholic (9%) respondents spoke more frequently about receiving help from outside the church than Apostolics (1%) and Anglicans (4%). Most of this outside support was through church links with several indigenous Zimbabwean Christian non-governmental organizations (namely, Family AIDS Caring Trust (FACT) and Catholic Development Commission (CADEC)) that receive funding from international partners. The following quotation is an example of FACT's integration into church activities:

I work with the youths in the church as their mother advisor. I can confirm that we are having workshops where such issues are addressed. We even invite youths and experts from other churches. In addition the people from FACT are sometimes invited to educate our youths. These workshops are being done regularly... (GR, female, Catholic, Nyazura 1)

Surprisingly, only one focus group (Anglican, Nyasura 1) mentioned support from wealthier, better-connected church members. Most congregations in the region were composed of poor subsistence farmers. Membership in the Anglican Church served as a means of accessing support from better-off Anglicans such as commercial farmers, as discussed below:

MA, female: ...In our church we have very successful people who are also very influential yet the rest of the church is just made up very low people...people who don't have anything
Facilitator: Can you give me an example of these two groups of people?
TA, female: Here we are talking about commercial farmers who have all the inputs
Facilitator: And these are the top guys?
MA: That's true... so these people came and offered to buy 200 bags of fertilizer, or they can say how many people in here want fertilizer if there are 500 members they will buy 500 bags of fertilizer for the church members and in return the 500 church members would go and work in their commercial farms for 5 hours. We then felt this was help coming our way (Anglican, Nyazura 1)

It happens that in a church we might have some influential members who are better off like that farmer we talked about. These people may also help those in need. I am saying this because we have seen some of our poor church members being helped by those well-to-do church members. It is through going to church that one would meet these kinds of relatives and friends who would feel like helping those church members who are poor but very committed to the church. That's why I said we get real friends and relatives who care from the church even when my blood relatives can't help. Even

those who have AIDS can get helped in the church by those who have the means. (PE, male, Anglican, Nyazura 1)

While there were no comments about international bridging among congregations, wealthier western Catholic and Anglican denominations are likely involved in funding the Christian NGOs discussed above. Focus group participants nonetheless appeared unaware of any international bridging within the church.

Non-supportive church responses

As discussed previously, there were more supportive responses than non-supportive responses among all groups. Overall, there were 331 statements coded as supportive church responses and 107 (24%) coded as non-supportive church responses. This section explores these non-supportive church responses and examines differences among the three church groups.

The Apostolic focus groups had a significantly higher frequency of text segments coded as church responses that were not supportive of HIV prevention, care and treatment (36% versus Anglican 15% and Catholic 17%). In particular, Apostolics spoke frequently about faith healing and curing HIV through prayer as an alternative to biomedical care (17 comments and 9% of total Apostolic comments versus none in Anglican focus groups and one in a Catholic focus group).

We now examine specific church responses to HIV that did not support prevention, care and treatment. The most common topic was: (i) people do not disclose their HIV status in church. Other frequent topics were: (ii) cruelty towards PLWHA in the church; (iii) church discourages biomedicine (limited almost entirely to Apostolics), and (iv) belief that HIV is punishment and that those infected must repent (again limited to Apostolics).

Hiding HIV from the church

References to people hiding HIV from the church were quite prevalent, particularly among Anglican (8%) and Apostolic (8%) respondents compared to Catholic respondents (4%). The following quotations show a sample of church member efforts to hide HIV from church members:

TH, female: What I know is that we just visit patients and we were doing this even before this disease called AIDS. We just visit patients in general, because people do not really open up, they will never admit that they have HIV/AIDS.

JU, female: Most of them say they have malaria. (Anglican, St Killins)

I also want to say that in our apostolic church people normally don't open up about their status because they believe their church's teachings which state that HIV/AIDS is proof of adultery, and adultery is totally forbidden. In our churches it is not possible to open up as the church leaders would then begin to accuse the person of adultery. (AP, male, Apostolic St Theresa 1)

In our churches to be honest there is really nothing happening to help AIDS patients or to fight that stigma. Some of our Apostolic churches do not allow their members to go the hospital for tests or any pills. So a lot of people do not know their status. They say it's enough to believe that partners do not have any other sexual partners besides their wives. So nobody can disclose their status to the church as they would be subjected to questions like how they got that disease when they are not allowed to have any other partners. Fine, in our churches they concentrate on teaching about faithfulness. (IT, female, Apostolic, Nyanga)

... We have a problem with some church members even hiding their ill relatives away from the church. Some people don't even tell church members that they have an ill relative at home. (AB, male, Catholic, Nyazura 1)

The frequency of comment on people hiding the nature of their illness from church members or hiding sick family members likely reflects a high level of stigma remaining among communities in general.

Cruelty towards PLWHA in the church

Cruelty towards PLWHA in the church generally took the same form as stigmatizing action in other areas of life: not wanting to touch, sit near or eat with someone known or suspected of being HIV positive. While participant references to cruelty towards PLWHA in the church were rare, these discussions generally linked closely to why people were thought to hide their HIV status from the church community:

There are also some people in the church who hide this illness from fellow church members for fear of being despised. Some women even laugh at those women with husbands who are suffering from HIV even within the church. So the wife will not reveal to the church for fear of that kind of humiliation from fellow church members. (EU, female, Anglican, St Theresa 2).

In the following, an HIV-positive woman, EN (Apostolic, St Theresa 2) shares her personal experiences of cruelty from other church members:

Within the church some people are still cruel and hard hearted... Even when we are talking to other people if I raise an idea that people do not really like you will hear comments like "AIDS has now got into your brain." That is so painful because one would be feeling bad for having disclosed their status to the public. A lot of people who have not had an HIV/AIDS sufferer in their families have such painful and crude comments to make about us HIV sufferers. (EN, female, Apostolic, St Theresa 2)

Church discourages biomedicine

Limited almost entirely to some Apostolic sects, there was evidence that church teachings and leaders strongly discouraged going to hospitals and taking medicine, as the following quotations illustrate:

Some of our Apostolic churches do not allow their members to go to the hospital for tests or any pills. So a lot of people do not know their status. They say it's enough to believe that partners do not have any other sexual partners besides their wives. (AA, male, Apostolic Nyanga Control)

...Some of our colleagues in the Marange sect do not allow their members to go to hospital; however the church leaders are known to be secretly going to the hospital when they or their loved ones get sick... So we would encourage the government to educate our church leaders so that people can be free to go to hospital (PE, male, Apostolic, Nyazura 1)

Members of Apostolic sects also mentioned having to ask for permission to seek biomedical care and that permission was only granted by church leaders in the case of injuries or wounds that refused to heal. Faith healing was frequently discussed as a viable alternative to biomedical care:

We also helped HIV/AIDS sufferers in our church, we send them for faith healing to our Bishop in the name of Christ and they have been healed. (ON, male, Apostolic, Nyazura 2)

We send the AIDS sufferers to our faith healing because we realized they were sick and that's our church procedure for people who are sick. We also send them there so that they can be helped. (PE, male, Apostolic, Nyazura 3)

It is noteworthy that the majority of times that Apostolic respondents brought up issues surrounding their church's discouragement of biomedicine they portrayed this discouragement as problematic. Some expressed hope that Apostolic sects that discouraged biomedicine would change. Others suggested that their church's strict stance was leading to new infections as the following illustrates:

... Our youths in our churches are not being encouraged to go for HIV tests before marriage and some innocent people may get the virus that way. (KU, female, Apostolic, St Theresa 2)

Notably there were only two comments (both Apostolic) about the church encouraging polygamy and four comments (also all Apostolic) on the church forbidding it, again highlighting the diversity of approaches taken across Apostolic churches.

HIV as punishment; infected must repent

Notions of HIV as God's punishment and something for which people must repent occurred only among Apostolics and were relatively uncommon (4% of comments).

You encourage people not to sleep around and that is also in line with God's teachings. It is my belief that God brought this illness as a punishment to those who sin (TE, female, Apostolic Nyazura 2)

GLADYS. This disease make people laugh at the sufferer because biblically this disease came as a punishment for people who sleep around, Deut 28 talks about punishment to the sinners. The result of sin is death. (GL, female, Apostolic, St Killins)

This approach to HIV perpetuates stigma, discouraging members from accessing testing, care and treatment.

Conclusion

This paper has examined church responses to HIV in eastern Zimbabwe by exploring comments made by Anglicans, Apostolics and Catholics during focus group conversations. This paper adds to the current literature on church responses to HIV in Africa by providing a case study of the ways in which communities in Zimbabwe find support or a lack of support from their churches as they respond to HIV. Previous research on African churches and stigma have found that the widespread conservative morality of Christian churches, which typically includes the stigmatisation of sexuality, particularly the sexuality of women and young people, has entrenched stigma and shame surrounding HIV (Campbell, *et al.* 2002, Zou, *et al.* 2009). However, in our research we were surprised to find no comments from Catholic and Anglican church members discussing HIV/AIDS as punishment for immoral sexual behaviour. Participants spoke of how monogamous married people can be infected by an unfaithful partner and how unfaithful people still need love and kindness if they become sick. Members of some Apostolic sects did speak openly and with vehemence about the 'immoral' behaviour that leads to HIV for those who transgress sexual norms, but these comments were relatively uncommon. Similarly, church discouragement of biomedicine was rare even among Apostolics who have, in the past, taken anti-biomedical stances (Gregson, *et al.* 1999).

While this finding is encouraging, the lack of overt stigmatizing comments about HIV as a punishment for sinful behaviour should not be interpreted as evidence that HIV/AIDS stigma is no longer prevalent. The high level of comments from all three churches about families caring for HIV-positive members feeling the need to hide HIV from the church suggests that stigma is alive and well. This finding is further bolstered by comments about cruelty from church members towards PLWHA and their carers. Perhaps participants from the Catholic and Anglican groups were particularly sensitive to the social desirability of not expressing personal stigmatizing attitudes in the focus groups, in the presence of outside researchers. They were, however, able to discuss generalized comments about other people hiding HIV from the church or make observations about having seen others being cruel to PLWHA.

Nonetheless, our study provides evidence that the major Christian denominations in Manicaland are playing an important role in supporting local HIV competence. Participants discussed supportive church responses to HIV in great detail and about three times more frequently than unsupportive responses. The capacity of

churches to inspire and encourage their members as they cope with extremely sick people with very limited material and economic resources was compelling. The organization and commitment of church-linked women's groups and home based care groups suggests that church members have developed a strong sense of solidarity and confidence in local capacities. Participants frequently mentioned church efforts to discuss HIV-related information and encourage accessing VCT and HIV testing and other biomedical resources. In addition, church access to external support networks can enable poor people to 'bridge' much needed resources. It will be important to follow up and investigate changes in church responses to HIV as ART increasingly prevents the physical deterioration of PLWHA. At a policy level, since the majority of churches studied are already offering high quality and compassionate care for the sick, they are likely to be able to put additional HIV nursing resources to good use. When considering stigma-reduction and the creation of social environments conducive to the uptake of VCT and ART, church members seem eager for more frequent and open conversations.

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Technical report 3

**How do indigenous community groups
talk about HIV?**

**The role of social capital in building HIV competence in
rural Zimbabwe**

Scott, K,
Campbell, C,
Gregson, S,
Nhamo, M,
& Nyamukapa, C,

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Abstract

Background: Very little is known about how indigenous community groups in Africa (as opposed to externally developed interventions) are affecting local responses to HIV. Social capital in the form of group membership has been found to have significant impact on health behaviour. However, the relationship between group membership and HIV-related outcomes is complex. Social spaces---meetings in which people can engage in critical dialogue and process alien information about HIV---may offer insight into the transformative potential of community group participation.

Research question: In what ways do indigenous community groups offer members access to social spaces for dialogue that can lead to HIV-competent community responses?

Methodology: We analyzed HIV-related dialogue among members of 15 community groups (123 people in total) in Manicaland, Zimbabwe such as church groups, burial societies, sports clubs and farmers groups, using critical discourse analysis. Dialogue segments were coded as supportive or non-supportive of community HIV- competence.

Findings: Participants in community groups accessed social spaces in which they (1) challenged each other and challenged social norms through revealing and discussing ideological dilemmas; (2) discussed and processed HIV-related information; (3) shared emotional stories about being infected and affected by HIV; and (4) shared both models of positive responses to the epidemic and plans of ways to better cope with HIV. However some dialogue appeared to hinder the development of HIV competence by (1) reinforcing damaging myths/concepts; (2) generating cruel or impractical solutions to deal with HIV; (3) providing a forum for 'teaching' incorrect HIV-related information and (4) reinforcing a sense of collective helplessness to do anything to protect oneself from HIV and negating the development of positive community coping strategies.

Conclusion: Participation in indigenous community groups can enable members to access transformative social spaces. However, not all group dialogue takes this form. Efforts must be made to work with local groups to encourage critical dialogue in order to allow members to challenge harmful social norms and conceive of positive local responses to HIV.

Key words: HIV competence, dialogue, indigenous local responses, social capital, group membership, Zimbabwe

Introduction

This paper explores how members of community groups talk about HIV. It seeks to add to the conceptualization of community-level influences on health, and in particular the psychosocial processes made possible by social capital in the form of community groups. Local groups, such as savings co-operatives, religious groups and sports clubs, play a complex role in community life. They affect community interactions and identities in ways that are increasingly believed to exert significant positive or negative impacts on health and can provide a key form of health enabling social capital.

Social capital refers to the networks that exist within communities that enable residents to work collaboratively and in conditions of mutual trust and support for mutual benefit (Kawachi 2006). Putnam (1993, 1995, 2000) focused on the importance of high levels of civic engagement, particularly through membership in voluntary community groups, on positive health-related behaviour and support. High social capital has been found to be significantly correlated with higher self-rated health and life expectancy (Kawachi, Kennedy, & Glass, 1999; Mansyur, Amick, Harrist, & Franzini, 2008).

Social capital is thought to promote health by facilitating access to beneficial information and creating norms of trust, social support, and reciprocity that reduce risky behaviour. However, the relationship between civic involvement, particularly group membership, and health outcomes is complex and still not fully understood (Hawe 2000). The existence of what has been called 'antisocial capital', i.e. networks generated by groups that normalize and perpetuate negative behaviours and reduce potential for positive connections (Baum, 1999), further complicates efforts to understand and promote health enabling social capital.

In terms of our understanding of HIV-related behaviour, social capital has proven to be an issue that defies generalization (Campbell, Williams and Gilgen, 2002; Pronyk, *et al.*, 2008). Correlations between group membership and HIV risk factors are not yet clear and demand further attention. For instance, Campbell, Williams and Gilgen (2002) found in their study of a South African mining community that correlations between membership in different groups and alcohol consumption, casual partners, and condom use with casual partners to be varied and not always in the directions hypothesized. While membership in some groups, such as sports clubs, were correlated with lower levels of HIV, other groups, such as savings clubs, were correlated with higher incidence of HIV among young men and greater likelihood of alcohol consumption among young men and women.

Pronyk, *et al.* (2008) found that residing in households with greater levels of social capital measured as a function of trust and solidarity was linked to lower HIV prevalence and higher levels of condom use for males and females. When social capital was measured as a function of group membership, higher levels were associated with protective psychosocial attributes and less risky behaviour but also with higher rates of HIV infection for females. Gregson *et al.* (2004) found that participation in local community groups was often positively associated with successful avoidance of HIV for young women. However, these associations depended on a range of factors that include the functioning level of the group, its purpose, and the education level of the individual participant.

There is growing interest in the concept of community strengthening and local sources of resilience, particularly in the context of HIV-affected communities. However there is less knowledge about how to conceptualize a resilient or competent community. Moreover, there is very little theoretical understanding of the types of health promoting psychosocial processes that group membership enables---and conversely the elements of other groups that hinder the development of HIV competence. When group membership can be found to promote positive health behaviours, we do not yet understand what it is about being a member of a group that encourages these behaviours. Equally importantly, our conceptualization of what aspects of some groups lead to riskier behaviour is still in its infancy.

This paper seeks to advance conceptualizations of community level HIV competence and contribute to the development of a theoretical model of the psychosocial processes at the heart of the relationship between group membership and HIV-related behaviour. We do this by presenting a framework through which to conceptualize how group membership affects HIV-related behaviour that has emerged from our analysis of extensive qualitative data gathered over the past five years.

Theoretical contribution

This paper aims to make a theoretical contribution to the literature on transformative social spaces, which focus on the role of dialogue in building critical consciousness among communities coping with health issues such as HIV. We examine peer-to-peer conversation between members of indigenous community groups to better understand the ways in which community participation leads to health enabling—or health damaging—social understandings of health and social issues.

Outsiders providing local people with information about health issues has proven insufficient; a generation of programme evaluations suggest that such information-based health promotion approaches have had remarkably limited impact on the behaviour of their audiences (Wallack, 2003). Information is often a very weak determinant of behaviour change, particularly amongst marginalised social groups whose freedom to control their behaviour may be limited by wider social conditions such as poverty or gender.

Furthermore, individuals are not 'empty vessels' that can be 'filled up' with new information. All human thinking takes the form of a process of dialogue – a communicative form, we might say – the process of debate or argument and counter-argument, conducted between individuals (Billig, 1996). People constantly evaluate new sources of knowledge both in terms of pre-existing assumptions, habits, custom, ideology and tradition, and also in terms of the often contradictory motivations that influence their behaviour as they move from one social setting to the next.

Health-related behaviours are not simply the result of individual knowledge and skills imparted to passive audiences by active health communicators. They are nested within complex social structures in which people collectively appropriate and construct new meanings, identities and behavioural possibilities from one moment to the next in response to the challenges they face in their lives. For this reason, effective health communication needs to facilitate situations that constitute a microcosm of 'the thinking society' – through encouraging target audiences to participate in the processes of

dialogue and debate through which identities and behavioural possibilities are created and recreated.

Building transformative social spaces

How can the types of social spaces most conducive to the processes of empowering and critical dialogue be characterised? Fraser (1990) argues that in unequal societies, the public sphere tends to be dominated by men rather than women, the wealthy rather than the poor, and to provide limited space for ethnic minorities to exert influence. Marginalised groups tend to lack the confidence, skills and social legitimacy to advance their needs and interests. For this reason, she posits the concept of 'counter-publics', which refers to safe separate spaces in which marginalised groups can retreat, to develop and 'rehearse' the types of critical arguments they will eventually take into the dominant public sphere as part of the project of challenging the power of dominant groupings, and demanding their share of symbolic and material social power.

What psycho-social processes need to take place within these 'counter-public' spaces, best equipping marginalised groups to respond effectively to the challenges of their environment? Education theorist Paulo Freire (1973) answers this question with his concepts of dialogical critical thinking and praxis, through which people are able to reflect on and transform their existing understandings of themselves and their place in the world, and act to improve their life circumstances.

HIV competence and safe social spaces for dialogue

In the context of HIV, this reflection and dialogue is central to the development of community-level HIV competence (Campbell 2003; Campbell, Foulis, Maimane, & Sibiya 2004; Campbell, *et al.* 2005a, 2005b; Campbell, Nair & Maimane 2007). An HIV competent community enables or supports the renegotiation of social identities and the development of empowerment and critical consciousness (Campbell & MacPhail 2002; Campbell & Jovchelovitch 2000). It supports dialogue between community members and critical reflection in contexts of misinformation, denial and stigma in relation to HIV and AIDS. Friere describes this process of empowering critical dialogue as *concientisation*. He suggests that discussion facilitates the development of critical and empowered understandings of one's circumstances and social environment, which in turn leads to critical and deliberate action (Freire 1973; Freire & Macedo 1987). HIV stigma has been found to limit opportunities for dialogue in HIV affected communities, severely curtailing opportunities for community members to challenge one another to think critically and constructively about local responses to the epidemic (Campbell, *et al.* 2005a).

We are interested in peer-to-peer dialogue made possible through membership in local groups because we hypothesise that it may enable critical dialogue. Such dialogue could inform the development of new ways of making sense of the world, and alternative social relationships. We present an analysis of dialogue between group members to explore the positive and negative forms of communication made possible by these social spaces.

Methodology

Study site

Manicaland is a province in eastern Zimbabwe with an HIV prevalence rate of approximately 20% (Gregson, *et al.*, 2010). Residents of the region are primarily subsistence farmers, or work for mining companies or large commercial forestry or tea estates. Most live in rural homesteads (compounds with several mud and thatch houses, a pit-latrine and animal pens), often without electricity. Many families have members working in major cities, some of whom send money back to the rural areas. Poverty is a major challenge and many local people receive food aid from international organizations.

Dataset

Our qualitative data consists of 15 focus group discussions in which 123 members of pre-existing community groups talked about HIV issues with their fellow group members. These focus group discussions sought to serve as ‘microcosms of the thinking society’ (Lunt 1999), giving us a sense of how group settings enable people to talk about HIV in health enabling and, at times, health damaging ways.

Table 1: List of groups and participants in focus group discussions

Type of group	Location and specific name	Focus group participants	Brief description
Church group	• Nyazura ZAOGA Women's group	8 (all female)	Members from this Apostolic church meet outside of regular church worship times. They engage in Bible study, discuss marital issues, and perform community outreach
Burial society	• St Theresa burial society	8 females, 3 males)	Members contribute small sums of money to a central fund to cover basic funeral expenses for themselves and other members (when they pass away). Members commit to organizing proper burials for one another and often sing at funerals. Generally meet monthly.
Home based care group	• Nyazura home based care • St Theresa community health workers • St Theresa home based carers	7 female) 8 females, 4 males) 10 females, 2 males)	Home based care groups are frequently linked to local churches or NGO. Members generally receive basic training in nursing and visit the homes of families with sick members. They offer emotional and practical support, often bringing blankets and food, helping bathe the sick, and providing advice, such as about nutrition or encouragement to visit the clinic. Membership is primarily female.
Rotating credit society	• Nyazura saving's club	6 female)	Members contribute money to a central fund and, when they reach a certain amount, the money is shared for income generating projects such as buying seeds. Members can borrow from the central fund at a low interest rate and non-members can borrow at a higher rate.
Women's group	• St Theresa Linkage Trust and Zimbabwe Ahead	8 female)	These groups are generally linked to government women's empowerment initiatives. These groups are often supported by government income generating grants.
Sports club	• Nyazura soccer club	9 (all male)	Usually all-male sports clubs organize tournaments (primarily soccer) against other regions.
Youth group	• Nyazura ZANUPF	9 (5 female, 4 male)	Generally organized by political parties or school teachers, these groups seek to develop leadership skills

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	youth			and provide recreation for young people (under 18)
	• St Theresa Roman Catholic Youth	7 (4 female, 3 male)		
Cooperative	• Nyazura garden cooperative	10 females, 2 males)	(8 2	Generally linked to income generation, participants meet to exchange advice, share resources (such as seeds) and discuss challenges (such as drought)
	• St Theresa CIDA	7 females, 4 males)	(3 4	
Farmer's group	• Nyazura Bee Keeping	10 females, 3 males)	(7 3	Farmers, both male and female, meet monthly to plan crops, discuss weather patterns and new technologies, share labour and access NGO assistance
HIV Group	• St Theresa Support Group	9 (7 female, 2 males)		HIV groups include post HIV test clubs (mostly PLWHA), HIV/ART support groups, youth HIV awareness groups and peer HIV education groups. They are generally linked to local clinics or NGOs.
	• St Theresa Peer educators	7 females, 2 males)	(5 2	
Totals	Groups: 15	Participants: 123	(85 female, 38 male)	

The focus group discussions were modeled on community conversations, an increasingly popular method of engaging community members in peer-to-peer dialogue about health and social issues (UNDP, 2004). The aim of these focus groups was to observe and document the pre-existing understandings, conversation styles and relationships between group members. The facilitators, who were social scientists trained in research methods, did not put forward any new information during the conversations. They attempted instead to elicit the breadth of knowledge, understandings and attitudes already existing in the group.

Our analysis of focus group discussions by members of community groups sought to answer the question: To what degree and in what ways do community groups offer members access to safe social spaces for dialogue that can lead to HIV-competent community responses? We analyzed the transcripts using critical discourse analysis, coding dialogue segments that pertained to positive or negative HIV responses, with particular attention to disagreement and consensus among participants. We focus on the 'action orientation' of discourse (Heritage, 1984), examining how statements, stories, jokes and all other parts of speech are highly context-specific and perform a wide variety of social actions for the speaker and on the speaker. In particular, discourse analysis enables us to identify and analyze the ideological dilemmas (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988) and interpretative repertoires (Gilbert and Mulkey 1984; Potter and Wetherell, 1987) that exist in a society.

Findings

We found that community conversations among group members contained elements that had the potential to contribute to the development of HIV competence as well as elements that risked hindering effective community responses to HIV. In terms of contributing to the development of HIV competence, we found the presence of rich dialogue in which community members (1) challenged each other and challenged social norms through revealing and discussing ideological dilemmas; (2) discussed and processed HIV-related information; (3) shared emotional stories about first hand

experiences of being infected and affected by HIV; and (4) shared models of positive responses to the epidemic and concrete feasible action plans of ways to better cope with HIV.

In terms of conversation outcomes that appear to hinder the development of HIV competence, we found that dialogue between group members could (1) reinforce and entrench damaging myths/concepts; (2) generate uncontested cruel or impractical solutions to deal with HIV; (3) provide a forum for 'teaching' incorrect HIV-related information and (4) reinforce a sense of collective helplessness to do anything to protect oneself from HIV and negate the development of positive community coping strategies.

(1) Dialogue in social spaces created by the groups: Facilitating the development of HIV competent communities

1.1 Challenging each other and challenging social norms

Our focus group discussions with members of groups revealed frequent engagement in rich dialogue where members both challenged one another and prevailing social norms. These moments of debate bring to the fore existing ideological dilemmas in the community, which represent conflict between different interpretative repertoires.

Ideological dilemma 1: Is it men or women who do not want to use condoms?

A surprisingly common dilemma arose around the question of whether men or women were behind low levels of condom use in the community. Most dialogue began with the conventional repertoire that men do not like condoms and that women try to navigate for their use but find it difficult to convince their sexual partners, particularly in the context of marriage. However in many conversations, it quickly became clear that another, less accepted repertoire existed, which complicated the subject positions of masculine sexuality and feminine responsibility. Women began expressing their own dislike of condoms and in doing so spoke of their own sexual pleasure and preferences.

In the following example from the Nyazura garden co-operative, a discussion on condom use began with conventional subject positions and interpretive repertoires but quickly deviated from the traditional discourse of male desire and female sexual passivity. SA (female) begins by stating "It's difficult to use them [condoms] in the home because men don't accept," and JU (female) agrees, adding:

The problem that we have with our men is that they are not used to the issue of condoms. It's foreign to them they always say that they don't want to do that because it's like sucking a wrapped sweet.

The discussion continues in a conventional vein, situating females as the responsible ones, who would like to use condoms, and men as irresponsible, unfaithful and pleasure-driven. Several men and women discuss how condoms are for using with sex workers and that men refuse them with their wives. RH (female) challenges these assumptions, stating that she actually does not want to use condoms herself. She frames condom use as an issue of trust and respect:

Personally I wouldn't want my husband to use condoms for me because I feel that he is not even respecting me.

Generally, women spoke about their role as 'innocent' and faithful with no desire of their own, pointing to men as the ones who want sex. MA (female) from the Nyazura Savings Club exemplified this subject position:

The problem with men is that whenever they get hold of money they think of spending that amount with prostitutes. We married women will be innocent staying at home expecting the husband to come back and these are the very people who come back with diseases.

While MA reflects a common theme, it was surprising that some other groups actually complicated this widely repeated construction of women and instead discussed female sexuality and desire. In the St. Theresa HIV Support Group, TH (female) points out that men were not the only ones who were promiscuous and desired sex:

When we go to the shops we get attracted to other men and decide to have sex with them. The only solution to avoid that is be faithful to our partners.

And a minute later FA (female) returned to the same theme:

At times we are attracted to other married men and we forget to wear condoms. At least we should wear condoms.

Conversations among members of the Nyazura Bee Keeping Group also brought out women's preferences:

Yes men always refuse to wear condoms. Even personally I don't want to wear those condoms. (CA, female)

Even among the middle aged females that made up the Nyazura Savings Club, where the overwhelming message was of men and young women being the problem, some nuance was added to the discussion of condom use. JA (female) blames men, saying they want to have unprotected sex both with women outside and with their wives at home, while the wives want them to use condoms. GR (female), however suggests the story is more complex because she points out that women see condom use in the home as unacceptable. AN and JO (both female) went even further, saying that sex without condoms is actually their preference.

JA (female): These men are troublesome these are the very people who are infecting us they indulge in unprotected sex and they still want to do that when they come back home. When they come back home if you ask him to use condoms he will vehemently disagree. Men are a problem.

GR (female): If men come with condoms we women are at the fore front we always blame them for bringing the condoms at home because we regard that condoms are made for prostitutes.

AN (female): The problem is that we don't want to have protected sex because the experience is not as pleasant as that with a condom.

JO (female): It doesn't matter because condoms give us uterus problems. Personally I don't use it because our skin is different from latex therefore the minute we use condoms our skin is irritated. That's why we don't want to use protection. I know of people who have that problem because of condoms.

Group membership can place people in dialogical situations that can bring out contradictions between the prevailing social script (that women want condoms but men refuse) and the more complex reality (that women see condoms as not suitable for sex between a man and wife and that women themselves prefer sex without them). These contradictions have the potential to spur critical thought and force people to re-evaluate their understandings of social roles and norms. This process of re-evaluation can lead to more honest discussions of HIV-related problems rather than enabling the unchallenged re-statement of simplified and incorrect social scripts.

Honest discussion does not always lead to re-evaluating social scripts, something that will be discussed further in section three. At times we discovered that participants found it easier to ignore fundamental contradictions than critically re-think their positions. Immediately after the revealing and non-traditional discussion (among members of the Nyazura Savings, above) about women not wanting to use condoms Club, JO (female) returned to the standard script, contradicting herself and restating that men not wanting to use condoms is the problem:

I suggest that you call for a workshop for men only where you talk to them about what we are saying and you hear their own views maybe they might change their attitude towards condom use.

No one in the group pointed out this contradiction.

Ideological dilemma 2: Why do young women and older men frequently have sex?

A clear ideological dilemma surrounded the issue of sex between young women and older men. On one hand, there was a commonly presented interpretative repertoire that girls are undisciplined, stubborn, greedy and Westernized. On the other hand, some people challenged this attitude, suggesting that the girls are pushed into it by (1) men who prey on them, (2) parents who encourage it for the money, and (3) poverty because young girls cannot afford school fees and there are no jobs available.

ND (female), from the ZAOGA church women's group exemplifies the attitude that young girls are undisciplined.

There should be parent to child communication. Parents should discipline their children so that they know how to behave properly and respect their parents unlike when discipline lacks that's when they become prostitutes.

The Nyazura Soccer Club tended to stick to conventional subject positions (men as uncontrollably sexual, women as temptresses). However, even in that group there were moments of critical thinking where members challenged the most common interpretive repertoire of male helplessness in the face of female attractiveness:

JO (male): When we were growing up we were told that it's functional to have extra marital affair because it becomes monotonous to indulge in sex with the same women all the time. It's better for men to have three women or so.

PR (male): The problem, which we experience, is that married men are taking our women, which is pretty unfair. These are the people who are spreading the virus.

AB (male): I agree because they date young schoolgirls who are innocent.

This excerpt offers a moment of critical thought. First, JO points out the social processes of being told as children that men ought to be unfaithful and PR and AB suggest that young women are not actually the ones to blame for fuelling the epidemic, instead, for the first time after an hour of discussion, bringing up the role that men play. The next comment, by MA (male), however, returns to the common social script:

I totally disagree [with earlier comments emphasizing male responsibility] because these young girls are the people who lure us men. Us men try to avoid them but they always want our attention. We cannot resist them.

His comments were met with companionable laughter, suggesting the agreement of the group. JO (male), though, returned to the roles and responsibilities of men, appealing for men to consider their own daughters:

The only solution that we have is for men to stop dating young girls because if your daughter was being done the same thing how would you feel?

A woman in the ZAOGA women's church group pointed out that parents of young girls play a role in encouraging transactional sex between their daughters and older men:

The other problem which I have realized is that at times we parents send our children to be promiscuous because we mothers want tasty things. Therefore instead of refraining the child from dating elder we encourage it (CH, female)

Finally, several women from the Nyazura Savings Club examined the deeper link between poverty and young girls having sex with older men, painting a picture not of bad girls or bad parents---and not even bad men---but of a difficult social environment.

JS (female): If we could have industries that would be better because youths would have something which can occupy them and they can get their own income.

MA (female): I support what has been said. That's why they are prostituting, because they will need to get money from men.

Ideological dilemma 3: Is abstinence practical?

Abstinence from sex came up among youth and church groups frequently. It was often put forth as a solution to HIV but encountered strong challenges from others who suggested it was not practical. In the St. Theresa CIDA group, VE (female) proposed that abstinence is the best way to deal with the HIV epidemic. However, several members challenged this opinion:

VE (female): I agree to abstaining [as the way to deal with the HIV epidemic]. I think it's the best thing that we can do.

GE (male): What [VE] has just said, it's not feasible because we have sexual feelings and we cannot do without indulging in sex. Then we can use condoms at that stage when people are HIV infected.

WI (female): I also wanted to oppose [VE] because it's not feasible. We even hear a lot of stories of nuns and fathers getting into relationships and fathers impregnating ladies. It's not normal for people to just abstain forever... *We always want to experiment and indulge in sex so that we have a feeling of what it is like.*

The dialogue suggests that abstinence may not be practical because both men and women desire sex. The final comment by WI (female), italicized, is a particularly frank assertion of female sexual curiosity. The debate also brings up an alternative way of mitigating the risk of HIV infection, i.e. sex with a condom.

Ideological dilemma 4: What is the role of personal agency in having unprotected sex in the context of alcohol use and visiting beer halls?

Another instance of dialogue bringing about challenges to social norms occurred in the St. Theresa CIDA Group. The following discussion about the link between frequenting beer halls and becoming infected with HIV brings up issues of the 'type' of person who can become infected (men who frequent beer halls versus religious leaders), where risky sex can take place, and the role of personal agency in having unprotected sex:

GR (male): ... I think they [previous speakers] have forgotten that having a lot of fun also causes people to be infected with HIV. Because when people visit the beer hall they might not want to have sex with women but they will eventually do that. Therefore it's wise not even to go to those places.

RA (male): I disagree with what [GR] has just said because we cannot give an example of people who frequent the beer halls as the only place where people can die with HIV. We have a lot of pastors who are also dying as a result of HIV. I think that it comes down to the individual. Even if people have sex at places that are not beer halls they can still get infected with HIV.

The tendency to deflect personal vulnerability to HIV by pointing to other groups and activities as high risk is challenged by RA (above). He suggests that contracting HIV is not necessarily about the type of place one frequents. HIV, he points out, can be contracted by even the most unlikely people (pastors). A similar debate occurred among members of the HIV support group in St Theresa:

AG (female): We should not take excess beer because our brain will be manipulated to the extent that we will never have time to wear condoms.

BE (male): I don't think excess beer causes AIDS because people can still be drunk and not have sex. They can still know what they are doing at that point... My point is beer doesn't cause AIDS. Let's look at what causes AIDS and not what leads to AIDS.

BE challenges AG's assertion that beer halls and drinking lead to unprotected sex, highlighting the role of personal agency and challenging the fatalism that often surrounds beer hall activity. Instead of seeing beer halls and drinking as unstoppable forces leading to risky sex, BE presents an alternative view that you can drink and not have sex. While research shows strong links between alcohol consumption, beer hall visits and HIV contraction (i.e. Kalichman, *et al.*, 2008), BE's opinion empowers people to engage in safer sexual behaviour even when drinking alcohol and visiting beer halls.

The above two discussions on beer halls and HIV move the discourse away from seeing HIV as a result of bad people doing bad things at bad places. They present alternative ways of understanding the situation: that HIV can be contracted by 'good people' (pastors) and that people who visit beer halls can still exercise agency and avoid HIV infection.

Ideological dilemma 5: Is there HIV stigma?

In the following dialogue, the members of the Nyazura Savings Club move from denying or minimizing the existence of stigma in the community to confronting honestly the challenges that remain for HIV positive people. The first two comments present the community as a place without stigma. However after those initial statements, participants begin to suggest that stigma is still rife and that keeping one's HIV status private makes a lot of sense.

WI (female): These AIDS patients are treated properly because we always see them walking in this community which shows that people treat them with courtesy.

JO (female): I agree because HIV/AIDS is no longer something which is foreign. People have accepted it just like any other disease. I recall at one time a man decided to kill himself after he was labeled that he was HIV positive. I can see that life has totally changed. People are now talking about these issues freely.

JA (female): But it's hard to encourage people to talk about their status because there are still people who will discriminate. Being quiet is better than disclosing one's status.

JO (female): Yes it's difficult imagine how people would react if they hear that I am positive. Let's tell each other the truth: it's not appropriate to disclose one's status.

WI: It's difficult but let's try and encourage people to talk about their status.

JA: You might say that but it's not practical anywhere. A person should do what's appropriate.

JO: As for now let's not encourage people to disclose their status until all people are informed.

This dialogue illustrates increasing consciousness of the social challenges facing HIV positive people. The participants move from simplistic and uncritical approaches (everyone is kind to HIV positive people, they should disclose their status) to more complicated and inconclusive understandings (discrimination exists, it is understandable that people do not disclose).

Ideological dilemma 6: Can you tell whether someone is HIV positive by looking at him/her?

In the Nyazura garden co-operative, several participants debated whether you can tell if someone is HIV positive by just looking at them or not. One member spoke out that she herself was HIV positive and challenged the group by pointing out that she looked healthy:

EM (female): People can see whether someone is HIV with their own eyes because a person's health deteriorates. Their hair starts to fall out and even if they apply Vaseline their skin will not respond.

AG (female): I tend to differ with what the previous speaker has said. It's difficult to tell if a one is HIV infected or not. You can see that I am strong but I am HIV positive. These are things that happen in life. Generally I can say it's difficult to tell if one is infected or not.

TE (male): I disagree to what [AG] has said. In most cases a person who is HIV positive can be identified easily. They don't have a specific illness at one time. They will say that they have problems with their legs and few minutes later they would have changed. They don't have a defined illness.

PE (male): This is true. Mostly they have wounds all over their bodies and their hair normally falls out.

The debate ended there and AG's argument seemed to be defeated by others who suggest that most of the time physical signs of illness are apparent. Nonetheless, the presentation of alternative points of view and the discussion of HIV-related issues among peers can create environments for critical thinking.

1.2 Discussing and processing HIV-related information;

Most of the groups we spoke to met weekly for several hours. Members were comfortable enough with one another to be able to discuss HIV-related information, some of which, because of its link to sexuality, marriage, gender and age, was quite sensitive. We found many instances where these discussions enabled people to construct new understandings of HIV and HIV-related behaviour, transforming foreign information into knowledge that resonated with their lives and social realities. During the focus group with members from the St. Theresa Linkage Trust for example, MO (female) asked a question that had concerned her:

MO (female): I have got a question before we wrap up. I want to know what will I do if I am given a skirt or a petticoat of someone who is HIV positive. Can I wear that or can I allow my daughter to wear it?

BE (female): Yes you can wear it even when that person used to have wounds. You can still wash the skirt and iron it.

The St Theresa Support group engaged in discussion on the possible dangers of kissing someone with HIV:

AG (female): Kissing only affects when both people have open wounds.

FA (female): At times people can contract HIV when they are kissing because a person will swallow another person's saliva.

BE (male): It's not like that. A person will have to swallow a lot of saliva and not just a few drops.

DA (male) suggests that HIV cannot be transmitted through breastfeeding because he knows it is encouraged by medical professionals. However a peer explains:

DA (male): On breast feeding I don't think it can transmit HIV because hospitals encourage mothers to breast feed their children.

ME (female): I can explain. When a child is in her mother's womb that child cannot contract HIV unless during delivery or when breast-feeding. But mostly they encourage mothers who are HIV positive to choose breastfeeding or using formula milk

In many group situations, we found a wide range of opinions about HIV-related messages, such as condom use. Some people were skeptical, confused, curious or dismissive of health messages; others were familiar and comfortable with them. Group membership facilitates meetings between different understandings and viewpoints. This enables people to ask questions or challenge their peers and develop an understanding of HIV-related information in a context that suits them.

1.3 Sharing emotional stories about first hand experiences of being infected and affected by HIV

There were many instances where group members volunteered information about their own HIV-positive status or discussed someone close to them who was infected. These disclosures added salience to hypothetical conversations and humanized HIV suffering. For example, this discussion between two members of the St Theresa Catholic Youth Group highlights the power of personal experiences with HIV to add emotional weight to discussions. It begins with DV (male) saying that he would not 'waste time' caring for someone poor who has HIV. However, when a group member, CH (male), points out that he himself lost a sister just two weeks ago, and that she was poor and ill treated, DV reframes his commentary. He redefines the neglect of poor people as something 'they' (i.e. other people, not himself) will do and presents his own personal experience of neglect of poor people with HIV, perhaps to illustrate to the group that he is sensitive to suffering of poor people with HIV.

DV (male): Money plays a pivotal role because honestly even myself I will not waste my time helping someone HIV-positive who is poor.

CH (male): You know I have a sister you passed away two weeks ago.

DV: OK. I am sorry about that.

CH: But I am not sure if it was AIDS or not you know. It's painful to talk about that. I was in denial. I just could not believe it. Maybe it's because we were poor, I don't know. She was being ill-treated....

DV: Exactly. That's what happens. It's very difficult when you don't have money. They will neglect you.

In the St. Theresa Support Group, PH (female) and TH (male) discuss the realities of disclosing one's status.

PH (female): If I hear that I am HIV positive it's best to tell my relatives so that they know about my status.

TH (male): Will they not tell me that I looked for the disease myself? You know it's a tricky situation; at times they don't treat me with courtesy.

While PH seems to propose that it is relatively straightforward to be open about being HIV-positive, TH questions this attitude, pointing out that it was very tough for her to be known to be HIV-positive. By sharing her firsthand experience, TH is forcing the group to talk about the reality of stigma in the community, and is challenging PH's perspective that the 'best' thing to do is to disclose to everyone.

1.4 Sharing models of positive responses to the epidemic and concrete feasible action plans of ways to better cope with HIV

There were frequent instances when group members developed action plans on how they could collectively respond to the challenges of HIV through helping PLWHA. Members of the Nyazura bee keeping group proposed seeking outside sponsorship:

GR (female): I was thinking that the government should try and initiate other projects such as poultry keeping and others, which they can think of.

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AN (female): We shouldn't expect the government to provide for us. We should try and initiate ourselves. For example we have the bee keeping club; let's try and find sponsors for our projects unlike looking up to the government!

In the following exchange, two members of the St. Theresa Catholic Youth Group develop concrete plans to speak to their peers about stigma and visit PLWHA.

DV (male): We are going to teach people about stigma at youth camps so that they also know about it. The reason I am saying that it's because that's when we get the opportunity to meet other youths.

EL (female): We should also encourage one another to visit patients at home.

At another point, different members of the St. Theresa Catholic Youth Group suggest that their mission can be helping HIV-positive people in the community, emotionally (through visiting and being concerned about their involvement in church), practically (through doing chores) and financially (through raising money to give to PLWHA):

DO (female): We should encourage patients to go to church and help them with money.

HA (male): Money to do what?

DO: Money to pay school fees because if the patient is the breadwinner it will be difficult for children to go to school.

CH (male): What if as a group that's what we have said? That we will help the patient by doing household and paying school fees if we raise enough money to do that?

The likelihood of the group following through with this plan is questionable, particularly surrounding the financial support. The interviewer asked the group how they planned to generate the money to donate and DO (female) admitted "We didn't think about that. We thought that we could contribute money and then donate to the less privileged." The St. Theresa Support Group discussed spreading anti-stigma messages both individually, for example with FU (male) saying he will teach his family members about stigma "because when anyone is ill they always attribute that to witchcraft but it's not that," and as a group:

We should teach other about stigma. Teach other people in the community and to perform dramas and poems. (BE, male)

The Nyazura Soccer Club discussed the practical limitation they faced in accessing condoms, pointing out that it is socially impossible to ask for condoms from a family member or an elderly lady:

JS (male): The peer educator [who is given condoms to distribute] is my sister. I cannot collect condoms from my sister!

AB (male): That's right! That's why we resort to indulge in unprotected sex. I cannot collect condoms from my sister or an elderly lady when they know that I am not married!

This dialogue was followed up by MA suggesting a practical way to resolve the problem of not wanting to ask community members for condoms:

We are also asking for condoms maybe if you could try and supply us with a box or so whenever we are in a camp because at times our players are tempted to indulge in sex whenever we camp away from home. (MA, male)

Having the team itself give out condoms, particularly when at away games would address the problem of men not wanting to ask their sisters or elderly ladies for condoms.

(2) The limits of dialogue: Examples of dialogue hindering the development of HIV competent communities

Despite many instances of dialogue playing a positive role in spurring critical thinking and creative problem solving, we also found evidence of dialogue hindering the development of HIV competent communities.

2.1 Reinforce damaging myths and concepts (blaming women, denying personal vulnerability)

While rich exchanges that brought about challenges to damaging myths were common, there were also some instances where myths were perpetuated and during group conversations. Some group discussions emphasized the interpretive repertoire that men need sex and cannot be expected to control their desire. Conversations also frequently supported the social script of female blame for HIV. Group members discussed women being at fault for denying their husbands enough sex, which would lead the husbands to extra-marital affairs. There were also instances where women were blamed for spreading HIV because they engaged in commercial sex work or 'tempted' older men into relationships. We found that groups where members were predominantly male most frequently engaged in this type of harmful dialogue. Here, NA (male) from the St. Theresa Burial Society blames women for denying their husbands sex.

When women deny men their conjugal rights it causes them to go look for them to go and look for other women who will be willing to do that and they will be infected with HIV/AIDS (NA, male)

Members of the Nyazura Soccer Club repeatedly blamed women and presented their sexuality as out of their control, an attitude that found widespread agreement among peers:

AB (male): The problem which we are encountering is that a lot of ladies are the ones that are spreading HIV because they lure us men and they are all after money...

JO (male): I totally agree. Women are a problem... When I was coming here I approached a lady and she shouted back at me saying you can come as long as you have the energy and money. I was totally shocked with what happened. I never expected that from that lady because she was one of the decent people in the society. Imagine she is still a school child but I am married!

PR (male): ... You might see a lady coming from the other side wearing a mini skirt you feel that I just have to indulge in sex with her because I can't control my feelings...

JO (male): You see ladies of a while back were decent and respectful unlike nowadays. Ladies of today cannot resist indulging in sex even if a man tells the lady to wait until they are married she will obviously separate with the men because she feels that he is not man enough!

Beyond gender-based blame, we also found evidence of dialogue that reinforced denial of personal vulnerability to HIV. For example, members of the Nyazura Savings Club repeatedly deflected any sense of their own vulnerability to HIV, emphasizing that it is an issue for the youth:

WI (female): HIV/AIDS is a major problem. A lot of youths are affected with that disease. We parents are worried.

JA (female): I totally agree to what have been said. Most of these youths don't even listen to us... We have difficulties with convincing these youths to behave in an acceptable manner.

MA (female): These children are greedy. They don't even listen to us when we warn them. The minute they start to frequent the beer halls they totally change their attitude towards parents. We are shocked with what's happening nowadays.

JA (female): Children have totally abandoned our culture they have adopted western life style, which is a problem.

Jane's focus on youth sexuality as the driver of HIV, and belief that 'convincing these youths to behave in an acceptable manner' is the best way to address HIV is widely agreed with by the other focus group participants. This agreement goes against the reality that many married and middle-aged people contract HIV and that simply lecturing youth to 'behave well' is overall ineffective. Moreover, it deflects discussion from the wider social drivers of HIV and the behaviour of older people.

2.2 Generate cruel or impractical solutions to deal with HIV

Sometimes groups came up with ways to cope with HIV as a community that were cruel or impractical. Such as harsh laws (including the death penalty) for sex outside of marriage:

There should be a law that if men date a young girl he should be sentenced to death. For example, in [village name], if a lady dates a married man she is penalized. The same should be done in this community. MI (male)

When discussing what the community could do to reduce the spread of HIV, women in Nyazura Savings Club suggested outlawing short skirts and sex work and instituting virginity testing:

AN (women): [The government should] stipulate a law which will forbid every lady from wearing a mini skirt or [engaging in] prostitution. This will help our community because people will be scared to commit such offences and therefore they will not frequent the beer halls.

JS (female): ...We would rather encourage virginity testing where every child has to undergo through that procedure. It should be compulsory. The chief should award certificates to the children who pass.

The Nyazura bee keeping group also proposed virginity testing, suggesting that it would 'scare' the children away from having sex (CR, female).

2.3 Provide a forum for 'teaching' incorrect HIV-related information

While instances of 'teaching' incorrect HIV-related information were rare, there were several instances when this occurred. In the St. Theresa Roman Catholic Youth Group, one member 'corrected' a peer with misinformation. DV told HA, who correctly believes that condoms prevent HIV transmission, that they actually only work forty percent of the time:

DV (male): ...Do you know that condoms and pills prevent pregnancy and not HIV?

HA (male): But do condoms not prevent people from getting HIV?

DV: To a certain extent. I think it's only forty percent. Remember condoms have pores and these allow the virus to penetrate therefore they don't prevent anything.

The youth also reported a story told to them by a local pastor. They reported that the pastor told them that second hand clothes have HIV on them and must be avoided. In both instances, no challenges were made to the misinformation.

2.4 Perpetuation of helplessness

Almost every group expressed a sense of helplessness, suggesting that their capacity to bring about positive change in the community was limited. Most groups appealed to the researchers for help. The following quotation by members of the Nyazura gardening cooperative highlights this sense of helplessness and reliance on outsiders to solve all problems:

I was thinking that now that you have come into the community and we have told you our problems that we have. It would be best for you to tell us what to do next because we no longer know what to do. (TB, male)

Conclusion

This paper looked at the types of dialogical situations that occur in the social spaces created when indigenous community groups meet and discuss HIV-related issues. We found that group members frequently engaged in rich dialogue where members both challenged one another and challenged prevailing social norms. We suggest that participating in group meetings can enable people to access this rich dialogue and debate. However, we also caution that not all forms of dialogue are supportive of positive community responses to HIV. Nonetheless, there was overwhelming evidence of group membership placing people in dialogical situations that can bring out contradictions between the prevailing social script (for example, that women want condoms but men refuse) and the more complex reality (that women see condoms as not suitable for sex between a man and wife and that women themselves prefer sex without them). These contradictions have the potential to spur critical thought and force people to re-evaluate their understandings of social roles and norms. This process of re-evaluation can lead to more honest discussions of HIV-related problems rather than enabling the unchallenged re-statement of simplified and incorrect social scripts.

There are many ways in which participation in community groups can increase local level HIV competence. Group members were comfortable enough with one another to be able to discuss HIV-related information, some of which, because of its link to sexuality,

marriage, gender and age, was quite sensitive. In engaging in these discussions, people were able to begin translating alien medical information into their local language and worldview. We found many instances where these discussions enabled people to construct new understandings of HIV and HIV-related behaviour, transforming foreign information into knowledge that resonated with their lives and social realities. There were also instances where group members volunteered information about their own HIV-positive status or the HIV-positive status of someone close to them. These disclosures added salience to hypothetical conversations and humanized HIV suffering. Sometimes group discussions led members to share positive and inspiring stories of local responses to HIV, such as a community member who overcame stigma to be kind towards someone with HIV. At other times group members developed ideas of how they could take action to mitigate the negative impact of HIV through working to help PLWHA/caregivers or promoting testing and trying to reduce stigma.

Despite these many positive outcomes we also found that sometimes, dialogue did not serve to increase local HIV competence. At times, it reinforced harmful attitudes (such as blaming women for the spread of HIV). At other times the lively debate on what should be done about HIV led to very cruel and impractical ideas, such as banning miniskirts, forcing virginity testing and enacting laws that punish adultery with the death sentence. There were also occasional instances where group members confidently taught others incorrect information. In addition, a sense of helplessness and dependency can be reinforced in group meetings when members focus on local problems without determining how they can address them. Some conversations returned again and again to the community's incapacity to reduce new HIV infections and need for external help. While it is undoubtedly true that communities need external support, some conversations failed to move on to discussions of the many local things that communities can do, especially when it comes to reducing stigma and encouraging less risky sex.

Participation in indigenous community groups can enable members to access transformative social spaces. These spaces allow people to engage in critical thinking where social norms are debated and action plans are developed. However, community groupings are not always supportive of HIV competence and can serve to reinforce damaging conceptions and a broad sense of helplessness. Greater attention must be paid to encouraging pre-existing forms of positive social capital in the form of group membership. It is vital to determine how best to move non-critical, stagnant group dialogue into more productive spaces, which allow members to challenge harmful social norms and conceive of positive local responses to HIV.

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Technical report 4

**In what ways do community groups
support optimal access and adherence
to antiretroviral treatment in Zimbabwe?**

Scott, K,
Campbell, C,
Madanhire, C,
Skovdal, M,
Nyamukapa, C,
& Gregson, S

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Abstract

Background: Little research has been conducted on how pre-existing indigenous community resources, especially social networks, affect the success of externally imposed HIV interventions. Antiretroviral treatment (ART), an externally initiated biomedical intervention, is being rolled out across sub-Saharan Africa. Understanding the ways in which community networks are working to facilitate optimal ART access and adherence will enable policymakers to better engage with and bolster these pre-existing resources.

Method: We conducted 67 interviews and eight focus group discussions with 127 people from three key population groups in Manicaland, eastern Zimbabwe: healthcare workers, adults on ART and carers of children on ART. We also observed over 100 hours of HIV treatment sites at local clinics and hospitals. Our research sought to determine obstacles to adherence and how indigenous resources were enabling people to overcome these obstacles to achieve optimal ART access and adherence.

Analysis: We analysed data transcripts using thematic network technique, coding references to supportive community networks that enable local people to achieve ART access and adherence.

Findings: People on ART or carers of children on ART in Zimbabwe report drawing support from a variety of social networks that enable them to overcome many of the material, symbolic, relational and institutional obstacles to adherence. Key support networks include: HIV groups; food and income support networks; home based care, church and women's groups; family networks; and relationships with healthcare providers.

Conclusion: More attention to the community context in which HIV initiatives occur will help ensure that interventions work with and benefit from pre-existing social capital.

Key works: Access and adherence, antiretroviral treatment, social capital, community groups, Zimbabwe

Introduction

1.1 Community mobilization and the response to HIV

Traditionally, donor-driven community programmes have taken the form of top down interventions imposed on communities by outside agencies. Little attention has been given to pre-existing indigenous community resources, especially social networks (such as social clubs, relationships between healthcare worker and patients, and family or neighbourhood connections). These community resources can be viewed both as positive social capital in their own right, and as having the potential to strengthen externally initiated programs. More attention to the community context in which HIV prevention, treatment and impact mitigation efforts occur will help ensure that new forms of HIV support work with and benefit from pre-existing indigenous social capital.

The authors of this paper had the opportunity to examine this link between social participation and responses to HIV, particularly around access and adherence to ART, in 2009 in Manicaland, an eastern province of Zimbabwe. Our qualitative research explored indigenous responses to HIV and local facilitators of successful antiretroviral treatment (ART) access and adherence.

This report presents our findings from Manicaland, asking the following questions: (1) What indigenous resources in Manicaland promote community level HIV competence? (2) What role do they play in facilitating the success of external interventions, specifically optimal access and adherence to ART?

The report focuses on the role of indigenous community resources in terms of (a) groups facilitated by NGOs and funders (e.g. support groups), (b) indigenous community groups (e.g. women's groups) and (c) informal networks (e.g. neighbours, friends) and relationships (e.g. nurse-patient relationships).

1.2 Manicaland research on community groups and ART adherence

This report arises from research on the relationship between social participation and ART adherence, conducted over two months in 2009 in Manicaland. Our study involved over 100 hours of ethnographic observation of treatment sites as well as 67 interviews and eight focus groups discussions (FGDs) with 127 people from three key population groups: healthcare workers, adults on ART and carers of children on ART (see table 1).

Table 1: Summary of study participants

	Participants			Interviews	FGDs
	Total	Male	Female		
Healthcare workers	25	14	11	18	1
Adults on ART	62	30	32	28	4
Carers of children	40	0	40	21	3
Total	127	44	83	67	8

Ethical approval for the study was granted by the Medical Research Council of Zimbabwe (Ref: A/681) and the Imperial College Research Ethics Committee (Ref: ICREC_9_3_13).

1.2.1 Context of research

Zimbabwe gained independence from colonial rule in 1980 and experienced initial positive growth in GDP and the introduction of free primary education and improved healthcare services (Richardson, 2005). However, from 1999 onwards the country has undergone political and economic turmoil, leading to GDP decline and inflation. This turmoil, coupled with the devastating effects of HIV/AIDS, has seen quality of life dramatically decline, echoed in a decline of life expectancy from 61 years in 1992 to 42 in 2010 (WHO, 2010; ZCSO, 2007).

Despite the highly challenging political, and economic environment facing citizens, Zimbabwe is one of the first African countries to show a declining HIV rate with the adult prevalence rate falling from a peak of 26.5% in 1997 to 14.3% at most recent measure (ZMoHCW, 2009), attributed in part to reductions in high-risk behaviour (Gregson, *et al.*, 2010). While there have been antiretroviral (ARV) drugs in Zimbabwe since the early 2000s, they were in extreme short supply and prohibitively expensive for most people. In the late 2000s the government and partner aid organizations succeeded in a massive scale up of ART. By December 2009 218,589 people, about half of those in need, were on free ART through the public health sector (UNAIDS 2010).

The HIV rate in Manicaland is approximately 20% (Gregson, *et al.*, 2010). Residents of the region are primarily subsistence farmers. Most live in rural homesteads (compounds with several mud and thatch houses, a pit-latrines and animal pens), often without electricity. Large commercial farming estates in the region employ a significant portion of the local population. Many families have members working in major cities, some of whom send money back to the rural areas. Poverty is a major challenge and many local people struggle to access adequate food and afford school fees for their children.

1.2.2 Research methodology

Adults on ART and carers of children on ART were sampled using snowball, opportunistic, and typical case sampling. Snowball sampling involved having openly HIV-positive community members already known to the researchers through previous work ask their peers to participate. Opportunistic sampling involved self selected

informants who approached the researchers asking to be interviewed because they had heard about the project. Typical case sampling involved approaching adults on ART or carers of children on ART as they visited hospital or clinic sites and asking them if they would like to participate. We accessed healthcare workers (nurses, HIV counsellors, pharmacists and a clerk) by first attaining permission to interview staff and observe hospital sites from the doctor or nurse in charge. We then asked the staff working most closely with people on antiretroviral care if they would like to participate.

Researchers' requests for interviews were only refused in one case, by an ART patient who cited time limitations. Topic guides explored changing perceptions of HIV, social support and ways of coping with HIV and ART, issues surrounding treatment adherence, and experiences at the health care centre. All interviews and focus groups were guided by a loose framework of subject-based questions to elicit rich in-depth responses about the contextual factors that facilitate or hinder optimal access and adherence to ART. Questions varied depending on the interviewee (i.e. nurses, people on ART and carers of HIV-positive children were asked somewhat different questions) but generally included: "What are some things that prevent people from accessing care at the clinic?" "What encourages people to be tested for HIV and to visit the clinic?" "What helps people on ART adhere take their pills when needed?" "Can you tell me about a time when someone you know was unable to adhere to ART?" and "Tell me about a positive/negative experience at the clinic." All audio files were translated into English and transcribed by trained researchers. To thank the informants, focus group participants were given soap, and interviewees were given a t-shirt.

Over 100 hours of ethnographic observation were conducted at the health centres, observing interactions as HIV-patients waited for the doctor, paid hospital fees, visited the pharmacy, and waited for nurses to review their progress on ART and prescribe refills of their ARVs. Researchers did not observe private interactions between patients and staff. Observation focused on hospital activity, including interactions between patients and staff and the arrangement of people in hospital spaces. Extensive detailed notes were taken by the researchers throughout the hours of observation, recording what occurred (and when), how people were organized within the clinic space and comments made about the experience. These notes were included in the body of text data (along with focus group and interview transcripts) for analysis.

Data were collected by three Shona-speaking fieldworkers and a fourth researcher working with an interpreter. We analysed the data transcripts using thematic network technique (Attride-Stirling, 2001), which involved carefully reading and then coding text sections according to our research interests in indigenous community networks. Codes were sorted into two overarching themes: obstacles to adherence were grouped as theme one (discussed next), and local-level facilitators were grouped as theme two (discussed in section three).

Section two: Obstacles to ART access and adherence

Before discussing the impact of various forms of social participation in helping people respond effectively to AIDS, particularly surrounding access and adherence to ART, we first describe the various obstacles facing those in need of ART in Manicaland. We discuss these obstacles in terms of four overarching categories: material, symbolic, relational and institutional.

2.1 Material obstacles

In the interviews and focus groups both patients and nurses referred to poverty as a key constraint on adherence, hindering patients' ability to take their drugs in a range of different ways. Some of the more prevalent material dimensions influencing ART adherence reflect the high levels of poverty that characterize the context of this study and primarily refer to a lack of food and money.

2.1.1 Inadequate access to food

A key component of the counseling and support that nurses provide ARV users involves their advice on the importance of patients eating nutritional foods as part of their treatment regimen. ARVs work best if complimented with a nutrition rich diet. Some patients discontinued their treatment because they struggled to find food, witnessed little progress, and experienced the discomfort that comes with taking powerful drugs on an empty stomach.

“They say sometimes they don't take their tablets if they don't have something to eat... there is this female patient whom we initiated on ART. We gave her the two weeks starter pack, and when she came back she had not taken the tablets, and we asked why, and she told us that she had not enough food to eat before taking the tablets.” ED, male, nurse

2.1.2 Distance to clinic and transport costs

Patients who could not afford adequate levels of food often also struggled to meet the transport costs associated with going to the health clinic to attend monthly medical reviews and to pick up their monthly supplies of drugs. This was particularly the case with patients who lived further away and who had no other choice but to walk (either because of inadequate transport infrastructure or the costs). Some patients were unable to find the time and energy to make the journey.

“Distance may discourage someone to come for medication. The patient might say ‘a-ah I'm tired of going all the way to the hospital’ ‘a-ah no I will go later’ and the person will be defaulting.” PA, female, nurse

In conditions of poverty, some patients had to travel from place to place to search for support from various family members, which meant that it was often difficult for them to attend their monthly reviews and drug collections.

"One patient said she had gone to Harare to visit her husband but she failed to raise the money to come back here on time for her review, so for two months she had no ARVs." TO, female, nurse

An ARV distribution system that would allow patients to pick up drugs from any health facility may help those patients who are on the move.

2.1.3 Hospital costs

Aside from the costs related to getting to the clinics, the treatment itself also came at a cost. This is despite the fact that the ARVs are given for free. The three health facilities through which we recruited our informants all charged patients US\$1 for their monthly consultation – a cost many patients struggled to meet.

"Some patients fail to raise money for the transport to come and collect their supplies and pay for their consultation fee. These are people who don't have any source of income. Sometimes they spend a lot of time trying to sell their produce and they might forget to take their tablets." AL, female, nurse

"We are unable to raise that dollar every month when we go for reviews." AU, female, patient

Patients who struggle with food and attending monthly consultations are less likely to adhere and therefore more likely to experience opportunistic infections. Whilst people get free ARVs, they have to pay for the treatment of opportunistic infections, a cost which is often so unaffordable that the patients do not see anything to be gained from seeking medical advice.

"At times one has no money and if I know I have to pay for medicine to treat an infection, that will prevent me from going to the clinic in the first place." AG, female, patient

In relation to material context, it was clear that poverty severely undermined ART adherence and in some cases put ART users at risk of experiencing viral replication and the advancement of AIDS (e.g. through lack of food or untreated opportunistic infections). We will discuss how indigenous community networks help patients overcome these problems in section 3.

2.2 Symbolic obstacles

Various dimensions of symbolic context appeared to serve as barriers to adherence. Barriers discussed below include fear of being recognised as an AIDS patient, reflecting a continued presence of stigma, and women's disempowered position within their household.

2.2.1 Fear of being recognized as an AIDS patient

Although patients reported that since the advent of ARTs there had been a reduction in the stigmatisation of PLWHA, many patients, particularly men, spoke of feeling the fear and embarrassment associated with being recognised as an AIDS patient, saying that stigma served as a barrier to timely accessing of services by many men.

“Men are generally afraid to be identified as HIV positive. They are shy and they may only ‘come out’ after they get seriously ill. Some are afraid that people will laugh at them or look down upon them for being HIV positive.” JO, male, patient

Once enrolled onto ART, many men were deterred from attending the monthly consultations which required them to go to the ‘AIDS clinic’ and wait in long queues together with other AIDS patients. In such a situation they were unable to keep their status a secret, and many found this prospect intolerable.

“People know that this is the AIDS clinic. Some patients when they come here, they will go past the place. Then when they see me going out of the clinic, perhaps to go for tea, they will approach me secretly to ask me privately to attend to them. When I ask him to come into the clinic he will be distressed to see that there is ‘Mrs so and so’ on the bench, whom he did not want to ‘come out’ to.” CL, male, nurse

2.2.2 Women’s disempowered position within households

In this context, women’s social and often disempowered position stands in the way of their ability to adhere to treatment. BR (female) had travelled from Manicaland to see her husband, a migrant worker lodging in Harare, to collect money for their children’s school fees. However, her husband decided to spend the money on his girlfriends, refusing to give her the money she would need to travel back to Manicaland for to collect her ARV treatment.

“It was his pay day and I waited for him to come back to his lodgings in Harare after work - to give me money so that I could travel back to the rural area. However he did not come back to his lodgings. He took his money from work and went to his girlfriend’s place. The second month he did the same thing. It was only in the third month that he gave me money so I could travel back. When I came back home after the third month I went to the clinic and explained to them that I was hadn’t been able to take my treatment for almost three months, because my husband would not give me the money to come back. The nurses were not impressed - but I was honest and they tried to help me, that’s why I had to go for CD4 tests again.” BR, female, patient

BR’s economic dependence on her unreliable husband highlights women’s marginalised position in this context. Husbands’ unwillingness to accept their wives HIV status, and to support their treatment, can sometimes result in women being threatened with divorce if

they insist that they are HIV positive in the face of husband disbelief, and express determination to adhere to their ART treatment.

“Some men refuse to believe that their wives are HIV positive. They themselves refuse to come to the clinic and get tested. Sometimes, if the wife comes here to get services, the husband will threaten to divorce the wife if she continues taking ARVs. This will affect her adherence.” CL, male, nurse

This suggests that women’s economic dependence on men, facilitated by local constructions of gender, can serve as a barrier to women’s adherence.

2.3 Relational obstacles

ART adherence is heavily influenced by the social relationships that exist between ART users and the people they interact with on a daily basis, including family and community members as well as service providers. While many of these relationships facilitate treatment through supporting ART adherence (discussed in section 3), some elements of relations to family, community members and healthcare workers hinder treatment. Hegemonic notions of masculinity and HIV stigma can both negatively impact adherence.

2.3.1 Hegemonic notions of masculinity

Rooted in hegemonic notions of masculinity, men saw HIV as a threat to their manhood and dignity and exhibited a profound fear of the disease. Sickness and hospital visits were associated with weakness and the loss of capacity to provide for the family. Men also feared that testing positive would represent them as irresponsible and promiscuous. They feared their wives would leave them or, if they were unmarried, that no women would be interested in them. Efforts to conform to these dominant notions of masculinity involved having multiple sexual partners and avoiding testing, severely undermining treatment.

Notions of masculinity and associated male fear of HIV was reported to cause some men to undermine women’s treatment. Many women felt unable to disclose their HIV status to their husbands, forcing them to take their pills in secret and act without a supportive treatment partner. There were some reports of men refusing to let their wives take ARVs or stealing the drugs for their own treatment. Women also reported feeling vulnerable to re-infection because of their husband’s extra-marital relationships and being stopped from attending clinic or support group meetings because husbands feared being associated with HIV.

2.3.2 Stigma

People repeatedly spoke of stigma in the general community as a key obstacle to effective HIV/AIDS management. HIV’s sexually transmitted nature links a positive status to deep shame and being labeled ‘promiscuous’. The loss of dignity associated

with being considered promiscuous is a reason many people choose not to know or confirm their HIV status and are hesitant to access treatment openly.

2.4 Institutional obstacles

At an institutional level, some churches and aspects of the health services available presented barriers to optimal ART adherence.

2.4.1 Churches can present obstacles to ART adherence

Our informants had mixed responses to the role of churches in facilitating or undermining ART adherence. The Apostolic Church was often cited for ignoring the impact of AIDS and discouraging its followers to take medicines. However, not all churches and denominations were a barrier to ART. Some churches actively discouraged traditional medicines and healing and promoted AIDS testing and ARVs.

“What discourages some people to take their tablets is the church. Many churches don’t encourage people to go to the hospital [...] The church that I attend is different, they don’t allow traditional medicine so I now rely on pills only.” KA, male, patient

2.4.2 Quality of health services can make ART access and adherence very difficult

With the roll-out of ARVs came the training of nursing staff and a decentralisation of CD4 count machines to speed up ARV reviews. All of this, together with the availability of free ARVs, has improved people’s trust and perception in the quality of health care services available to them.

Having said this, despite the progress that had been made, many challenges remain, including the shortage of health staff. One patient explained how staff shortages (resulting in long waiting times) can discourage patients from going for their check-ups.

“There are times when we feel it is impossible to see a doctor, and one might as well just discontinue treatment and stop going there only to waste time waiting in the queue.” RO, female, patient

Other challenges faced by the health services, undermining the quality of services available to ARV users, include continued resource constraints, poor management, difficulties with repairing dysfunctional equipment, power cuts and limited access to water.

The above dimensions of context can all present obstacles to ART adherence. However, our research found that various forms of social participation helped people overcome these barriers and achieve high levels of ART adherence.

Section three: Social groups that facilitate access and adherence to ART

3.1 Formal health-related groups and interventions

Formal groups facilitated or supported by NGOs and outside funders include HIV support groups (often linked to clinics), NGO-linked community HIV education and NGO financial and food aid networks. These groups played a major role in facilitating ART access and adherence.

3.1.1 HIV support groups

The most frequently and emphatically discussed form of social support in interviews and focus groups with people on ART were HIV support groups. HIV support groups, usually organized by clinics or NGOs, were mentioned repeatedly as a major facilitator of optimal treatment. People spoke passionately of their HIV support group as central to their ability to cope with life as an HIV-positive person and ART-adherent. Support groups provided people with an opportunity to speak openly with others in the same situation. They offered a vital connection to others and a place to share problems and gain confidence to cope with challenges, as the following quotations describe.

“We [people in the support group] give each other hope. We are also happy that now people can talk freely.” HE, male, ART patient

“...The main sources of support are fellow people living with HIV/AIDS, especially those from support groups.” MA, female, ART patient

“Every time when I am feeling low, I rely on the support group. I talk about it with my colleagues in the support group. When I first joined this group many of the members were teaching me to accept my condition and that way whatever happens will be acceptable. That way we know very well that we have the hospital, the counselor and the support group when we need anything.” TE, female, ART patient

Interviewees and focus group participants discussed how support groups encouraged them to keep attending clinic appointments:

“...People still need a lot of encouragement and push. As members of support groups we keep encouraging each other not to miss our reviews.” AL, female, ART patient

“[In HIV support groups] those who are already on ART are encouraged and advised to keep their review dates and always remember to go back to the clinic.” TS, female, ART patient

Rather than saying the support group *reminds* people to go to the clinic, FGD participants like TS (above) said that the support group *encourages* people to remember to go to the clinic. The issue is not presented as people actually forgetting to go to the clinic. Instead, it is discussed as an issue of people losing the encouragement

and sense of hope necessary to 'push' them into continuing to attend appointments. This difference highlights the role of social supports to create a facilitating environment in which people can overcome the many barriers to ART adherence.

Practical information is also exchanged in support groups, such as recommendations on using condoms to avoid re-infection, when to visit the clinic, and tips on how to adhere correctly (such as sending one another's children to remind each other, getting an alarmed watch, and carrying pills to work in case of unexpected overtime). Support groups can also provide PLWHA access to income generating projects, as mentioned below:

"We are also happy that HIV positive people here are organized and we have our support group. It is so encouraging to have an arrangement whereby we meet on a regular basis as people living with HIV/AIDS. There are prospects that we can do more income generating projects."
OT, female, ART patient

While financial support was considered desirable, our FGD and interview participants were far more emphatic about the emotional and social elements of support groups. The following quotations highlight the types of positive emotional and social exchanges that can occur in HIV support groups. When asked what they would say to someone newly diagnosed as HIV positive, MA (female) and TE (female) (below) said the following:

"I will tell the person that I have been through the same road and I have been able to get advice and counseling from others at the support group. I will advise the person to join the support group. I will discuss with the person all the fears I used to have and how I overcame them. I will also advise them to go to the clinic every time they don't feel good."
MA, female, ART patient

"I will tell them that the fact that they have tested HIV positive does not mean they are now a lesser being, nor is it the end of life. I will also advise the person to go to the [HIV] clinic and also to join the support group. I will also advise the person to avoid stress and also learn to accept their result. I will encourage the person in a way that many people have been supportive to me." TE (female), ART patient

The above quotations highlight the range of essential types of support offered, including: talking to others undergoing the same process, discussing fears, exchanging practical advice about going to the clinic, rebuilding a shattered sense of self, accepting one's status and raising hope among newly diagnosed people for ongoing health through treatment.

Members of support groups also reported a desire to reach out beyond their group to discuss HIV with the larger community.

“I think as members of support groups, we should always educate others we meet in the community about the goodness of going for HIV tests.” TH, female, ART patient

This interest in reaching out to the general community highlights that support groups have enabled members to resist stigma to an extent that they can talk publically about HIV. Members of support groups expressed a positive sense of self, speaking of their groups as having a responsibility to help others in the community.

3.1.2 NGO-linked community education

HIV education programmes in the area had an indirect link to facilitating ART adherence. Peer education often focused on clearly outlining the ways in which HIV spreads, ensuring families living with an HIV positive person that regular interaction would not lead to infection. Education programmes can build awareness of the treatment options available, encouraging more people to get tested for HIV earlier. In the following, a woman on ART expresses her approval of education campaigns, linking education to early engagement with healthcare services:

“I think NGOs that deal with HIV/AIDS issues should continue the good work... Continue visiting and talking to people... People should be educated that it’s better to go to hospital before they are bed ridden. I think information campaigns should continue.” MA, female, ART patient

Healthcare workers expressed faith that NGO education programmes could increase support available for PLWHA and their carers, especially elderly grandparents caring for children on ART. In the following quotation a nurse illustrates how indigenous local volunteer groups accessed NGO support to run community education programs aimed at building supportive environments for children on ART and their carers:

“We have talked to the home based care volunteers about the problem [of grandparents struggling to support their grandchildren on ART]. They then approached [an NGO] for assistance to facilitate a workshop. They educated the community that they should try to build trust with grannies who are caring for orphans. In the event that the granny volunteers to disclose the status of the child then the community can also become the child’s treatment partner.” RS, female, nurse

The network of actors discussed by RS (nurses, local volunteer groups, an NGO, community, grandparents caring for children on ART) highlights the need to engage many groups to build supportive environments for people on ART.

3.1.3 NGO linked financial and food support networks

Support networks involving NGO contributions of financial support and food were frequently cited during interviews and focus groups as a vital facilitator of optimal treatment. Food aid, distributed by local NGOs to families with HIV positive members, served to help overcome material, symbolic and relational barriers to treatment. On a material level, increasing the amount of food available in the home helped ensure families could access adequate nutrition. Having enough food to go around for all members of the family ensured that PLWHA could eat the necessary meals to accompany each dose of antiretroviral pills. Elderly people caring for children with HIV were cited by some informants to benefit especially from food aid. As the following quotation explains, access to food for families headed by grandparents was a vital step in enabling children on ART to receive optimal treatment and nutritional support.

“Some of these children are being cared for by old grandparents so they lack food but now that problem has been met because a lot of organizations are distributing food in the area.” TI, female, nurse

Elderly carers, coping with physical deterioration, were particularly concerned about accessing the resources necessary, including food, to care for their grandchildren. Taking ARVs on an empty stomach causes great discomfort and can contribute to some people dropping out of treatment.

Informants reported that people became more open to being tested as a way to access food aid, as discussed below:

“[Before,] it was never like that. Nobody would really want to be associated with such a disease. A lot of people now want to get tested so that they can also get some food which sometimes given to people living with HIV/AIDS.” GI, male, ART patient

In addition, food aid strengthened symbolic and relational support for PLWHA in their households by reducing the burden of caring for sick family members. Having an HIV positive person in one’s home enabled families to access much needed food aid.

“I would say that what encouraged most people is that... [An NGO] initiated food handouts as well as [another NGO]. People started flocking here to come and get tested. They wanted to know whether they are HIV positive or not. Almost everyone came for testing.” BE, female, nurse

MU, a nurse, points out that the food packs both encourage testing and adherence to clinic appointments.

“People want to get tested so that they can also access the food aid. Those already on ART also make sure they come every month because that’s when they will be getting their food packs.” MU, male, nurse

Men have been found to be more resistant to HIV testing and treatment than women (Skovdal, *et al.*, forthcoming). Food aid has played a particularly important role in encouraging men to get tested, as discussed below:

“[An NGO] is giving food aid to people are living with HIV, those with cancer as well those with TB. So it has become the only way one can access this food aid, so many people are opting to be tested, that’s when we are seeing some men coming out now.” EV, female, nurse

Allowing HIV positive people to access food aid appears to have enabled some to reassert their masculine identity as providers for the household.

3.2 Indigenous, community initiated groups

Communities have extensive indigenous networks of support which exist without external funding or organizations. A recent study found that 34% of men and 58% of women in Zimbabwe were members of at least one functional community group (Nhamo, Campbell and Gregson, 2011). These groups include church groups, burial societies, rotating credit societies, farmer’s groups, sport and dance clubs, youth clubs, and women’s groups. While many of these social groups likely have indirect effects on access and adherence to ART, three groups in particular (home based care groups, church groups and women’s groups) came to light during our research as playing a central support role.

3.2.1 Home Based Care groups

One of the most remarkable indigenous, community initiated groups in Manicaland are Home Based Care (HBC) groups. Closely associated with support groups and often linked to churches and women’s groups, HBC groups are voluntary organizations with primarily female membership who visit the homes of sick people in their communities. They offer to help with cooking and cleaning and will provide encouragement, spiritual support (praying for the sick) and advice (encouraging a healthy diet and to visit the clinic). They are generally not linked to clinics or hospitals as WE, a nurse, explains:

“We are just told that there are Home Based Caregivers in the communities. Some of them we do not even know, some are even our clients but we do not know about it. So the home based care group meets and conducts meetings, giving each other feedback about their patients how they are progressing or maybe they died.” WE, male, nurse

HBC networks were said to play a particularly important role as treatment partners for children on ART living with elderly guardians:

“...On the challenges of old carers, the workshop came up with resolutions that it was the responsibility of the HBC volunteer to assist

them so that the child correctly take his medication. If she [the HBC worker] is visiting someone she should have another person monitor the child.” RS, female, nurse

Often, home based care workers were the first response point to HIV in the community, by suggesting chronically ill people visit clinic and by offering guidance to local people seeking advice. In the following TC (female) explains how widowed women often sought help from HBC workers:

“So the way it started was when someone was widowed... the wife would go to home based care group and say, ‘I don’t understand the way my husband died maybe he was positive.’ With their encouragement ...some would get tested and learn their status.” TC, female, ART patient

AN explains how she found her local support group through asking the home based care group for help.

“I went to the clinic and got tested and was told that my blood is infected and I accepted it. I then went to Home Based Care for a support group.” AN, female, ART patient

These largely unsung volunteer groups, without office space or budgets, were referenced several times during interviews and focus groups as a source of practical support (helping with chores and taking people to clinics) and emotional support.

3.2.2 Church groups

As discussed in section 2, churches play a somewhat conflicted role in the narrative of HIV in Manicaland. While they perpetuate some views that lead to fear and stigma surrounding HIV they also provide a pillar of support and encouragement for those caring for PLWHA in very difficult circumstances. The support provided to PLWHA can help them adhere to ART.

Many people drew social, spiritual and occasionally material support from their faith and from their fellow church members. Church members worked individually or organized in groups to: (a) provide money for PLWHA to buy food or other goods, get transportation to the hospital and pay medical fees; (b) physically care for PLWHA (washing, cooking, carrying inside or outside, applying lotion to skin infections); (c) donate labour in the form of ploughing fields or fetching things (such as medicines); (d) care for families of PLWHA (bathing and feeding the children of PLWHA) and (d) praying for PLWHA.

3.2.3 Women’s groups

Women’s groups, often linked to churches, also provided emotional support for people on ART, as the following quotation describes:

“Now I am taking ARVs and I clearly understand that everyone is at risk of getting HIV/AIDS. We have our support group but we also meet as women every Wednesday. I have a friend who always encourages me and try to make me have a positive attitude when I am down. I also do the same with fellow HIV sufferers. We try to up lift each other.” OT, female, ART patient

3.3 Informal networks and relationships

3.3.1 Family/home networks

The network of support available to PLWHA in the home has a strong effect on ART access and adherence. It is crucial that family members are aware and understanding of their treatment regimen, so that they can help remind the patient about when to take drugs and when to attend consultations. Treatment partners and, in the case of children on ART, adult carers and guardians, can provide practical, material and emotional support. Other people in the home, including older children, can also help create a supportive context for people on ART. In the following quotations, a nurse and patient highlight the link between adherence and family support:

“I have realized that generally [those who adhere to ART are] those people who have others who support them in the family.... Those who don't have any support from family members are the ones who would say, ‘Some days I forgot to take the pills’.” EV, female, nurse

“My family encourages me and urges me not to miss my appointments because they now appreciate how these drugs have helped me to recover.” PA, female, ART patient

Another nurse, NO (female), discusses how an unsupportive family environment can hinder adherence:

“Some of the reasons [for failing to adhere] have to do with the family. There are difficult families. Some patients they have not yet disclosed to the family or to their spouses. When they are at a gathering they can't take the tablets.” NO, female, nurse

Carers of children on ART repeatedly stated the strength of their commitment to support optimal ART adherence. They emphasized their commitment to the child's wellbeing and recounted their efforts to ensure that children attended their monthly hospital review and accessed the food and drugs necessary to stay healthy. Strong family links also served to encourage PLWHA to adhere to their treatment. The desire to see one's children grow up and to support the family was often cited as a central consideration and source of hope for those on ART:

“I love my family so much that I don’t want to die and leave them so I religiously do what I am supposed to do to keep myself fit. I try to be there on all appointments... My main motive is to keep all that I am advised to do so that I can at least look after my children and at least see them through their young ages.” AG, female, ART patient

Older children were frequently reported by interviewees to help facilitate ART adherence of adults or younger children in the home. As MA, a nurse, explains, children sometimes had higher literacy skills than their parents and, along with other adults in the home, could help those on ART remember when to take their pills:

“Let’s say at times it is a mother or father who can’t read, he can tell his children to tell him when the time is 6 o’clock so that he can take his medication. Explaining to family members the instructions of taking the medication helps a patient take the medication properly as they would remind him when the time for taking his pills is due. So you would find children saying to their mother have you taken your pills it is now 6 o’clock am or pm. So it helps that if children or relatives know about your status they can help in taking their medication.” MA, female, nurse

Elderly guardians (usually grandparents) frequently referenced the contributions made by children, both financially through bringing money into the home, and practically, through doing chores and reminding them about a younger child’s pill time and appointments.

“The other children are the ones who are reminding me, they remind him [the child on ART] to take the tablets and they also tell me that he has taken the tablets and is now leaving for school.” NK, female, elderly guardian of child on ART

ART patients and nurses stressed that even one key supportive family member can make a huge difference to adherence and overall patient wellbeing. OT, an ART patient, describes the importance of her strong relationship with her daughter-in-law:

My daughter-in-law is my source of strength and support. She does not have living parents herself but she cares for me as if I was her own mother. If she gets a message that I am not feeling well the next morning she will be here to see me. I want to thank God for my family because they support me so much.” OT, female, ART patient

Extended family also played a support role, often by sending food and money to PLWHA:

“Disclosing to relatives is also very helpful... I was ill on and off, but my relatives would run around to help me...Much of the [financial] help was coming from relatives. Even my children know that I am HIV positive so

some of the time I will be feeling unwell. They are very nice to me; they always try to make sure that I don't do the hard activities. It is good to disclose to relatives and children because that way all these people have been supporting me all this while." MA, female, ART patient

3.3.2 Community/neighbourhood networks

In conditions of poverty, a key contributing factor to ART adherence is community support. One patient highlighted how people in his village have organised themselves so that they all support each other.

"The best thing about my village is the way we are living. When it comes to ploughing, people share knowledge so that they can plant for themselves and sell to each other. People are encouraging each other to take their children to school. If there is anyone who is sick, and the relatives have died, people will come and help." KA, ART patient

In addition to support from community members in general, the patients participating in this study also spoke about the importance of support from peers in providing encouragement and advice. Such support was available both through support groups (discussed in section 3.1) and through friends.

"I have a friend who always encourages me and tries to make me have a positive attitude when I am down. I also do the same with fellow HIV sufferers. We try to up lift each other." ER, female, patient

3.3.3 Relationships with healthcare providers

The development of positive long term relationships between healthcare workers and patients was cited by participants as central to achieving optimal adherence. Patients and care givers attended several sessions with both HIV nurses and HIV counselors before being initiated on ART and after initiation, at regular periods throughout treatment. In the following two quotations, nurses emphasize the importance of developing strong nurse-patient relationships:

"That relationship or that openness between the nurse and the patient can encourage a patient to adhere to drugs. Then health education between the patient or the family member or the caregiver and the nurse can encourage adherence of the patient." MS, female, nurse

"I am sure it's all a function of good counseling; if the patient understands the pre-ART counseling then they will not have a problem adhering because we explore all these issues of adherence and educate them that non-adherence may have serious consequences on

their body's ability to respond to ART. We give them all the information so they feel the need to keep their time of taking these tablets." MU, male, nurse

Developing trust and mutual respect between healthcare workers and patients encouraged patients to continue coming to the clinic and to openly discuss confusion, adherence problems and concerns. Patients spoke frequently and of the importance of networks of support available through the clinic. In the following, TC, an ART patient, drew on her relationship with the counselor at the clinic for emotional support and was also referred to home based carers:

"In fact for me it was really hard, very hard indeed, especially when I first discovered that I was HIV positive. I got so stressed... So I decided to go back to the hospital and discussed my issues with the counselor who was there. She talked to me at length and also referred me to the home-based care team who talked to me and try to make me understand that it was not the end of my life." TC, female, ART patient

Patients valued the dedication of healthcare staff and often described them as a key source of support.

Conclusion

Social participation offers people on ART and carers access to vital forms of support to overcome obstacles to adherence. Externally implemented programmes, such as the roll out of ART across sub-Saharan Africa, can benefit from understanding and working with pre-existing social networks.

HIV support groups were the most emphatically praised form of social participation by ART patients, with many suggesting that these groups offered them the emotional support needed to gain hope and remain committed to treatment. NGO food and income generation support helped PLWHA overcome material barriers to optimal treatment as well as relational and symbolic barriers through restoring their capacity to contribute food or money to their households. Home based care groups emerged during our research as remarkably dedicated and valued volunteer organizations. ART patients and healthcare staff frequently referred to HBC groups as acting as emotional and practical support. Church groups and women's groups also supported people on ART, primarily through tending to the sick.

Family networks were another resource available to people on ART with great potential to help them access and adhere to ART. Treatment partners, such as a spouse or (in the care of children) guardian, provided emotional support and encouragement as well as practical help. Family members reminded ART patients about appointments and pill timings. They also helped ART patients access enough money for food, travel and hospital fees.

Strong relationships between healthcare providers and patients enabled people on ART to access optimal ART. Counseling before and throughout treatment was cited as a very valuable form of support whereby PLWHA gained both information and a sense of camaraderie and hope. Overall, this report has highlighted the extensive indigenous networks of support that work to help PLWHA overcome barriers in order to access and adhere to ART.

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Technical report 5

**Grassroots community perceptions of a
peer education intervention in Zimbabwe**

Scott, K,
Campbell, C,
Mupambireyi, Z,
Nhamo, M,
Nyamukapa, C,
& Gregson, S

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Abstract

This paper presents community perceptions of a state-of-the-art peer education programme in Manicaland, Zimbabwe. The intervention aimed to reduce HIV incidence by distributing free condoms, training commercial sex workers (CSWs) to provide community-based peer education, running income generating projects and improving STI treatment services. In this paper we report specifically on community perceptions of the peer education component of the wider programme.

While the intervention succeeded in increasing HIV knowledge among men and condom acceptability among women, as well as reducing HIV incidence and rates of unprotected sex among men who attended education events, it did not succeed in reducing population level HIV incidence. A biomedical and behavioural outcome evaluation of the project has already been conducted.

In the programme evaluation literature, critiques have been raised of project evaluations that limit themselves to the views of outside health professionals and neglect of the views of target community members and local project staff. Our study expressly sought to supplement prior evaluation with a study of community perceptions of the programme.

We conducted eight focus group discussions and 11 interviews with a total of 81 people including: CSWs and peer educators, male clients of CSWs, local nurses, general community members, and local project staff employed to implement the intervention. Thematic analysis of transcripts highlighted three factors that were seen by community members and local project staff to have impacted on the intervention's disappointing outcomes: (1) difficulties of implementing all the elements of the intervention, particularly the proposed income generation component in the wider context of economic strain; (2) a moralistic approach to commercial sex work by programme staff; and (3) limitations on the programme's ability to engage with the social realities facing community members. Limitations included particularly the unlikelihood of messages from CSWs reaching other female community members and widespread distrust and dislike of condoms.

We conclude that local community networks have strong potential to undermine externally imposed programs that present new information without engaging with local resistances to change, and without taking into account local constraints on action.

Key words: HIV/AIDS intervention, programme evaluation, Zimbabwe, community engagement

Introduction

This paper explores local community perceptions of the peer education component of an STI/HIV intervention in rural Zimbabwe. The intervention did not succeed in its goals of reducing population level HIV and STI infection through distributing free condoms, training commercial sex workers (CSWs) to provide community-based peer education, running income generating projects and improving STI treatment services. We first discuss the HIV situation Zimbabwe, the theory underlying our research focus on community perceptions and background on the STI/HIV intervention. We then discuss our present study, which consisted of post-intervention focus group discussions and interviews with community members (commercial sex workers, male clients of the sex workers and the general public) and key intervention stakeholders (nurses in the region and program co-ordinators).

Taking up the concern expressed by development anthropologist David Mosse (2005), we seek to move away from evaluation approaches that place the onus of success or failure solely on the beliefs and behaviours of target communities, with disappointing results explained by blaming local culture, local political leaders or technical minutiae of programme messages. Instead we seek to contextualise the programme more widely, focusing on the extent to which the intervention was able to generate social environments that supported the possibility of healthier behaviours. Our findings centre on three key issues which community members and local project staff viewed as decreasing the potential effectiveness of the intervention. First, they expressed the view that the intervention faced difficulties implementing all its elements, particularly the proposed income generation component in the wider context of economic strain. Second, local community members reported that programme staff maintained a moralistic approach to commercial sex work. And third they perceived the programme as having had a limited ability to engage with the social realities facing community members. In particular, their views suggested that the programme did not account for the rigid social distance maintained by female community members from CSWs, which made message diffusion unlikely. It also did not engage with and challenge the deeply rooted and widely held dislike and distrust of condoms throughout the community.

HIV in Africa and Zimbabwe and interventions that have sought to reduce its transmission

As of 2009, UNAIDS/WHO reported that there were 22.4 million HIV-positive people in sub-Saharan Africa (5.2% of the adult population), with almost 2 million new infections occurring in 2008. Heterosexual intercourse remains the epidemic's driving force in sub-Saharan Africa and commercial sex work plays a major role (UNAIDS/WHO, 2009). Zimbabwe's adult prevalence rate was 14% at most recent measure (UNAIDS, 2009), making it one of the hardest hit countries in sub-Saharan Africa and the world. Manicaland, an eastern province of Zimbabwe and the region in which the research discussed in this paper took place, has the second highest HIV rate in the country at approximately 20% (Gregson, *et al.*, 2010).

Billions of dollars have been poured into interventions that have sought to reduce the spread of HIV with frequently disappointing results. Declines in HIV infection rates, while

heartening, have not been conclusively linked to behaviour change interventions rather than the natural course of the epidemic or behaviour changes brought about through indigenous or individual responses (Gaillard, *et al.*, 2006; Stephenson & Obasi, 2004). Randomized control trials examining the impact of behaviour change interventions have been found to have no overall impact on HIV incidence rates (Cowan, *et al.*, 2010; Corbett, *et al.*, 2007; Kamali, *et al.*, 2003)

Theoretical contribution

When interventions succeed or fail it is vital to examine why they have done so to inform future policy and practice (Campbell & Russo, 1999). Our theoretical approach centres on Pawson and Tilley's (1997) concept of 'realistic evaluation' that advised programme evaluators to pay attention both to features of the programme being implemented and the context in which the programme takes place in order to understand outcomes. Pawson and Tilley (1997) are skeptical of traditional evaluation methods that ask "Does this work?" or "What works?" Instead, they encourage researchers to ask "What works for whom in what circumstances?" because of the highly different effects of interventions on different people and in different contexts. This evaluation approach fits into the 'enabling contexts' approach to health promotion introduced by Tawil, Verster and O'Reilly (1995). This approach understands health behaviour not simply as the result of individual behavioural decisions but also as responsive to the contexts in which people live. It advocates that health interventions not only to try to persuade people to change their behaviour, but also to seek to reframe the environmental contexts in which people make choices, examining the extent to which interventions enable people to change through building better environments (Tawil, *et al.*, 1995; Campbell, 2000).

Mosse (2005) highlights the tendency for programme evaluators to blame unhelpful beliefs or behaviours of target community members as their key explanatory variables, with little attention to issues of programme design or implementation. He argues that evaluations of disappointing programmes too often focus on events, situations and people outside of the framework of health or development expertise and authority when trying to determine what went wrong. They may cite problematic local culture or gender attitudes that led local people to resist the intervention. Like Pawson and Tilley, Mosse emphasizes the importance of contextual factors, particularly how the intervention is implemented, its relevance to the community and the power dynamic between local actors, international donors and the intervention team. He argues that accounts for intervention failures distances the inputs and actions of health and development professionals or agencies from any responsibility, stating: "accounting for failure is a way to stabilise existing models of expertise and authorised expectations" (Mosse, 2005)

The Manicaland STI/HIV Intervention

As already stated, our peer education programme of interest was part of a wider integrated programme that implemented several HIV/AIDS management strategies in Manicaland in the early 2000s. Although the aim in this paper is limited to community perceptions of one component of the programme, we provide information about the wider programme as context for our argument.

A team of researchers in the UK and Zimbabwe conducted a cluster-randomized control trial that investigated the effectiveness of combined community- and clinic-based HIV prevention in Manicaland, eastern Zimbabwe. A detailed description of the STI/HIV intervention, data collection, analysis and results is presented in Gregson, *et al.* (2007). Here we provide an overview of the Manicaland STI/HIV Intervention, which this present paper explores through qualitative follow-up interviews and focus groups.

Between 1999 and 2002, six communities in Manicaland received targeted and population-level programmes to (a) promote safer sexual behaviour and (b) improve the treatment of STIs that facilitate HIV-1 transmission. Six randomly selected pair communities did not receive the intervention but continued to receive standard Government healthcare services, including basic STI management, social marketing of male and female condoms, condom distribution, and limited HIV/AIDS-focussed awareness meetings and poster/flyer campaigns. The intervention was to consist of (1) peer education and condom distribution amongst commercial sex workers (CSWs) and male clients at workplaces, beer halls and in the general community, supported by income-generating projects; (2) strengthened STI services at local health centres; and (3) open days with HIV/AIDS education activities at health centres to promote safer sexual behaviour and to increase the uptake of local STI treatment services. The peer educators were selected from the local commercial sex worker populations and were to be supported in leaving commercial sex work through income generating projects. A total of about 63,000 peer-education meetings were held, and 6.8 million condoms were distributed by the programme in the intervention communities.

Before and after the intervention participants in all 12 communities (six intervention and six control) gave blood samples for HIV testing and answered a series of questions on STI cases and treatment, HIV knowledge, and sexual and health-seeking behaviour. They answered these questions using a non-judgemental and confidential secret voting box interview procedure.

Disappointing findings of the Manicaland STI/HIV Intervention

The findings, while positive for some indicators, were overall disappointing. There was no significant difference in HIV-incidence between the intervention communities and control communities, after controlling for sex, age group, and baseline HIV prevalence. In fact, HIV rates were non-significantly higher in the intervention communities. Self-reported STI symptoms and reports of consistent condom use were similar in both sets of communities. Surprisingly, more young women in the intervention than in the control communities had started sex, and reports of unprotected sex with a casual partner in the study period were more common in the intervention communities. Also, more men in the intervention communities agreed with the statement that “condoms reduce the pleasure of sex”.

Nonetheless, STI treatment for men was more effective in the intervention communities, measured by reported reduced symptom recurrence. HIV knowledge among men was also higher in the intervention communities as was female agreement with the statement “condom use within marriage is becoming acceptable.” In addition, men who

actually attended HIV education meetings in the intervention communities, after adjustment for the targeting of activities to groups with high-risk behaviour, had significantly reduced HIV incidence and less unprotected sex. This finding suggests the intervention managed to have a positive effect on the men who were directly exposed to HIV meetings. Overall however, the intervention failed to have a positive affect at the community level and possibly had detrimental effects on the onset of female sexual activity and condom use with casual partners. For further information on the intervention please refer to Gregson, *et al.* (2007).

The present qualitative study Methodology

The scope and limitations of this paper are re-emphasised here: First, we do not seek to comment on the wider integrated programme as a whole but only on the peer education programme. Second, in commenting on the peer education programme, we do not seek to provide any definitive ‘diagnosis’ of programme strengths and weaknesses, but only to report – in a more limited way - on community perceptions of these factors. We emphasise here that community views present a very partial lens on what happened, and that there will be other perspectives (from epidemiology, behavioural science and biomedicine for example) which will offer other explanations. Having said that, we believe the perceptions of members of the programme’s target audiences provide one valuable piece in the wider puzzle of explaining the outcomes of a complex programme implemented in a complex social setting.

Against this background, this paper presents qualitative follow-up research into the experiences and opinions of community members and those closely associated with the intervention on the ground. We spoke to 81 people in the region through eight focus group discussions (FGDs) and 11 individual interviews. We held the following FGDs: one with peer educators (who were also current or former CSWs); one with CSWs who were not peer educators; three with men who frequent CSWs, and three with general community members. Our individual interviews were with: two peer educators (current or former CSWs), five staff members from local clinics that offered STI and HIV services, and two project implementers. Figure 1 provides a detailed description of our dataset.

Figure 1: Dataset

Type	Transcript details	Location	Participants
FGDs	1 Peer educators/CSWs	Nyazura	8 females
	2 CSWs	Nyanga	9 females
	3 Male clients	Nyazura	8 males; clients of CSWs
	4 Male clients	Nyabadza/Nyahukwe	6 males; clients of CSWs
	5 Male clients	St Theresa	12 males; clients of CSWs
	6 General public	Nyabadza/Nyahukwe	7 participants, male & female
	7 General public	Sagambe	10 participants, male & female
	8 General public	St Killins	10 females
Interviews	1 Peer educator/CSW	Selbourne	Female
	2 Peer educator	Selbourne	Male

3	Key informant (clinic staff)	Eastern Highlands	Male
4	Key informant (clinic staff)	Mupotedzi	Male
5	Key informant (clinic staff)	Mupotedzi	Male
6	Key informant (clinic staff)	Tsonzo	Male
7	Key informant (clinic staff)	Tsonzo	Male
8	Nurse (Sister-in-Charge)	St Theresa	Female
9	Nurse (Nurse-in-Charge)	Central	Male
10	Project implementer (Project Co-ordinator)	Whole Manicaland region	Female, ID: PI1
11	Project implementer (Peer education co-ordinator)	Whole Manicaland region	Female, ID: PI2
Total: 8 FGDs & 11 interviews			81 people

Participants were recruited through convenience sampling at a random selection of intervention sites. The FGDs and interviews took place over a two week period in 2006. All people approached to participate agreed. FGD participants were given a large block of soap and interviewees were given a T-shirt to thank them for their time. Prior ethical approval was obtained from the Research Council of Zimbabwe – Number 02187 – the Applied and Quality Research Ethics Committee in Oxford, United Kingdom – N97.039 – and UNAIDS Research Ethics Committee – ERC 98/03.

Questions varied depending on the FGD participants or interviewee but generally included: whether and how they had experienced elements of the intervention, particularly the peer education; whether they had learned anything; what they thought about the model of having current or former CSWs become peer educators; how people cope with STIs; local thoughts on condom use; and whether they had seen any behaviour change. Participants/interviewees were also asked “We distributed a million condoms in this community, but there are just a few that were used; what do you think happened to the rest of them?” “STI/HIV rates were reported to be the same or higher in the intervention sites as the control sites. What do you think could have caused this?” and, specifically for the project implementers “Were there implementation problems? What were they?”

The FGDs and interviews took between an hour and an hour and a half. They were conducted in Shona by the third and fourth authors, both social workers and experienced qualitative fieldworkers, and recorded then translated and transcribed into English.

Analysis

We used Attride-Sterling’s thematic network analysis technique (2001) to analyse the transcripts. This analysis first involved reading and rereading the data. Second, we went through the transcripts and summarized text segments (usually one to five sentences long) categorised according to their basic theme. The basic theme is the underlying idea

that a text segment expresses, such as “sex workers must reform” or “sex workers not respectable”. These basic themes were then grouped into organizing themes and then universal themes, such as “moralistic attitude about sex work”. We developed three universal themes which speak to our research interest of why the STI/HIV intervention had disappointing results and serve as the three sub-headings in the findings section, below.

Findings and discussion

Before discussing the three themes that dominated our analysis of our qualitative data set, we briefly outline how local people reported to have understood the Manicaland STI/HIV Intervention. Gregson *et al.*'s 2007 article and our above overview present the official project description in terms of implementation strategies and quantifiable programme goals and outcomes. However we wanted to investigate and record how the local people in Manicaland communities actually experienced the intervention.

We found widespread awareness of the intervention, with nearly everyone in the focus groups, from male clients of sex workers to married women, expressing some level of familiarity with the programme. The predominant community understanding was that the intervention consisted of distributing condoms and ‘reforming’ commercial sex workers (i.e. getting them to stop selling sex) then training them to become peer educators. The peer education was understood to consist of conducting educational talks and skits in the community on HIV, primarily in beer halls (the main site of arranging transactional sex), as well as workplaces and local clinics. The following quotations are a sample of how community members described the intervention:

So what they [peer educators] would do is that usually Monday or Wednesday morning they will go and talk to people at the work place. Maybe you will be a group of about 10. They will talk to you and they will act their drama and after that they will ask questions. Mostly they will be teaching about sexual issues... they teach women to take good care of their husbands. (General public FGD 6, person 6)

They [peer educators] give people condoms (General public FGD 6, person 3)

Every Wednesday they [peer educators] have meetings at the clinic where they will be teaching about HIV. (General public FGD 7, person 5)

These [peer educators] did educate us. Like myself, I didn't know how to put on a condom for quite a long time but through their programme which they used to do in the beer hall when they would do a demonstration on how to put on a condom. After that it became easy for me to put on a condom. Because in some cases the condom would just tear off while I was trying to put it on. (Male clients FGD 4, person 1)

The key messages that people reported from the intervention were from the peer educators and focused on how to use a condom (as described in the quotation above) and not being promiscuous:

In such dramas they would depict how sleeping around may result in someone's death. Their role plays were good because they would make people understand their message of what would likely happen if someone sleeps around. (Male clients FGD 4, person 5)

The improved clinical management of STIs that was also part of the intervention was understandably not a prevalent part of community awareness considering few people would have compared STI services across regions.

FGD participants and interviewees frequently expressed conflicted and shifting opinions about the Manicaland STI/HIV Intervention. FGDs and interviews generally began with positive responses, where community members discussed how much they appreciated the intervention and how much they learned, perhaps in part because they perceived the interviewer to be affiliated with the intervention¹. People in highly resource-poor settings, as Manicaland certainly is, may have an incentive to please outside researchers or program implementers in order to retain ties to networks that represent a link to funding and potential future interventions.

As the interviewer gained rapport and emphasized the need for frankness however, participants began discussing the elements of the intervention that they did not like or understand and often revealed that their sexual health-related behaviours and attitudes towards condoms had remained unchanged and resistant to the intervention's messages of faithfulness and condom use. For instance at the beginning of interview 1 with a peer educator (SB001) she reported that "people accept condoms; we have not faced any resistance towards condom use". Later in the interview she had the following exchange where it became apparent that condoms were not popular and used very irregularly:

Interviewer: How many clients do you think CSW have per week?

Peer educator: An average of twenty-one clients per week.

Interviewer: How many condoms does a single commercial sex worker use per week?

Peer educator: Approximately seven condoms per week.

Interviewer: Do they use condoms all the time they have sex?

Peer educator: No they don't use condoms all the time, they only use condoms with a new client but as soon as they get used to each other they abandon condom use.

Interviewer: What are your views regarding condom use?

Peer educator: It's not feasible to use a condom all the time. Please try and find another safer method if there is any. (Peer educator interview 1)

¹ The interviewers were affiliated with one of the NGOs that had implemented the intervention but were not personally involved

People expressed conflicted attitudes towards the model of training former CSWs to become peer educators. Many appreciated the idea of getting women who were open about sex and who could freely enter beer halls to become educators. However at the same time, people questioned how the community could respect the views of such women, who were widely disrespected by other community members. They operate in a context where promiscuous sex and alcohol consumption by women was highly problematic. We discuss community reflections on the intervention's approach of having CSWs become peer educators in more detail in subsection 3. These inconsistent and conflicted attitudes resonate with Gregson *et al.*'s (2007) findings from the quantitative analysis of the intervention's limited and inconsistent outcomes.

The three themes that emerged from our analysis of community perceptions of the intervention's lack of success in building supportive community contexts for change were as follows: obstacles to actually implementing all elements of the intervention, moralistic approach to commercial sex work that exacerbated stigma and reduced chances for sex worker solidarity, and challenges engaging with the social realities facing community members. We now move on to discussing these themes.

1) Challenges in implementing all components of the intervention

The Manicaland STI/HIV Intervention proposal was multifaceted as discussed earlier. However informants reported that several key elements were not fully implemented, hindering the capacity for other elements of the intervention to succeed.

One program implementer (PI2, interview 11) listed multiple implementation issues challenging the programme. These included a lack of monitoring and supervision of the peer education programme from the implementing parties; the failure of one of the four key NGO partners to deliver the co-ordination and support promised; and another of the key partners failing to deliver funding pledged to some of the income generating projects.

CSWs trained to be peer educators commented that they did not receive follow-up training and had trouble remembering what they learned during the peer education training, as the following quotation describes:

Refresher courses should be improved at least they should be done within a short duration not after a long time when we have forgotten what we once trained. The other issue is that [a partner NGO] should visit us on a regular base and furnish us with information, education and communication material. We kindly ask [another partner NGO] to help us also when conducting refresher courses (Peer educator interview 1)

Even in those cases where programme funding was available, the income generating projects were not successful. The program implementer PI2 explained that the projects were unsustainable because of tough economic conditions, drought and inadequate NGO support: A revolving loan given to a single women's association (which was to

help CSWs in three of the six intervention sites) decreased significantly in value because of inflation². Proposals that seed loans to 'reformed' CSWs would be repaid after harvesting did not work, because of poor harvests. Another rotating credit club introduced by the intervention sought to pool members' resources to invest in small income generating projects and share proceeds among members on a revolving basis. However it too dissolved when the money lost value because of inflation. Grants and loans for income generating projects given by another NGO were used by former CSWs to buy materials and dyes for a textile project. In that instance, the beneficiaries did not understand that their efforts were supposed to become self-sustaining and expected the NGO to continue to contribute money for more materials and dyes. They then abandoned the project when ongoing support was not forthcoming. An income generating project in which former CSWs knitted gloves to sell to people working on forestry estates received a donation of wool but was not economically sustainable.

Without sustainable income generating projects, the economic elements of the local context continued to be those of poverty and unemployment. Sex work remained a viable survival strategy:

[The CSWs] didn't change their behaviour because they were not given other incentives such as money for survival (key informant interview 7, clinic nurse)

Nonetheless sex workers continued to be exposed to the program message that they should stop selling sex and earn money in another way. In the following quotation, CSW 1 in FGD 1 says the program 'advised' them to do self help projects and told them that sex work is not the only way of earning money:

...They [the peer educators who transmitted the program messages] only advised people on starting up self help projects. They stated that prostitution is not the only way of raising income but to be hardworking doing different projects like fruit vending (CSW FGD 1, person 3).

This message was, for most CSWs, untrue: sex work continued to be the only feasible way to earn money. The message that alternative sources of income are available, if only they were 'hardworking' enough, failed to recognize the economic reality facing the sex workers. Considering that the context in which sex workers operated did not change, it is unsurprising that their sexual behaviour remained the same. The next section examines the moralistic elements of the intervention's message more deeply.

2) Moralistic and unrealistic approach to commercial sex work that exacerbated stigma, reduced chances for sex worker solidarity and undermined sex worker credibility

The CSWs who became peer educators felt pressure to leave the sex industry because alternative means of earning income would be made available to them. For example,

² Zimbabwe suffered from very high inflation during the years of the intervention. The rates were 1999: 57%, 2000: 55%, 2001: 112%, 2002: 199% (Muponda, 2009)

below a CSW recounts that she has been encouraged to start an income generating project and be faithful:

They encouraged us to start income generating projects and to be faithful to one partner in order to reduce the risk of being infected with HIV/AIDS. (CSW 6, FGD, site 7)

From the onset, the attitude of ‘rehabilitating’ CSWs expressed by local project implementers implied that their choice of work was undesirable – perpetuating their stigmatisation. An anti-sex work messages and emphasis on monogamy was ingrained in the language of both project staff and the CSW peer educators and conveyed through education sessions and skit performances. Participants in FGDs and interviews repeatedly referred to the fact that the peer educators had not ‘reformed’ and speculating about the extent to which they reduced their number of clients. For example, one key staff member commented that:

Some of the peer educators were not honest; the idea was that they would reform once they assume the peer educator’s role but most of the peer educators did not reform. Instead they continued to fight for the same male clients with their peers (PI2, interview 11)

In discussions between intervention staff and community members, staff asked if the peer educators were ‘better now’ (i.e. had stopped selling sex) and whether they served as good examples by influencing non-peer educator CSWs to ‘leave that behaviour’. The peer education messages suggested that sex work was the result of a lack of work ethic and poor self control. For example, in the FGD with peer educators and CSWs for instance, a participant commented:

I have watched them [peer educators] teaching and for those who listen and understand, we have learnt a lot on self control. Now a person knows how to practice self control (Peer educator/CSW FGD 1, person 9)

Equating sex work with a lack of self control was stigmatizing and failed to recognize the challenges of the work and the economic situation.

Despite the failure of the income generating projects to enable CSWs to move out of sex work, the community members we spoke to reported ongoing exposure to messages that CSWs, particularly those selected to be peer educators, should ‘reform’ by leaving sex work and practice and promote monogamy. Unsurprisingly, such ‘hypocrisy’ was greeted with amusement or contempt by other community members, who were aware of the sex workers’ continued source of income, in a way that undermined the profile of the project in the wider community, as this male client notes:

It was easy to learn [the risks of promiscuity] from their dramas but they themselves were not able to practice what they were teaching (Male clients FGD 4, person 4)

Since community members understood the validity of peer educators as contingent on them giving up sex work (something that was not economically possible) community members reported that they could not take the peer educators seriously. This male client of CSWs explains:

After they change they can then educate other people, but if they don't change people will not listen to their words that are not accompanied by the appropriate behaviour (Male clients FGD 5, person 1)

The additional messages that the CSW peer educators delivered (for example how to correctly use a condom) lacked salience to many people since the deliverers of the message lacked credibility. Moreover, in order to continue their commercial sex work they needed men to have sex with them, putting them in a further difficult position of simultaneously transmitting messages of faithfulness and needing to recruit clients, discussed in the following:

I once came across a peer educator and she invited me to her place... This did not go down well with me because I thought that she was not supposed to look for sexual clients because she is a peer educator (Male clients FGD 3, person 8)

You know the problem is that these peer educators, after working, they resort back to their old style of being promiscuous. They take advantage of their position to advertise themselves. I have an example of one peer educator who is dating a married man. (Key informant interview 4, clinic staff, MP01)

This incompatible position was noted by many sex workers, clients and key informants and was cited as evidence of the peer educators' failure, rather than the program's problem.

The interviewees and FGD participants emphasized that the program focused on ending sex work, which did not improve a sense of solidarity or empowerment among CSWs. As the following quotation highlights, sex workers operated in competitive and unfriendly environments, making it difficult for them to discuss sexual health issues and strategies:

From the way I look at it, a prostitute and a prostitute can't be good friends. And some of the peer educators are prostitutes so the people [CSWs] won't listen to the message that the person will be saying. They despise both the message and the person (Peer educator/CSW FGD 1, person 9)

Sex workers were thus positioned by those we spoke to (including CSWs themselves) as not 'hardworking', 'lacking in self control', seemingly unaware of a multitude of other income generating options and having to give up sex work in order to be capable of

educating others. This approach created a very difficult environment for peer educators to operate in and reduced the capacity of male clients and other CSWs to benefit from the educative elements of the intervention.

3) Lack of meaningful engagement with the social realities in the community

Our analysis of community perceptions suggests that from their perspective, the peer education program design (with its focus on the provision of information and condoms) was a blunt instrument in the complex social context in which people accessed and interpreted information and made sexual behaviour choices. They suggested that the programme failed to adequately take account of their local realities, particularly around the issue of message diffusion and condom use.

Although local people expressed an understanding that HIV messages were supposed to diffuse from the commercial sex workers to wider society, they commented that this diffusion was not feasible. This lack of diffusion is echoed in Gregson, *et al's* (2006) finding that men who were exposed to peer education meetings had reduced rates of STIs and HIV; this benefit did not extend to women and the general community. The existing 'segregated' social system, with high levels of stigma and disapproval of sex work, created an often impenetrable social boundary between sex workers and 'respectable' women.

We found that many men socialised with both groups of women, interacting with CSWs whilst also participating in 'respected' society either through marriage or eligibility for marriage. In so doing, they were secretive about their contact with sex workers. If their wives were aware of this contact, they often chose to turn a blind eye to it.

This led to a three-fold complexity: first, women sought to distance themselves from CSWs and thus limited their own exposure to the peer education messages. Second, men who were exposed to the peer educators were very unlikely to talk openly about what they learned to their wives, because that would be seen as evidence of infidelity. Third, married women were displeased with peer educators trying to talk to men since they felt that peer educators were still CSWs seeking clients.

Married women maintained a distance from CSWs. This distance was both physical, in that they would not visit the same places as CSWs, and emotional or intellectual, in that they would not value and listen to messages put forth by CSWs. The following quotation highlights the distance between CSWs and other women:

It [the model of training CSWs to be peer educators] was not good. They should have chosen good people who are fit to do that, people who can control their behaviour. (General public FGD 6, female, person 7)

These people [peer educators] did not have the respect of other women. It is very difficult for other women to see anything good coming from prostitutes. So other women did not even value that programme (Male clients FGD 4, person 2)

What they were doing was good because they were dedicated to their job. The only problem was that we knew their behaviour and that it was bad. ...And we are the ones who look down upon them and say: 'What can they teach us?' (General public FGD 7, female, person 2)

Non-CSW women avoided beer halls, a key area where much of the intervention took place. Beer halls are the site of a large portion of commercial sex arrangements and are frequented by men and unmarried women who are generally soliciting commercial sex partners. Married, self-described 'respectable' women would never go to a beer hall and married men would never want their wives to know they visited one since it is often considered tantamount to having bought sex. If a married man was exposed to the intervention's messages he would not be able to discuss it at home with his wife because it was seen as evidence that he had interacted with a sex worker. The following quotation highlights this dilemma:

If we get home and try to use condoms with our wives they think that we have been practicing using condoms in beer halls (Male clients FGD 5, person 12)

Beyond distancing themselves from CSWs, married women were also concerned with peer educators trying to speak to their husbands in the community and at work as the following quotation discusses.

I think it was a good approach because it would make the peer educators themselves realize that what they were doing was not good because it was fuelling the spread of HIV. But it did not really work because when wives get to see these commercial sex workers educating their husbands, they would think that these commercial sex workers are now after their husbands, so it also needs respectable people to do such kind of work. (Male clients FGD 4, person 5)

Finding educators and venues where women and men beyond CSWs and clients could be exposed to the intervention's messages may have been valuable, as is suggested here:

I think it was a good idea to 'send a thief to catch a thief' because it was a way of making sure that those who are infected would not continue to infect those who are not infected. But I also think it would be proper to include those who are not 'thieves', I mean those who were not commercial sex workers. (Male clients FGD 4, person 2)

From our point of view it was very good because they [CSWs/peer educators] were the people who knew how they used to do it and now they become the ones who understand that there is this

disease. But there is one issue. Why did you just make them women, why not men as well? Where were the men? (Male clients FGD 5, person 3)

By only using CSWs as peer educators the intervention was unable to challenge the context of stigma around sex and low levels of communication about HIV and sexual health between couples.

Message to ‘use condoms’ failed to engage with complex reality: strong resistance to condoms

The intervention strongly promoted the message that community members should use condoms. Peer educators promoted condom use in their educational meetings and had condom distribution targets (of 1000 per month). Boxes of free condoms were placed in clinics and public toilets throughout the intervention communities. However, STIs and HIV continued to be contracted at the same rates as the control communities, suggesting that the intervention efforts failed to increase the use of condoms.

The FGDs and interviews suggest that the interventions message to “use condoms” did not meaningfully engage with the social realities of the target community. While some people commented that they learned how to actually put on and dispose of a condom, there was no evidence that the intervention had discussed widespread local resistance to condom use and strategies to increase condom use in the face of this resistance, as this quotation highlights: “They educated us on condom use but they never gave us practical information or assistance on behaviour change” (CSW 1, FGD site 7). People certainly heard and remembered the pro-condom message—many interviewees, including CSWs, parroted the idea that condoms should be used—but there was overwhelming evidence that most people did not like condoms and did not use them.

During the focus group discussions reference was made to numerous complex reasons why the community resisted condom use. We only briefly outline the reasons people resisted condoms; the focus of our argument is not on why people did not use condoms but how they perceived the intervention as having failed to engage with this resistance in a meaningful way.

First, both men and women spoke frequently of enjoying sex more without condoms. Second, condoms were closely associated with use between a sex worker and client so community members felt it was very difficult to initiate the use of condoms between a husband and wife. Third, among CSWs, condoms were seen to indicate a high level of emotional and social distance; when a client and sex worker continued to have sex beyond two or three times condoms were expected by both parties to be discarded because they couple become ‘close’, even though it remained a commercial client-sex worker arrangement. Fourth, the blue condoms distributed free by the intervention were specifically disliked, especially in comparison to another brand of condoms (Protector Plus) available on the market. Reasons for this dislike stemmed from suspicions that the condoms were from European or American donors who infected them with HIV. In addition people did not value the intervention condoms because they were sure that

free things were of poorer quality, suggesting they were made of cheaper material than the Protector Plus condoms and irritated the skin and caused rashes. However the Protector Plus condoms were cited as too expensive. Fifth, clients of CSWs were suspicious of female condoms because they thought CSWs reused them from client to client. Sixth, women in general were suspicious of male condoms because they thought some men would prick the condom to spread HIV or get women pregnant. An additional factor may have been that clients offered more money for condom-free sex, which was attractive to CSWs who were very poor. However, this factor was debated with some informants arguing that there was no difference in price.

Resistance to condoms was complex, multifaceted and deeply ingrained across many sections of society, particularly CSWs, their clients, and married couples. Failure to use condoms can be linked to perceived low vulnerability to HIV, a symbolic link between condomless sex and intimacy, fatalistic attitudes about HIV and death, female distrust and suspicion of men, male distrust and suspicion of women (particularly CSWs) and many other social psychological community issues. It could be seen as overwhelming to attempt to break down the issues underlying such strong resistance. However, not engaging with these reasons for disliking condoms and promoting only a simplistic message that condoms should be used (which is how local people reported experiencing the intervention) was not effective. Local people did not feel that the intervention's key message on condom use engaged or resonated with their local realities.

Conclusion

The reasons for success or failure of any programme are likely to be multi-faceted. In this paper we have sought to add to understandings of the outcome of the Manicaland STI/HIV Intervention through eliciting the views of target community members and local programme implementation staff on the peer education component. As emphasised above, this is just one of several perspectives on a complex programme in a complex social situation. Our analysis pointed to a web of inter-related factors that, in the view of community members, served as obstacles to the success of the programme.

Local programme implementers commented that their efforts were impeded by inconsistent buy-in and support from project partners in the NGO and public sectors. The perceived programme expectation that sex workers would reform their behaviour was undermined by the failure of its income generation efforts in a harsh economic climate. Given the lack of alternative survival strategies for women, programme pressures on sex workers to reform probably perpetuated the already strong stigmatisation of this group of women (both by themselves and by the wider community). In the light of the large academic literature on the negative impacts of stigma on prevention efforts, an approach which recognised and accepted the economic pressures on women to engage in sex work might have been more successful. The latter approach is standard practice with sex worker programmes in other parts of the world, and is frequently cited as one of the determining factors of success in sex worker projects in India, for example (Cornish, 2000a, 2000b).

In addition, local people took issue with the use of sex workers as peer educators. Many people we spoke to regarded this as an unwise strategy for various reasons. Community members argued that the programme was undermined by its use of sex workers as bearers of pro-condom and pro-fidelity messages, since they are widely known to be sexually promiscuous and often condom averse. They said that the use of a highly stigmatised group (sex workers) and highly stigmatised venues (beer halls) as the major focus of peer education efforts distanced the programme from more 'respectable' community members.

Although the rationale of peer education involves the promotion of debate and dialogue amongst community members, with particular focus on obstacles to behaviour change and how these can be overcome, the community members felt the programme involved didactic messages about the importance of condom use, how to access condoms, and how to put them on. They did not note effort to acknowledge or tackle widespread resistance to condoms. As a result, whilst the programme seems to have increased knowledge about condoms, it did not seem to have made any progress in dislodging pre-existing resistance to using them.

This paper highlights the ways in which local community networks have strong potential to undermine externally developed programs. New information and behaviour cannot be embraced by communities without engaging with local knowledge and resistances to change, and without taking account of local constraints on action.

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Technical report 6

The role of community conversations in facilitating local HIV competence: Case study from eastern Zimbabwe

Nhamo, M,
Scott, K,
Campbell, C,
Madanhire, C,
Nyamukapa, C,
& Gregson, S.

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Abstract

Community conversations are an intervention method through which local people work with a facilitator to collectively identify local strengths and challenges and develop practical strategies to solve local problems. This paper examines the potential of community conversations to strengthen positive responses to HIV in resource-poor environments. We conducted 18 community conversations (with six groups at three points in time) with a total of 77 participants in Manicaland, eastern Zimbabwe. Participants were invited to reflect on how they were responding to the challenges of HIV, both as individuals and in community groups, and to think of ways to better support openness about HIV, kindness towards people living with HIV and greater community uptake of HIV prevention and treatment. Community conversations appeared effective at contributing to local HIV competence by (1) enabling participants to brainstorm concrete action plans, (2) providing a forum to develop a sense of common purpose in relation to implementing these plans, (3) encouraging and challenging participants through the involvement of outside facilitators, (4) providing an opportunity for participants to move from passive recipients of information to active problem solvers, and (5) reducing silence and stigma surrounding HIV. Our discussion cautions that community conversations, while holding great potential to help communities recognize and use their strengths and capacities, are not a magic bullet. Poverty, poor harvests and political unrest frustrated and limited many participants' efforts to put their plans into action. Support from outside the community, in this case the increasing availability of antiretroviral treatment, played a vital role in enabling communities to challenge stigma and envision new, more positive, ways of combating the epidemic.

Key words: HIV competence, stigma reduction, Zimbabwe, community conversations, indigenous responses

Introduction

Whilst community mobilisation is widely advocated as a pillar for an effective HIV response in Africa, much remains to be learned about the mechanisms through which mobilisation exercises its allegedly beneficial effects. Furthermore, much remains to be learned about how to best facilitate such mobilisation. This paper examines the potential of community conversations to facilitate local HIV competence in resource-poor communities. An HIV competent community is a context in which people are able to work together to support appropriate accessing of HIV testing and treatment, the provision of compassionate care for people living with HIV/AIDS (PLWHA), open and non-stigmatizing discussions of HIV, and concrete strategies to prevent new infections (Nhamo et al, 2010).

We conducted 18 community conversations with 77 participants led by trained local facilitators in rural eastern Zimbabwe. Community members were invited to discuss how they were responding to the HIV epidemic both as individuals and in community groups, and to come up with strategies to improve local contributions to prevention, care and treatment in the future. In this paper we will discuss ways in which these conversations increased aspects of local HIV competence and the processes through which the approach had its effects. However we also caution that communities cannot be expected to solve all of their problems through conversations; poverty and political turmoil made it difficult for people to put many of their plans into action. Moreover, many positive changes in community attitudes towards HIV (including willingness to talk openly about HIV and go for testing) were closely linked to the increased availability of antiretroviral treatment (ART) at the time of our study, reaffirming that there is no single 'magic bullet', and that community strengthening approaches such as ours need to be part of a wider toolkit of responses.

Theoretical framework

Community HIV competence

Community involvement is a vital precondition for effective HIV/AIDS management. It is said to play an important role in enabling health-related behaviours and reducing HIV-transmission (van Wyk et al. 2006), and in the reduction of stigma (Poku & Sandkjaer, 2007). It is also vital for facilitating timely and appropriate accessing of health and welfare services where these exist (Hadley & Maher, 2001; Segall, 2003; Bak, 2004), and for supporting optimal treatment adherence (Coetzee et al. 2004).

Campbell and colleagues have developed the concept of HIV competence (also called AIDS competence) to describe the ideal health enabling community environment in the context of HIV/AIDS. They conceptualise HIV competent community contexts as social environments that support and enable people to act in ways that enhance their health and wellbeing (Campbell et al. 2007; Nhamo et al., 2010). An HIV competent community is one where community members work collaboratively to support each another in achieving sexual behaviour change; the reduction of stigma; support for people living with AIDS and their carers; co-operation with volunteers and organisations seeking to provide HIV-prevention and AIDS-care; and effective accessing of existing health services and welfare grants (Campbell & Gibbs, 2008).

Central to the notion of HIV competence is critical thinking about local challenges and strengths to develop strategies for improving care of PLWHA, prevention of new infections and appropriate accessing of available testing and treatment services. Education theorist and social activist Paulo Freire argues that critical thinking by marginalized groups can often constitute a key precondition for action and health-enhancing individual and social change (Freire, 1973). Freire's 'transformative communication' approach maps out the processes through which subjects pose problems and critically examine everyday life experiences through discussion (Freire, 1973; Campbell & Cornish, 2011; Diemer et al., 2006). In this paper we take up Freire's theory of social change by seeking to implement an intervention that engages communities coping with high HIV rates in critical thinking and the development of action plans as a precursor to change (Vaughan, 2010).

Community dialogue can enable people to translate and digest new information in order to apply it effectively to their lives. Such discussions often form the starting point from which people begin to take action to tackle the impacts of the unequal social relations that often underlie ill-health (WHO Social Determinants of Health Report). Fraser (1990) argues that in unequal societies marginalised groups are excluded from the public sphere in which governments and other leaders make significant decisions about the shape of social life. They tend to lack the confidence, skills and social legitimacy to advance their needs and interests. She suggests the creation of 'counter-public' spheres, which are safe separate spaces in which marginalised groups can retreat, to develop and 'rehearse' the types of critical arguments they will eventually take into the dominant public sphere. Community conversations adopt Fraser's approach by attempting to create alternative spaces that enable people to discuss issues away from mainstream social environments that promote the status quo, thereby opening space for new ways of thinking and questioning.

Community conversations

The term 'community conversation' describes discussions among local people, guided by a trained facilitator, that support critical thinking and problem solving around key community issues (Born, 2008). Community conversations have been used to address a range of issues including: mental health stigma among ethnic minorities in Scotland (Knifton, et al., 2010); increasing employment opportunities for high school youth with disabilities (Carter, et al., 2009); improving early childhood educational alignment (Rogers & McComas, 2010); efforts to determine health issues and better meet health needs among populations such as rural people, particularly Native Americans, in North Dakota (Moulton, Miller, Offutt, & Gibbens, 2007) and elderly Cambodian refugees in Massachusetts (Grigg-Saito, Och, Liang, Toof, & Silka, 2008). The term has been applied to post-performance or talkback sessions in the field of community theatre or film screenings on issues ranging from the incarceration of African American men to environmental justice (Ellis, 2000; Born, 2008).

However, whilst the approach is widely used, there is little or no systematic account of the methodology of community conversations methodology in the peer-reviewed academic literature. Moreover, the vast majority of the few articles that exist discuss initiatives in North America, with almost no academic writing on the use of community conversations to address issues in resource-poor countries. However, in the grey literature, the United Nations Development Program (UNDP) has pioneered the use of this method in resource-poor communities in Africa, particularly surrounding gender and HIV issues in Ethiopia (UNDP, 2004). In this context, the effectiveness of this methodology in changing community attitudes and practices first came to light through the work of Ethiopian women's rights campaigner Dr. Bogaletch Gebre. She founded the African women's self-help centre Kembatti Mentti Gezzimma (KMG) and has been credited with reducing the practice of female genital mutilation in Ethiopia (Shetty, 2007) primarily through developing and implementing the community conversations technique.

Although some researchers loosely use the term 'community conversation' to describe an informal focus group (Megwa, 2007) or discursive trends in a community (i.e. the ways people talk about issues in their lives) (Wexler, 2006), community conversations are generally considered to be a unique and new intervention type that is distinct from focus groups in several key ways (Ellis, 2000). First, community conversations are focused on generating action plans. They have an explicit 'problem solving' agenda, aiming to spur critical thought that enables people to formulate local solutions to local issues. By comparison, focus groups are more research oriented, aiming to gather information about social relations and understandings. Second, community conversations explicitly aim to change participants' worldviews and conceptions of what is possible, while focus groups aim to understand things as they are.

Conducting community conversations

Community conversations are used in the context of solving social problems. They involve posing questions and thinking points about why problematic social situations are the way they are, what actual and latent local responses and strengths exist in the community to tackle these, and how problematic social relations could be improved. Community conversations are ideally conducted by facilitators who are regarded as local and invested in the community (UNDP, 2004) and are trusted by local people (Shetty, 2007). The facilitator brings together a group of people who consider themselves to be members of the same community. They are generally individuals living in the same area and experiencing the same local strengths and challenges.

Six to ten people was chosen as the optimal number of community conversation participants in order to have groups small enough to ensure that all members have an opportunity to speak, but large enough to maximize discussion and diversity of opinion. The facilitator poses questions to the group and invites discussion, emphasizing the importance of respectful disagreement, honesty and problem solving (Born, 2008). Dr. Gebre, the pioneer of community conversations in Ethiopia, recognizes that conversations may have to take up practical and immediately pressing issues in a community (such as a broken bridge) before moving on to deeper, systemic or taboo issues (such as female genital mutilation or HIV) (Shetty, 2007). The facilitator does not

attempt to teach or advise community members; rather, his or her role is to bring out pre-existing community understandings and strengths and to encourage the community to analyse and solve local problems. As problems and solutions are discussed, the facilitator guides the participants to develop concrete action plans (Born, 2008). Ideally, the facilitator will convene additional conversations on an on-going basis to discuss how implementing the action plans is going and develop additional strategies to overcome challenges.

Methodology

Context: HIV in Zimbabwe and Manicaland

Manicaland is a province in eastern Zimbabwe with an HIV prevalence rate of approximately 20% (Gregson, et al., 2010). Residents of the region are primarily subsistence farmers or workers in mining enterprises, large commercial forestry operations, or tea estates. Most live in rural homesteads (compounds with several mud and thatch houses, a pit-latrine and animal pens), often without electricity. Many families have absent members working in major cities, some of whom send money back to the rural areas. Poverty is a major challenge and many local people receive food aid from international organizations. During the late 2000s the political situation in Zimbabwe made it difficult for many international organizations to operate, causing most to withdraw services and exacerbating food insecurity.

Anti-retroviral therapy (ART) for HIV became significantly more widely available across Zimbabwe in the late 2000s, as a result of concerted government and partner aid organization efforts. By December 2009, 218,589 people in Zimbabwe, about half of those in need, were on free ART through the public health sector (UNAIDS 2009). In Manicaland, free antiretroviral drugs became increasingly available in hospitals from late 2008. However, significant barriers to access remained, including: paying for transportation to and from hospitals, accessing a doctor (of which there are very few) to initiate treatment, and paying the hospital fee (usually \$1US) (Skovdal et al, 2011).

The data set

Eighteen community conversations were conducted in batches of six over the course of three rounds: May 2008, September 2008, and February 2009. This time period enabled an exploration of changing attitudes over time, particularly as ART became increasingly accessible from 2008 to 2009. We aimed to have the same participants in each of the six groups at rounds one, two and three in order to follow up and ask them about changes they had observed between conversations. However, because of the difficult economic and political situation, which at times limited travel, many groups during the second and third rounds included new participants to fill empty spaces. Overall, 77 different people participated--35 more than would have if the exact same participants attended all three rounds. The second round, in September 2008, was during a particularly fraught political period and as such we faced the most difficulties accessing repeat attendees. In the second round, half of most groups were new participants with one group being an entirely new group of people. The conversation groups in round three, in February 2009, included a far higher percentage of repeat participants. See table 1 for details.

We conducted the conversations at two locations (three groups in Nyazura and three in St Theresa). Nyazura is a small township with a high rate of migration and informal work (particularly small scale sale of goods at the roadside and unregulated diamond panning), meaning fewer long term relationships developed between residents. St Theresa on the other hand is a rural area with strong, deeply rooted community relationships, centred on a mission station and hospital. Most residents farm their own land.

Community conversations were conducted by two trained Zimbabwean researchers (the third and fourth authors), one male and one female. Both spoke Shona, the local language, as their mother tongue.

Table 1: Description of dataset

Time	Location	Participants	Group code
T1 (May 2008)	Nyazura	7 (4 male, 3 female)	NA
	Nyazura	7 (4 male, 3 female)	NB
	Nyazura	6 (2 male, 4 female)	NC
	St Theresa	7 (3 male, 4 female)	StA
	St Theresa	9 (5 male, 4 female)	StB
	St Theresa	6 (4 male, 2 female)	StC
T2 (Sept 2008)	Nyazura	6 (2 male, 4 female) [2 old, 4 new]	NA
	Nyazura	6 (4 male, 2 female) [4 old, 2 new]	NB
	Nyazura	8 (3 male, 5 female) [0 old, 8 new]	NC
	St Theresa	7 (2 male, 5 female) [3 old, 4 new]	StA
	St Theresa	8 (3 male, 5 female) [4 old, 4 new]	StB
	St Theresa	8 (4 male, 4 female) [4 old, 4 new]	StC
T3 (Feb 2009)	Nyazura	7 (3 male, 4 female) [7 old, 0 new]	NA
	Nyazura	6 (4 male, 2 female) [6 old, 0 new]	NB
	Nyazura	7 (3 male, 4 female) [6 old, 1 new]	NC
	St Theresa	9 (4 male, 5 female) [7 old, 2 new]	StA
	St Theresa	9 (3 male, 6 female) [8 old, 1 new]	StB
	St Theresa	8 (4 male, 4 female) [3 old, 5 new]	StC
Total		77 individuals	

All participants were given a large block of soap as a token of gratitude for their time. Ethical approval for the study was granted by the Research Council of Zimbabwe and the Applied and Qualitative Research Ethics Committee, Oxford, United Kingdom.

Coding and analysis

After translation to English and transcription the transcripts were read and reread before coding. Using NVivo qualitative analysis software, we coded text segments relevant to our research interest in how community conversations can impact local HIV competence. We thus coded the following: participant comments and reflections on the community conversations and facilitators (what they liked or did not like, thanking

facilitators); discussions of strategies to respond to HIV developed during the community conversations; comments on HIV-related issues in the community getting better or worse; comments on community member support for one another or cruelty towards one another; and comments on gaining HIV knowledge and gaining intent to respond differently to HIV. We then analyzed and grouped the coded segments to develop the seven sub-themes, which serve as the sub-headings in 'findings', below.

Findings

Overview

What role did community conversations play in increasing HIV competence amongst participants? The data suggest that, while community conversations are not a magic bullet, they appear to have made a significant contribution to developing HIV competence through: (1) enabling participants to develop concrete and practical action plans to combat stigma and better support PLWHA; (2) encouraging and challenging participants to think creatively and take positive action with the encouragement of outside facilitators; (3) encouraging open discussion on the taboo subject of HIV; (4) enabling participants to move from passive recipients of HIV-related information to active problem solvers, and (5) providing an opportunity for participants to conceive of ways to move from information to action.

Each of these points will be taken up in turn in Part I of the detailed findings section, below. Part II discusses the contextual factors beyond the control of community members that (6) facilitated and (7) hindered the capacity of community conversations to build HIV competence. On the one hand, the increasing availability of ART in from late 2008 was a particularly supportive context for the goals of the intervention. On the other hand, negative contextual features, particularly severe poverty, poor harvests and political upheaval, limited the feasibility of action plans.

The community conversations were generally animated and ranged in length from one to two hours, with most being approximately one and a half hours. Women and men participated equally. The conversations frequently generated debate and storytelling among participants, with some people recounting highly emotional—sometimes tragic and sometimes inspiring—personal stories of coping with HIV/AIDS among their family or friends. The facilitators guided the discussions through a wide range of issues, generating discussion on topics including: who PLWHA disclose their HIV status to; whether HIV stigma is a problem in the community; where, when and how people discuss HIV avoidance, testing and treatment; the physical and financial accessibility and social acceptability of HIV testing and treatment services; what local efforts are being made to support PLWHA and reduce new infections; problems encountered when attempting to help PLWHA or talk about HIV; and ideas to reduce risky behaviour, stigmatizing attitudes and poor quality care for PLWHA. Each conversation also featured two 'break out sessions' where the group was split into two. The resulting smaller groups were asked to list ideas of how they could reduce stigma in the community and what efforts they were already making to support PLWHA and

encourage prevention, testing and treatment. The groups came back together and presented and discussed their ideas.

Community members came up with many concrete action plans and reported some success at enacting these plans during follow-up conversations. In addition, there was evidence of critical discussion with participants debating whether or not HIV stigma existed and if it could be reduced, the roles of men and women and young and old people in the spread of HIV, and the practicality of various ideas of better supporting PLWHA and reducing new infections, discussed further below. Participants frequently told the facilitators that the conversations improved their community's capacity to respond more positively to the challenges of HIV by breaking the silence around stigma and encouraging discussion. There were countless instances, particularly in the third round of conversations, where participants described a great deal of change in the community's attitude towards HIV, with many attributing it, to the intervention, at least in part.

Before detailing our specific findings from these community conversations we must emphasize that there are many caveats about the limitations of reported behaviour change in the HIV/AIDS field. Participant reports cannot be taken as conclusive evidence that changes occurred in the broader communities outside the conversations, or that any changes can be attributed to the conversations. Participants may have felt an incentive to please the facilitators by emphasizing the effectiveness of the intervention, perhaps in hopes of maintaining links to the facilitators or accessing future assistance. Individuals may have sought to exaggerate their virtues in order to impress other participants. In addition to features of the within-group dynamics, group participants themselves referred to countless other environmental factors, outside of the group contexts, that enable or frustrate community efforts to cope effectively with HIV, discussed in part II. In the local context, a particularly significant development between rounds one and three of our groups was the increase in ART availability in the region through the efforts of the Zimbabwe health ministry and foreign donors. Such a significant and positive external event would have strongly reinforced group efforts to promote positive and creative dialogue and HIV-related action plans.

In this paper, rather than focusing on whether community conversations changed behaviour and attitudes in the community outside of the conversations, we are concerned with examining the extent to which community conversations were able to function as social spaces for critical thinking and the development of action plans amongst participants, which Freire would argue were a necessary precondition for community level change. However, as emphasised above, we cannot claim that these are a sufficient condition for behaviour change. We acknowledge that a range of other factors – from situational factors to individual differences amongst participants – would mediate the translation of plans into action that would result in positive health outcomes.

Part I: In what ways did community conversations contribute to HIV competence?

We now present our detailed findings on the five specific elements of community conversations that appeared to facilitate the building of HIV competence.

(1) Conversations enabled participants to develop concrete, practical action plans to better cope with HIV

An HIV competent community is one in which members conceive of concrete ways by which they can contribute to better supporting PLWHA, reducing stigma and new infections, and encourage access to available HIV testing and treatment services. Our findings suggest that the community conversations (CCs) were effective in supporting participants to jointly come up with possible new strategies to cope with HIV: participants brainstormed how better to care for PLWHA, how to reduce HIV stigma and how to encourage prevention, testing and treatment. For example, some participants decided to distribute condoms and to teach people “that AIDS is not a curse from God, but just a disease” (JO, male, Time 3, StA). In other instances, participants collaborated to develop more effective means of helping PLWHA. In the following, SY offers food assistance and his offer is taken up by MA:

SY (male): I want to say that I might be out of touch on some of these things because I am actually busy with work at my plot most of the time. But I want to ask anyone here to let me know if they find any challenges with regards to food for any of the patients³ they visit. I am more than willing to assist with food. They can tell me, I have maize which I think can assist others in need. So next time when you visit let me know what challenges you have I may assist, I don't mean to say I will give everything you need but I will definitely do something about it.

MA (female): I also want to thank [SY] for offering to help, I also have a certain couple who are HIV positive and ... their worry is food. So [SY] I will definitely approach you after this session for those people. (Time 3, StA)

Participants also developed concrete action plans such as taking turns in maintaining vegetable gardens for food to donate to PLWHA and approaching church leaders to encourage additional discussions about HIV:

This has been a very hard year and we really had to struggle because sometimes these patients expect to receive some material assistance over and above our prayers and counselling and keeping them company. ... That's why we came up with an idea of gardens so that we can supply them with vegetables whenever we visit them. (DO, female, Time 3, StA)

...In our church I have approached my pastor and the bishop who came here after you guys [the group facilitators] left and I put the issue of AIDS forward to them. They received my message very well and began to encourage people in the church to set up a fund that is meant to benefit HIV/AIDS sufferers. (EU, female, Time 3, StB)

Other concrete strategies to help reduce stigma and help PLWHA included: helping bathe and cook for the children of PLWHA, donating fresh milk and firewood as well as

³ The term ‘patients’ is commonly used by people in Manicaland to refer to HIV-positive people suffering the physical decline of AIDS.

vegetables to families with HIV-positive members, praying for PLWHA (a simple but significant way of showing kindness), ploughing, planting and harvesting the fields of people too sick to do so themselves and maintaining normal community relationships with HIV-positive people (such as continuing to visit their homes and ensuring they are able to keep their positions in the church). For example, ME presented her simple but profound idea on how to approach PLWHA in non-stigmatizing ways:

I think we should at least try to be free to these patients and get them to talk, to be friendly and avoid viewing them as helpless patients, which happens when we show a lot of pity for them. If we were friends we should see them as our friend and try to talk them as if nothing has changed about them. (ME, female, Time 3, NB)

Many participants had been helping care for PLWHA within their home for years before the community conversations began, but said that they had previously felt constrained in talking openly about their experiences given the very high levels of HIV stigma. Through having the opportunity to speak about the needs of PLWHA and developing strategies to address these needs with community members beyond their immediate family, participants were able to reframe HIV from a family-level issue to a community-level issue.

Whilst participants proposed some strategies to reduce the spread of HIV and promote testing and treatment, these ideas were often not as concrete or practical as their strategies to better support PLWHA. Many planned to verbally encourage people they knew who suffered repeated illnesses to go for testing and warn young people against pre-marital sex. A few people reported having tried to convince sex workers to stop selling sex. These strategies were vague, taking little account of the underlying social and economic drivers of risky sexual behaviour. The strategy of condemning the risky behaviour of others is often used to distance those who condemn from a sense of their own personal vulnerability (i.e. focusing on young people or sex workers as those at greatest risk of HIV, rather than acknowledging how people 'like them' were also at risk of infection).

Nonetheless, participants did share some practical solutions on the subject of prevention, testing and treatment. Most commonly these included helping people get to the clinic through donating money for transportation or helping to physically carry them if they were very ill; getting community leaders (village chiefs and church leaders) to talk more about HIV in forums such as funerals and Sunday services; and strategically accessing external support (mainly NGO help) for the community. This latter idea was mostly exhibited through participants asking the facilitators to run the same intervention in additional areas, such as schools and churches. For example, one participant said: "...you guys can make a difference if you take this programme to schools (AI, female, Time 2, StC) and another said "I think they [young people] also need to be targeted with programmes like this one because when we try to warn them they would just brush aside everything we say as just rhetoric. They don't value what we say" (OT, female, Time 1, NB). Participants recognized the facilitators as a link to resources and knew that

their symbolic status added salience and credibility to HIV messages and thus appealed to them to help the community.

Developing concrete ideas regarding how to help the community better support PLWHA and encourage prevention, testing and treatment was a positive process for two reasons: first and most obvious, having an action plan increases the likelihood of implementing positive changes because participants have concrete ideas of what they can do. There were many reports by participants in the second and third conversation rounds suggesting that they did in fact take up these action plans. Second, by encouraging the development of action plans, participants began to frame HIV as something they could positively influence.

(2) Participants were encouraged and challenged by involvement of outside facilitators

Formal accounts of the community conversations approach emphasise the use of a trained local facilitator (Shetty, 2007). In this regard we diverged somewhat from the formal guidelines. While both our facilitators were Zimbabwean and spoke the Shona language of the participants, neither of them had personal links with our two study communities. Furthermore, both of them were post-graduate educated and employed in professional research jobs whereas the CC participants were less formally educated and farmers or manual labourers. Our findings suggest that a key driver of community conversation success was the presence of relatively high status facilitators from outside the community. Community members appeared to trust and relate to them but also expressed respect for them and gratitude that they had come to the region and cared to help. The presence of outside facilitators seems to have appealed to participants and strengthened the effectiveness of the conversations for three main reasons, discussed below.

a. Participants felt motivated by facilitators and inspired to act

Respondents repeatedly said that the involvement of the facilitators in the CCs inspired them to put their plans into action. They said that they were keen not to 'let down' the facilitators, given the trouble they were taking to implement the intervention.

We talked about HIV at community gatherings and gave soap to PLWHA so that everyone in the community can see what you have been teaching us. Since you came here there is now a big difference. So we wanted others to know that there is this programme. (TH, female, Time 3, StB)

Participants seemed to take the expectation that they implement their action plans very seriously:

AN, female: I visited someone with HIV and cleaned her home because we had been taught by you that we should help those who are sick, so I did it so that I can put what I have learnt in practice, and I also wanted others to know how they can treat their patients.

PH, female: I also helped because you taught us to do that. (Time 3, StB)

It is noteworthy that participants mentioned having been ‘taught’ when CC facilitators specifically avoided imparting any HIV related messages or suggesting strategies. This could indicate that local people were keen to give credit to the facilitators for gains made. It could also indicate that participants perceived having been taught when in fact the CCs had drawn out latent understandings and conceptualizations already present among the group.

b. Participants felt valued, not forgotten

At the time of the CCs, many foreign NGOs had withdrawn from Zimbabwe as a signal of their disapproval of the current political regime, and opportunities for community group meetings and activities were significantly limited by political conflict, and laws that were passed to limit opportunities for people to gather in public. Against this background, participants expressed a sense of ‘honour’ to have the chance to participate in the groups, and an associated sense of responsibility to try to generate some positive community gains from their involvement. Participants expressed a sense of having been abandoned by other organizations, as the following quotations illustrate:

They [an NGO] used to give but not on monthly basis, but they have just vanished (SE, female, Time 2, NB)

They [an NGO] stopped some few weeks before the March elections and they have not resumed their activities since then (SI, male, Time 1, NC)

The ‘participation fatigue’ spoken of by Parry and Wright (2003) and Strand (2008) – cited as undermining peoples motivation to engage in AIDS programmes in other contexts - did not appear to be an issue. In contrast, participants were very eager to engage with the community conversations and were thankful and heartened to see outsiders come to help.

I just want to thank you guys for coming here, it shows a lot of commitment on your part, and I hope this is not the last time we are seeing you here and we hope to move together as we fight stigma. We hope soon you will be able to come to our church and give a talk as I requested. I hope you will consider that request. Some organisations who used to work here have completely forgotten us because since the days when they were stopped by the political situation we never saw them back, we just hope they are considering coming back again. (MA, male, Time 3, StC)

With so few resources coming from the outside to assist their communities, the presence of these facilitators appeared to represent a valuable link to external support and evidence that poor rural people had not been forgotten.

c. Facilitators challenged participants to think in new ways about HIV issues that were locally seen as normal or unchangeable

The facilitators performed another role that appeared to enable these conversations to spur critical thinking and the development of feasible action plans: they challenged normative worldviews and behavioural options. In this respect it appears to have been

vital that outsiders injected new ideas into the CC dialogues. As the following quotations illustrate, the facilitators took care not to impose new ideas in a prescriptive way, rather seeking to feed them into the discussions to serve as the raw materials for the development of new ways of being and seeing.

The following dialogue (Time 1, NC) shows the facilitator asking critical questions of participants to encourage them to move away from a simplistic understanding of an HIV-related issue---in this case young people's promiscuity and associated behavioural problems, such as acting 'spoiled' (i.e. not helping at home and desiring consumer goods), acting 'sassy' (i.e. not adhering to parental instruction) and skipping church. One participant, with the agreement of the larger group, presented the opinion that the government was contributing to their children's bad behaviour by enacting a law that recognised people over 18 as adults, and therefore beyond the legal control of their families. Blaming this law enables community members to avoid discussing local issues leading to youth promiscuity, and fails to admit that 'youth promiscuity' concerns children much younger than 18 years. The facilitator asks questions to get participants to think through their understanding of the issue:

Facilitator: You are the ones who are facing all these challenges; what do you think should be done?

NI, male: ... I think the government has also a role to play. I think the government is enacting some laws that make it hard for us to control our kids.

Facilitator: Which laws are these?

NI: The government says that at 18 years the child is now free to do whatever they want... [This law is on the legal age of majority for voting] That's when our children begin to tell us that they are adults and no longer want parental guidance. Ladies, am I not telling the truth here?

[Some noises suggest agreement]

Facilitator: Do you mean your youths are only giving you problems when they are 18. And before that they would have been well behaved all along?

NI: They begin [misbehaving] at around 14.

Facilitator: So would the same law cover them?

NI: No.

The facilitator did not propose any alternate understanding and did not teach or impose his views. Instead, he gently pushed participants to see the issue in a new way. After the above exchange, the participants came up with other ideas (rather than blaming the law recognizing adulthood at age 18) to address the risky sexual behaviour of young people. Ideas included adding more Christian education to the schools and encouraging parents to be stricter with their children. While these ideas are not necessarily revolutionary, they are better than blaming an unrelated government law and they show evidence of participants thinking of community action plans to reduce risky sexual behaviour among young people.

Participants emphasized how deeply changed they were by taking part in the community conversations and linked the experience closely to the facilitators. For instance, one participant said: "You gave us the impetus to do this, you made us do this and we can't stop it now" (AN, female, Time 3, StC). As mentioned earlier, we must

consider the chance that participants may have been overemphasizing the impact of the intervention in order to please the facilitators, perhaps in hopes of ensuring future visits and programming. Nonetheless, as KU, female, below, suggests, being questioned by outsiders often forces new ways of thinking and seeing the world, something participants valued and wished others could experience:

I encourage you to even come to our church and talk to people the way you were talking to us--by asking some questions we learn a lot and one would wish that everyone could get this opportunity. (KU, female, Time 3, StC)

Participants frequently asked the facilitators to run the same intervention with additional groups. These requests suggest that participants valued the community conversations and believed others in the community would also benefit from participating.

(3) CCs constituted a forum in which people could develop sense of community, common purpose

Bringing community members together and encouraging them to discuss their local strengths and challenges appeared able to bolster a sense of common purpose. This was particularly evident in Nyazura, a community of more transient traders and informal labours, without the same level of entrenched family and neighbourhood ties as the more agrarian St Theresa.

Most of the people in this community are just resident here they have relatives far away, so they also feel loved when we help them, people become more united and feel more related than they are. I am sure your coming here has helped us to begin to feel like we are just all related. I think you have helped us to bring us together and begin to see other people in this community as family even though we are not related. (TA, female, Time 3, NB)

After you left us last time we sat down as a group and decided that we should work together and coordinate our efforts, so we agreed that we meet regularly and talk about the patients that we would be having in this community from time to time so that we find ways of helping them where we can. Many people in this community come from other areas – and though we are strangers we decided that the only source of our help is each other. So we decided that we should visit HIV/AIDS sufferers and bring them what we can afford, sometimes we go to see the patient and ask them what they want to eat, then we try to make their desired things available. (TE, female, Time 3, NB)

Participants also commented on the conversations' role in unifying church groups and helping HIV-positive people become more open about disclosing their status:

... Since you came here we have been holding inter-church gatherings to make sure everyone is on the same footing. These groups have brought more unity among churches, and it has recently been said all churches should also talk about HIV/AIDS during their services. Now it seems HIV/AIDS sufferers are now feeling proud. Now that you have come here

they will say "we have HIV" because once they say that people begin to be very helpful. (TH, female, Time 3, NB)

While community conversations need to take place among people who already consider themselves to be united as a community, our study suggests they can facilitate a deeper sense of collaboration and common purpose amongst participants.

(4) CCs enabled participants to move from passive recipients of HIV-related information to active problem solvers

Participants credited the conversations with helping them envision themselves as agents who could contribute to building local HIV competence. Many mentioned that local knowledge of HIV was sound and there was no need for more information. Instead, they expressed a lack of collective agency to move from information to action.

Your coming here is helping us with a lot of things. Though we knew about HIV/AIDS we really never thought we could also do something ourselves until you came and talked to us. I personally was at least doing my little part but I never thought we could actually work as a group and achieve something. Now I find that when we go as a group we lighten the burden very much for the care giver. The caregiver is normally used to only seeing one visitor after a while. When we visit, the women start washing and cleaning the house, while the men will help to lift the patient, changing their position (SI, male, Time 3, StA)

KU below, again emphasizes that the conversations not only taught him about HIV but also made him think critically about his own capacity to do something:

I have learnt a lot from attending your sessions. I have learnt that I should do something to assist HIV/AIDS sufferers in our community. After I took it to our church we began visiting HIV/AIDS sufferers regularly - bringing whatever small things we can, be it a piece of soap or just some bananas, and continuing to visit and pray for them. Some patients had food but needed assistance to stand up or be carried to the toilet, so I and my group assisted some people in that way. Sometimes we just talked to the patients, or helped them fetch some firewood. We were trying to give them hope. (KU, female, Time 3, StA)

JA's statement, below, gets to the heart of the value of community conversations:

Action speaks louder than words. People are now saturated with information so I will try to show what I mean by being extra good to patients. (JA, male, Time 3, NC)

At this stage in the epidemic, people are 'saturated' with information about HIV. For JA, the CCs offered the possibility of turning such information into action.

(5) Community conversations reduced the silence and stigma surrounding HIV

By bringing people together and encouraging open discussion of HIV, community conversations reduced the silence surrounding HIV. Participants shared personal stories about HIV and came to see that almost every family was somehow affected by the disease. In the following, CL comments on how prior to the programme, supporting PLWHA were seen as a private family issue rather than a community responsibility:

[The community conversations] have helped us to be more serious on taking care of the patients. It has helped us to realize that they are people just like us, they need us, they need our love. Because long back we use to think that a patient is someone who is within my household, but your coming helped me to realize that I should take care of everybody, I should help. (CL, Time 3, NC)

Bringing people together to talk about HIV with facilitators who ask challenging questions about the status quo and encourage new ways of thinking can break the silence and reduce stigma. Ethel (below) reflects that the discussions have made it easier to talk about HIV:

...Now we know how we can work together. We are no longer shy or afraid to talk about HIV/AIDS. You have helped so much and now we can discuss and talk to each other freely and now we are able to continue meeting as a group even after you guys have gone. You guys have made us mature and this had moulded us by getting knowledge and skills from sharing with others. (ET, female, Time 3, StB)

The conversations appear to have forced discussion about HIV and enabled participants to reframe their understandings and attitudes towards PLWHA. WI (male, Time 3, StA) reports that the conversations have “been very effective in changing how we perceive HIV sufferers.”

Part II: Contextual influences that facilitated or hindered effectiveness of the community conversations

HIV competence of a community is influenced by a complex array of factors that lie beyond the reach of a single specific intervention. A large research literature highlights contextual drivers of community responses to HIV, such as systemic poverty and entrenched gender norms. We now turn to examine contextual factors that (1) facilitated or (2) hindered participants’ efforts to implement their action plans.

(1) Facilitators: ART availability

In the third round of CCs, participants repeatedly referred to the role of ART availability in bolstering their efforts to implement the action plans formulated in the CCs. Participants closely linked a perceived reduction in HIV stigma to the availability of treatment. For example, in the following quotation, AM links improved levels of testing and reduced stigma to opportunities to access ARVs:

There was a person we didn't think would survive into the next month, but we encouraged them to consider going for HIV tests and to see the doctor. Now that person is looking very healthy. We have also asked the doctor to make regular visits so that St Theresa people no longer need to go to Rusape to collect their monthly prescriptions or for medical check-ups. So I think what you have done here is working very well, since you have been here we go about our villages talking about what we have learned and encouraging the sick to get tested so they can be put on ARVs. (AM, female, Time 3, NC)

AM attributes this change to the CCs, however if it weren't for the newly available treatment options, the idea of encouraging people to go for testing would not be as compelling. The possibility of being treated reduces the stress and trauma of finding out one's status, opening up the possibility for HIV-positive people to return to health, reducing the burden on families and communities. DO, in the following quotation, reinforces the link between improved community attitudes towards HIV and treatment availability:

Now that we have the information and the facility where people can access ARVs at St Theresa, I think people are beginning to realize that HIV/AIDS is not a death sentence (DO, female, Time 3, StA)

(2) Hinderers: Poverty, poor harvests, and political upheaval

The late 2000s when this research took place were particularly challenging for Zimbabweans. Hyperinflation⁴ from 2006 to 2009 rendered the Zimbabwean dollar useless, meaning that trade (including the purchase and sale of crops by farmers) was almost completely shut down, shelves in stores were barren and employees in almost all sectors from nursing to education to office work went unremunerated for months. As AN explains: "...this money has been devalued so much that you cannot buy anything with it; so poverty has really limited our efforts" (AN, female, Time 2, StB). On top of hyperinflation, as AL (male, Time 2, StA) explains, the region faced several seasons of drought that severely reduced harvests: "...This year there has been drought so much that even the well known crop producers did not harvest anything." Poverty and drought curtailed many efforts to increase visits to provide support to PLWHA. PLWHA and their families often were in desperate need of food or money for medicine. Visiting their houses empty handed was considered both culturally inappropriate and callous, making it hard for conversation participants to implement plans of increasing social relations with PLWHA.

I think the major challenge [in acting on our CC plans] has been poverty that made it difficult for us to meet the expectation of the patients we visited. The most important thing that we also failed to make available has been food and a decent or good diet. Unfortunately we had a very poor harvest. (KT, female, Time 3, StB)

⁴ In 2006 inflation was 1281%, in 2007 inflation was 66,212% and in 2008 inflation was 231,150,888%. In October 2008 US\$1 = Zim\$2,621,984,228, leading up the abandonment of the Zimbabwean dollar in 2009. (Official

Poverty also reduced the capacity of community members to offer physical care to PLWHA, because carers were unable to access gloves. Since people were understandably highly reluctant to touch open sores and human waste without gloves, they were often hesitant to visit the homes of very sick people to offer assistance, further isolating PLWHA and their families.

Sure, sometimes we go to see these HIV/AIDS sufferers and they would have messed themselves but we no longer have gloves to use we find it hard to handle that. My honest request is that if we can only get a regular supply of gloves. (NA, male, Time 3, StC)

Moreover, poverty and hunger fuelled the risky sexual behaviour that causes HIV to spread, particularly by creating conditions in which young women engaged in transactional sex with older men:

Our efforts to give information to young people are often hampered by poverty. Our young girls think that if they go out with older man they can get what they want and all their poverty can be a history. All these hardships associated with economic situation makes it hard for young people to change. (VE, female, Time 3, StA)

The difficult political situation in Zimbabwe was another very salient contextual feature that frustrated participant efforts to help to PLWHA and increase discussions around HIV issues. As mentioned above, it led many NGOs to withdraw from the country, removing much needed HIV awareness programs and food supplementation initiatives. Moreover, the implementation of and amendments to the Public Order and Security Act (POSA) made it illegal to meet in groups larger than two people without explicit permission from the police. Efforts to raise money for PLWHA were curtailed by accusations of political activity:

Some of the problems we encountered recently, while a lot of AIDS patients had openly told us their status, so we embarked on a door to door campaign to raise money for these patients but recently the political environment was not enabling at times being accused of trying to raise money for the opposition party. (LA, female, Time 2, NA)

In addition even group visits to the homes of PLWHA became highly risky, as MA (male) and AN, (female) explained:

MA (male): Without saying too much let me also say that, in recent times we also had a problem because visiting patients was not easy due to the political environment, it was not easy to make such movements, as this was prohibited by the political activists here.

AN (female): I think like what [MA] has said the major obstacle for us to work as a group has been the political environment that was so tense and we were not allowed to be seen in groups. We were not free to visit these patients as a group.

MA: That is true and it was really serious to such an extent that one day when I had a small group of church members that had visited a certain patient and we were approached and told to call off that gathering as they were considering it a political rally/gathering rather than a small group of

church members going to see a patient. We were ordered to stop all those activities. We did that to save the lives of the church members and the patients themselves. (Time 2, StA)

Community collaboration and dialogue are absolutely central to the community conversations approach—and to the idea of social change in general. Curtailment of community gatherings severely limits peoples' opportunities to develop or implement action plans to improve local responses to HIV. Our facilitators had to get police permission to run the conversations and, as discussed in the methodology section, had trouble bringing together groups.

Conclusion

The value of community conversations stems from their creation of social spaces for dialogue, which can enable marginalized people to engage in critical thinking. People must have opportunities to conceive of strategies for change. However, they are only a necessary condition for the implementation of strategies, and not a sufficient one. Community conversations cannot counter the effects of poverty, poor harvests and political upheaval that limit the capacity of local people to solve the problems they face. They take place within a wider social, political and economic context that plays a major role in enabling or frustrating community efforts to combat HIV. Community conversations cannot make a woman economically empowered enough to leave transactional sex work, nor can they put bus fare to the clinic in the pocket of a young man seeking an HIV test and they cannot bring ART to a rural community.

Where they do appear effective is in helping people respond to existing environments in a manner that promotes health, for example through making the uptake of available services more socially acceptable, thus reducing the stigma of being seen in the clinic collecting ARVs. They appear to help participants develop concrete strategies to help. They provide a forum in which to build a sense of community and common purpose, to encourage and challenge participants to conceive ways to move from information to action, and to reduce the silence and stigma surrounding HIV. The presence of external facilitators is vital in the creation of alternative social spaces in which new ways of thinking about HIV challenge local people to develop constructive strategies for change.

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Technical report 7

**Community-level factors enhancing or
restricting the impact of a cash transfer
programme in Manicaland, Zimbabwe**

Skovdal, M,
Mushati, P,
Nyamukapa, C,
Gregson, S,
& Robertson, L

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Abstract

This document reports on the experiences and perspectives of community members in Manicaland, Zimbabwe, who have had some involvement in a pilot cash transfer programme. The report highlights that community members, when given the opportunity to participate in a social welfare programme, are well placed to ensure the success of the programme. Community members are capable of identifying the neediest households to benefit from the programme as well as ensure benefitting households access the funds. It was also observed that community and extended family members apply social pressure to ensure that the cash given to vulnerable households are not misappropriated. The involvement of the community in the Cash Transfer programme helped minimise community-wide conflict and jealousy. The Cash Transfer programme also provided benefitting households with opportunities for social participation (e.g. through savings clubs or income generating activities) to help sustain their livelihoods.

The enhancing and restricting community-level factors discussed in this report highlight the importance of considering the social contexts in which programmes are being implemented. Through such a consideration, agencies must be cognizant of the interface between their intervention and the community. As such, there is an urgent need for the 'community response' agenda to be reflective about how *they* can both enhance and potentially undermine community responses – moving beyond the community mobilisation agenda where the responsibility for social change lies with the community. To do this, implementing agencies must consider both the latent community structures and the social contexts as well as explore the potential ways through which community members can get involved in the programme in any meaningful way – enabling community members to take ownership of the programme. Against this background, this technical report point towards the importance of the *nature of partnerships* between resourceful organisations and local communities and proposes a framework for 'locating health and development programmes in a social context':

To locate health and development programmes in a social context, agencies must...

- a. Actively involve and encourage the meaningful participation of community members
- b. Consider local structures and dynamics which may enhance or impede the programme
- c. Consider the compatibility of their programmes with local responses
- d. Corporate with other support services
- e. Consider potential unintended consequences as a result of the programme and their presence in the community

Introduction

Orphan prevalence is increasing in many sub-Saharan African countries due to increases in adult mortality resulting from high HIV prevalence (UNICEF, UNAIDS, & USAID, 2004). Furthermore, children are made vulnerable by increased morbidity amongst parents and other caregivers (Foster & Williamson, 2000). Studies from sub-Saharan Africa, including many from Zimbabwe, indicate that orphaned and vulnerable children (OVC) are at risk of a variety of adverse health, education and other social outcomes, such as increased risk of mortality (Watts, Lopman, Nyamukapa, & Gregson, 2005), morbidity (Lindeblade, Odhiambo, Rosen, & DeCock, 2003; Watts & Gregson, 2007), adverse sexual health outcomes and/or HIV infection (Birdthistle et al., 2009; Gregson et al., 2005), reduced school enrolment and/or attendance (Ardington & Leibbrandt, 2010; Monasch & Boerma, 2004) and psychosocial distress (Cluver, Fincham, & Seedat, 2009; Nyamukapa et al., 2010).

Interventions are therefore required to target the specific characteristics that lead to increased health and educational risks amongst OVC. One such intervention is Cash Transfer (CT) programmes. Cash transfer programmes typically provide money to poor families to invest in human capital. These transfers may be unconditional or conditional, that is, transfer of the cash is dependent on investments in human capital such as taking children to school or for regular health check-ups (Rawlings & Rubio, 2005).

The growth in popularity of cash transfer schemes has been accompanied by a growing body of literature reporting on the effectiveness of the programmes. In the case of conditional cash transfers this may be measured by uptake of targeted health intervention (Barham & Maluccio, 2009; Lagarde, Haines, & Palmer, 2007). In Latin American some evaluations have extended to look at health outcomes in terms of child development (L. Fernald, Gertler, & Neufeld, 2008; L. C. H. Fernald, Gertler, & Neufeld, 2010; Ozer, Fernald, Manley, & Gertler, 2009). In Malawi – a low-income country – that conditioned on school attendance and specifically targeted young women aged 13-22 years (particularly those that had already dropped out of school), found significant reductions in risky sexual behaviour, early marriage and pregnancy (Baird, Chirwa, McIntosh, & Ozler, 2010).

Recently however concerns have begun to be voiced about the lack of in-depth contextualised evidence on how CT programmes can be implemented without undermining latent coping strategies. Inter alia, there have been questions about their implications for equity, stigma and quality of care (Devadasan, Elias, John, Grahacharya, & Ralte, 2008); for health system weakening or strengthening (Travis et al., 2004); for intra-household relationships and decision making and support of female empowerment (Molyneux, 2006); for unintended but increasing pressures on women (Smith-Oka, 2009); for state paternalism (Aschroft, Marteau, & Oliver, 2008; Marteau, Aschroft, & Oliver, 2009); and for citizenship (Lomeli, 2005). Cash Transfer programmes can be expected to communicate values and shift understandings of how vulnerable families are best supported, and as such, it is not only the health and educational outcomes that are the target of CT programmes that may be shaped. Changes may therefore be as much about identity, values and sense-making as observable practice change (Mannion & Davies, 2008).

In summary, it has been highlighted that although CT programmes produce promising outcomes for children's health and educational attainment, there is a lack of understanding of *how* CT programmes can mitigate potential unintended consequences of CT by locating themselves in social contexts. It is against this background that this technical report seeks to generate a theoretically informed, in depth understanding of the implementation of a cash transfer programme from the perspectives of those involved, and to advance critical thinking on how to locate social welfare programmes in social contexts.

Intervention and report aims

Research into cash transfers provided to households caring for orphaned and other vulnerable children has shown the positive effects such programmes can have on the health and education of vulnerable children, but as yet there is little understanding of how such population-based interventions are integrated into a community context, involving community members in the planning and implementation of the programme. To explore this further, a community randomised trial is being carried out in Manicaland to investigate, not only the effects of cash transfers on the well-being of children living in vulnerable households, but also the community-level factors that enhance or restrict the impact of the cash transfer programme.

In the evaluation, 30 communities have been randomised to receive one of three programmes: a conditional cash transfer (CCT) programme - where conditions are attached to the cash transfers to ensure that child beneficiaries are sent to school and access basic health services; an unconditional cash transfer (CT) programme; or basic agricultural assistance (the control programme). Census questionnaires are used to evaluate the effects of the cash transfers on school attendance, vaccination status and birth registration. The baseline census was conducted in September 2009, before the cash transfer programmes began, with a follow-up survey scheduled for November 2011. To explore community perspectives on factors that may enhance or restrict the impact of the cash transfer programme, a series of structured interviews and focus groups were conducted between June and August 2010. It is the aim of this technical report to unpack the social resources that enhance or limit the impact of a Cash Transfer programme and work towards a framework for locating Cash Transfer programmes in a social context

The findings presented in this report will contribute to two of the four research questions addressed in the World Bank report:

1. What are the community-level determinants of various types of intervention outcomes?
2. What are the implications for policy and practice to create 'AIDS competent communities'?

Methodology

This evaluation reports on the perspectives of 42 adults and 4 children who participated in 19 structured interviews and three focus group discussions. As detailed in Table 1, the informants represent a diverse mix of stakeholders, including key informants, direct beneficiaries of the conditional and unconditional cash transfer programmes as well people benefitting from the agricultural assistance programme who acts as the control group.

Type of informants	Individual interviews		Focus Groups		TOTAL NO. OF INTERVIEWS
	Adults	Children	Adults	Children	
Key Informants	6	0	1 (9 people)	0	7
Cash Transfer Beneficiaries	3	1	1 (9 people)	0	5
Conditional Cash Transfer Beneficiaries	4	3	0	0	7
Controls	2	0	1 (9 people)	0	3
TOTAL NO, OF PEOPLE	15	4	27	0	46 22

Table 2: Qualitative evaluation informants

Each group of informants were interviewed using a topic guide developed specially to explore their perspectives on the cash transfer programme. Although the questions on the topic guides were formulated slightly differently to each group of informants, we conducted a thematic content analysis (Attride-Stirling, 2001) of the transcripts to pull together core themes running through the entire data that. We are therefore not seeking to draw attention to individuals accounts and their individualised personal experiences of the programme (vis-à-vis their context), but to map out some of the more prevalent experiences and perceptions as reported by the informants. The analysis uncovered three primary themes: i) community involvement in the programme; ii) community competence and iii) opportunities for social participation. The key themes emerging from the analysis are illustrated in Table 2 and form the structure of our discussion of the findings.

Themes		Community-level factors	
Primary	Secondary	Enhancing factors	Restricting factors
Community involvement in the programme	Selection process	<ul style="list-style-type: none"> - Community-based committees mobilized to identify deserving beneficiaries 	<ul style="list-style-type: none"> - Community members finding it difficult to assess the vulnerability of potential beneficiaries because people feel inclined to lie in order to access support - HIV/AIDS related stigma
	Cash distribution	<ul style="list-style-type: none"> - Community-based committees are given the trust and opportunity to disperse funds - Community members help picking up funds for those who are unable 	<ul style="list-style-type: none"> - Corruption - Changes in the household composition of benefitting households - Illness and disability
	Monitoring	<ul style="list-style-type: none"> - Community-based compliance committee - Community members apply social pressure to ensure cash are not misappropriated - The programme was well-published, good general awareness of the programme 	<ul style="list-style-type: none"> - Not all community actors aware of who benefits from CT
Community competence	Solidarity	<ul style="list-style-type: none"> - Community members are supportive and understanding for the need of the programme - Community members support vulnerable households 	<ul style="list-style-type: none"> - Narrow targeting - Conflict and discrimination - Poor household dynamics
	Knowledge and skills	<ul style="list-style-type: none"> - Community members have knowledge and skills to sustain their livelihoods 	
	Outside support	<ul style="list-style-type: none"> - Vulnerable households are able to access support from NGOs 	
Opportunities for social	Rotating credit schemes	<ul style="list-style-type: none"> - The Programme has enabled vulnerable 	

participation	households to join rotating credit schemes
Cash Transfers serve as a springboard for income generating activities	- The Programme has enabled benefitting households to invest in livestock
Recognition and use of local strengths	- The Programme has empowered households to support vulnerable children
Community support structures	- The Programme has mobilized new support structures, including compliance buddies and community-based committees taking children's interests at heart.

Table 2: Community-level factors enhancing or restricting the Cash Transfer programme

Findings

Table 2 (and appendix 1 which includes quotations) summarises the key findings of this study. We will now discuss each of the themes emerging from our analysis.

Community involvement in the programme

This technical report highlights that community members, when given the opportunity to participate in a social welfare programme, are well placed to ensure the success of the programme. Community members participated in different capacities. Community members were elected to participate both in the selection of beneficiaries as well as monitoring progress and compliance of programme conditions. Community members participating in these teams were elected because of their position as respectable and honourable community members. These community members, drawing on their local knowledge were able to identify the neediest households to benefit from the programme and played a key role in ensuring that beneficiaries complied with the programme conditions applicable to them. One beneficiary for example talks about how all the beneficiaries in her local area are households with orphaned children, suggesting community members have done well in selecting needy households.

“In our group, there are no benefitting families with children who are not orphans, so I think they have done well in selecting needy households”
CT beneficiary

That said the committees did not select the benefitting households without any problems. Aside from some community members being inclined to lie about their circumstances in order to become a beneficiary of the programme, a few eligible

households were afraid of participating in the programme because of the association between HIV/AIDS and the implementing agency (Manicaland Project).

“One of the main problems is people were lying. Some people were giving wrong information about their household status” Community committee member

“Some people did not want to join the programme, others were shy, they thought with the type of work they do [AIDS work], it won't be proper to be seen joining the programme so they ignored the programme.” CT beneficiary

These restricting factors, although with contradicting outcomes, make it difficult for the community compliance committee to enrol deserving beneficiaries onto the programme. A case of corruption or nepotism also emerged from the transcripts, with one senior official refusing to remove the names of undeserving individuals, despite recommendations from the community committee.

Community members also played a key role in monitoring the compliance of cash transfer conditions. Benefitting households were aware of the conditions and knew that someone from the community might come and check up on them. The impact of this awareness was described by one benefitting guardian:

“If the money you receive has conditions, you will buy for kids because anytime the compliance buddies can come to see my children” CT beneficiary

Nevertheless, despite such expected hitches, involving community members in a meaningful way is likely to increase the likelihood of programme success and, as we shall now see, acceptance.

Community competence

But also the wider community helped enhance the outcomes of the cash transfer programme. They did this by helping to ensure that benefitting households access the funds available to them and by applying social pressure to ensure the cash was not misappropriated.

“For my father to pay for the school fees, the money would have had to have gone through his friends and they will ask him to pay on your behalf. This is the only time he will pay, the friends would have pressured him into paying” Boy benefitting from CCT

Also extended family members would help ensure that money given to children with their family network would not be misappropriated by their parents. Although not everyone within the community (including key stakeholders such as school leaders) were fully aware of the programme, there was good general knowledge about the programme.

People knew that the programme was targeting desperately poor households with children and felt a sense of sympathy for that.

“The project came to help vulnerable families and we are happy about that.” Community member

“I feel happy that orphans are getting money, deserving and needy orphans should receive money. I see them receiving money and this makes me happy.” Community member

This solidarity, coupled with the involvement of the community in the programme, arguably helped minimise community-wide conflict and jealousy. Although some people felt disgruntled by the fact they did not benefit from the programme, most people, even in the control groups, were very happy about the programme and showed their full support. Although this report does not look into the conditional versus unconditional cash transfer debate, it is worth noting that an overwhelming majority of informants are pro conditions and articulate that the conditions create a fairness that unconditional cash transfers do not possess. Conditions may therefore also contribute to the widespread acceptance of the cash transfer programme.

Opportunities for social participation

The cash transfer programme provided benefitting households with opportunities for social participation to help sustain their livelihoods. Despite numerous complaints that the funds transferred to vulnerable households are inadequate and can barely pay for the school fees, some households still managed to use a small fraction of the received funds as a springboard to participate in income generating activities (IGAs) or rotating credit schemes.

“The other significant change is that people are using the money to send children to school but also to make household developments like digging of safe wells and buying assets like goats.” Committee member

“The improvement which I can see is that when we get the money you can buy a chick/hen and you rear it. It is better if some of the money remain behind and get invested. It will help.” CCT beneficiary

“We started a rotating credit scheme on the 6th of December 2010. Each person was contributing \$5. There were 4 so the total was \$20. The hope was that we were going to raise money to buy each club member a goat.” CCT beneficiary

The primary aim of both the IGAs and the rotating credit schemes is to invest in assets that will provide them with a more sustainable income. Goat and bee keeping, as well as chicken rearing were often mentioned as opportunities that the cash transfer programme had led to. Despite the conditions or strong encouragements to pay for children's

schooling, the cash transfer programme gave the beneficiaries a sense of control – even if in practice this was not the case. Beneficiaries often felt empowered, and appreciated the recognition of their strengths to provide adequate care and support to the children. Finally, returning to where we started, the programme provided a selected group of community members with opportunities to play a more active role in the programme, including committee members and compliance buddies.

Discussion

The findings section has highlighted a number of facilitating and restricting community-level factors, some which relate to latent community structures and others which are a result of the interface between community life and life circumstances and the cash transfer programme. Figure 1 summarises the facilitating and hindering community-level factors impacting programme success that are either latent or induced by the cash transfer programme.

Amongst the latent community assets contributing to programme success is solidarity. It is a characteristic that helps ensure that community members are supportive of the programme and the households benefitting as well as being, accepting of the fact that only a small proportion of vulnerable households will benefit from the programme. But also the local knowledge and skills of people involved was important. Beneficiaries drew on their local knowledge and skills to make the most out of the funds they received (e.g. by joining rotating credit or invest remaining funds in livestock) and community members participating in the programme implementation used their knowledge to ensure that the selection and monitoring of benefitting households was done in a culturally sensitive manner.

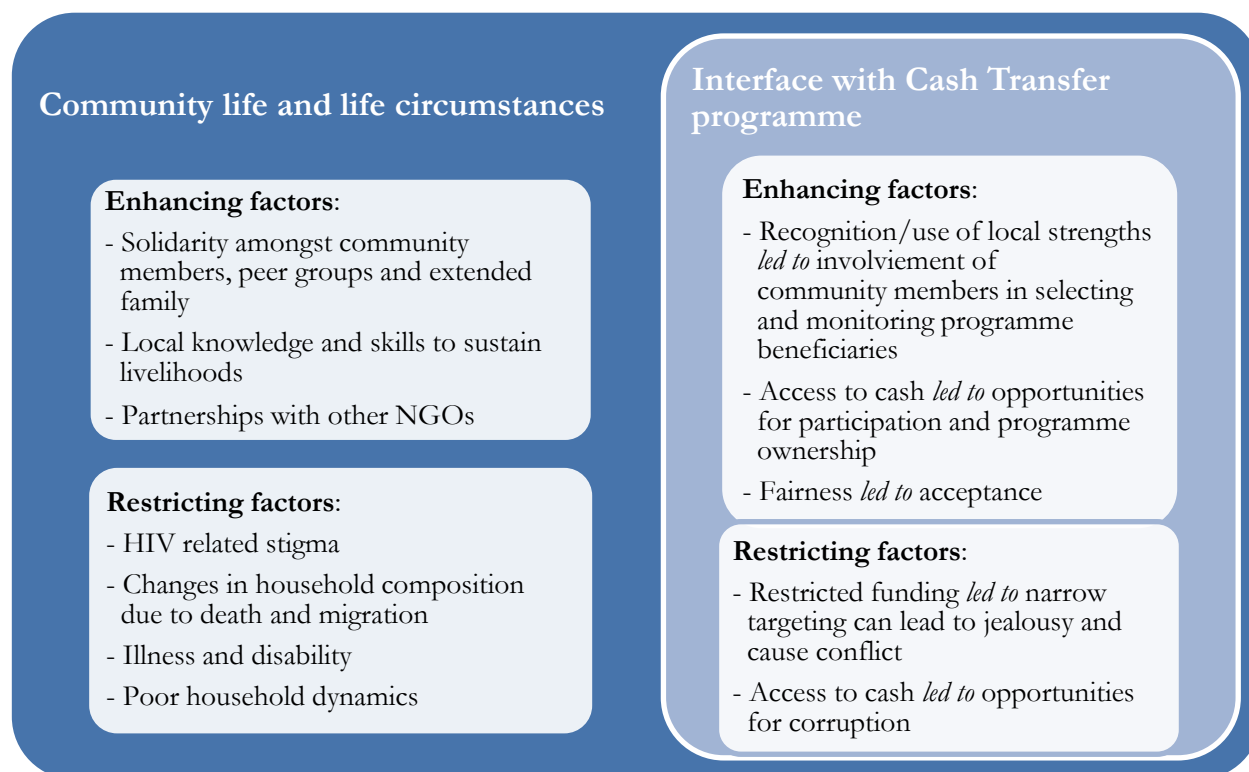


Figure 1: Community-level factors enhancing or restricting the Cash Transfer programme

Drawing on and building on these latent community assets, the cash transfer programme brought forward a number of additional community resources. The cash transfer programme recognised and made use of local strengths, it actively involved community members in the implementation – fostering a sense of ownership - and it opened up opportunities for social participation. The fact that the programme was considered fair, particular in areas where conditions were attached, led to an acceptance and support of the programme.

As outlined in Figure 1, there were of course also a number of restricting factors at a community-level. The ones latent to community life include HIV stigma, changes in household composition due to either death or migration, but also illness and disability or poor household dynamics may interfere with programme success. An example of poor household dynamics may be if an orphaned child has lost both parents and lives with a step mother who does not care about the child. Also households where the male head of house drinks alcohol excessively, is it difficult to ensure that the children benefits from the programme. The cash transfer programme – through its interaction with the community – could also hinder programme success. The fact that not all needy households got enrolled onto the programme left some people feeling jealous or resentful, causing conflict. Also the sudden access to cash opened up for opportunities for corruption, lying and cheating to ‘get a piece of the pie’ so to speak.

Recommendations for policy and practice

The enhancing and restricting community-level factors discussed in this report highlight the importance of considering the social contexts in which programmes are being implemented. Through such a consideration, agencies must be cognizant of the interface between their intervention (and the organisation they represent) and the community. As such, there is an urgent need for the ‘community response’ agenda to be reflective about how *they* can both enhance and potentially undermine community responses – moving beyond the community mobilisation agenda where the responsibility for social change lies with the community. To do this, implementing agencies must consider both the latent community structures and the social contexts as well as explore the potential ways through which community members can get involved in the programme in any meaningful way – enabling community members to take ownership of the programme.

Against this background, this technical report point towards the importance of the *nature of partnerships* between resourceful organisations and local communities and proposes a framework for ‘locating health and development programmes in a social context’:

To locate health and development programmes in a social context, agencies must...

- a. Actively involve and encourage the meaningful participation of community members

- b. Consider local structures and dynamics which may enhance or impede the programme
- c. Consider the compatibility of their programmes with local responses
- d. Corporate with other support services
- e. Consider potential unintended consequences as a result of the programme and their presence in the community

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Appendix 1: Coding framework with quotations

Themes		Community-level factors			
Primary	Secondary	Enhancing factors	Quotes	Restricting factors	Quotes
Community involvement in the programme	Selection process	- Community-based committees were mobilized to identify deserving beneficiaries	<p>“I was selected by the community to be a beneficiary so I think people are happy that I am benefitting from the programme.” CT beneficiary</p> <p>“in our group, there are no benefitting families with children who are not orphans, so I think they have done well in selecting needy households” CT beneficiary</p>	- Community members finding it difficult to assess the vulnerability of potential beneficiaries because people feel inclined to lie in order to access support - HIV/AIDS related Stigma	<p>“One of the main problems is people were lying. Some people were giving wrong information about their household status” Community committee member</p> <p>“Some people did not want to join the programme, others were shy, they thought with the type of work they do [AIDS work], it won’t be proper to be seen joining the programme so they ignored the programme.” CT beneficiary</p>
	Cash distribution	- Community committees draw on local community structures to mobilise beneficiaries for the disbursement of funds - Community members help picking up funds for those who are unable	“Our strategy to tell people about the cash disbursement was to go through schools and churches, knowing that most people attend the church and tell people to pass on the message to each other. At schools we tell the headmaster who tell the children, who then will go with the message to their parents. Since we started doing that we have never had any	- Community members not empowered to address corruption - Changes in the household composition of benefitting households - Illness and disability - Change of cash distribution plans and poor communication	“Some people’s names were appearing twice and some better off people were included in the programme but did not qualify. We were asked to write all this on a piece of paper. The papers were collected and taken to their offices but the next time they came these names were still appearing on the list. On the next disbursement some of these did not turn up to

		<p>major problems of mobilizing people” Community committee member</p> <p>“As I am unable to pick up the cash, I asked my next door neighbour to become authorized to get my cash” CT beneficiary</p>		<p>collect their money because they were told they did not qualify to be in the programme. But when the names continued to appear on the list this people are still getting their money. So this is really confused us as a committee because we did not understand why we were asked to write down those names and nothing is being done about the issue. Mr XX said we cannot take out those names” Community committee member</p> <p>“Some people who were married got divorced and the woman went away with the child. So those are some of things that are happening.” Community committee member</p> <p>“The main problem on the day of receiving money is communication, because sometimes we wait for them from 9am, like this time but will only receive money around five or six” CT beneficiary</p>
Monitoring	- Community	“for my father to pay for	- Not all community	“We should have a register

		<p>members apply social pressure to ensure cash are not misappropriated</p> <ul style="list-style-type: none"> - Community members given the role to monitor - The programme was well-published, good general awareness of the programme 	<p>the school fees, the money would have had to have gone through his friends and they will ask him to pay on your behalf. This is the only time he will pay, the friends would have pressured him into paying” Boy benefiting from CCT</p> <p>“We have started checking for birth certificates in our villages and checking if children are going to school” Community committee member</p> <p>“If the money you receive have conditions, you will buy for kids because anytime the compliance buddies will come to see my children” CT beneficiary</p> <p>“I see that the programme was well advertised, because when the programme begun each and every one of us was asked questions in view of what we needed help with” CT beneficiary</p>	<p>actors aware of who benefits from CT</p>	<p>of benefitting children so that we are able to identify that these children are on the program. I think that would be a good idea. I think next time we should have it so that we even if we request for levies and no payments have been done, we can wait because we would know that definitely payments will be made. It will be good.” Key informant (head teacher)</p>
Community	Solidarity and	- Community	“It brought cohesion	- Narrow targeting	“There is an issue of

<p>competence</p>	<p>programme acceptance</p>	<p>members are supportive and understanding for the need of the programme - Community members support vulnerable households</p>	<p>because there were people who were very poor” CT beneficiary</p> <p>“The project came to help vulnerable families and we are happy about that.” Community member</p> <p>“I feel happy that orphans are getting money, deserving and needy orphans should receive money. I see them receiving money and this makes me happy.” Community member</p>	<p>- Conflict and discrimination - Poor household dynamics</p>	<p>discrimination. Look at these old ladies there, they are too old to work and they have no other source of income, they are widows and by themselves. They are very old, but they are not benefiting.” CT beneficiary</p> <p>“I have heard others say that there people who are no longer greeting each other” CT beneficiary</p> <p>“what is happening in the community is problematic; because some people view the programme as favoring some people whilst ignoring others” CT beneficiary</p> <p>“If children are orphaned and live with their step mother is an example of when a child will not benefit and will just go on foot or on slippers. She may feed her own children and say: “I have orphans like these” and the community sees that for real she has orphans, but the orphans do not get anything.” Community member</p>
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	Knowledge and skills	- Community members have knowledge and skills to sustain their livelihoods	“Last year we tried to grow vegetables and tomatoes but now we only have chicken (road runners) that we are looking after so that when we do not have money we can sell some of these chickens.” CCT beneficiary		
	Outside support	- Vulnerable households are able to access support from NGOs, made easier after obtaining birth certificates	“The Chiedza programme selects people from the villages and gives them chickens and stock feeds. They then tell the people to grow their own maize in the coming rain season to feed their chickens because they will not be getting any stock feeds the next seasons. So when the chickens starts laying eggs they sell the eggs and use the money to buy stock feeds and look after the children in their households.” CT beneficiary “birth certificates make it easier to take children to the hospitals and also for securing food.” CCT beneficiary		
Opportunities for social	Rotating credit schemes	- The Programme has enabled	“People can look after themselves now because		

<p>participation</p>		<p>vulnerable households to join rotating credit schemes</p>	<p>some people were taken for a workshop in Mutare to train them on rotating credit schemes. Now you find rotating credit schemes have been established” CCT beneficiary.</p> <p>“We started a rotating credit scheme on the 6th of December 2010. Each person was contributing \$5. There were 4 so the total was \$20. The hope was that we were going to raise money to buy each club member a goat.” CCT beneficiary</p>		
	<p>Cash Transfers serve as a springboard for income generating activities</p>	<p>- The Programme has enabled benefitting households to invest in livestock</p>	<p>“The other significant change is that people are using the money to send children to school but also to make household developments like digging of safe wells and buying assets like goats.” Committee member</p> <p>“The improvement which I can see is that when we get the money you can buy a chick/hen and you rear it. It is better if some of the money remain behind and get invested.</p>		

		<p>It will help.” CCT beneficiary</p> <p>“There are many people who are grateful for the programme because they managed to buy some goats so that they continue to pay for their children school fees.” Community committee member</p>		
Empowerment and decision making	- The Programme has empowered households to support vulnerable children	<p>“The cash transfer programme is good in that it gives the power to the household head to decide on what is needed in the household like taking their children to clinic or paying fees.” Community committee member</p> <p>“The strength of the cash transfer is in that a house is give the opportunity to make decisions it is given an opportunity to use that money in any way they like” Community committee member</p>		
Community support structures	- The Programme has mobilized new support structures, including compliance buddies and			

		community-based committees taking children's interests at heart.			
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Technical report 8

Community sources of support for AIDS-affected, AIDS-infected and orphaned children in Zimbabwe

Morley, C,
Skovdal, M,
Campbell, C,
Madanhire, C,
& Nyamukapa, C

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Abstract

Youth in Zimbabwe are at a high risk of being AIDS-infected, AIDS-affected, or orphaned. Stigma and negative representations of orphans and vulnerable children (OVC) inhibit community efforts to provide optimal support to HIV-positive children and children caring for HIV-positive family members; it is particularly detrimental to their health and wellbeing when compounded with other sources of struggles and hardship. Our work recognizes children's perspectives, agency, and unique coping strategies and seeks to bring their voices to the heart of the policy and research process, while drawing attention to existing support networks, both family- and community-based, that often sustain OVC.

Thirty draw-and-write data sets created by children ages 10-12 in Zimbabwe were analysed for barriers to community support, sources of solidarity and children's coping mechanisms. The supporting codes were split into two global themes, community competence and agency. While the stories and drawings contained more challenges than sources of community support, the sources of aid and positive portrayals of OVC that were represented are illuminating. Children found support in peers, friends, family members, and within their greater community. They exercised agency on multiple levels and actively took advantage of local resources and support systems. Children recognised OVC's lack of culpability in their disadvantaged situations; this recognition served as a precursor for engaging in acts of community solidarity that assist OVC. We believe there is room for programmatic and policy improvements to complement existing community coping strategies.

Key words: Child carers, community responses to HIV, orphans and vulnerable children, children's agency, draw-and-write methodology, Zimbabwe

Introduction

Youth in Zimbabwe have a high risk of being HIV-positive, having a family member who is HIV-positive, and/or being orphaned. There are an estimated 150,000 cases of paediatric AIDS (children ages 0-15) in Zimbabwe and the HIV prevalence rate for youth aged 15-24 is 5.1%. There are 1,400,000 orphaned children under the age of 17 in Zimbabwe, with an estimated 1,000,000 of those children orphaned as a result of AIDS (UNICEF, UNAIDS, & USAID, 2004; UNAIDS, 2002). These factors make children particularly vulnerable to additional adverse health effects, economic difficulties, low academic achievement, and psychosocial distress (Chase, Wood, & Aggleton, 2006; Bhana, 2008; Watts et al, 2007; Nhamo, Campbell, & Gregson, 2010). Despite these hardships, children often cope effectively with their difficult situations (Skovdal & Campbell, 2010). Understanding what forms of community-based support children identify as the ones best situated to assist (OVC) is vital to ensuring that they are effectively supported within a local community context.

The draw-and-write technique has been identified as an enabling way to engage children as active participants in age-appropriate research (Backett-Milburn & McKie, 1999; Horstman, Aldiss, Richardson, & Gibson, 2008; Knighting et al, 2010). It is particularly appropriate to use with children who are vulnerable, ill, or whose physical, emotional, or mental wellbeing is compromised (Ogina & Nieuwenhuis, 2010; MacGregor, Currie, & Wetton, 1998; González-Riviera & Bauermeister, 2007). The draw-and-write technique allows for participation of children who may be illiterate or have a limited vocabulary, who may not be comfortable expressing themselves verbally, who may have barriers to communication, or who might prefer to represent their thoughts through pictures (Pridmore, 1996; Ogina & Nieuwenhuis, 2010). While Backett-Milburn and McKie (1999) caution that the draw-and-write technique fails to provide knowledge of the external social environment that influences the process through which children form perceptions, Knighting, et al (2010) find that the data itself provides rich insight into the children's socio-economic and cultural contexts.

Stigma and negative social perceptions of AIDS are cited as one of the key obstacles to effective diagnosis and treatment of children with AIDS in Africa as well as a barrier to supporting children who are caring for AIDS-affected relatives (Miller & Major, 2000; Bhana, 2008; Castle, 2004; Foster et al, 1997; Joffe & Bettega, 2003; Skovdal et al, 2011; Campbell, Nair, Maimane, & Nicholson, 2007; Campbell et al, forthcoming; Dovidio, Major, & Crocker, 2000). It inhibits health and wellbeing in its own right and exacerbates additional challenges that OVC face. It also hinders community efforts to provide support to children caring for parents dying of AIDS, undermines children's confidence, increases their risk of forceful and/or high-risk sexual behavior, and contributes to their lagging educational performance (Johnson, 2006; Pascoe, et al., 2010; M. Chitiyo, Changara & G. Chitiyo, 2008). To date, most research on African children and AIDS has been limited to the opinions of adults or community outsiders (Skovdal, Mwasiagi, Webale, & Tomkins, 2010; Campbell, Skovdal, Mupambireyi, & Gregson, 2010). Our work recognizes children's unique coping strategies and seeks to bring their voices to the forefront of the conversation, while giving attention to existing family- and community-based networks (Nyamukapa & Gregson, 2005; Saller, 2009; Skovdal, Mwasiagi, Webale,

& Tomkins, 2010; Skovdal & Campbell, 2010).

Agencies implementing health and development programmes must:

- View children as agentic and recognise their power as social actors as they interact with peers, family members, and their greater community
- Accurately characterise the diverse and varied struggles that OVC face within their communities
- Understand which existing community resources and support systems are the most beneficial for OVC and promote these networks
- Use stigmatised children's lack culpability for their disadvantaged positions as a starting point for future interventions

Report Aims

This research looks children at the forms of community-based support that children identify as effectively supporting OVC, with the intention of reinforcing these ideal community environments through policy and practice. The goal of this particular project is to gain a greater understanding of mechanisms for community support for OVC. Understanding the implications of child-on-child stigma as well as the pathways that children use to improve their situation in conjunction with those that lead to negative consequences will provide valuable insight into possible entry points for future interventions. In particular, in examining the ways that OVC are and are not stigmatised, enhance the possibility that these interventions will have positive results. These outcomes can take the form of access to services, economic support, assistance with physical labour and chores, and psychosocial support.

Through our work we hope to gain a more comprehensive understanding of the ways that children, in the context of their greater community, view OVC with the intent of informing direct, actionable interventions. In particular, we are interested in examining how positive representations of children, such as utilizing agency or taking advantage of local resources and systems of support, can potentially mitigate some of the material and psychosocial struggles that these children face.

This report contributes to two research questions addressed in the World Bank report:

- What forms of community support do children see as the ones best able to assist OVC?
- What are the implications for policy and practice to create “AIDS- and orphan-competent communities?”

Methodology

Twenty-eight children ages 10-12 from both urban and rural eastern Zimbabwe created 30 sets of stories and drawings, which were collected by the Manicaland HIV/STD Prevention Project, a collaborative scientific research institute in Manicaland Province, Zimbabwe. A breakdown of the age, sex, and geographic location of the participants follows in Table 1. Ethical approval was granted for this research by the Medical Research Council of Zimbabwe and the London School of Economics and Political Science. UNICEF (2002) guidelines for undertaking research with children were followed and written consent for participation and publication was obtained from all participating children and their parents/guardians. The data were collected using one of three different open-ended prompts, namely 1) draw a picture and write a story about a child who has AIDS, 2) draw a picture and write a story about a child who is affected by AIDS, or 3) draw a picture and write a story about a child who is orphaned. No additional guidance or further prompting was given, so children were free to create stories and drawings that were either purely imaginary or based on personal or real-life experiences.

Ten stories and their paired drawings from each prompt were analysed. Since the guiding research question was to identify the forms of community support that children see as the ones best able to assist OVC, the data were analysed as a single corpus representing the views of OVC. The stories were coded first, as their content tended to be more detailed and explicit, and the drawings were analysed with the accompanying story in mind. Using thematic network analysis (Attride-Stirling, 2001) as a framework for understanding the data, they were grouped into numerous basic themes, fewer organising themes, and ultimately 3 global themes: *struggles* that OVC faced in their daily lives contrasted with examples of individual *agency* and solidarity which translated into external support through *community competence*. Codes were included in the final analysis only if they were present in at least two of the three sets of data, as an indication that they were applicable to OVC in general and not simply to the specific subgroup about which they were written. The full coding framework and organised thematic network follows in Table 2.

Prompt	Number of Data Sets	Sex	Age	Location
AIDS-affected	10	5 girls, 5 boys	3 10yrs, 2 11yrs, 5 12yrs	8 urban, 2 rural
AIDS-infected	10	5 girls, 5 boys	1 10yrs, 6 11yrs, 3 12yrs	7 urban, 3 rural
Orphaned	10	6 girls, 4 boys	3 10yrs, 3 11yrs, 4 12yrs	6 urban, 4 rural
Total	30	16 girls, 14 boys	7 10yrs, 11 11yrs, 12 12yrs	21 urban, 9 rural

Table 1: Characterisation of children who were participants in the research.

**Two of the data sets that were drawn for the AIDS-infected prompt were drawn by children who also created data sets for the orphaned prompt. That is, a total of 28 children created 30 data sets.

Thematic Network Coding Framework

Global Themes	Organising Themes	Common Themes
Agency	Sustaining Households	Child helps with chores Head-of-household responsibilities
	Taking Control	Living on the streets Prioritizes education
	Using Knowledge and Skills	AIDS contracted through "unsafe" sex
Community Competence	Outside Support	Access to healthcare Community group accessible
	Recognition of Strengths	Children hard working
	Reconciliation	Children not culpable "Fairy-tale" ending (child eventually happy)
Struggles	AIDS	Child sick Hair falling out Skinny Visibly ill
	Difficult Living Situation	Adults not contributing Family members are cruel Limited time Orphaned
	Educational Challenges	Doesn't attend school Poor academic performance
	Maltreatment	Physical abuse Sexual abuse
	Poverty	Dirty Hungry Lacking money Poor clothing
	Psychosocial Difficulties	Crying Suicidal Unhappy
	Stigma	Avoided by other children Feels shame Loneliness Others fear contracting AIDS Teased

Table 2: Community-level factors that support or restrict children's coping strategies

**In addition to the above codes, the following 18 codes appeared in only one of the three data sets and thus were not included in the final analysis as they were deemed to be specific to the subgroup identified in the prompt and not OVC more broadly: called national helpline, child wishes she was never born, few material possessions, kind/cheerful, late to school, little rest, loves parents, no support from teacher, not lonely, other children punished for teasing, parents on drugs, parents well tended in hospital, plays with friends, relatives won't care for the child, school far away, smart, strong, worries.

Findings

Overall, the stories and drawings contained more challenges and struggles than sources of social and community support. In addition to pervasive stigma, OVC dealt with the physical ramifications of AIDS and other illnesses, difficult living situations, educational hardships, maltreatment by family and community members, poverty, (which was often further exacerbated by their other struggles), and psychosocial difficulties, including crying, sadness, and suicidal thoughts. The struggles were numerous and varied, and there was frequent overlap, as struggles in one area were frequently identified as contributing to struggles in another. While children were quick to pick out physical demonstrations of challenges (skinny children, hair falling out, dirty, wearing patched clothing) they were also perceptive of less obvious hardships, such as lack of access to quality healthcare, shame, and loneliness. Yet, while the struggles did outnumber the sources of agency and community, the sources of support and positive portrayals of children that were represented are telling.

Children found support in peers and friends, in their family members, and within their greater community. They exercised agency on multiple levels and actively took advantage of local resources and support systems. Children identified recognition of other children's lack of culpability for their disadvantaged situations as a precursor for engaging in acts of community solidarity, which was identified as one of the best pathways to pursue as a way to assist OVC. All of these supportive and enhancing representations were ultimately coded into the themes of *Agency* and *Community Competence*.

Agency

Sustaining Households

There are many examples of children exercising agency to help maintain a functioning household. Children are drawn cooking, cleaning, bathing ill family members, giving parents medicine, and caring for siblings. They are often described as waking up early and going above and beyond what would otherwise be expected of them. They earn extra money to contribute to the family income and are perceived as taking on roles associated with a head of household.

"She [an AIDS-affected girl] woke up early in the morning she had to sweep the yard and rooms, she had to go to the river and fetch some water, she

had to see that her parents have eat, bath, and change clothes. She used to clean toilets and wash the clothes for them.” Boy, age 12, urban

“In the morning Alice [an AIDS-affected girl] will cook for her mother and she will go with food for her mother and a bottle of water, cup and some pills. She is always busy as a bee she has no time for rest.” Boy, age 11, urban

Taking Control

Children are described as very dedicated to their education, making sacrifices to attend school, putting effort into their homework, and insisting that younger siblings stay in school. They are also depicted as making a conscious decision to leave an abusive family and to live on their own on the streets. They are represented as doing whatever it takes to survive, be it eating from the bins or stealing food.

“She [an AIDS-infected girl] decided to live in the streets asking for money and food.” Boy, age 10, urban

Children are also represented as taking both responsive and proactive measures to help family members. They assert themselves for the benefit of their siblings as a way to support them as individuals and the family as a unit.

“She [an AIDS-infected girl] lived with her brother and tried by all means for her brother to go to school and food to eat.” Boy, age 12, urban

Using Knowledge and Skills

Children understand that “risky” sexual behaviour, such as sleeping with prostitutes or sleeping with multiple partners, can lead to AIDS. This accurate knowledge surrounding HIV transmission is an asset that can help them to make safe choices regarding sexual health behaviour. While knowledge itself does not directly translate into positive behaviour, it is a necessary prerequisite for children to make informed choices that promote their health and wellbeing.

“He [an AIDS-affected boy] transported goods from south to Zimbabwe on his way he would sleep with many different girls so he got AIDS.” Boy, age 12, urban

“He [a prostitute] approached her [an AIDS-infected girl] and they became friends. She went to his home and slept with the man. So this lady was HIV positive because she slept with a positive guy.” Girl, age 10, rural

Community Competence

Solidarity

Children represented their friends, neighbours, and teachers as being helpful and willing to lend a hand when needed. Community members are depicted assisting with

household chores, making a special effort to buy from the child at the market, aiding with caregiving for a sick relative, and providing emotional support and companionship for an otherwise lonely child.

“Rudo help her friend Pamela [an AIDS-affected girl] all the time. Even to the market then went together happily. Many people like to buy at Pamela and Rudo’s table because they are always happy.” Girl, age 11, rural

“They [her classmates] started helping her [an AIDS-infected girl] and her teacher and other teachers helped until she was given her happiness back.” Girl, age 12, urban

Outside Support

Hospitals and clinics are present in many of the stories and medical professionals are frequently represented as helpful people who will occasionally go out of their way to assist the child. The nurse drawn below is assisting a child who is HIV positive. Local churches and community centres are referenced as places where children receive support and guidance. Police officers are described as intervening when a child is being abused in several of the stories.



[an AIDS-infected girl] Girl, age 12, urban

Musa [an orphan] was a hardworking boy at school but because of his stepmother he failed his schoolwork. He was beaten again but this time his leg was broken [. . .] the police arrived to arrest Musa’s stepmother. Musa was taken to the hospital.” Boy, age 12, urban

Recognition of Strengths

Children are represented as very hard working. They are slightly less frequently described as smart and strong. They take on demanding chores without complaining and often still manage to attend school and/or find time to play with their friends. This

willingness to perform needed tasks above and beyond what their peers might be expected to undertake is a positive attribute that children recognise in OVC.



[an AIDS-affected girl] Boy, age 12, urban

“Nhamo [an orphan] is a strong man. He is intelligent but no one pays his school fees.” Girl, age 11, rural

Reconciliation

Many of the stories end with a very positive and upbeat ending, essentially “and the child lived happily ever after,” even if the child in the story is described as ill, poor, abused, etc. We interpreted these endings as references to the child “deserving better,” or acknowledgement of the child’s undeserved misfortune. There are also many references to children deserving pity or sympathy, and multiple subtle examples of children not being culpable for difficult situations they find themselves in.

These “happy endings” are often in stark contrast to the rest of the story, that often depicts the child in more negative than positive light. While a story may have several paragraphs about a child who is overworked, dirty, and struggling in school, the final sentence will differ starkly in tone and will suggest that the child will eventually reap positive rewards for enduring undeserved hardships.

“Nobody will play with her Chiediza. They say Chiediza is a fool and they said they don’t want to play with her because she is an orphan. [. . .] I think that if she works hard at school one day she will become someone special like those people who were once poor and become rich.” Boy, age 10, urban

Additionally, there are calls to assist OVC rather than stigmatising or ostracising them in pieces that have otherwise depicted them in an unflattering light. The indication seems to be that “it is common” to think of and treat OVC negatively but that the participant also knows that such sentiments are themselves negative. Ultimately, the children are represented as unfortunate victims of their circumstances who should be treated with kindness and generosity.

“Other children laugh and tease him [an AIDS-infected boy]. At school he has no friends at all. I feel pity for him. He sits by himself in class and at break time. In the morning he does not eat and he does not carry anything to eat or drink. Some pupils at his school say he stinks others say he does not bath. He is always crying. He is always alone. My advice to others is not to tease or laugh at people who live with AIDS because most of them need your love and care. They have not asked for the disease.”

Boy, age 12, rural

Discussion

Community competence and agency reinforce each other to counteract struggles. Children demonstrate agency as they take advantage of networks of support offered by their community while the assistance they receive from their community can in turn enable them to be more independent and exercise more agency. That is, many of the responses and coping strategies that are depicted can be jointly employed to counteract stigma, which was identified as a struggle on its own but also intensifies other struggles, as well. Children see a variety of elements included in community support, from direct material help to assistance with chores to gestures of kindness and charity, that assist OVC.

There are some additional avenues that were not present in the data that could be used in conjunction with the existing strategies. While the positive aspects that were mentioned can mitigate some of the struggles that OVC face, additional strategies that were not mentioned, and therefore can be assumed to not currently take place in the communities, could be introduced. For example, methods of income generation aimed at improving the current situation and increasing economic empowerment, and not merely subsistence survival as represented in the data, could complement the existing coping strategies. This intervention could be supported by a local, national, or international NGO.

The following flow diagram (Figure 1) shows the interplay between individual agency, community competence, and struggle mitigation. The symbiotic relationship between agency and competence is heightened by external factors that work together to counteract the struggles that OVC face. Given community and regional diversity, the influence of each component is not assumed to be equal or constant. While the three elements together provide a strong basis for counteracting the struggles, they will vary in their influence from situation to situation. They provide a framework from which to tailor programmes that best fit locally identified needs, and should be seen as a malleable tool to use within a nuanced and unique local context.

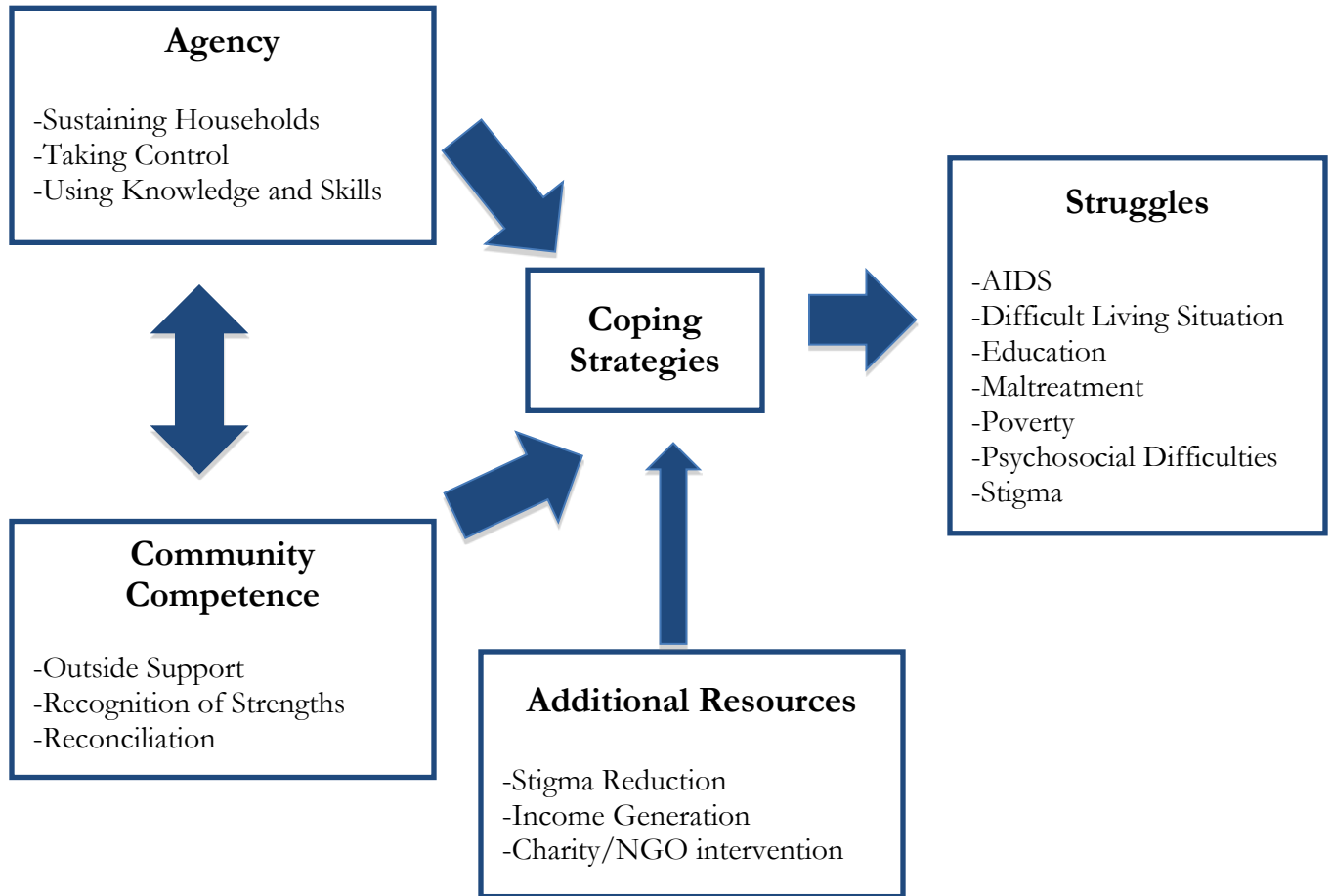


Figure 1. A representation of the avenues of support for OVC that help them to overcome struggles.

Policy Implications and Practical Recommendations

Stigma and negative social representations, while often stated to be undeserved or unfair, are pervasive. Further, this stigma spans a spectrum and ranges from fairly minor stigma (a child is dirty) to strong accusations that the child is inherently bad (the child should never have been born and there is no hope for a better future). Local NGOs, charities, and policy makers can begin to counteract and reduce stigma by paying particular attention to the local context of the children, specifically the community norms and support networks, so as to tailor their intervention to meet the unique and nuanced needs of individuals and communities (Campbell, Skovdal, Mupambireyi, & Gregson, 2010). Efforts to reduce stigma should take place in tandem with efforts that use and strengthen existing community solidarity networks, since these are identified by children as particularly effective in supporting OVC. Children are depicted as being individually

agentic to survive (living on the streets, begging) but when they take initiative together with other members of their community, including their peers, neighbours, teachers, or local charities, the avenues for support become stronger and their coping processes more effective.

The data also demonstrate the need to address not only the social and relational aspects of struggles that OVC face but the more practical challenges that stem from economic hardships and extreme poverty. These aspects were frequently referenced within the stories and drawings but no direct solution or coping strategies were presented; this is another area that might benefit from the influence of policy or programming by external organisations. While this intervention would not be a “magic bullet” solution to solve issues of financial hardship, introducing microcredit schemes, cash-transfer programmes, or other income-generating activities have the potential to improve the lives of OVC (Skovdal, Mwasiaji, Webale, & Tomkins, 2010).

To better capitalise upon community-based support networks, policy agencies should:

- Incorporate existing community systems of support into their interventions
- Focus on interventions that aim to reduce stigma as a way to support OVC
- Identify ways to enhance children’s agency and community competency working in tandem to confront the variety of struggles that OVC face
- Consider charity-supported income generating activities as an entry point to supporting OVC

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Technical report 9

Social capital and policy: A review

Scott, K.

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Background

Social capital refers to the productive value of connections between and across people and groups in societies (Putnam, 2000). The idea suggests that social networks between peers or similar groups in a community (bonding social capital) or across groups with disparate characteristics (bridging social capital) have value that can bring about positive outcomes. The term was first used in 1916 by L. J. Hanifan, an American educational theorist and rural school state supervisor, in reference to social cohesion and personal investment in the community. The concept has since become a common theme in sociology, psychology, public health, political science and development studies. It gained traction through its use by urban theorist Jane Jacobs (1961) to discuss the value of neighbourhood social interaction, by political scientist Robert Salisbury (1969) to define benefits of interest group membership in the US, and by the sociologists Pierre Bourdieu (1986) and James Coleman (1988) to discuss the dynamics of power relations in social life and the facilitation of individual or collective action. The concept reached widespread popularity in the 1990s with the World Bank taking up social capital as a research focus and the publication of *Bowling Alone: America's declining social capital* (1995), an essay (and, later, book by the same name, published in 2000) by Robert Putnam arguing there had been an erosion of social intercourse in America, which undermines civil engagement and democracy.

Exactly what social capital is and its value in society remains contested. Bourdieu, Putnam and Coleman all primarily understand social capital as the property of groups whereby they can extend their life chances (Gilding, 2010). However, Bourdieu focused on the advantages that people and groups with access to certain types of social capital have over others. Putnam in contrast tended to emphasize the positive effects of social capital on society as a whole through its capacity to strengthen levels of trust, mutually beneficial action and democratic participation. Coleman argued that social capital is essentially neutral: it facilitates action of individuals or groups but this action may or may not be positive for society as a whole (Foley & Edwards, 1997).

Social capital and public policy

The concept of social capital has been taken up in policy circles since the late 1990s. Having been ascribed many social benefits, from enhancing health to improving educational outcomes and child welfare to reducing crime rates and tax evasion, policy makers are concerned with better understanding the range of positive effects social capital can have and how it can be bolstered. In addition, social justice and public health advocates, such as Lawrence Wallack have pushed policymakers towards using government action to promote social capital (c.f. Wallack 2000). There is strong interest by national governments, particularly in Australia, the UK, the USA and Canada, as well as international development organizations, led by the World Bank, in finding ways to integrate a better understanding of social capital into policy to maximize benefit to society.

How can social capital affect society?

There are many theories about how social capital actually serves to benefit groups and societies. In addition, as discussed earlier, several theorists have argued that forms of social capital can harm individuals or groups or benefit some to the detriment of society more broadly (Baum, 1999; Mustafa, 2005). Referred to as 'antisocial capital', some networks generated by groups can normalize and perpetuate negative behaviours and reduce the potential for positive connections (Baum, 1999). For example, some tightly knit groups can be xenophobic and harmful to outsiders. Other groups such as gangs in America can create dense social networks of support for members but shun or harm those who seek to leave the gang and participate in mainstream society (Portes, 1998). Campbell, Williams and Gilgen (2002) found in their study of a South African mining community that correlations between membership in different groups and alcohol consumption, casual partners, and condom use with casual partners to be varied and not always in the directions hypothesized. While membership in some groups, such as sports clubs, were correlated with lower levels of HIV, other groups, such as savings clubs, were correlated with higher incidence of HIV among young men and greater likelihood of alcohol consumption.

Despite these potential negative effects, the OECD, after reviewing an array of studies, reported that social capital has an overall positive social and economic effect (OECD 2001). The World Bank also reported (2002) that there is 'increasing evidence' that social capital is critical for poverty alleviation and sustainable development. What are the positive ways that social capital has been said to generate benefits to society?

- *Reducing transaction costs:* business arrangements, for example, with high levels of trust between parties can lessen the need for detailed contracts to cover all possible interpretations and contingencies and for monitoring of the other party to ensure their compliance. Group based lending schemes such as the Grameen Bank and tontine in West Africa rely on the social capital of members to reduce the cost of loans. Since members know one another better than the bank does, members use their social networks to decide who to team up with for loans and to enforce repayment, allowing the bank to offer low interest (Grootaert, 1998).
- *Promoting cooperative behaviour:* social cooperation can benefit participating individuals and society more general. For example, if wealthier parents work with less wealthy parents to campaign to improve their local public school rather than moving their children to private schools, all the children in the community will benefit from better public education. In developing countries, agreements among communities to jointly manage a common resource such as water or forests can overcome seasonal shortages or unsustainable resource usage (Grootaert, 1998, Ostrum, 1995).
- *Diffusing knowledge and innovations:* From job offers to new forms of social media to the latest medical information (such as where to access tests or treatments), people are likely to access knowledge and innovations through well developed social channels.

- *Enhancing personal well-being and associated spill-overs:* Participants in communities with high levels of social capital have better access to sound social supports, social connections with others and ultimately better health outcomes. They are more likely to be 'hired, housed, healthy and happy', leading to lower social expenditure on welfare, healthcare and tax receipts (Productivity Commission, 2003). Research in Australia showed that people tend to get jobs through informal mechanisms such as family and friends or professional contacts rather than impersonal avenues such as job postings (Stone, Gray, & Hughes, 2003).
- *Positive effect on health:* A number of studies show that social capital level has a positive impact on health promotion (e.g., decrease in infectious diseases, prevention of risk behaviours, improved maternal and infant health), taking charge of health (e.g., social justice, community involvement), and psychosocial mechanisms (e.g., social support, social inclusion) (Bouchard, Roy, & van Kemenade, 2005, Kawachi, Kennedy, & Glass, 1999; Putnam, 2000; Baum, Palmer, Modra, Murray, & Bush, 2000). The Public Health Agency of Canada's 2003 General Social Survey, cycle 17, found that having 12 or more strong social ties had a positive impact on an individual's self-reported state of health, when compared to those with smaller social networks (Public Health Agency of Canada, 2003).

Key issues at the intersection of social capital and policy

Policy makers are currently unable to fully predict the effect of new policies on existing levels of social capital. They are also generally unable to understand how existing social capital will impact the outcomes of new policies (Frank, 2003). The following sections discuss the key issues currently under debate at the intersection of policy and social capital:

Can social capital be built intentionally by good policy?

Many health activists argue that building positive social capital ought to be a primary concern of policymakers. For example, in their paper on the relevance and role of social capital in health promotion and community development, Wakefield and Poland (2004) point out that social capital is closely linked to equity and interaction between citizens. They argue that social connections are contingent on, and structured by, access to material resources---making social capital intrinsically linked to economic and political structures. They suggest that current policy discourses focus on the importance of connection and cohesion without addressing the fundamental inequities in access to resources that underlie these connections. Thus policy must focus on increasing social justice so that citizens have the material and social equity required for positive community interaction.

In the Australian Government's Productivity Commission report on social capital, the following ideas are presented on how policy could build social capital.

- Public campaigns, and more flexible work arrangements, to encourage greater civic participation; and government support for community groups, events and volunteering.
- Traffic management and urban design changes to create safe spaces for children to play, to encourage neighbourliness, and to facilitate 'mingling' between social groups.
- School size, governance and curriculum changes; increases in the availability and scope of extra-curricula activities; and mandating community service for students.
- Welfare system changes; and the devolution of responsibilities from central agencies to local governments, the non-government sector and/or families and individuals.
- Changes to existing government service delivery models to increase opportunities for local level design input and ongoing participation.
- The use of 'citizen juries' and 'deliberative polls' in policy formulation to encourage greater community participation and trust in government.
- Government subsidies for household and public internet and telecommunications services, to overcome the 'digital divide' and increase access to networks and information, particularly for the poor.
- 'Corporate social responsibility' initiatives to help build bridging social capital between business and (other elements of) civil society and to increase levels of trust. (Productivity Commission, 2003)

These ideas, however, have not yet received adequate research. Few experimental studies have taken up this issue. However Pronyk et al (2008) conducted a randomized control trial in South Africa to see if an intervention could generate social capital. Their intervention explored the effects of a combined microfinance and training intervention on levels of HIV and intimate partner violence. The intervention also explicitly sought to build social capital through stimulating participation in social networks, enhancing solidarity, and mobilizing communities around priority concerns including gender and HIV. After two years, they found higher levels of social capital in the intervention group than the comparison group, although confidence intervals were wide. Qualitative research illustrated that economic and social gains enhanced participation in social groups, and the positive and negative dynamics that emerged within the program. There were numerous instances where individuals and village loan centres worked to address community concerns, both working through existing social networks, and through the establishment of new partnerships with local leadership structures, police, the health sector and NGOs. More research into conscious efforts to bolster social capital is needed to better understand the effect policy and interventions have on this resource.

How does social capital affect policy?

Existing levels and forms of social capital in a community will have an impact on policy implementation and effectiveness. High levels of social capital in some areas may make community members resistant to policy that encourages greater social openness to outsiders, such as immigration-related policy. In other cases, existing social capital may improve the reach and effectiveness of policy interventions. For example, a study by Awio, Northcott, & Lawrence (2011) examined the role of social capital in bolstering organizational accountability mechanisms and citizen benefit. They found that small, grass-roots NGOs in Uganda account for their actions and expenditures by harnessing the attributes of informal, 'bottom up' social capital thus saving costs (for example not requiring expensive auditing) and increasing community involvement and benefit from their programming.

Can policies erode social capital?

There is some concern that poorly thought out or even well intentioned policies can erode existing community-based social networks. For instance, public liability laws intended to protect the public from harm can reduce the viability of community events and organizations (Productivity Commission, 2003). Recent efforts in New York City to improve childhood nutrition have sought to ban the sale of sugary snacks. However this ban has been lamented by some parent groups as effectively prohibiting bake sales, which they argue raise money, increase community and help children learn to organize events (Otterman, 2010). The Commission on Cohesion and Integration in the UK conducted research on children's friendships and children and parent attitudes towards those of different religions and ethnicities. The report found that government allowance of faith schools and enhanced school choice has led to separation of children based on ethnicity and religion (particularly the separation of Muslims from others). The report argues that allowing separate schooling for children eroded social connectivity between children and families of diverse religions and ethnicities (Bruegel, 2006). Parental prejudices, when coupled with choice surrounding where their children go to school, reduced the chances of children from different backgrounds being in the same primary class.

Social capital as both a cause and outcome of social equity

The OECD's (2001) large review found that economic inequity may be both a cause and consequence of inequality in social capital. Countries with high levels of trust and social engagement tend to be more equal in terms of income, adult literacy and access to further learning, although the direction of causation between social capital and equality is uncertain. Societies with high levels of social capital may press for policy that improves equity, which in turn could again increase levels of social capital. Likewise, societies with low levels of trust and connectivity may not support policy that improves equity, feeling less inclined to help those they do not trust and relate to and thus more in favour of private, voluntary and non-governmental services and programming.

Political ideology, social capital and policy

Political ideology and one's opinion of the appropriate role of government plays a large role in how people interpret the relationship between social capital and policy (Productivity Commission, 2003). Conservatives may argue that government involvement in social life erodes social capital because it replaces community and voluntary efforts with mandated, bureaucratic ones (Fukuyama, 1999; Ostrom, 2000; Norton, 1998). Those who align ideologically with more socialist politics, argue that government involvement in efforts to promote equality will improve social capital because people will have more in common and interact with more diverse groups (Cox, 1995, OECD 2001). Many health advocates take up this latter stance (Wakefield & Poland, 2005), arguing that social capital is linked to basic material equality. Policy which promotes this equity, such as policy that gives all citizens equal access to good school, housing and healthcare, will by nature create deeper and more extensive social capital. People are unable to have diverse and expansive socially beneficial networks when society is highly segregated (such as through urban ghettos and affluent suburbs).

How to measure social capital

Recent criticisms of social capital often raise doubts about the measurements used to illustrate its beneficial effect. Paxton (1999) and Stone (2001) argue that most measures of social capital are actually measures of its outcomes. For instance, voting levels have been used as a measure of social capital levels when in fact they should be considered an outcome of social capital (Paxton 1999). In addition, most studies count the quantity of social capital proxies (interactions, trust, etc) rather than the quality, when both aspects are relevant to social capital (UK ONS, 2001).

Social capital's unequal benefit and cost: women and marginalization

Social capital is not necessarily distributed equally among members of a society. When social capital increases it may further concentrate social capital among a subset of society with few links to others (Grootaert, 1998). Rose (1995) discusses Russia's hourglass society in which the rich at the top benefit from many social connections to one another while the poor at the bottom grapple with high rates of crime and low levels of social trust.

Social capital also demands high investments from participants, particularly of time. Policy makers seeking to build or tap into social capital must be conscious that historically, the time investments of women, particularly through voluntary social work, have been undervalued. Putnam's lament of the loss of club membership in *Bowling Alone* may have to do with changing domestic arrangements, with women entering the workforce—something Putnam indicates is detrimental to society (Morrow, 1999). The different ways in which men and women cultivate and use social capital must not be overlooked; women are generally responsible for maintaining affective and familial relationships (Reay, 2002 in Morrow, 2003). Additionally, policy to develop social capital in resource-poor communities must be conscious of the time investments demanded of the poor. It may not always be worthwhile for poor people to participate in savings clubs or farming cooperatives if the social capital they generate fails to link them to significant additional resources (Grootaert, 1998). Molyneux, in her (2002) discussion of social

capital being taken up in Latin American development, cautions that efforts to bolster social capital can be used to avoid dealing with deeper issues of citizenship and rights. She also highlights the near-absence of gender discussion in development and social capital literature, particularly by the World Bank.

Conclusion

Social capital remains difficult to define and measure but is a concept that nonetheless has the potential to benefit societies when taken into account during policy creation. Developing policy to build social capital is inherently political because it is linked to concepts of social equity. Policy frequently links to how governments or agencies will redistribute limited resources and thus comes down to a decision of what population and initiative gets support, where the resources come from and what people and programs are excluded. Social capital—the connections between people—is limited by the interactions people can have with one another, interactions made possible

Researchers have developed a series of guidelines for policy makers on how to promote—or at least not reduce—social capital. Ireland’s National Economic and Social Forum (2003) suggests social capital can be protected and bolstered by policy makers if they: heed both “bottom-up” and “top-down” influences on policy; work with citizens, communities, intermediary agencies and government; conceive of individuals as active citizens, based on the principles of mutual help and responsibility; recognise community voluntary effort and reward achievement; and recognise the importance of locality in addressing complex and cross-agency issues. Cox and Caldwell (2000) suggest the following list of questions to analyse policies and programs to investigate social capital in policies:

- Does the policy increase people’s skills to engage in social activities with people they do not know — their sociability?
- Does the policy target some groups at the expense of others, or create feelings of scapegoating or exclusion?
- Does the proposed form of service delivery allow the building of informal relationships and trust with all stakeholders?
- Does the project help extend networks, confidence and optimism among participants?
- Do participants increase their capacity to deal with conflict and diversity?

Most reports on social capital conclude that it appears to be a valuable public policy tool, as it provides a new and potentially fruitful perspective for examining how public policies and programs can draw on social ties as a means for achieving their objectives (Franke, 2005). However more research into its impact on policy and, vice versa, policy’s impact on social capital is needed. Greater understanding of relational dynamics and networks of co-operation that exist at various levels and in various spheres is required—with attention particularly paid to the costs and benefits of social capital on marginalized groups.

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