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Building partnerships to support community-led HIV/AIDS management: a case study from rural South Africa.

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Key messages:

Community involvement (essential for optimally effective HIV/AIDS management in rural communities) is best enabled through partnerships with outside support agencies.

Small NGOs are often successful and responsive partners, but their contributions are not always sustainable. Many obstacles stand in the way of effective public sector and private sector involvement in partnerships in rural areas.

There is an urgent need for governments to move pro-partnership policies from rhetoric to action, through creating public sector working conditions that make partnership working possible, especially in health and welfare settings.

Marginalised communities will seldom have the capacity to build and sustain partnerships without the help of a committed and well-networked external change agent.

Abstract

The importance of partnerships between marginalized communities and support agencies (from public sector, private sector and civil society) is a pillar of HIV/AIDS management policy. Such alliances are notoriously difficult to promote and sustain. We present a case study focusing on the first stage of a project seeking to build partnerships to facilitate local responses to HIV/AIDS in a remote rural community in South Africa. To date this project has been successful in its goal of training volunteer health workers in home-based care, peer education, project management and procedures for accessing grants and services. The paper focuses on the project's other goal – to create external support structures for these volunteers (drawing on government departments, local NGOs and private sector philanthropists). The partnership aims to empower volunteers to lead HIV-prevention and AIDS-care efforts, and to make public services more responsive to local needs. We illustrate how features of the local public sector environment have actively worked against effective community empowerment. These include a rigid hierarchy, poor communication between senior and junior health professionals, lack of social development skills and the demoralisation and/or exhaustion of public servants dealing with multiple social problems in under-resourced settings. We outline the obstacles that have prevented private sector involvement, suggesting a degree of scepticism about the potential for private sector contributions to development in remote areas. We discuss how the project's most effective partners have been two

small under-funded NGO's – run by highly committed individuals with a keen understanding of social development principles, flexible working styles and a willingness to work hard for small gains. Despite many challenges, the partnership formation process has seen some positive achievements which we outline, discussing the essential role played by an External Change Agent, and concluding with a discussion of the possibility of building long-term structures to sustain the project.

Introduction

The importance of partnerships between marginalized communities and support agencies – from the public sector, private sector and civil society – is a pillar of international HIV/AIDS management policy (UN AIDS, 2006). However, such alliances are notoriously difficult to promote and sustain. Much remains to be learned about factors that promote or hinder successful partnership working – to map out the conceptual and practical terrain between well-intentioned policies, and the realities of working in resource poor settings (El Ansari and Phillips, 2001a).

We report on a project seeking to build partnerships to facilitate community responses to HIV/AIDS in Entabeni, a remote rural community in South Africa, where 43% of pregnant women are HIV positive. HIV/AIDS is highly stigmatised. Access to health and welfare support is limited by poverty and geographical isolation. Local health volunteers provide the only assistance available to many dying of AIDS. Trained through the uncoordinated inputs of missionaries, NGOs and patchy government interventions, most work for no pay, with little training, walking long distances up hills, often in searing heat, from one homestead to another.

Their work includes fetching food and water, cleaning patients and in extreme cases transporting them in wheelbarrows or on relatives' backs to access roads for transport to the nearest hospital, 30km away. Working outside of supportive health and welfare systems, in a climate of hunger, poverty and hopelessness, this group is remarkable for their dedication and commitment.

This paper's authors encountered Entabeni in our work for HIVAN, an NGO concerned with improving HIV/AIDS networking in KwaZulu-Natal province. After 18 months of research and dissemination of findings (Campbell *et al*, 2005, Campbell *et al*, 2006), Entabeni health volunteers and the area's traditional chief invited HIVAN to help establish a three-year project to strengthen local responses to HIV/AIDS. This paper is written one year into the life of this project.

The project's first goal involves facilitating volunteers' access to skills (home-based nursing, counselling, peer education, training and networking) and helping them build supportive relationships with local groupings (e.g. youth and gardening groups) and local church and traditional leaders. This has been relatively easy to achieve through training courses, support and mentoring of trainees and the construction of communication networks between volunteers, community leaders and community organisations (Campbell, Nair and Maimane, 2007, discuss this aspect of the project). The status and confidence of the volunteers have risen through organising a youth rally, establishing and staffing a local outreach centre, and running a 'cascade' of workshops where trainees eventually serve as trainers, passing skills to growing numbers of local people. Volunteers have continued their daily visits to AIDS-affected households, offering nursing care, counselling and health information.

The second goal was to create external support structures for volunteers, in the form of sustainable working relationships between the community and strategically placed partners. The aim of these partnerships would be to: support the work of the volunteers; facilitate community access to resources and services needed for the effective care and support of people living with HIV/AIDS (PLWHAs), especially grants and skills building; develop service providers' understanding of the community's challenges and needs; and secure local and external partners' commitment to contributing time and resources to meeting small practical goals developed by the partnership committee.

In the course of their formative Entabeni research, and research dissemination workshops that followed, HIVAN scoured the local district for potential project partners, identifying six agencies with an interest in participating: local government departments of health and welfare, the local municipality, a philanthropic business-funded NGO, a counselling NGO and a small missionary NGO. Each welcomed the opportunity to work in partnership with such a remote community, saying they had previously lacked contacts and access for this. The HIVAN team planned to use our networking skills and contacts to facilitate bridge-building between health volunteers and these agencies. The challenge of mobilising these agencies to turn their verbal commitments to partnering into concrete actions has been a daunting one. This process forms the focus of this paper.

Conceptual framework

A substantial literature deals with the role of partnerships in community health. Much focuses on US contexts very different to remote rural South Africa (e.g. Roussos and Fawcett, 2000; Scott and Thurstone, 2004). Closer to home there is growing discussion of the role of public-private partnerships in furthering public health goals in developing countries in policy documents (e.g. UN AIDS, 2006; South African Government, 2003) and academic papers (e.g. Haider, 2003; Nishtar, 2004; Richter, 2004). However, as discussed below, remote communities such as Entabeni may lie beyond the reach of the private sector. For this reason, the reality of our situation points to public sector and NGOs as possible community partners.

There is also a literature on partnerships between development agencies in the North and deprived communities in the South (Eyben, 2006; Lewis, 1998). This is also not appropriate for our context, with our partnership's participants all based in South Africa. Another body of literature discusses the role of partnerships in improving the provision of services to 'user' communities (e.g. Carnwell and Buchanan, 2005). Here users are viewed as *beneficiaries* of services provided by professionals rather than active *participants* in service provision as is the case in Entabeni (where volunteers actually provide home-based care services).

Our project seeks to break down traditional distinctions between 'users' and 'providers' of health services. To be effective, partnerships to support grassroots responses to HIV/AIDS have greater chances of success if they view target communities as *subjects* – equal partners in leading and implementing collaborative efforts – rather than the *objects* of the efforts of outside professionals (Campbell, 2003). We distinguish strongly between *interventions* imposed on communities from the outside, and programmes that *facilitate or strengthen local community responses*. The Entabeni project aims to work with residents to improve their access the capacity, resources and networks that will enable them to contribute directly to more effective HIV/AIDS management in their isolated, service-poor community.

Despite rhetoric about involving communities, most HIV/AIDS programmes in sub-Saharan Africa are biomedically and/or behaviourally oriented, designed by outside experts with little reference to the worldviews of beneficiaries, with tokenistic community participation (Campbell, 2003). By contrast, our project is community-led and community-owned. The volunteer team was already in operation when HIVAN encountered the community, the project was conceived of by local people, and the project plan was formulated in close consultation between HIVAN and Entabeni residents. HIVAN's role is purely one of external change agent, helping local people develop the resources, partnerships and capacities to optimise the role health volunteers have defined for themselves.

Supporting efforts by marginalized communities to create 'health-enabling social environments' (Tawil *et al.*, 1995) cannot succeed without effective alliances between communities and more powerful groupings. Putnam (2000) refers to links between communities and outside agencies with economic and political power to help them meet their goals as 'bridging social capital'. Bourdieu (1986) argues that limited access to social capital (durable networks of socially advantageous inter-group relationships) perpetuates poverty and social disadvantage, hindering people from improving their life circumstances. Our project seeks to facilitate community access to such networks, which we argue are a key feature of an 'AIDS competent community' where residents are best placed to respond appropriately to the epidemic (Campbell *et al.* 2007; Lamboray and Skevington, 2001).

Two bodies of research are most directly relevant to our concerns. El Ansari discusses inter-sectoral partnerships for public health in South Africa, emphasising the importance of local ownership of projects (El Ansari and Phillips, 2001a), empowerment of health care workers (El Ansari and Phillips, 2001b) and the recognition of grassroots expertise by health professionals (El Ansari, Phillips and Zwi, 2002). Much of their work draws on large quantitative surveys e.g. of partner attitudes. In a methodological paper, El Ansari and Weiss (2005) highlight the need supplement surveys with more qualitative research. The current paper locates itself within this gap - presenting an in-depth case study of the challenges facing an HIV/AIDS-related partnership aiming to strengthen local responses to HIV/AIDS in a rural community.

The second body of relevant research is Campbell's (2003) case study of a multi-stakeholder partnership to support HIV-prevention in a South African mining community. She highlights five features of an effective partner: commitment to HIV/AIDS management and partnership, conceptualisation of HIV/AIDS as a social development issue, incentive to participate in the partnership, mechanisms for partner accountability to target communities, and agency capacity to make a meaningful contribution (especially funding and trained personnel). A successful partnership should also have access to the organisational infrastructure necessary to organise and host partner meetings and co-ordinate partner efforts. We return to these points below.

Building partnerships: from rhetoric to reality

We now discuss our attempts to mobilise the six agencies who emerged as potential partners in HIVAN's 18 months of research and community consultation with the Entabeni community. Partnerships move through three stages: formation, implementation and maintenance (El Ansari and Phillips, 2001b). The focus of this paper is the 'formation' stage, the process of recruiting partners to participate. Our findings draw on several contacts we had with each partner: an initial one-to-one research interview; partners' participation in workshops to discuss research findings;

individual meetings between partner representatives and the first author to discuss possible participation in the partnership; and where it occurred, partners' participation in our two preliminary partnership meetings. Three HIVAN staff also kept detailed field diaries throughout this period.

To recap, within the public sector there were three distinct partner groupings: Department of Health (hospitals, a local clinic, and a local primary health care facility);

Department of Welfare;

Municipality (district government).

One potential partner represented the private sector:

The philanthropic wing of the regional Chamber of Commerce.

Two were from civil society:

Entabeni's local social development committee spearheaded by a Scandinavian missionary;

The regional branch of a national counselling charity.

Each is discussed in turn.

Potential public sector partners

Our research highlighted that Entabeni residents were failing to access government health and welfare services. We hoped the partnership would provide communication channels through which agencies could inform community members about their services, and community members could feed back information about problems in accessing services, and gaps in service provision. Ideally the outcome of this dialogue would be increased public sector responsiveness to community needs, and improved community access to services and grants. Public sector agencies have a strong policy mandate from the central South African government to engage in such dialogue with communities, and as already stated, every partner initially expressed enthusiasm for project participation. What types of obstacles prevented them turning their verbal commitment into action?

Department of Health

Entabeni lies at the boundaries of three *hospital* catchment areas. Hospitals are vital for treating AIDS-related opportunistic infections, and over time will be involved in rolling out antiretroviral drugs as these gradually become more available. With few roads, and limited or unaffordable transport, many find it difficult to access hospitals at all. For many who do get there, the AIDS services are difficult to find. The HIVAN team spent frustrating time following the 'yellow feet' that would allegedly lead them to the AIDS service in one hospital, only to find we were walking around in circles.

In initial interviews, hospital superintendents lauded the potential of the Entabeni project, saying that improved communication with remote communities could increase their ability to offer effective medical care. However the best overworked hospital managers could do was to send nursing sisters to represent them at partnership meetings – who lacked the decision-making power required by an effective partner representative. When asked to feed back project information to their senior managers, they said they would gladly deliver letters from HIVAN to senior hospital officials, but had no influence over whether these would be read or acted on.

A specific *Primary Health Care (PHC) Nurse* had long been allocated to Entabeni, travelling in a mobile clinic around the areas served by a large district hospital. Her role is explicitly defined as supporting volunteer carers, and prior to the project she

had established monthly meetings with Entabeni volunteers, collecting written reports of each month's work.

With low literacy and limited access to pen and paper, volunteers battled to compile these reports. In research interviews they complained they had never received any feedback from this nurse. The nurse told us she filed these reports away – periodically passing on summaries of them to her supervisor. She in turn said she had never received any feedback from her supervisor on these. When HIVAN members suggested she might discuss the content of these reports with volunteers, advising them on how to address the numerous problems they reported, she said such a course of action had not occurred to her, but that she would do so in the future.

In this and many other contacts with public service officials, it is clear that they lack the skills and channels to liaise with both target communities and supervisors. HIVAN is currently working with the PHC nurse to develop strategies for supporting volunteers, including giving them regular feedback and guidance. HIVAN has also liaised with the nurse's supervisor to reassure the nurse that her supervisor approves of these new developments.

There is a *district AIDS office* located in the nearest town, which pays a small stipend to the leader of the volunteers. On hearing he had never had formal contact with this office, HIVAN suggested he approach them for advice on various problems facing the volunteers. His visit to this office was greeted with hostile incredulity. The agency official expressed anger that a community representative should approach the office, saying that she would initiate any contact that was necessary. She refused to talk to him, saying he was wasting Department money by being away from the community he was paid to serve, and reducing his stipend as a penalty for 'wasting' the day.

Department of Welfare

Many people lacked skills to access welfare grants, with others unable to afford transport to the welfare office. Those who managed to gather the necessary documentation and fill in the necessary forms sometimes waited for years before grants materialised.

The regional Department of Welfare (DoW) faces a strong national policy directive to implement social development approaches to HIV/AIDS. However, the area's designated social worker did not have any social development skills, trained only to implement one-to-one counselling and grant allocation from his office desk. He had never been to Entabeni. Whilst he appreciated the potential value of the project, he told us he couldn't see any way of fitting project participation into his current working life.

At the time of writing HIVAN is working with him to develop community outreach strategies, and trying to contact his supervisors to discuss DoW involvement in the Entabeni partnership. This is endlessly time-consuming, involving on-going and, to date, unsuccessful attempts to telephone, email and fax DoW officials to organise a meeting.

Municipality

We initially had high hopes of the Municipality (local government). A senior official quickly grasped the opportunities the project offered for contact with a remote community (after the HIVAN team alerted him to Entabeni's existence on the

'catchment area' map on his wall). He enthusiastically attended early partnership discussions, making insightful contributions – saying that the project could serve as a municipality model of 'best practice' for HIV/AIDS work in poor communities.

Having the support of a well-informed senior official, with a sound appreciation of the value of partnerships, was a boost for the project in its early stages. However, over time it became clear that his ability to act was limited by resource constraints and the vast geographical area the municipality is expected to support. After many unsuccessful phone calls to contact him for a meeting, his secretary said he was 'drowning in work', having been allocated 60 new projects for the coming year, with no extra personnel. Furthermore it emerged that his ability to help a single innovative project was limited by the competitive local councillors he had to answer to. They refused to support his plan to devote resources to a promising project in a single community – irrespective of its potential value as a pilot project, insisting that any assistance given to one community should be given to all.

Despite limitations we hope that he will serve as a valuable ally to attend occasional partnership meetings and provide limited help on particular occasions (e.g. he has offered the assistance of an international volunteer he will be mentoring for one year).

Our contacts with the municipality have highlighted the limited role Entabeni's elected councillor has historically played in accessing municipality resources, and feeding his constituency's views into municipality meetings. The project plans to work with him to develop this role.

Building partnerships with the public sector?

Our experiences suggest that volunteers are constrained by a public sector context that actively hampers effective grassroots empowerment. In HIVAN's role as External Change Agent, every aspect of attempts to involve public sector partners has been time-consuming and stressful. Many constraints limit the ability of public servants to exercise the flexibility and initiative needed to make public services more responsive to local needs.

As discussed above, the project was welcomed in meetings with senior civil servants, but due to pressure of work, they directed us to the more junior officials directly responsible for Entabeni. These ranged from skilled and talented individuals offering services in almost impossible conditions with little supervision or support – to those who were underemployed or disorganised, lacking training and/or motivation to address the pressing social problems facing them every day. For example, a full-time worker on a local government poverty-alleviation programme said he seldom worked for more than two hours a day, not knowing what to do, and with no accessible supervisor.

Even the most effective junior staff were hampered by bureaucracy. Many found it impossible to get permission to attend the partnership meetings. E.g. the sister in a regional Voluntary Counselling and Testing facility was keen to attend meetings and to include Entabeni in her programme, but could not do so without the permission of her District Manager – to whom she had no direct access. It took HIVAN six months, 10 phone messages and 8 emails to get a response from the manager's office. Even those who managed to get permission to attend partnership meetings often had limited access to agency cars – essential for accessing this remote area.

Limited communication between junior and senior civil servants made it difficult for juniors to incorporate partnership participation into their existing job descriptions. Senior officials were often too busy to talk to them. But most importantly the institutional culture did not accommodate the possibility that junior staff members might have anything of value to say, with very limited opportunities for new ideas to move up the power hierarchy. Given that more junior staff tend to interact with grassroots communities, and are best placed to report their views back to their agencies, this culture limits opportunities for grassroots views to be heard in the health or welfare sector.

Overall there appeared to be an overall climate of demoralisation and hopelessness amongst the civil servants we encountered – with the scale of the problems facing them and their lack of skills to address these (see also McIntyre and Klugman, 2003).

Potential Private Sector Partnerships

There is currently much emphasis on the private sector's potential to contribute to social development programmes (UN AIDS, 2006; Haider, 2003; Nishtar, 2004; Richter, 2004). Entabeni is some distance from regional towns and businesses. However, HIVAN made a promising link with a philanthropic NGO funded by the regional Chamber of Commerce. In the project's early stages we hoped they would provide stipends for some volunteers. The NGO director was positive about the project, actively participating in a HIVAN research dissemination workshop and making several offers of assistance. However, she resigned shortly afterwards. Subsequent contacts with her colleagues suggested she had not discussed these offers with her organisation. They said their brief was to prioritise the immediate vicinity of their town, and that they lacked resources to support such a remote community. Also that the NGO had a new five-year funding plan, which made it impossible for them to take on unbudgeted commitments. Our experience suggests the need for a high dose of realism about the potential of the public sector to contribute to development in remote areas.

Non-government organisations

There is a long history of NGOs supporting social development programmes – with strategies ranging from top-down (replicating public sector programmes and not facilitating grassroots mobilisation) to bottom up (supporting communities in roles such as advocacy and service delivery in remote areas) (Desai, 2002). To date, the most promising partners in the Entabeni Project have been two NGOs – both small, under-funded and run by deeply committed individuals.

Entabeni Development Project

This group is coordinated by a lone Scandinavian missionary who raised a small grant and came to Entabeni several years ago, working with local people to set up a crèche, vegetable gardens, craft projects and a hospice for AIDS patients – built on church land by local people, and staffed by community volunteers. She also provides a small stipend for a few health volunteers.

She works painstakingly slowly out of her deep commitment to community ownership of development, and takes no personal credit for the group's achievements. She is driven by strong religious convictions, personal enthusiasm, a willingness to live in an isolated place with few amenities – and most of all her ability to see possibilities for change and growth in impossibly difficult conditions.

She has been a tremendous asset to the Entabeni partnership: making financial contributions to project activities (e.g. to buy meat for project events); making her home available for meetings; and her car available to transport young people to skills training sessions. With her keen understanding of bottom-up social development, her ideas have been a constant resource. For example, she and her development committee conceptualised a successful youth rally to publicise a schools-based peer education programme run by volunteers. Most of all, her enthusiasm and motivation have served as a constant source of inspiration to project participants.

Counselling NGO

Our second very effective partner has been the local branch of a national counselling NGO. The director is a retired business woman who lives in a nearby town. She raises her own funds, draws a minimal salary and is dynamic, articulate and confident.

From the early stages she has attended project meetings, listened carefully to the community's accounts of their needs, and almost immediately volunteered to provide appropriate courses for volunteers, and monitoring and support services for trainees. She has worked with local residents to establish a health outreach centre in a building loaned to the project by a local leader, which she has equipped. She delivers on commitments, seldom misses a project meeting or function, and is a constant source of useful ideas. She has also linked the project to her wide network of contacts in the region.

Sustaining the inputs of local NGOs?

Small NGOs are flexible, fashioned around being immediately responsive to local needs. Staff often work for little or no payment, motivated by personal dedication, inspired by a vision of a better world. They operate on tight budgets, relying heavily on individual inputs.

The challenge is how to make this work sustainable over the long term – a key project goal. This would eventually mean institutionalising project activities within more permanent and stable agency structures, probably public sector structures, given that the effectiveness of small hand-to-mouth NGOs often depends on non-durable resources such as the dedication of individual staff members and unstable funding sources. The challenges of handing work of this nature from relatively affluent individuals, driven by personal convictions, to civil servants facing the stresses of poorly paid jobs and difficult working conditions, remains a strong one.

The role of the External Change Agent (ECA) in partnership formation

Whilst the role of ECAs is frequently discussed in the community development literature (Chambers, 1983; Mansuri and Rao, 2004; Van Klinken, 2003), we are not aware of any discussions of this role in relation to HIV/AIDS management. We turn to examine the role the first author has played as HIVAN team leader.

We have already outlined challenges facing partnership formation in Entabeni, and the longer-term outcome of these efforts remains to be seen. However, we can say with confidence that without HIVAN's role as ECA, little or none of the networking outlined above could have happened. HIVAN has devoted endless time, energy and tenacity to the challenge of mobilising partners. In many ways we are unusually qualified to carry out this role – a three person team with high levels of academic, community development and networking experience, backed up by 18 months of

prior research and dialogue with local residents and potential external partners. If HIV/AIDS management experts are to continue to advocate partnerships as a key strategy for HIV/AIDS management, we believe there is a need for much greater acknowledgement of the resource-intensive nature of partnership formation.

HIVAN has played the key role in identifying potential partners, convincing them of the rationale for partnership working, and keeping contact over time. Administratively this has been a mammoth task. E.g. Several public sector contacts do not keep diaries, and individuals are often unable to commit to attending meetings in advance. People may give incomplete contact details – such as the telephone number of their agency switchboard, without their personal extension, so that when HIVAN attempts to ring them, the switchboard operators are unable to connect us. Contact fax machines don't always work. One key nursing sister is too busy to talk on the phone during the day, only contactable at home after 9.30pm.

Participants report that partnership meetings have provided a unique opportunity for interaction between disparate groups, many of whom had never met before (e.g. officials from different branches of the Department of Health responsible for Entabeni). Furthermore many public sector participants report that the partnership meetings have given them their first opportunity to hear the views of their target community members. Partners also value informal networking opportunities during tea breaks at meetings, where discussion is loud and animated.

HIVAN has also engaged in face-to-face discussions with individual partners to identify latent social development skills and to brainstorm ways to build community interaction and support into their existing work-plans. Here, a key challenge has been to motivate public servants who may have 'lost their edge' over years of working in a pressured and de-motivating environment. A HIVAN team member has referred to the way in which these face-to-face meetings can bring the 'sparkle' back into the eyes of demoralised public servants, as they see the possibility of being able to work more effectively to 'make things happen', realising that HIVAN is willing to support them in developing new ways of working. A key aim of HIVAN is to create a model of effective networking, showing that energetic and persistent communication can open up new ways of responding to HIV/AIDS.

Conclusion

As outlined above, the Entabeni project had a two-fold aim: to facilitate volunteer training and community mobilisation, and to build supportive external partnerships. Meeting the first objective continues to be relatively easy. It is the second one that presents endless challenges. Our involvement in this work has reversed our naïve initial representation of the community as 'the problem' and the partners as 'the solution'. Over time it has become clear that this community has strong capacity to learn skills and mobilise energetically to address the challenges of the epidemic. Most often it is the external partners – particularly those in the public (and private) sectors – that lack the capacity and/or skills and/or organisational systems that would enable them to support community responses.

Our experience is directly contrary to the general community development literature, which often paints a picture of willing and able partners battling to mobilise reluctant communities (e.g. Blair 2000; Campbell, Cornish and McLean, 2004). On the contrary, we now believe that there is as much need to build 'AIDS competence' amongst public sector partners as there is to build skills, capacity and networks within the Entabeni community.

Assessing progress to date in terms of Campbell's (2003) criteria for effective partners: each partner *committed* themselves fully to participation in the project in early interviews and workshops. In terms of *conceptualisation*, partners appreciated the complexity of the epidemic, their limited ability to make a significant contribution in isolation from other agencies, and the urgent need to involve grassroots people in efforts to provide more effective support and service provision. In terms of *incentives* for participation, every partner spoke of their agency's principled commitment to targeting isolated rural communities for HIV/AIDS management work, using community outreach and social development strategies.

Despite these factors, aside from our two NGO partners (who had a keen appreciation of working closely with communities), public sector representatives lacked social development training, and any clear knowledge of how they should go about implementing community outreach approaches. Lack of formal systems for recognising or ensuring *accountability to service beneficiaries* was one element of this. *Agency capacity* was the other obstacle: shortages of suitably trained personnel and funding limitations in the face of the multiple demands of rural communities battling with HIV/AIDS in conditions of poverty. A further criterion, which needs to be added to Campbell's (2003) checklist, is the need for positive *morale and confidence* amongst potential partners – sorely lacking in many of the public sector representatives we have encountered in our efforts to date

Within the context, what are the prospects for on-going efforts to work with these groups? This paper has reported on the first of a proposed three year project, and there are two more years to go. Even at this early stage, the project has been very successful in mobilising effective NGO support. Much positive groundwork has been done with some public sector partners, and with more time and persistence some of these relationships should start bearing fruit. Progress has also been made with some individual public sector employees around morale-building and assistance in thinking through ways in which they might respond more effectively to community needs. The primary health care nurse is giving valued monthly feedback to health volunteers, with the blessing of her supervisor. A senior municipality official is a vociferous supporter of the project in principle if not in practice, and has identified it as a potential model of best practice for other communities.

Furthermore, whilst the HIVAN team have found the process of partnership building laborious and challenging, grassroots Entabeni residents have a long history of battling to gain public sector support in addressing their life challenges. Community representatives have attended almost all of HIVAN's meetings with external partners. They do not have unrealistic expectations of what the partnership project will achieve, and place an extremely high value on each of the very small steps that the partnership formation process has taken so far. This illustrates one of the benefits of following a 'facilitation' rather than an 'intervention' strategy. It gives project participants the space to formulate small steps, which are in line with what can realistically be achieved in terms of existing capacity (both within and outside the community) and to appreciate the achievement of small gains, rather than to continually be striving to achieve grandiose and externally imposed goals, and to lose sight of significant but small developments along the way (Alinsky, 1973; Wieck, 1984).

Whilst we do not undermine the challenges facing the project in building sustainable partnership structures once the HIVAN team withdraws in two years time, formal structures *do* exist for sustainability. The current project plans visualise the establishment of a permanent structure spanning four agencies. This would be coordinated by the municipality, and include Entabeni's dedicated social worker, the

primary health care nurse, and hopefully the counselling NGO – who would meet regularly with community representatives on an on-going basis.

What are the implications of these experiences for practice and research in the partnerships field? In relation to international debates about the practice of HIV/AIDS management in resource-poor settings, we hope to have illustrated the urgent need for more attention to be given to the complexity and resource-intensive nature of partnership building by health and development agencies concerned with HIV/AIDS management. Whilst we have no doubt that partnerships have a crucial role in fighting the epidemic, much greater attention needs to be paid to the need for suitably qualified and dedicated external change agents in facilitating their development. In relation to the practice of HIV/AIDS management in South Africa, our findings point to the urgent need for the government to give much higher priority to the promotion of social development capacity in health- and welfare-related public sector agencies to enable them to support communities in responding to the challenges of the epidemic. This is particularly urgent in rural areas where people have very limited access to services (Scott, Chopra, Conrad and Ntuli, 2005).

Our case study contributes to urgently needed qualitative studies of factors that intervene between partnership ideals and practice in the HIV/AIDS field. Whilst the generalisability of case study findings from one setting to another is best judged on a case by case basis according to the judgement of skilled social researchers or activists (Flyvberg, 2001), we hope and believe that colleagues researching and seeking to build partnerships in a range of deprived countries and contexts will find value in our account of the triumphs and challenges that we have faced in the first year of our partnerships building efforts. If grassroots community involvement is indeed a key dimension of effective HIV-prevention and AIDS-care in marginalized communities, better understandings of how to promote partnerships – between communities and those agencies capable of facilitating such involvement – remains one of the biggest single challenges in the fight against HIV/AIDS.

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