

**BUILDING PARTNERSHIPS FOR HIV & AIDS
MANAGEMENT IN A DEEP RURAL
COMMUNITY IN SOUTH AFRICA**

**By
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ABSTRACT

The importance of partnerships between marginalised communities and support agencies (from the public sector, private sector and civil society) is a pillar of HIV & AIDS management policy. Such alliances are notoriously difficult to promote and sustain. The thesis presents the findings from a longitudinal, qualitative case study of a project seeking to build partnerships to facilitate local responses to HIV & AIDS in a remote rural community in South Africa. The partnership aimed to empower community stakeholders to lead HIV-prevention and AIDS-care efforts through the support of local government departments, NGOs and the private-sector, and make public services more responsive to local needs. I highlight the value of building long-term relationships with, and ownership of the project by community stakeholders, i/ by involving community stakeholders in partnership building and facilitation from the very beginning of the process, and; ii/ through a compliance with, and respect for community protocols and norms in the process of entry, community engagement, and partnership facilitation. I illustrate how features of the local public sector environment have actively worked against effective community empowerment and partnership. These include a rigid hierarchy, poor communication between senior and junior health professionals, lack of accountability, limited social development skills, and the demoralisation and/or exhaustion of public servants dealing with multiple social problems in under-resourced settings. I 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. The most effective partners have been the NGOs — run by committed individuals with a keen understanding of social-development principles, flexible working styles and a willingness to work hard for small gains.

Despite the challenges, the partnership has achieved many positive outcomes, including the formalization of the partnership and its institutionalization within a permanent government structure. I outline these achievements and discuss the essential role played by an external change agent in facilitating the process of partnership building.

I conclude with eight key lessons learnt and recommendations which emerged out of the research. Firstly, partnerships are embedded in and influenced by the contexts within which they are located; secondly, stakeholder organizations must create an enabling environment to encourage and sustain partnership participation; thirdly, capacity building and empowerment of partners is crucial for ensuring ownership and sustainability of the partnership; fourthly, partnerships within resource (human and physical) poor contexts like Entabeni, where skills and resources are scarce, require the services of a dedicated, skilled facilitator or external change agent; fifth, partnership building needs to be guided by regular monitoring and evaluation and a systematic documentation of the process; sixth, relationships based on trust are a central pillar of partnerships; seventh, partnerships are as much about individuals as they are about communities and organizations, and; finally, partnerships can and do work, in spite of the many challenges that may be encountered.

DECLARATION OF ORIGINALITY

I declare that the thesis is my own original work and was carried out in the School of Development Studies, University of KwaZulu-Natal, Howard College Campus, Durban, under the supervision of Professor Eleanor Preston Whyte. Any work done by others has been properly acknowledged in the text. None of the present work has been submitted for any other degree or examination at any other University.

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DECLARATION BY SUPERVISOR

This thesis, which I have supervised, is being submitted with my approval.

Professor Eleanor Preston Whyte

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DEDICATION

To Vusi, friend, colleague and chairperson of the Entabeni partnership committee, who succumbed to his battle with 'TB and meningitis' in October 2008. You were a guiding light and inspiration to all of us.

Hambe Kahle, my friend.

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LIST OF ABBREVIATIONS

HIV	Human Immunodeficiency Syndrome
AIDS	Acquired Immune Deficiency Syndrome
STIs	Sexually Transmitted Infections
ARV	Antiretroviral Therapy
VCT	Voluntary Counselling and Testing
PLWHA	People living with HIV and AIDS
HBCs	Home Based Carers
QLR	Qualitative Longitudinal Research
ECA	External Change Agent
RDP	Reconstruction and Development Programme
NGOs	Non-governmental organizations
CBOs	Community Based Organizations
FBOs	Faith Based Organizations
DOW	Department of Welfare
KZN	KwaZulu- Natal
OSECP	Outer Southeast Community Project
ASSA	Actuarial Society of South Africa
MRC	Medical Research Council
TAC	Treatment Action Campaign
HSRC	Human Sciences Research Council
UNAIDS	United Nations Programme for HIV/AIDS
USAID	United States Agency for International Development
UNDP	United Nations Development Programme
WHO	World Health Organization
HIVAN	Centre for HIV/AIDS Networking
SANAC	South African National AIDSs Council

PART ONE

Context and Background to the Study

Chapter 1

The Partnership Study: What is it about?

1.1. Introduction and purpose of the study

Over the past decade there has been growing interest in alternative approaches to HIV prevention underpinned by the community development philosophy of *partnership*, community participation and empowerment (Anderson and McFarlane, 2008; El Ansari and Weiss, 2006; Heenan, 2004; Campbell 2003; Lasker, Weiss and Miller, 2001; Gray, 1989). Initiatives to promote alternative community HIV prevention strategies are located against the background of current debates about the possible links between healthy communities and social capital (Islam, Merlo, Kawachi, Lindström and Gertham, 2006; Heenan, 2004; Campbell, 2003). However, a major question confronted in the task of building social capital is: ‘How do you create it?’ Much literature on social capital has avoided this question by focusing instead on definitions, models, and measurements (Durlauf and Fafchamps, 2004; Macinko and Starfield, 2001). The research presented in this thesis attempts to address this gap by reporting on a longitudinal, empirical process of building bridging social capital in the form of a multi-stakeholder partnership¹ for HIV and AIDS management between the Entabeni community² (a deep rural resource-poor community in Northern KwaZulu-Natal) and external service-provider stakeholders in the region.

In the language of community development, networking between local community groups and appropriate support structures (in the public, private and civil society sectors) is referred to as *bridging social capital* (Putnam, 2000; Woolcock, 2002). Development wisdom indicates that this is best promoted through the strategy of *multi-stakeholder partnerships* between civil society, government and private sector representatives (Dale and Newman, 2008; El Ansari, 2005; Dowling, Powell and Glendinning, 2004; Baum and Ziersch, 2003; Campbell, 2003). The study presented in this thesis is a micro-level analysis of the mechanisms and processes involved in facilitating the Entabeni partnership (unit of analysis), which comprised of

¹ By multi-sector partnership I mean collaborations between government, the private sector, civil society organisations (NGOs, CBOs, and FBOs) and the community.

² Community refers to the people who live in a specific geographical area.

stakeholder³ representatives from the Entabeni community (including four home-based carers, a religious leader who was also a traditional leader and municipal councillor, a community health worker and traditional leader, a senior citizen and retired teacher, and a teacher and youth representative) and service-providers from the public, private and civil society sectors (Departments of Welfare and Health, local government or municipality and non-governmental organisations) from the immediate but external geographic surroundings of the community (between 15-60km away).

From an academic perspective, the study arose out of the need to address the gap between the rhetoric and the reality of partnerships for HIV and AIDS management within a resource-poor South African context. A survey of the academic literature on partnerships reveals an inadequacy in the systematic documentation of evidence-based partnerships for HIV and AIDS management (value, successes, failures, lessons learnt) within an African and particularly South African context to serve as guidelines for those embarking on partnerships for HIV and AIDs management (Cooke-Lauder, 2005; El Ansari, Philips and Hammick, 2001, Kreuter, Lezin and Young, 2000). Drawing on a critical conceptualization of social capital, this thesis reports on a longitudinal (four year) qualitative case study of the Entabeni partnership-building process, for the purposes of filling the gaps that exist in partnership intervention strategy, partnership policy and the academic literature on partnerships.

The practical aim of the Entabeni partnership study was to achieve collective ownership for meeting the challenges posed by HIV and AIDS within Entabeni and the strategies required to manage and limit the negative impacts of this pandemic by:

- (i) supporting the work of the health volunteers or home-based carers (HBCs) in the community;
- (ii) enabling the health volunteers and community partners to facilitate community members' access to resources and services needed for the

³ By 'stakeholders' I refer to the various groups that have an interest in, live, work or have some form of stake or interest in the well-being of a particular geographically demarcated community. These might include representatives of women's groups or youth groups, of provincial and national health departments, of foreign-funded NGOs and so on.

- effective care and support of people living with HIV and AIDS (PLWHAs), especially accessing grants and building skills;
- (iii) developing service-providers' understanding of the community's challenges and needs; and
 - (iv) securing community and external partners' commitment to contributing time and resources to meeting relatively small practical goals developed by the partnership committee.

The author of this thesis (often referred to as the researcher or external change agent), was personally involved in facilitating this community-driven (Beard and Dasgupta, 2006) partnership-building process, spending many days in the field and becoming totally immersed in the dynamics of the Entabeni community and the Entabeni partnership. The outcome has been a detailed case study that addresses the following research questions:

1. Why are partnerships important in HIV and AIDS management in resource-poor settings?
2. What are the processes involved in building such partnerships?
3. What are the factors that facilitate partnerships?
4. What factors hinder partnerships?
5. What are the lessons learnt in setting up new partnerships?
6. Does the study contribute to the development of the concept of social capital in general and specifically in the field of HIV and AIDS?

As may be seen below, I contextualize the study within a brief description of the process of entry into the Entabeni community, elaborating on this in Chapters 4 and 5 of the thesis.

1.2. Rationale and Background to the study

The partnership study is situated within a larger project which seeks to facilitate grassroots responses to HIV and AIDS in Entabeni, a remote rural community in KwaZulu-Natal, South Africa, where 40 percent of pregnant women are HIV positive (Dorrington, Johnson, Bradshaw and Daniel, 2006) and HIV and AIDS is highly stigmatised. Access to health and welfare support is limited by poverty and

geographical isolation. Local health volunteers (home-based carers) provide the only assistance available to many dying of AIDS.

Working outside of supportive health and welfare systems, in a climate of hunger, poverty and hopelessness, the home-based carers are remarkably dedicated and committed.

I encountered Entabeni in my work for HIVAN, an NGO concerned with improving HIV and AIDS networking in the KwaZulu-Natal province. After 18 months of facilitating a formative research study in the area and disseminating the research findings through consultative workshops with key stakeholders (see Chapter 2), Entabeni home-based carers and the area's traditional chief (iNkosi) invited the HIVAN team to help establish a three-year project to strengthen local responses to HIV and AIDS in the community (see Chapters 2 and 4). The overall aim of the project was to build AIDS-competence through working with the local people to identify obstacles to effective HIV and AIDS management, to develop strategies which they can use to support one another in responding to the epidemic, and be more effective in accessing help and support from outside the community.

An AIDS-competent community is defined as one where community members work collaboratively to support one another in achieving: sexual behaviour change; the reduction of stigma (a key obstacle to effective HIV and AIDS management, often deterring people from accessing prevention and care services); support for people living with AIDS and their caregivers; co-operation with volunteers and organisations seeking to tackle HIV-prevention and AIDS-care; and effective accessing of health services and welfare grants, where these exist (Campbell, Nair, Maimane, 2006).

I and Professor Catherine Campbell were co-directors of the Entabeni project, with me serving primarily as external change agent and co-ordinator of project activities. Campbell, who is based at the London School of Economics, co-ordinated the conceptual aspects of the project. Sbongile Maimane, the third member of the research team, played a key role in local community liaison and fieldwork management, while a fourth member (Zweni Sibiyi), also fulfilled the role of community liaison and fieldworker for a short period. He however resigned from HIVAN after the first year of the project.

The *project's first goal* involved facilitating the volunteer home-based carers 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), the local church and traditional leaders. This was 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). The status and confidence of the volunteers have grown through their participation in a youth rally (see Chapter 5), establishing and staffing a local outreach centre (outcome of the partnership project – see Chapter 7), and running a cascade of workshops where trainees eventually served as trainers, passing skills to growing numbers of local people. The volunteer Home based carers continue with their daily visits to AIDS-affected households, offering nursing care, counselling and health information.

The *second goal*, which is the focus of discussion in this thesis, was to create external support structures for the home-based carers and other community stakeholders in the form of sustainable working relationships between the community and strategically placed partners. While effective grassroots community involvement is a vital aspect of effective HIV and AIDS management (see Chapter 5), marginalised community members often lack the skills, confidence, networks and political and economic influence and resources to drive forward health projects without significant outside support. I (author of the thesis) committed my networking skills and contacts to facilitate bridge-building between the community stakeholders and key service-provider agencies (see Chapter 6), defining my role as researcher and external change agent. The academic and practical aims of the partnership intervention have been highlighted above.

1.3. Partnerships, HIV and AIDS and social capital

The literature on HIV and AIDS, partnerships and social capital is discussed in detail in Chapters 2 (HIV and AIDS) and Chapter 3 (social capital, partnerships and HIV and AIDS) of the thesis. The discussion below merely situates the research within the climate of the HIV and AIDS epidemic globally, in Sub-Saharan Africa and South Africa at the time of planning and inception of the study (2003/2004).

In 2004, it was estimated that 37.8 million people in the world were living with HIV (range: 34.6–42.3 million) with 4.8 million people becoming newly infected (more than any one year before), and 2.9 million people dying of AIDS in 2003 (UNAIDS/WHO, 2004). There was also a growing feminization of the epidemic, with every year showing an increase in the number of women infected with HIV. During this period, it was estimated that, globally, nearly half of all people infected with HIV between the ages of 15-49 were women, while the proportion in Africa reached 60 percent. The gender inequality that existed in this continent also meant that women living with HIV and AIDS often experienced greater stigma and discrimination.

The epidemic was also deemed to be responsible for wrecking economies, orphaning children, widowing parents, exhausting health systems, straining education, deepening poverty, and leading to the social stigmatisation and discrimination of people living with the virus (UNAIDS/WHO, 2004). The following statement by the head of the Joint United Nations Programme on AIDS (UNAIDS), Dr Peter Piot (Graham, 2004), aptly sums up the status of HIV and AIDS at the time: "*The virus is running faster than all of us.*"

Sub-Saharan Africa was the hardest hit, with close to two thirds of all people living with HIV being found in this region (approximately 25 million) despite it being home to just over 10 percent of the worlds population. The predominant mode of HIV transmission was heterosexual transmission. African women were being infected at an earlier age than men, and the gap in HIV prevalence between them was growing. A review of infection levels between women and men aged 15–24 indicated that this difference was even more pronounced in this age group, e.g. this ranged from 20 women for every 10 men in South Africa (UNAIDS/WHO, 2004).

South Africa had the highest number of people estimated to be living with HIV and AIDS in the world (5.3 million as of the end of 2003) (UNAIDS/WHO, 2004), with the HIV prevalence rate being much higher than that of the Sub-

Saharan African region overall. At this point, the epidemic was already having a profound impact on many aspects of South African society and it was projected to affect the country's economic, education, and health sectors if more was not done to stem its tide (WHO, 2005). Further, and as a middle-income country that had significant political and economic importance in the African continent (USAID, 2001; World Bank, 2006), the future course of South Africa's HIV and AIDS epidemic would have broader implications for Africa overall.

Within South Africa, it was revealed that KwaZulu-Natal had the highest HIV rates (39.1 percent) in the country with rural KwaZulu-Natal bearing the brunt of the epidemic (Peltzer, 2003). The partnership study was influenced by this context and advised by universal discussions on HIV and AIDS at the time which motivated for the adoption of bridge building or partnerships between public, private and civil society groups to jointly manage HIV and AIDS in communities burdened with the epidemic (Nelson, Prilleltensky, and MacGillivray, 2001; Lasker et al., 2001; Gillies, 1998)

Aside from the practical aim and goals of partnership study, I sought to break down traditional distinctions between the users and providers of health services. Philosophically, this approach was led by Campbell's (2003) argument that "*...in order to be effective, partnerships to support HIV-prevention and AIDS-care have the greatest chance of success if they view target communities as subjects – equal partners, or even leaders, in collaborative efforts – rather than the objects of collaborative work by outside professionals*". Hence, a strong distinction is made between interventions imposed on communities from the outside, and programmes that facilitate or strengthen local community responses. The Entabeni project aimed to work with home based carers and community stakeholders to improve their access to the capacity, resources and networks that would enable them to contribute directly to more effective HIV and AIDS management in their isolated, service-poor community (see Chapter 5).

Despite rhetoric about involving communities, most HIV and AIDS programmes in Sub-Saharan Africa have been predominantly bio-medically and/or behaviourally

oriented, designed by outside experts with little reference to the worldviews of beneficiaries, with tokenistic community participation (Campbell, 2003). In contrast, the partnership project is community-driven and community owned. The health volunteer team was already in operation when the research team encountered the community. The project was conceived of by the local people, and the project plan was formulated in partnership and close consultation between the research team and Entabeni community stakeholders. My role was purely one of researcher and external change agent, helping local people develop the resources, partnerships and capacities to optimise the role health volunteers and community stakeholders had defined for themselves.

1.4. Research methodology

The decision around choice of methodology was linked to the aim of the research (project seeking to build partnerships to facilitate local responses to HIV and AIDS in Entabeni), and, to the research questions; hence the choice of a qualitative, longitudinal (over four years) case study (Entabeni partnership) to facilitate the research enquiry.

The value of the qualitative longitudinal method (QLR) for empirical processes of this nature lies in its ability to investigate and interpret the nature and process of change over time in various social contexts (Holland, Thompson and Henderson, 2006; Corden and Millar, 2007). In the social sciences, there is growing interest amongst policy makers in QLR since it is recognized that while quantitative methods provide answers to 'what' questions, there is still very little known about 'why' and 'how' (Holland, Thompson and Henderson, 2006). Much of the work considered relevant to this thesis (see Chapter 3), draws mainly on large quantitative surveys. In a methodological paper, El Ansari and Weiss (2006) highlight the need to supplement surveys with more qualitative research. This thesis, together with other more recent studies, locates itself within this gap – presenting an in-depth qualitative case study of the challenges facing an HIV and AIDS-related partnership aiming to strengthen local responses to HIV and AIDS in a resource-poor community over time.

A more detailed discussion of this methodology and its application to the study is discussed in Chapter 4 of the thesis.

1.5. Conclusion

This chapter outlined the overall purpose of the study, the key research questions to be addressed, motivating for its value and providing the rationale and background to the study. I situate the study within the partnerships and social capital literature and highlight the value of the methodology (qualitative, longitudinal case study) in facilitating the research. Gaps are identified by the study in the partnerships literature on intervention and methodology. I provide an outline below of the chapters that follow, and which form the basis of this thesis.

1.6. Thesis Structure

The thesis is divided into two parts, comprising eight chapters overall. Part one encompasses the first four chapters and provides the context and background to the study. The second part of the thesis provides an analysis of the data gathered in three findings chapters, each fitting into the first two stages (formation and implementation) of development of the partnership as described by El Ansari and Philips (2001a), but incorporating aspects of the second two stages (maintenance and outcomes) as well. The thesis concludes with a chapter highlighting lessons learnt, as well as conclusions drawn and recommendations made for future research, intervention and policy for partnerships and HIV and AIDS management.

Part One: Context and Background to the Study

Chapter One – The Partnership Study: What is it about?

This chapter is an introduction to the study. The purpose and rationale for the study is discussed and research questions listed. This is followed by a brief overview of the partnership and HIV and AIDS literature, conceptual framework and research methodology.

Chapter Two – Understanding the Context: HIV and AIDS, Entabeni and the community's response to the epidemic

This chapter provides general descriptive facts and statistics on HIV and AIDS, particularly in the South African context and as it relates to KwaZulu-Natal and the

community of Entabeni. An overview is provided of South African government policy and its (South African government's) historical response to the AIDS epidemic. I contextualize the partnership study, providing an overview of the formative research and subsequent dissemination and stakeholder consultation that contributed to the planning and facilitation of partnership study.

Chapter Three – Facilitating Social Capital through Partnerships for HIV and AIDS management – A Literature Review

This chapter provides a critical overview of the literature on social capital, drawing on its relevance to partnerships for HIV and AIDS management via a discussion of the key social capital theorists. I emphasise Putnam's (2000) conceptualisation of bridging social capital as it relates to networking and partnerships. A comprehensive review of the academic and grey literature on partnerships is then provided, identifying its relevance and value for HIV and AIDS management in resource-poor contexts and highlighting gaps in the literature within which I situate the findings of the thesis.

Chapter Four – Research Methodology

This chapter discusses the research methodology, a qualitative longitudinal case study, and presents an overview of the research process and the framework of analysis, using Campbell's (2003) criteria for effective partnerships. The data collection tools, issues of reliability, validity and ethical considerations are also discussed in detail.

Part Two – Discussion and Analysis of Data, Conclusions and Recommendations

Chapter Five – Laying the Foundation: Collaborating with the Community stakeholders

This chapter provides a discussion and analysis of how the initial stages of partnership-building, described as the *formation phase* (El Ansari and Philips, 2001a) unfolded. I describe the process of recruitment of community stakeholders and the factors that either challenged or enabled the initial processes of collaboration with the

community stakeholders. In this and the next two chapters, I draw on and respond to all the research questions highlighted in Chapter 1 of the thesis.

Chapter Six – The external stake-holder partners: Who are they and what did they bring to the partnership?

This chapter continues with a discussion of the *formation* stage of the partnership-building process, focusing on the process of recruitment of potential external service-provider partners, highlighting the challenges encountered and factors that facilitated the process of collaboration with the external partners.

Chapter Seven – Implementation of the Entabeni partnership

This chapter provides a thorough analysis and discussion of these the implementation stage of the partnership, drawing on Campbell's (2003) framework for effective partnerships but extending this framework to allow for a broader interpretation of these criteria and a discussion and analysis of the findings within additional constructs.

Chapter Eight – Lessons learnt, conclusions and recommendations

This chapter concludes with a discussion of the key lessons learnt, a summary of the main themes that emerged in this study and recommendations for future research, intervention and policy.

Chapter 2

Understanding the Context: HIV and AIDS, Entabeni and the community's response to the epidemic

2.1. Introduction

The partnership study is a micro-level response to the broader challenges posed by HIV and AIDS globally, within South Africa, KwaZulu-Natal and rural communities specifically. The literature confirms that partnerships are often embedded within communities and influenced by the context within which it exists (Butterfoss, Lachance, Orians, 2006; Lasker, Weiss and Miller, 2000). Hence in contextualising this study, I present a descriptive overview of the 'what', 'where' and 'how' of the context within which the Entabeni partnership was embedded. In so doing, I present the opportunity for assessing the generalisability, appropriateness (El Ansari and Weiss, 2006) and scaling up of findings from this study to other projects of a similar nature and within similar contexts.

I highlight the following in this chapter:

- The status of HIV and AIDS globally, in Sub-Saharan Africa and South Africa, focusing on the progression and impacts of the virus within the South African apartheid governance structure, and the post apartheid governments responses to the epidemic;
- A synopsis of the Entabeni community, its challenges, cultural practices and response to the epidemic;
- A summary of the formative research⁴ conducted in the Entabeni community and the process of dissemination and stakeholder consultation that influenced current interventions in the community, one of which is the Entabeni partnership study being reported on in this thesis.

⁴ Formative research occurs before a programme is designed and implemented or while a programme is being conducted. It helps agencies understand the interests, needs and attributes of populations and communities and therefore contributes to appropriate and strategic planning.

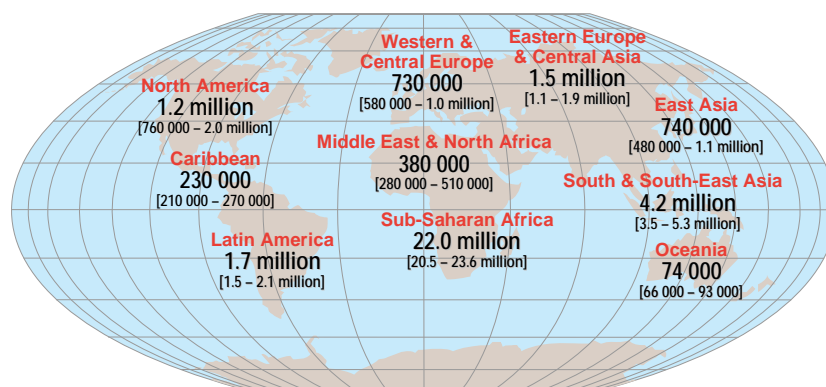
2.2. The current status of HIV and AIDS globally and locally

According to the Joint United Nations Programme on HIV and AIDS (UNAIDS, 2006), HIV and AIDS has been one of the most disastrous diseases in modern times. The report estimated that since the discovery of the HIV virus in 1981, more than 20 million people around the world had died from AIDS and some 39.5 million people were living with HIV at that time. Of those infected with the HIV virus, more than 17 million were women and some two million were children under the age of 15 years.

Presently, while the percentage prevalence has been reduced by 16 percent (UNAIDS, 2008), the continued new infections (even at a reduced rate) have contributed to the estimated number of people living with HIV, 33.2 million [30.6–36.1 million], being the highest ever (see Figure 1). This drastic reduction in is largely due to the intensive efforts made to re-assess India's HIV epidemic, and because of the changes in HIV prevalence occurring in the following six countries: Angola, India, Kenya, Mozambique, Nigeria, and Zimbabwe. In Kenya and Zimbabwe, there is increasing evidence that a portion of the decline is related to a reduction in new infections, partly because of less risky behaviours (UNAIDS, 2008).



Adults and children estimated to be living with HIV, 2007



Total: 33 million (30 – 36 million)

July 2008 e

4

Figure 1: Estimated number of people living with HIV globally (UNAIDS/WHO, 2007)

Globally, the HIV incidence rate (the proportion of people who have become infected with HIV) is believed to have peaked in the late 1990s and to have stabilized subsequently (see Figure 2), with the exception of the African continent which continues to be the epicentre of the AIDS pandemic (Whiteside, 2003; UNAIDS/WHO, 2008)

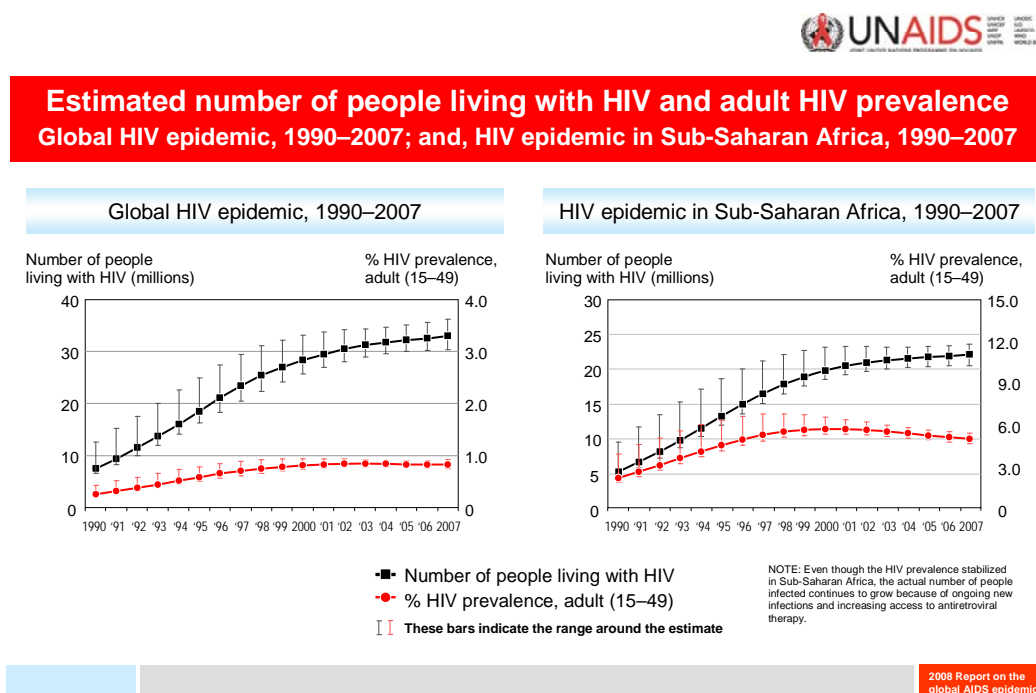


Figure 2: Global and Sub-Saharan HIV epidemic, 1990-2007 (UNAIDS, 2008)

Sub-Saharan Africa has been particularly devastated by the pandemic, continuing to be the region most heavily affected by HIV worldwide (see Figure 2). In 2007 this sub-region accounted for two thirds (67 percent) of all people living with HIV and for three quarters (75 percent) of AIDS deaths globally (see Table 1) (UNAIDS/WHO, 2008). It was also estimated that 1.9 million [1.6–2.1 million] people were newly infected with HIV, while 22 million [20.5–23.6 million] people were living with HIV in the sub-region in 2007 (UNAIDS/WHO, 2008).



Regional HIV and AIDS statistics and features, 2007

	Adults & children living with HIV	Adults & children newly infected with HIV	Adult prevalence (15–49) [%]	Adult & child deaths due to AIDS
Sub-Saharan Africa	22.0 million [20.5 – 23.6 million]	1.9 million [1.6 – 2.1 million]	5.0% [4.6% – 5.4%]	1.5 million [1.3 – 1.7 million]
Middle East & North Africa	380 000 [280 000 – 510 000]	40 000 [20 000 – 66 000]	0.3% [0.2% – 0.4%]	27 000 [20 000 – 35 000]
South and South-East Asia	4.2 million [3.5 – 5.3 million]	330 000 [150 000 – 590 000]	0.3% [0.2% – 0.4%]	340 000 [230 000 – 450 000]
East Asia	740 000 [480 000 – 1.1 million]	52 000 [29 000 – 84 000]	0.1% [<0.1% – 0.2%]	40 000 [24 000 – 63 000]
Latin America	1.7 million [1.5 – 2.1 million]	140 000 [88 000 – 190 000]	0.5% [0.4% – 0.6%]	63 000 [49 000 – 98 000]
Caribbean	230 000 [210 000 – 270 000]	20 000 [16 000 – 25 000]	1.1% [1.0% – 1.2%]	14 000 [11 000 – 16 000]
Eastern Europe & Central Asia	1.5 million [1.1 – 1.9 million]	110 000 [67 000 – 180 000]	0.8% [0.6% – 1.1%]	58 000 [41 000 – 88 000]
Western & Central Europe	730 000 [580 000 – 1.0 million]	27 000 [14 000 – 49 000]	0.3% [0.2% – 0.4%]	8 000 [4 800 – 17 000]
North America	1.2 million [760 000 – 2.0 million]	54 000 [9 600 – 130 000]	0.6% [0.4% – 1.0%]	23 000 [9 100 – 55 000]
Oceania	74 000 [66 000 – 93 000]	13 000 [12 000 – 15 000]	0.4% [0.3% – 0.5%]	1 000 [<1 000 – 1 400]
TOTAL	33 million [30 – 36 million]	2.7 million [2.2 – 3.2 million]	0.8% [0.7% – 0.9%]	2.0 million [1.8 – 2.3 million]

July 2008 e

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information.

3

Table 1: HIV and AIDS regional statistics for 2007 (UNAIDS/WHO, 2008)

South Africa's AIDS epidemic continues to be the worst in the world. At the end of 2007, an estimated 5.7 million people were living with HIV (UNAIDS, 2008), while 18.3 percent of adults between 15–49 years were living with HIV in 2006 (Department of Health, South Africa, 2007). Figure 3 provides a graphic estimation of the number of people living with HIV in South Africa between 1990 and 2007 (UNAIDS/WHO, 2008). A report by the Department of Health "National HIV and Syphilis Sero-prevalence Survey in South Africa 2006", (2007), an annual study looking at HIV prevalence amongst pregnant women from antenatal clinics, revealed that 29.1 percent of pregnant women were living with HIV in 2006.

Number of people living with HIV, 1990-2007

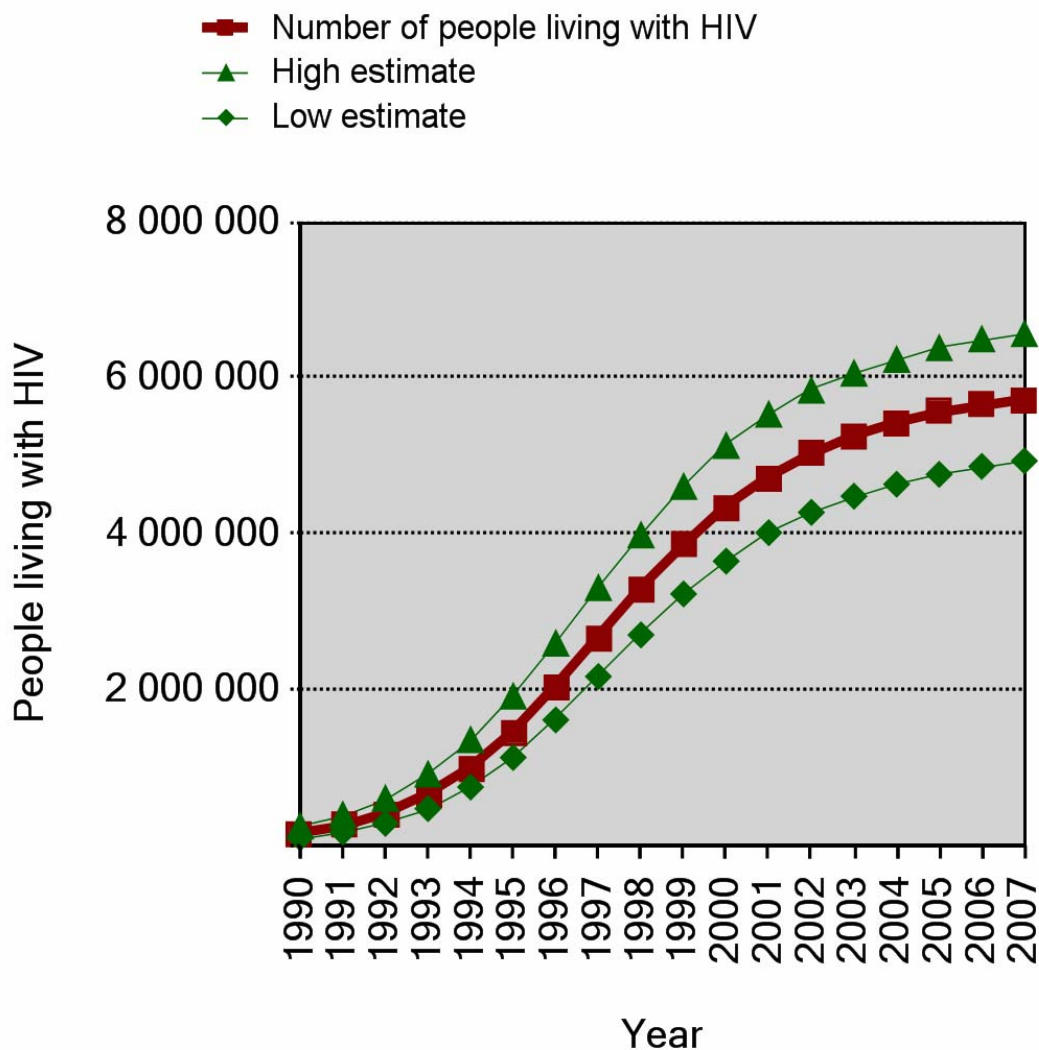


Figure 3: Estimated number of people living with HIV in South Africa between 1990-2007 (UNAIDS/WHO, 2008)

The rate of infection among young women continues to be much higher than that of men, with women between the ages of 15–24 years accounting for approximately 90 percent of all new HIV infections in South Africa (Rehle, Dorrington, Shisana, Pillay and Puren, 2007), as Figure 4 below indicates.

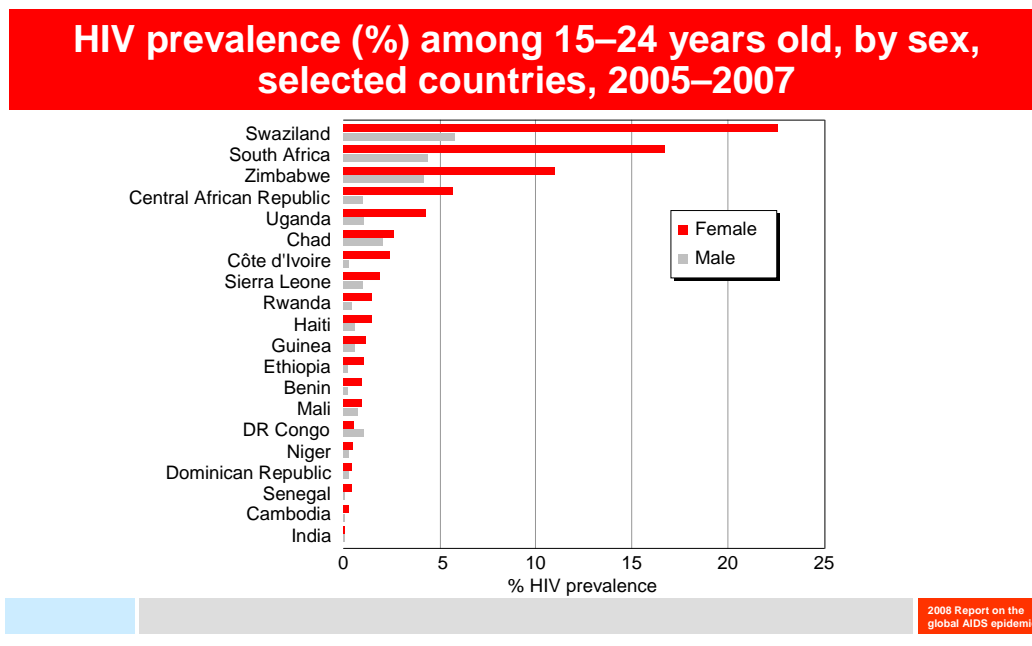


Figure 4: HIV prevalence among 15-24 year olds, by sex, in selected countries

(UNAIDS, 2008)

In terms of mortality, the head of the Medical Research Council (MRC) stated that AIDS killed around 336,000 South Africans between mid-2005 and mid-2006 (“In South Africa”, 2006), while the ‘AIDS and Demographic model of the Actuarial Society of South Africa’ (2005), recorded 345,640 AIDS deaths in 2006. This comprised 47 percent of all deaths in South Africa for 2006. It was further estimated that 71 percent of all deaths among adults aged 15-49 years were due to AIDS (Dorrington, Johnson, Bradshaw and Daniel, 2006). Currently, AIDS claims 1000 lives every day with approximately 350 000 AIDS related deaths occurring every year (see Table 2 below). Average life expectancy in South Africa is also dismal for both women (49 years) and men (47 years). Without AIDS, life expectancy could have been around 67 years (UNAIDS, 2008).

Table 2: Estimated number of adults and children who died of AIDS in South Africa (UNAIDS/WHO, 2008)

	2001	2007
Adults and children	180 000	350 000
Low estimate	130 000	270 000
High estimate	250 000	420 000

Within South Africa, HIV prevalence rates are not standardized but differ among provinces (see Figure 5 – map of South Africa), with the province of KwaZulu-Natal again having the highest HIV prevalence rate in the country (see Table 3). In this province, where the community of Entabeni (geographical area of study) is situated, 39.1 percent of the population was estimated to be HIV positive (Department of Health, 2007).

Table 3: Provincial HIV prevalence estimates: Antenatal clinic attendees, South Africa 2004-2006 (Department of Health South Africa, 2007)

Province	HIV pos. 95 percent CI 2004	HIV pos. 95 percent CI 2005	HIV pos. 95 percent CI 2006
KwaZulu-Natal	40.7 (38.8 - 42.7)	39.1 (36.8 - 41.4)	39.1 (37.5 - 40.7)
Mpumalanga	30.8 (27.4 - 34.2)	34.8 (31.0 - 38.5)	32.1 (29.8 - 34.4)
Free State	29.5 (26.1 - 32.9)	30.3 (26.9 - 33.6)	31.1 (29.2 - 33.1)
Gauteng	33.1 (31.0 - 35.3)	32.4 (30.6 - 34.3)	30.8 (29.6 - 32.1)
North West	26.7 (23.9 - 29.6)	31.8 (28.4 - 35.2)	29.0 (26.9 - 31.1)
Eastern Cape	28.0 (25.0 - 31.0)	29.5 (26.4 - 32.5)	28.6 (26.8 - 30.4)

Limpopo	19.3 (16.8 - 21.9)	21.5 (18.5 - 24.6)	20.6 (18.9 - 22.3)
Northern Cape	17.6 (13.0 - 22.2)	18.5 (14.6 - 22.4)	15.6 (12.7 - 18.5)
Western Cape	15.4 (12.5 - 18.2)	15.7 (11.3 - 20.1)	15.1 (11.6 - 18.7)
National	29.5 (28.5 - 30.5)	30.2 (29.1 - 31.2)	29.1 (28.3 - 29.9)

N.B. The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.



Figure 5: Map of South Africa showing the nine provinces in the country

Rural areas, in which almost half of the South African population lives, are particularly vulnerable to the epidemic because of poor access to essential services like hospitals, clinics and social welfare, and the additional challenges of poverty, food insecurity, poor infrastructure, etc. (Ntsebeza, 2006; Barnett and Whiteside, 2004; Topouzis, 1998). Rural areas in KwaZulu-Natal were especially affected by the epidemic. A longitudinal study conducted with a rural population in KwaZulu-Natal indicates that HIV prevalence among resident men and women continues to rise, with HIV prevalence peaking at 51 percent among resident women aged 25-29 years, and 44 percent among resident men aged 30-34 years. The highest infection rates (57.5 percent), are among 26-year old women (Welz, Hosegood, Jaffar, Bätzing-Feigenbaum, Herbst, and Newell, 2007). I discuss the impacts of the epidemic on the rural community of Entabeni in this chapter.

Having contextualised the study within the current climate of HIV and AIDS globally and locally, I believe that any HIV and AIDS research or intervention within South Africa cannot be divorced from an understanding and awareness of its turbulent history and the South African government's response to reducing the spread of the HIV virus thus far. I discuss this below, highlighting the role played by key politicians in hindering progress in the fight against HIV and AIDS in South Africa.

2.3. The History of HIV in South Africa: Apartheid, Political Turmoil and AIDS Denialism

South Africa is essentially a new democracy with a distinctive history marred by an inequitable distribution of resources, wide-scale racial and gender discrimination and major social upheavals (Cichocki, 2007). This past is relevant to the explosive nature of the AIDS epidemic in the country and its devastating impacts on mainly previously disadvantaged communities.

The first cases of HIV emerged in South Africa in 1982 in the midst of the horrors of apartheid and when political unrest reigned. The HIV and AIDS problem was therefore largely ignored, and it began to silently take hold in society (Republic of South Africa, 2006; Berry, 2004). Thus, while world attention was focused on the major political and social changes occurring in the country between 1993 and 2000, with the country's first democratic elections and Black president being sworn into

office, HIV prevalence rates were soaring. By the mid-990s, prevalence rates had risen by 60 percent, but the government response to what was obviously becoming a public health disaster was slow (Cichocki, 2007). HIV rates continued to rise from 4.3 percent in 1993 to a high 24.5 percent in the year 2000 (Department of Health, 2002).

This seemed to finally get the attention of the South African Department of Health, who, in 2000 outlined a five-year HIV and AIDS plan. However, this had little support from the then President of South Africa, Thabo Mbeki. His consultation with a group of HIV denialists, headed by Dr. Peter Duesberg⁵, resulted in President Mbeki rejecting conventional HIV science and instead blaming the growing AIDS epidemic on poverty. AIDS denialists believe that HIV does not cause AIDS and that anti-retrovirals should not be used for HIV prevention or treatment (Nattrass, 2006; Cichocki, 2007). At an international AIDS conference held in Durban, South Africa, in the year 2000, President Thabo Mbeki, reiterated the message that AIDS was caused by poverty and not by HIV. In 2004, he declared that he did not know anyone who had died of AIDS. This ‘AIDS denialism’, together with the Health Ministers (Manto Tshabalala-Msimang's) emphasis on nutrition and alternative natural treatments as a means to fight the HIV and AIDS epidemic over anti-retroviral drugs has been argued to have undeniably hampered the response to HIV and AIDS in the country (Nattrass, 2006; Sheckels, 2004; Stephens, 2007). The following statement by Edwin Cameron, a judge of the Supreme Court of Appeal is indicative of the far reaching impact of AIDS denialism in the fight against HIV and AIDS in South Africa.

“For South Africa, the significance of Aids denialism is momentous. It has to be, since our president, President Thabo Mbeki, has publicly countenanced and officially encouraged it. The president's stand has caused predictable confusion and dismay among ordinary South Africans - with unavoidably devastating consequences in an epidemic where public education about self-protection and the necessity for behaviour change is a life-saving centrality” (Cameron, 2003)

Alongside this AIDS denialism and misinformation about AIDS treatment, false beliefs about how HIV can be transmitted is also a concern. In April 2006, on trial for

⁵ Duesberg is a member of the National Academy of Sciences in South Africa.

the alleged rape of a HIV positive woman, South Africa's former Deputy-President, Jacob Zuma, embarrassed the country on national television by reporting that he had showered after unprotected sex with an HIV positive woman to decrease his chances of contracting the virus. There was widespread dismay amongst the AIDS prevention community that a politician (particularly one who had once been the head of the National AIDS Council) could display such ignorance. They feared that his statement would cause confusion amongst the public and in the process undermine years of AIDS prevention campaigns by civil society (Green and Gordin, 2006).

Many believe that the widely publicised views of ANC (African National Congress) politicians like former President Thabo Mbeki, the former Health Minister Manto Tshabalala-Msimang and the former Deputy President, Jacob Zuma, have shown total disregard for the scientific evidence on HIV transmission or the value of ARVs, and added to the climate of misinformation that surrounds the problem of AIDS in South Africa (Nattrass, 2006; Stephens, 2007). Zackie Achmat, leader of the Treatment Action Campaign (TAC), the country's leading AIDS activist group, argues that the real hindrance to antiretroviral drug provision in the country is not the lack of funding, but the attitude of the Government (Nduru, 2006).

Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa, stated in 2006 that:

"South Africa is the unkindest cut of all. It is the only country in Africa... whose government is still obtuse, dilatory and negligent about rolling out treatment. It is the only country in Africa whose government continues to propound theories more worthy of a lunatic fringe than of a concerned and compassionate state... I'm of the opinion that they can never achieve redemption." (Kaiser Network, 2006:3)

Although the government has been widely criticised in the past for its AIDS policies and response to the AIDS epidemic, the uproar at the government's denialism to the AIDS epidemic at the 2006 World Aids conference in Toronto, Canada, heralded a drastic change in the Government's stance, led by former Deputy President Phumzile Mlambo-Ngcuka. In public comments and private meetings, she emphasised that the Government believes unequivocally that HIV causes AIDS. She also indicated that anti-retroviral drugs must be the centre-piece of the Government's response, while at the same time playing down the dietary recommendations of lemons and beetroot,

long cited by former Health Minister Manto Tshabalala-Msimang as key to fighting AIDS.

"We must take our fight against Aids to a much higher level... we must tighten up so that ARV drugs are more accessible, especially to the poor. Education and prevention of HIV infection must be scaled up. Our people want us to unite on this issue in the best interests of the health and wellbeing of our nation. Working together we can defeat this disease" ("SA Government", 2007).

The Treatment Action Campaign indicated at that point that after years of hostility and legal battles, government officials were working with them to realise some of their long-standing demands. These included setting targets for dramatically expanding the availability of anti-retroviral drugs through the public health system. Presently, about 200 000 people receive the government drugs, making the public programme one of the biggest in the world. However, they are only reaching just one quarter of the estimated 800 000 in need of ARVs ("SA Government", 2007).

In March 2007 the Government, led by the deputy Minister of Health, Nozizwe Madlala-Routledge, formally launched the National Strategic HIV/AIDS plan 2007 to 2011 to guide the South African National AIDS Council (SANAC). This plan emphasizes the importance of co-operation between the government and civil society groups and the need for partnerships (HIV and AIDS and STI strategic plan for South Africa, 2007-2011). The author of this thesis, representing HIVAN and the research team, was fortunate to contribute to this policy process through research seminars organized by the Deputy Minister of Health in 2007. The author advocated for multi-sectoral partnerships as an innovative strategy in responding to HIV and AIDS, highlighting the importance of community participation and community consultation in health policy on HIV and AIDS.

However, in August 2007, Madlala-Routledge, the driving force behind the national strategic plan, was fired by the former President Thabo Mbeki for travelling to a meeting in Spain without his permission. Madlala-Routledge claims that she was unfairly dismissed. AIDs activists and organisations condemned the firing as unjustified and highly detrimental to the national struggle against AIDS in South Africa. There were suggestions that President Mbeki had been looking for an excuse

to dismiss Madlala-Routledge because she had challenged the claims made by himself and former Health Minister Manto Tshabalala-Msimang about the science behind HIV and AIDS, and the importance of antiretroviral drugs (“The Unjustifiable firing”, 2007; “SA's pacifist politician”, 2007)

Mark Heywood, the head of the AIDS Law Project, a prominent HIV and AIDS organisation in South Africa, summed up the feelings of many people in his statement about the South African government's response:

"They have lost at least five years. They're behind on prevention. They're behind on treatment. They're behind on planning for the social impact of HIV. But it's not too late to prevent a whole other generation of people from getting HIV." (Timberg, 2006)

Most recently (September 2008), major upheavals within the African National Congress resulted in President Thabo Mbeki being recalled as President of South Africa and a new interim President (Kgalema Motlanthe) being sworn to office. This resulted in a reshuffle in ministerial positions, with a new Minister of Health, Barbara Hogan, taking over the Health portfolio from former Minister Manto Shabalala Msimang (“All the President's men and a few women too: New faces in high places”, 2008). Zackie Achmat of the Treatment Action Campaign (TAC) described Hogan's appointment as ‘the best news that South Africa could have had’ (“Achmat hails Manto's replacement”, 2008).

Below, I contextualize this study by providing a detailed overview of the Entabeni community and the challenges they face with regards to HIV and AIDS, their community led response to the care of PLWAs, and the formative research and intervention strategy that was facilitated by the research team in support of the local community's response to the epidemic. This section is placed here rather than in the chapters on the findings (Chapters 5, 6, 7) as it covers the period before the actual initiation of the partnership study.

2.4. The Entabeni community. Who are they and how have they responded to the epidemic?

“*The community context is an important determinant of health outcomes.*” (El Ansari, 2005:760)

The Entabeni community⁶ is situated 30km from the nearest town or hospital. Access to health and welfare services is limited due to limited and often un-tarred roads and a general lack of money for transport. Clean water and electricity is scarcely available. Cholera, tuberculosis, and HIV and AIDS (36 percent of the population) are rife, while adult illiteracy (39 percent of adults have no formal schooling), unemployment (53 percent of economically active population) and poverty (25 percent of households in the district have no form of income) are high (Umlalazi Municipality, 2008). Most people in the community depend on subsistence farming, but this is threatened by the hilly landscape (see Annexure 3) and droughts. An iNkosi or traditional chief is the central authority in the community but often delegates power to the local ward leaders or traditional leaders, many of whom lack confidence and leadership skills and have often not received formal schooling. The power structures in the community are patriarchal. Men generally practice polygamy and women have little power to protect themselves in sexual relationships (Campbell, Nair, Maimane and Sibiyi, 2005).

Much has been written about the way in which the African AIDS epidemic is driven by power inequalities between youth and adults, and between men and women (Campbell, 2003; Campbell, Foulis, Maimane and Sibiyi, 2005). These inequalities are particularly severe in this conservative and remote community, where people have little access to education or to new ideas of any kind. In Chapter 5 of the thesis, I discuss the impact of these *power inequalities* on the participation of women and youth in the Entabeni partnership.

Informal care within these impoverished households is generally the responsibility of women in the family or in the neighbourhood. They are often the only form of support available to people living with HIV or dying of AIDS and are themselves often burdened by poverty, having minimal access to regular sources of income and food or transport to hospitals and clinics and they lack basic resources for home nursing

⁶ The name Entabeni is a pseudonym used to protect the identity of the people in the community. The community is situated in a deep rural area in Northern Kwa-Zulu Natal

(gloves, bedding and clean water). In addition, the stigmatisation of AIDS isolates PLWHAs in the community and makes people reluctant to disclose their status. Often the burden of care is the final straw for already over-extended rural women, some of whom are sick themselves. Caring for these AIDS patients in the final stages of their lives often places carers at risk of physical and psychological burnout, family breakdown and the destruction of household economies (Campbell and Foulis, 2004; Campbell, Nair, Maimane and Sibiya, 2008).

The main source of assistance to people with AIDS in Entabeni and their carers is a group of volunteer health workers (home-based carers) who visit AIDS-affected households providing basic nursing assistance and emotional support (Maimane, Campbell, Nair and Sibiya, 2004). This includes a group of approximately 80 local residents (nearly all women) who have low standards of education with only a handful having completed their secondary school education. They have varying talents and skills. Some, but not all, had been trained (prior to the research team's entry into the community) in basic home nursing through the unsystematic and temporary inputs of patchy government programmes and NGOs. In addition, a dedicated but single overseas missionary had spent two years in the community with a miniscule grant, engaging in various social development activities, including the construction of a fledgling hospice that was only able to assist a small number of people (approximately six) dying of AIDS.

These volunteers are led by an inspired group leader (Mr. Nxumalo), who was born in the community. He spent 20 years away from the community, during which time he received training in home-based care from a course run by a national non-governmental organisation. On his return to the community, he used these skills to mobilise a team of volunteer home-based carers in Entabeni (see Chapter 5). This is a 'bottom-up', community-led and community-owned initiative, completely resourced by local volunteers which I elaborate on later in Chapter 5.

The volunteers are remarkable for their dedication and commitment, and their willingness to work incredibly hard for the smallest of gains. Whilst a small number of them received a minimal stipend from a local community based organisation (CBO), most of them work for no pay, with few skills, having to walk long distances

on foot, up and down steep hills, often in searing heat, to households which may be several kilometres apart. After long walks to households, volunteers may sometimes be turned away by families who refuse to admit they have a relative with HIV/AIDS. Their work is arduous. It includes fetching firewood and water, cooking, cleaning patients and in extreme cases supervising the transport of patients in wheelbarrows or on relatives' backs to the nearest roads to seek transport to hospital. Even when people do manage to get to hospitals, due to overcrowding and lack of resources in rural hospitals, swamped by the AIDS epidemic in addition to a range of other challenges, people are seldom admitted, at best being given symptomatic treatment for opportunistic infections and then sent home (Campbell et al., 2008)

For those who prefer African traditional medicine, the area has many traditional healers who treat their patients through herbal and/or spiritual methods. Some claim to be able to cure AIDS. There is no evidence to support this claim, and such claims invariably end in disappointment for desperate families who may have drained their meagre resources to fund such treatments. Others offer various forms of psychological support and nutritional advice.

The map below illustrates the district and local municipalities in KwaZulu-Natal, along with the names of surrounding South African provinces (SA) or countries. The Entabeni community is situated within the Umlalazi Municipal district (DC28).

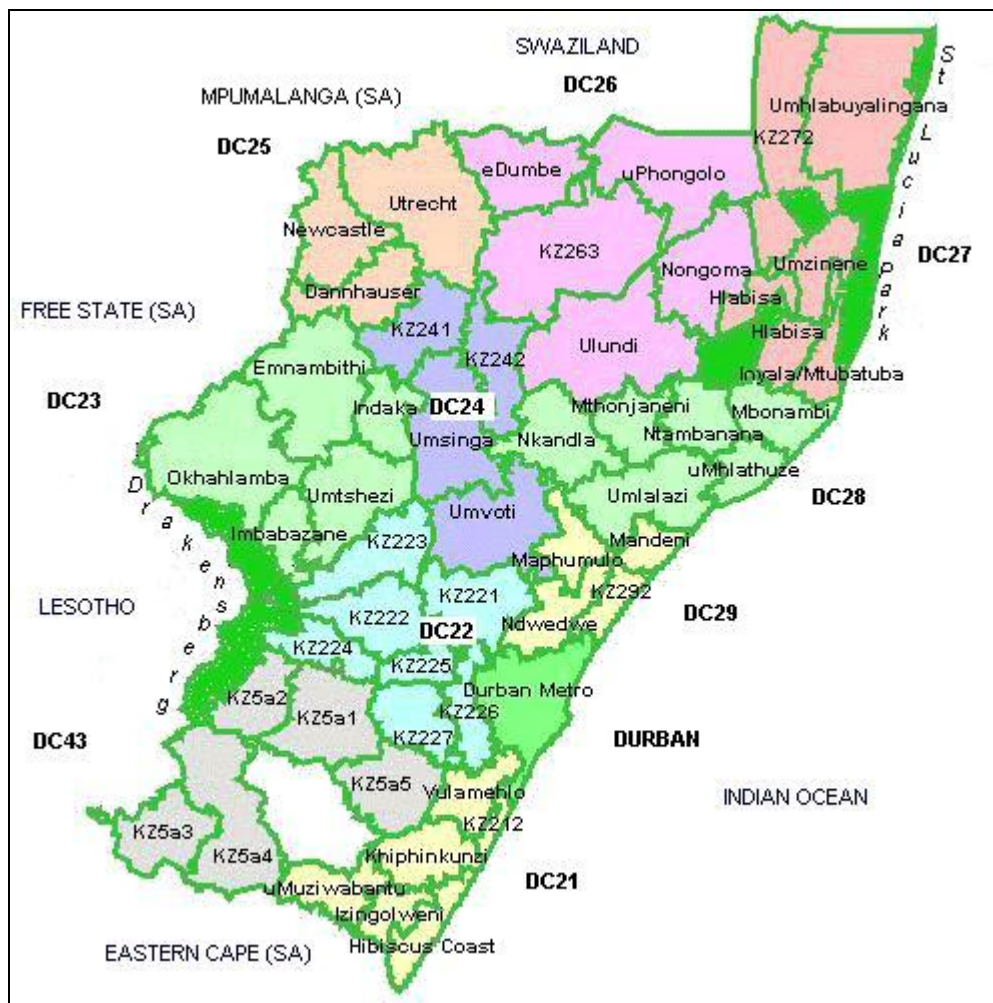


Figure 6: Map of KwaZulu-Natal

2.5. The Formative research

The research team first entered the Entabeni community in 2003 as part of their brief to conduct case studies of community responses to HIV and AIDS in KwaZulu-Natal. They were introduced to the local traditional chief by a colleague who had relatives in this community, and was concerned about the high levels of death and suffering in the wake of the AIDS epidemic. The traditional chief arranged for the HIVAN team to meet the volunteer health worker leader, giving him permission to assist their work in Entabeni (see Chapter 5). On this basis, formative research was undertaken between 2003 and 2004 involving various stakeholders in the Entabeni community and the region (see 5.3.1. in Chapter 5).

In reference to the discussion of an AIDS competent community in Chapter 1, it was assessed that people had patchy *knowledge* about HIV-prevention and poor AIDS-care skills. Fear, denial and stigma meant that there were virtually no *social spaces* in which people could openly discuss HIV and AIDS or how to respond to it. There were low levels of *ownership* of, or responsibility for addressing the problem in a demoralised community with few links to the outside world.

People saw HIV and AIDS as overwhelming and showed little individual or community agency to tackle it. There was very little recognition of local *strengths*, and also of the value and efforts made by the volunteer health workers in caring for PLWHAS in the community. The stigmatisation of HIV and AIDS made people reluctant to have any contact with the volunteers, or even acknowledge their existence, lest other community members suspected that they or family members might be HIV-positive. When asked who should solve the problem of HIV and AIDS, people tended to say that it was the government who was responsible, but had only a vague idea of whom or what the government was. In terms of ‘bonding’ social capital (see 3.2.2. of Chapter 3), high levels of denial, stigma and secrecy had undermined the likelihood that local people would come together to develop effective community-level responses to HIV and AIDS (Campbell, Nair, Maimane, 2006).

Despite these challenges, the community had, however, remarkable strengths in the face of HIV and AIDS. These included the love and commitment of family members who cared for dying relatives, and the dedication of the volunteer health workers who worked tirelessly with few skills and little recognition in caring for the sick and dying in the community. Furthermore, several groups expressed their willingness to become more involved in HIV and AIDS management efforts, but said they lacked the training and confidence to do so. These included young people (in and out of school), and some (but not all) local ward leaders and religious leaders.

In terms of *bridging social capital*, people had few links with outside sources of help. Community members lacked the skills and resources to access welfare grants and geographically distant hospitals and clinics. In planning the partnership case study, I scoured the region around the community for potential partners. Further details of this process are discussed at length in Chapter 6 of the thesis. One poignant example of

the difficulties faced by people in the community was given by a Catholic nun who supports volunteer health workers and does hospice work in an adjacent community. She said she had gone to the top of one of Entabeni's thousands of hills and tried to shout to attract the attention of the people, hoping that this would be a good way of calling to local people who might be interested in working with her. After a poor response to her shouting, she decided to give up on Entabeni and place her energies in more accessible and responsive workplaces (Campbell, Nair, Maimane, 2006 and 2007).

2.5.1. Dissemination of formative research findings and stakeholder consultation

The second stage of the research team's engagement with the community took the form of a series of research-dissemination workshops in late 2004 and early 2005. In designing the feedback workshops we sought to do more than merely report back the formative research findings. At that time we did not know if we would succeed in our application for funding to become more involved in HIV and AIDS management work. For this reason we developed a 'dissemination as intervention model', with workshops designed to report research findings in ways most likely to facilitate what we regarded as the six features of an AIDS-competent community (see Chapter 1).

The workshop had four sections: (i) building HIV and AIDS-relevant knowledge; (ii) discussing the impact of AIDS on the local community, as well as obstacles to meeting patient and carer needs; (iii) identifying and building on existing community strengths; and, (iv) formulating possible individual and group contributions to more effective local HIV and AIDS management. Apart from section (i), where input came from group participants alone, the other three sections began with a brief input from the research team outlining the research findings, followed by small group discussions of the implications of the findings for possible local action.

The research team facilitated workshops with nine groups of local residents (see Chapter 4). One of the aims of the workshop was to encourage people to consider ways in which they could mobilise limited local strengths and resources to deal with HIV and AIDS, and to counter the tendency to wait for outside experts (e.g. the government) to take control of the problem. This was necessary for encouraging ownership and agency by the community, and also because the likelihood of this

happening without significant intervention was limited by a combination of public sector resource constraints and the remoteness of the area. Due to this, these nine groups did not focus specifically on the fifth component of an AIDS-competent community, namely building partnerships with potential support agencies outside the community, although this was a key goal of the overall project. The potential role of partnerships was the central focus in the tenth dissemination workshop, discussed in Chapters 5 and 6.

In assessing the extent to which these workshops succeeded or failed in contributing to the objectives of promoting AIDS competence at this early stage of the research team's partnership with the community, the following was gathered. As indicated above, the first phase of the workshop focused on building *knowledge* through the provision of opportunities in which people could consolidate the fragments of knowledge that they had between them. This involved dividing workshop participants into small groups to discuss the causes of HIV and AIDS before reporting back to the plenary. There were two reasons for this. The team's workshop policy was that workshop facilitators (members of the HIVAN team) would not interrupt, or seek to correct what they regarded as any misconceptions that arose in the course of the group discussions. Firstly, because we sought to run workshops which provided opportunities for participants to process information about HIV and AIDS in ways that made sense to them within the framework of their own worldviews and possible worlds. Secondly, because we sought to facilitate knowledge-building in such a way that participants would feel a sense of personal ownership of any knowledge they acquired in the discussions. Thus, they would be more likely to retain and use this knowledge than would be the case with knowledge seen as other or the property of experts, as the formative research suggested had been the case in the past (Campbell et al., 2008).

In the feedback sessions after the workshop, and in evaluation interviews, workshop participants repeatedly said that the most valuable aspect of the workshops were that they had gained a great deal of useful information. This is interesting, given that the workshop facilitators specifically did not provide any information. All the information discussed at the workshops was provided by workshop participants. This suggests that what people in this community lacked was not so much information, as the chance to

share and consolidate the fragments of information that were available to them, and to translate these into ways in which made sense to them.

Thus, from the research team's perspective, what people gained from the workshop was not so much information per se, as the *social space* to process it and to take ownership of it. For many participants, the workshop was the first opportunity they had had to discuss AIDS-related issues in a supportive group setting.

People generally spoke openly at these workshops. In the context of the silence and stigma surrounding AIDS, some participants showed great courage in speaking openly about family members, often teenage children, who had died of AIDS. The groups were also successful in exposing participants to an unstructured and democratic discussion format, many of them for the first time.

In assessing the extent to which the workshops facilitated and promoted a sense of *ownership* of the challenge of HIV and AIDS management by participants, workshop discussions revealed that people *did* start to openly acknowledge the extent of the problem in the community, and the fact that they were personally vulnerable. However, there was consensus amongst participants that given a lack of basic skills, and given the stigmatised nature of HIV and AIDS, it was unlikely that community members would lead an accelerated response to HIV and AIDS in the absence of an external change agent of some sort. This point is taken up below.

To what extent did the workshops increase participant confidence in the *existence of local strengths and resources* – both individual and collective – to respond to HIV and AIDS? The workshops definitely served to increase peoples' recognition of the value of the community health workers and their need for further support. To a certain extent the group discussions got some people thinking about possible assistance that they could offer to the volunteers, as well as people living with AIDS and their carers at the individual level. These included forms of support such as prayer, showing love and compassion, visiting people with AIDS and helping carers with housework and home chores. However, aside from individual strategies, a discussion of more collective efforts tended to be vague and general. These comments revolved around the need for the community to join together to fight HIV and AIDS, and the need for

volunteers and community leaders to work more closely together. However these discussions tended to be abstract, lacking in any real action agenda.

In addition to disseminating findings to the nine groups of local community residents, a tenth workshop was held with potential partners from outside the community, including government service-providers (linked to hospitals, clinics and welfare departments in the wider region), the regional municipality (the local level of government to which some economic and political power is delegated by national government), a missionary, representatives from a counselling NGO, and a provincial commercial sector representative. The outcome of this workshop is what led to the implementation of the *Entabeni partnership* (see Chapters 5 and 6).

2.5.2. Establishing the Entabeni project and partnership intervention.

In all the dissemination workshops, there was general agreement that the volunteer health workers were best placed to lead a programme seeking to promote greater local ownership of the challenge of HIV and AIDS management, and a greater awareness of the role that community-level responses can make in addressing the challenge. In follow-up discussions between the volunteers and the research team, it was decided that they would do this through activities such as creating opportunities for confidential discussions amongst different peer groups about the impact of HIV and AIDS in their own lives and possible responses; through training a wider range of community members in HIV-prevention and AIDS-care skills; through networking both inside and outside of the community to create support networks for people living with HIV/AIDS and their carers; and to improve the community's ability to access distant and hard-to-reach health and welfare services are available (Campbell et al., 2008; Nair and Campbell, 2008).

The volunteers welcomed the possibility of expanding their role, on condition that appropriate training and support was available to them for this role. They too were unanimous that without the input of an external change agent to provide an impetus for accelerated action, it was unlikely that local people would have the confidence to overcome stigma and initiate more intensive community-led efforts to support the volunteers. Community residents invited the research team to take on this role in partnership with local community representatives over a three-year period. The

research team was able and willing to do this, subject to being able to secure funding for the project. At the time of the initial stages of the partnership study, the team had secured funding for the first year of the proposed project and was seeking funding for two years thereafter, which was eventually secured (Campbell, Nair and Maimane, 2006).

Against this background, the partnership with the Entabeni community was initiated in the interests of pursuing the two key project goals highlighted in Chapter 1 of the thesis, with Goal Two being the focus of this study.

The intention of the author was to work with stakeholders from the Entabeni community in facilitating a partnership project for the next few years to address the two fold challenge of HIV and AIDS and the lack of access to essential external services and resources by building bridging networks with external stakeholder organisations.

2.6. Conclusion

HIV and AIDS continue to wreak havoc in the world and cause untold misery to those who have been infected and affected by the virus. While the incidence of HIV seems to have stabilized in many parts of the world, South Africa continues to be the epicentre of the AIDS pandemic. Rural communities like Entabeni are particularly vulnerable because of the added challenges of poverty, lack of capacity and their marginalised status.

The country's turbulent history and the government's response to the epidemic have not helped to curb the spread of the virus. Some believe that the rapid rise of HIV and AIDS in the country is directly related to the government's confusing and contradictory stance taken on HIV prevention measures in the country. Controversial statements made by former senior politicians caused a huge outcry globally and within South Africa, resulting in a positive turn-around in government response.

Formative research undertaken in the Entabeni community highlights the multiple challenges the community faces, including poverty, poor infrastructure, gender inequalities, stigma, poor support of PLWHAs and their carers and limited access to

health and other essential services (social grants and services). The community, through a consultation process, invited the research team to support a community led HIV and AIDS management programme in the community. The partnership study is situated within this project.

Chapter 3

Facilitating Social Capital through Partnerships for HIV and AIDS management: A Literature Review

3.1. Introduction

The concept of social capital has enjoyed a remarkable rise to prominence in social science disciplines since the last decade (Woolcock and Narayan, 2000; Kawachi and Kennedy, 1997; Wilkinson, 1996). Community development and health sectors have drawn on the concept in seeking to understand current health and developmental challenges (Dale and Newman, 2008; Szreter and Woolcock, 2004; Subramanian, Lochner and Kawachi, 2003; Campbell, 2003; Pearce and Smith, 2003; El Ansari and Philips, 2001c; Wilkinson, 1996). The central premise is that the networks of relationships embedded in social capital can be a valuable collectively ‘owned’ resource, providing the opportunity for *communication* and the exchange of ideas, building *reciprocity*, *mutual aid* and ultimately encouraging the emergence of *mutual trust* (Realo, Allik and Greenfield, 2008; David and Li, 2008; Pearce and Smith, 2003; Hooghe, 2002; Woolcock and Narayan, 2000). These networks and concrete interactions encourage and provide the basis for collective action or *collaborative partnerships* between people across sectors, who are able to work together to resolve their collective problems more easily (David and Li, 2008), improve the health of their community, and facilitate long term sustainable development (Dale and Newman, 2008; David and Li, 2008; El Ansari and Philips, 2001a; Campbell, 2003; Putnam, 2000; Bourdieu, 1986).

More recently, investing in social capital to facilitate social change processes through innovative partnerships and community participation by “...*strengthening the capacity of people and communities to satisfy their needs, solve problems and improve their quality of life*” (Darcy De Oliveira, 2002:15), has come to represent a strategy that is increasingly being supported by well-known social scientists and development practitioners, such as Manuel Castells, Anthony Giddens, Amartya Sen and Robert Putnam, amongst others (Darcy De Oliveira, 2002). The Entabeni partnership study situated itself within this conceptualisation of social capital in facilitating bridging social capital (discussed below) between the Entabeni community

and external stakeholders in the region for the purpose of jointly managing HIV and AIDS in this community.

This dissertation draws insights from two related bodies of literature, *social capital* and *partnerships* to establish a conceptual framework for analysing the community driven partnership intervention in Entabeni and answering the research questions posed in Chapter 1 of the thesis. While the areas of conceptual overlap and cross-fertilization are discussed throughout, for conceptual clarity, I divide the chapter into two sections. The *first* outlines some of the definitions that surround the concept of social capital, tracing its conceptual history and main theoretical developments by drawing on the works of the key social capital theorists, including Bourdieu (1986), Coleman (1988, 1994), Putnam (1993, 1995, 2000), Portes (1998), Grix (2001), Woolcock (2002), and, more recent theorists that have incorporated social capital in assessing varying social issues like health, community development, income and gender inequalities. They include Mayer and Rankin (2002), Campbell (2003), Moore, Haines, Hawe and Shiell (2006), Dale and Newman (2008), Realo, Allik and Greenfield (2008), among others. I also present a critique of the concept and highlight why social capital has gained increasing popularity over the years. I conclude this section with a discussion of the key components of social networking as first identified by Putnam (2000), including bonding, bridging and linking social capital and the synergy between bridging social capital and partnerships. The *second* section focuses on the concept of partnerships, highlighting the link between partnerships and HIV and AIDS management and reviewing various theoretical contributions to the process of the development of partnerships. I discuss the value of partnerships in facilitating networking and access to scarce resources and capacity in resource-poor communities like Entabeni. I also highlight the possible challenges they may encounter in the process of partnership development with external service-provider partners.

3.2. Just what is Social Capital?

While the concept of social capital has gained much momentum in the health and development literature over the last decade (Small, 2002; Campbell, 2003; Beard and Dasgupta, 2006; Wakefield and Poland, 2005), a common definition for the concept has yet to be found. What is, however, common to most accounts of the concept is the

assumption that social capital is embedded in social relationships that facilitate collective action (David and Li, 2008; Field, 2003). Its resources include norms (e.g. reciprocity that encourages bargaining and compromise), trust and networks of association between groups that meet consistently for a common purpose. A community that has high levels of social capital, (i.e. where social networks comprise the fabric of society), generally has a good quality of life and great economic growth potential (Narayan, 1999; Heenan, 2004; Haddad and Maluccio, 2002).

Portes (1998:7) supports this notion of social capital being embedded in relationships: “*Whereas economic capital is in people’s bank accounts and human capital is inside their heads, social capital inheres in the structure of their relationships. To possess social capital, a person must be related to others, and it is these others, not himself, who are the actual source of his or her advantage*”. Simply described, social capital exists only when it is shared. I draw on this notion of social capital being embedded in a range of relationships between people, describing how this occurred in the process of collaboration between the Entabeni community (Chapter 5), and the external stakeholder partners (Chapter 6). I contend that it is central to the process of partnership formation and to facilitating *collaborative advantage*, i.e. the advantages that are gained from collaboration or synergy that cannot be achieved alone (Vangen and Huxham, 2005).

Currently, the broadest and most all-encompassing view of social capital includes the social and political environment which shapes social structure and enables norms to develop (Yip, Subramaniana, Mitchella, Leeb, Wangc, and Kawachi, 2007; Szreter and Woolcock, 2004; Szreter, 2002). This form of analysis incorporates formalized institutional relationships and structures, such as the government, the political regime, the rule of law, the court system as well as civil and political liberties; hence accounting for the virtues as well as the vices of social capital, and emphasizing the importance of forging ties within and across communities. It supports the notion that the ability of social groups to act in their own interest depends crucially on the support (or lack thereof) that they receive from the state as well as the private sector and vice versa. Economic and social development is encouraged when representatives from the state, corporate and civil society sectors create forums through which they can

identify and pursue common goals (Dale and Newman, 2008; Realo, Allik and Greenfield, 2008; Campbell, 2003; Grix, 2001; Woolcock and Narayan, 2000).

Woolcock and Narayan (2000:3) assert that, “... *the basic idea of social capital is that a person's family, friends and associates constitute an important asset, one that can be called on in a crisis, enjoyed for its own sake, and leveraged for gain*”. I argue that what is true for individuals is also true for communities; hence those communities with a stronger stock of social capital are able to be more effective in meeting challenges, including HIV and AIDS.

Broadly speaking then, the concept refers to those features of social relationships such as interpersonal trust, networks and norms that are or actually could be drawn upon by people to solve common problems (Islam et al, 2006).

Before progressing to a critique of the concept, I present an overview of the theoretical development of social capital theory, highlighting those aspects of the concept that were taken up and analysed in the Entabeni study. These include Putnam's concept of *networking* and *bridging social capital* and Bourdieu's emphasis on *unequal power relations* in perpetuating inequality and the *access to resources* gained through the *social relationships* between people.

3.2.1. The theoretical development of social capital theory

The origins of social capital can be traced to the influential works of Pierre Bourdieu (1986, 1998, and 2000), James S. Coleman (1988, 1994) and Robert D. Putnam (1993, 1995, 1996, 2000, and 2007). It is these conceptualisations of social capital that has given prominence to the concept and brought it to the fore.

In 1985, the French sociologist, Pierre Bourdieu, developed a theory of social capital which is considered by some to be the most theoretically refined among those that introduced the term in contemporary sociological discourse (DeFilippis, 2001; Portes, 1998). He defined social capital as “*The aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition*” (Bourdieu,1986:248). He places the source of social capital in social structure and in social connections. He built his version of social capital on Durkheimian micro-

foundations and his macro-sociology draws extensively from the Marxist school of thought (Wacquant, 2005; Portes, 1998; Foley and Edwards, 1999).

Portes (1998) believes that Bourdieu's analysis of the concept is by far the most theoretically refined among the initial social capital theorists. He was the first to provide a systematic and explicit analysis of the concept in the present sense. His definition focuses on the benefits that accrue to the individual in his many and deliberate interactions and networks with and participation in groups for the purpose of creating this resource. He identifies and describes a number of different kinds of capital including cultural capital (cultural goods and services including educational credentials), economic capital (money and property) as well as symbolic capital (resources available to an individual on the basis of honor, prestige or recognition, and which functions as an authoritative embodiment of cultural value).

Bourdieu's concept typifies a neo-Marxist approach to social capital in his emphasis on *access to resources* and the issues of *power* in society (Wacquant, 2005), a notion that is analysed and exemplified in Chapters 5, 6 and 7 of this thesis. He sees these generic types of capital as a means by which power is mediated in society. By linking each of these forms of capital with power, Bourdieu's use of the term makes it evident that social capital, just like economic capital, is not evenly distributed in society. Instead, social capital can be used to produce or reproduce inequality, by e.g. people gaining access to powerful positions through the direct and indirect employment of social connections. He also argues that social inequalities are caused and sustained through a range of social processes that involve the interaction of the different forms of economic capital, human/cultural capital and social capital. He argues that the value of social capital exists in its ability to assist members of society gain access to these other forms of capital (Wacquant, 2006; Campbell, 2003). He emphasises two aspects of social capital that are particularly important; the *social relationships* that allows an individual to *gain access to the resources* that their associates' possess and the quality and amount of those resources that they gain access to (Bourdieu, 1986).

Following on the initial works of Bourdieu, James Coleman (1988), who is rooted within the functionalist tradition of Durkheim and Parsons, was responsible for bringing social capital into the mainstream of the American social sciences (Beard

and Dasgupta, 2006). He challenged Bourdieu's construct of social capital, arguing that social capital lies in the relations and networks in which people are embedded rather than in individuals themselves. Drawing on rational choice theory, James Coleman (1994) looked to social capital as part of a wider exploration of the nature of social structures. He argues that social capital is defined by its function. "*It is not a single entity, but a variety of different entities, having two characteristics in common: they all consist of some aspect of a social structure, and they facilitate certain actions of individuals who are within the structure*" (Coleman 1994: 302).

Grix (2001) identifies the value of Coleman's work in his emphasis on the:

- *access* to certain social networks and the type of *context* within which these networks are embedded;
- *access to information channels* embedded within social structures representing social capital, which he deems is essential for determining a person's subsequent actions.

Hence, the value of his contribution to social capital, in relation to its relevance to resource-poor communities like Entabeni and the Entabeni partnership, lies in the benefits that could accrue to these communities if they have *access to resource-rich networks* and belong to a structure that possesses abundant amounts of social capital.

Bourdieu's use of the term appears to be narrower than Coleman's, but he used the term to explain particular social phenomena, such as how some people of privilege managed to gain access to *powerful* positions through their social connections. So while he retains Coleman's neutrality of the resources themselves, he shows how it can be used to create *inequality*.

While it was James Coleman's thought-provoking work in 1988 that brought social capital into the realm of the social sciences and operationalised it for the purposes of research, the principal social capital theorist for community development practitioners and researchers is Robert Putnam (1993, 1995, 1996, 2000, and 2007). His many works have re-defined the concept of social capital and become extremely influential in development studies in the United States as well as internationally (DeFilippis, 2001; Beard and Dasgupta, 2006; Coffé and Geys, 2008). His earlier work on social capital helped to spread the functional approach to social capital. He, along with

Woolcock (2001), is considered to offer the most succinct definition of social capital, with both placing emphasis on social networks. Putnam (1993:167) conceptualizes social capital as "...features of social organisation, such as trust, norms, and networks that can improve the efficiency of society by facilitating co-ordinated actions." More recently, Putnam (2007:137) reiterated this version of social capital when delivering a lecture on 'diversity and community in the 21st century', "*I prefer a 'lean and mean' definition: social networks and the associated norms of reciprocity and trustworthiness.*"

Trust is therefore an essential and central component of social capital, facilitating cooperation and the ability to work together to achieve common goals. Social trust, as opposed to personal trust, arises from two related sources: norms of *reciprocity* and networks of civic engagement (Herreros, 2004; Scull, 2001). Norms of reciprocity can be of two sorts. *Balanced reciprocity* involves simultaneous exchanges and leaves no outstanding debt, while *generalised reciprocity* is a continuous exchange relationship that can be unbalanced at any point in time and consequently the relationship involves mutual expectations for future repayment. Putnam argues that it is the norm of generalised reciprocity that is the highly productive component of social capital, and that it is most likely to be associated with dense networks of social exchange. However, like many scholars around the world, he laments the declining trust among people in the United States over the last four decades (Putnam, 2000). Scholars similarly confirm that generalised trust is ebbing, especially within Third World contexts where people are suspicious of government, fear crime and mistrust politicians and each other (Fattore, Turnbull and Wilson, 2003; Burchell and Leigh, 2002; Putnam, 2000). One of the reasons for this generalised decline in trust in society is related to a general decrease in social capital. Thus, an increase in social capital will lead to increased levels of trust through associational life and civic engagement (Yip et al., 2007; Herreros, 2004; Fattore et al., 2003; Putnam, 2000; Coleman, 1994). Herreros (2004) places emphasis on the role of the state in creating social capital. Hooghe (2002) on the other hand, claims that social capital studies that focus on trust should rather focus more on reciprocity since it is a weaker, more procedural norm than that of trust, which requires a degree of normative consensus. It can therefore be adapted to function better than trust in divided, plural and increasingly diverse societies. These points are analysed in Chapters 6 and 7 of the thesis.

Robert Putnam's (1993) initial analysis of the concept, in his book *Making Democracy Work* is regarded by many to be *the* source for defining the concept of social capital. Today it is fair to say that most people have come to know of the concept by way of Putnam (Grix, 2001). The Entabeni partnership study draws on and is situated within the theory of networking described by Putnam (2000) and Woolcock (2001) as it relates to bridging social capital, described in the following section. I also draw on the more recent works of Moore, Haines, Hawe and Shiell (2006), who have built on Putnam's (2000, 2007) theory of networking and who advocate for a social network approach to social capital. They maintain that the network approach allows for an assessment of, and understanding of issues related to the quality and impacts of social relationships, access to resources and the broader macro effects of class, gender, race, and age on individual and group networks, and thus health outcomes.

Putnam popularized the concept of social capital by linking it to a number of major public policy concerns. In his 1993 study of the comparative effectiveness of regional government in Italy, Putnam adapted Coleman's approach and defined social capital as "*features of social organisation*", comprising three components:

1. social networks (especially voluntary associations),
2. moral obligations and,
3. norms and social values (especially trust) that facilitate the process of people working together to achieve shared objectives.

His central thesis is that a region with a well-functioning economic system, a tradition of civic engagement, citizen participation and high levels of political integration is a result of the region's successful accumulation of social capital (Siisiäinen, 2000), one that will contribute to an effective and democratic government (Grix, 2001). Putnam identifies the key source of social trust to be embedded in the *norms of reciprocity and the networks of civic engagement* that is measured by a person's participation in social groups like the Rotary club, bowling club, etc. Through their participation in these groups, people are introduced to the rules and democratic principles held by these associations and they often then feel encouraged to become more involved in the political and democratic processes of society (Putnam, 2000).

A major paradigm shift in social capital was spearheaded by Michael Foley and Bob Edwards (1999) who advocate for a *context dependent* conceptualization of social capital, arguing that social capital is embedded within specific *social contexts* which influence the means by which it is accessed and how is used. This conceptualization was built upon by Maloney, Smith and Stoker (2000) who, borrowing from the work of Coleman (1988, 1994), emphasized the role played by *political structures and institutions in shaping contexts of associational life*. Again, the notion of *context* becomes particularly relevant to the Entabeni partnership study and to an understanding of the process and outcomes of the development of bridging social capital in this community. A detailed review of the contextual features that provided the backdrop for, and influenced the Entabeni partnership study, is presented in Chapter 2 of this thesis.

I also draw, in my implementation and analysis of the Entabeni study, on the recent works of Woolcock (2002) and Grix (2001), who, together, have contributed to a new paradigm, which Grix (2001) refers to as the ‘Post-Putnam’ school and, which focuses on:

- *access* to specific stocks of social capital in society by individuals or groups
- acceptance of an uneven distribution of and access to social capital resources in society across class and groups (*power inequalities*)
- *qualitative research* methods involving interviews and small scale targeted surveys, enabling an in-depth understanding of the actors perceptions of their relations with others; hence moving away from a focus on quantity of associations as opposed to quality of relations between individuals, groups, institutions, etc.
- the *role of governance* in influencing the form and access to social capital

3.2.2. Social networks – bonding, bridging and linking social capital

The literature on social capital generally distinguishes between three specific types of networking⁷ that are necessary to achieve a healthy and prosperous community (Szreter and Woolcock, 2004; Putnam 2000; Campbell, 2003; Kim, Subramanian and

⁷ Formal and informal networks are central to the concept of social capital. They are defined as the personal relationships which are accumulated when people interact with each other in families, workplaces, neighbourhoods, local associations and a range of informal and formal meeting places.

Kawachi, 2006). These include bridging, bonding and linking social capital. In a study done by Kim et al., (2006:116) in 40 communities in the United States to measure the effects of different forms of social capital on health, they concluded that, “*Interventions and policies that leverage community bonding and bridging social capital might serve as means of population health improvement.*”

I acknowledge the value of bonding social capital for improved community health, having focused largely on facilitating this aspect of social capital in the broader Entabeni project discussed in Chapter 2 of the thesis. However, my focus in this thesis is on *bridging social capital* and the process of facilitation of bridging social capital in the form of the Entabeni partnership process to jointly manage HIV and AIDS in Entabeni.

Bonding social capital refers to the relationships and social cohesion between homogeneous groups (such as youth groups, religious or socioeconomic groups), who often share similar ethnicity, social status and location. It is based on local ties, trust and shared moral values and reinforced by working together (Beugelsdijk and Smulders, 2003; Campbell, 2003; Putnam, 2000).

The second type of social capital is *bridging social capital*. It refers to the structural relationships and networks that cross social groupings. It often involves coordination or collaboration with external associations that serve as mechanisms of social support or information-sharing across communities and groups (Kim et al., 2006; Beyerlein and Hipp, 2005; Turner and Nguyen, 2005; Vidal, 2004; Woodhouse, 2006; Narayan, 1999). More recently, Putnam (2007:143) defined bridging social capital as “...*ties to people of a different generation or a different race or a different gender*”. These types of linkages to outside resources can become crucial to the survival of the individual or community (Engeström, 2001; Putnam, 2000) and it is these contacts with different groups or networks that is positive (Beyerlein and Hipp, 2005; Turner and Nguyen, 2005; Vidal, 2004; Woodhouse, 2006; Beugelsdijk and Smulders, 2003).

The third type, *linking social capital* refers to the links and relations that are forged between individuals and groups that belong to different social strata. These links facilitate access to useful resources or to influence policies (Dahal and Adhikari,

2008; Woolcock, 2002; Putnam, 1993; Pretty 2003). Linking social capital crosses status, linking poor people and those in positions of influence.

Putnam proposes that while bonding social capital is good for "getting by" it is bridging social capital that is crucial for "getting ahead" (Putnam, 2000). "*Bonding capital is good for under-girding specific reciprocity and mobilizing solidarity... Bridging networks, by contrast, are better for linkage to external assets and for information diffusion.... Moreover, bridging social capital can generate broader identities and reciprocity, whereas bonding social capital bolsters our narrower selves.... Bonding social capital constitutes a kind of sociological superglue, whereas bridging social capital provides a sociological WD-40*" (Putnam, 2000: 22-23); hence while horizontal ties are needed to give communities a sense of identity and common purpose, bridging ties transcend various social divides (e.g. religion, ethnicity, socio-economic status) and is crucial for community health and wellbeing (Dahal and Adhikari, 2008; Kim et al., 2006).

It is noted that Putnam did not really interrogate linking social capital at length or come to grips with the implications or the different outcomes that different combinations of the three types of social capital will produce (Field 2003). For the purposes of this thesis, I draw on aspects of what he refers to as linking social capital in my reference to bridging social capital, interpreting links and access to external networks as bridging social capital, as done by other scholars (O'Brien, Phillips, and Patsiorkovsky, 2005; Larsen, Harlan, Bolin and Hackett, 2004; Beugelsdijk and Smulders, 2003;).

The value of *bridging social capital* is inherent to the notion of getting ahead since it facilitates networks to external groups with power and access to resources. It is commonly known that if one wants to gain access to scarce resources or good jobs, one should acquire memberships to exclusive clubs, etc., since one usually has to know people in 'high places' that have the power and inside contacts to make this possible. Hence '*it's not what you know but who you know*' that forms the basis for much of the conventional wisdom of social capital theory (Coffé and Geys, 2008; Beyerlein and Hipp, 2005; Turner and Nguyen, 2005; Vidal, 2004; Woodhouse, 2006; Woolcock and Narayan, 2000; Campbell, 2003; Szreter and Woolcock 2004). The

discussions in Chapter 5, 6 and 7 of this thesis support the notion that, “*Social networks provide direct access to both resources and information. They also constitute the most proximate spheres of interaction in which individuals come to perceive resources to be both available and valuable*” (Foley and Edwards, 1999:167).

Interestingly, in cross-sectional studies conducted with residents from disadvantaged, predominantly minority communities in Birmingham, Alabama (Mitchell and LaGory, 2002), and additional studies conducted in Baltimore, Maryland (Caughy, O'Campo, Muntaner, 2003), and Adelaide, Australia (Ziersch and Baum, 2004), findings suggest that stronger *bonding ties* within disadvantaged communities may be detrimental to the health of residents while *bridging social capital*, (measured by the strength of trust and associational ties between people of a different race and educational background as the respondent), was associated with lower levels of mental distress. The following section examines this in detail.

3.2.3. The downside to social capital

A discussion of the virtues of social capital cannot be devoid of a discussion of its possible vices. Despite a general acceptance in the literature that social capital, in the form of networks and social ties, is immensely beneficial in facilitating access to resources and collective problem solving, several scholars have highlighted its possible drawbacks as well. I elaborate on the common criticisms levelled against the concept in the literature, narrowing in on a critique of the social capital-health link, for the purpose of this study.

Aside from the fact that the term social capital has been extensively criticized for basically becoming “...*a catch-all phrase, like civil society, that is impossible to pin down, but regarded as somehow desirable*” (Grix, 2001: 191), one of the downsides to social capital is that it can also be open to varying interpretations by decision-makers and policy-makers, which in turn could have negative implications for resource-poor communities and economically disadvantaged people.

Social capital researchers have also been criticized for ignoring the possible negative outcomes of social capital (Kawachi et al, 2004; Szreter and Woolcock, 2004). The

negative impacts of bonding social capital for individuals and general community well-being has been especially interrogated and criticised. Close-knit communities with strong bonding social capital can expose community members to restrictive societal regulations and sanctions that limit innovation and individual entrepreneurship. Findings from studies done by Mitchell et al., (2002), Caughey et al., (2003) and Ziersch et al., (2004), (see 3.2.2.), also suggest that closer ties with neighbours can have a negative effect on the health of residents, especially in deprived communities. This could be linked to the notion that in disadvantaged communities, stronger bonding ties may involve greater expectations to assist neighbours, causing greater financial and mental strain. By implication, health within such communities is best promoted through their access to resources outside the immediate community, facilitated through bridging networks (Kawachi and Kennedy, 2006; Kawachi, 2006; Ziersch and Baum, 2004).

In addition, Portes (1998) warns against underestimating the ability of a community with strong bonding social capital in resisting outside 'interference' and intervention or in blocking members of historically oppressed groups from participating in mainstream society. This can range from community resistance to the implementation of public measures, to a group like the Ku Klux Klan who have an abundance of social capital (shared norms facilitate the achievement of cooperative ends), but whose beliefs have negative externalities for the society within which they are embedded (Landry, Amara and Lamari, 2001; Fukuyama, 1999; Narayan, 1999).

More generally, Davies (2001) criticizes the concept for being gender-blind and ethnocentric, while Sixsmith, Boneham and Goldring (2003), argue that most of the literature on social capital is based on secondary data analyses not primarily established for social capital. I respond to this gap in the literature, providing primary, empirical data on the facilitation of bridging social capital within a South African context which I describe in detail in Chapters 5, 6 and 7 of this thesis.

The state – market – social capital link has also come under fire. Decision-makers who adopt the neo-liberal doctrine will favour the market and use social capital to justify privatization or the reduction of public services to the detriment of the social aspects of society (Fukuyama, 1999; Landry, Amara and Lamari, 2001). Baum (1999)

warns against social capital accumulation being left to the market in poor communities, emphasising that it will accentuate the inequities that already exist between the more affluent and the poor. “*Social Capital should not be seen as a substitute for economic investment in poor communities nor as a panacea for socio-economic hardship. Yet seeing it in this way would be particularly attractive to governments who wish to reduce state spending on welfare*” (Baum, 1999:177). On the other side of the coin, for those decision-makers that support social justice and community aspects of society, social capital will be seen as a goal to increase state intervention and control of the market to ensure that inequalities and social injustice are reduced.

With regards to the social capital/health link, while much has been written about the value of social capital for community health (Kawachi and Kennedy, 2006; Sretzer and Woolcock, 2004), academics and interventionists are cautioned against looking at it too narrowly (Pearce and Smith, 2003). Even its most eager supporters have pointed to its limitations, indicating that its value for health has yet to be firmly established (Islam, Merlo, Kawachi and Lindström, 2006; Wakefield and Poland, 2005; Kawachi, Kim, Coutts and Subramanian, 2004). Baum’s (1999) critique of the literature on social capital and health revolves around *romanticizing* the notion that close knit communities, with strong bonding social capital, are necessarily healthy communities. He believes that some of these socially cohesive societies can also be exclusionary and distrustful of outsiders and therefore not be healthy for those perceived as *outsiders* (Fukuyama, 1999). Labonte (1999) indicates that while some scholars have shown much enthusiasm and optimism about the concept and its application to the health field, others have adopted a more sceptical view of social capital, believing that it is very similar to what health promoters and community organizers have been doing all along. Optimists on the other hand, are excited about its ‘revolutionary potential’, in the link it makes between social relationships and thinking about society.

Pearce and Smith (2003), recommend that health researchers analyse the community level social capital/health link from a broad perspective, within the context of the macro-level policy impacts on community health, rather than looking at it in isolation. Ignoring this link could result in ineffective social policy, and, at worst, be harmful to the health of communities and individuals. Since many questions remain unanswered

around the interrelations between social capital and health, Islam et al (2006) recommend a more careful, and continued exploration of this concept to give future direction to policy development and health-service delivery.

The concept has also been criticized for being seen as an avenue for introducing aspects of the social into (economic) development policy (Kawachi and Kennedy, 2006) while also adopting an economic, neo-liberalist approach to viewing social relations, in a way that transforms social movements into “*community development organisations seeking to harness ‘grassroots empowerment’ for the competitive workfare state*” (Mayer and Rankin, 2002:804). Critics have gone so far as to imply that the popularity of the concept for some (policy makers, public sector), lies in the potential for it to be a cheaper option than pursuing the goal of reducing income inequalities. This kind of thinking has an element of ‘victim-blaming’, where poor people are seen as responsible for being unhealthy because of their lack of participation in community/civic activities (Campbell, 2000).

3.3. Partnerships for HIV and AIDS management

Having reviewed the social capital literature and noting the criticisms levelled against the concept, I argue that local efforts to manage HIV and AIDS in marginalised communities cannot succeed without effective and supportive bridging networks between these communities and more powerful, often externally situated, groupings. Putnam (2000) and Woolcock (2001) refer to these links between communities and outside agencies with economic and political power as bridging social capital (discussed above). 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. The Entabeni partnership project sought to facilitate community access to such networks, which, as I have already mentioned, is a key feature of an AIDS competent community (see Chapter 2) where residents are best placed to respond appropriately to the epidemic (Lamboray and Skevington, 2001; Campbell et al., 2007). I argue that while partnerships occur for many reasons, for marginalised, resource-poor communities like Entabeni where capacity is scarce and access to essential services a challenge, partnerships can provide the ‘glue’ to connecting and influencing fragmented services (Lasker, 2000; McLaughlin, 2002), facilitating access

to scarce resources (Vangen and Huxham, 2005) and strengthening a community's capacity to improve their health and facilitate development (Dale and Newman, 2008; Chavis, 2001).

Below I provide a review of the literature on partnerships, focusing on the various empirical contributions to the process and challenges of facilitating partnerships, discussing the partnerships/health/HIV and AIDS link and how it relates to the Entabeni partnership study.

3.3.1. Partnerships, community participation and HIV and AIDS

A substantial literature deals with the role of partnerships in addressing the complex health and social challenges confronting all sectors of society (DeFillipi and DiSorbo, 2006; El Ansari and Philips, 2004; Snape and Taylor, 2004; Campbell, 2003; Gray, 1989). The global dialogue on the challenges eroding development and positive social change increasingly cites partnerships as a strategy for tackling the 21st century health challenges (Sanders and Baisch, 2008; DeFillipi and DiSorbo, 2006; Snape and Taylor, 2004; El Ansari and Philips, 2004; Lasker, Weiss and Miller, 2001). The general thrust behind this approach (applicable to this thesis) is that there are limits to what people can do on their own, especially communities that have been ravaged by the AIDS virus and whose normal support systems and networks have been weakened by the epidemic (DeFillipi and DiSorbo, 2006).

However, and as illustrated above, much of this literature focuses on US or UK contexts, very different to remote rural South Africa (e.g. Sanders and Baisch, 2008; Scott and Thurstone, 2004; Roussos and Fawcett, 2000). In the UK, the language of partnerships has become entrenched in public sector policy, reflecting a desire to move toward a more integrated, multi-sectoral and multi-professional approach to service delivery, based on the assumption that this approach will improve service delivery and outcomes (Tizard, 2008; Atkinson, 2005; Dowling, Powell and Glendinning, 2004); hence public policy discussions in the UK now focus on how to make partnerships work rather than debating whether partnerships is the best choice for working in particular situations and contexts. McLaughlin (2002:1) sums up the general support for partnerships with the following quote: *“To argue for the importance of partnerships is like arguing for ‘mother love and apple’-partnerships*

have an inherently positive feel about them and it is almost heretical to question their integrity”.

Closer to home, much more attention is now being focused on the role of public-private partnerships as a strategy for furthering public health goals in developing countries at policy level (e.g. South African Government, 2003; UNAIDS, 2006) and by academics (e.g. Haider, 2003; Nishtar, 2004; Richter, 2004). Dr Olive Shisana, the head of the Human Sciences Research Council in South Africa has supported this call, urging government to hear the resounding message that innovative partnerships, involving a collaboration between key stakeholders from the public, private, and civil society sectors, is crucial for meeting the target set by African heads of government to manage HIV and AIDS effectively, and “.. *change the socio-cultural context that makes it difficult for people to adopt safe sex practices*” (Shisana, 2007:2). However, while this may be ideal for promoting joint management of HIV and AIDS, this study will show that remote communities like Entabeni may lie beyond the reach of the private sector. Thus, the reality within such a context may call for an adjustment of the ideal, and an adaptation to what is realistic, possible and doable. Chapter 6 discusses the position taken by the Entabeni partnership participants with regards to the input of the private sector in the Entabeni partnership process.

There is also a literature on partnerships between development agencies in the North and deprived communities in the South (Lewis, 1998; Eyben, 2006). This is also not appropriate for the Entabeni context, with the partnership 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). As already indicated (see Chapter 1), the Entabeni partnership process was based on the premise that partnerships to support grassroots responses to HIV and 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 collaborative work by outside professionals (Jewkes & Murcott, 1998; Campbell, 2003). Thus, this approach advocates for the partnership model to move away from

focusing on service delivery that works on *behalf of the people* (intervention model) to a focus on facilitating change through the active participation of grassroots people (marginalised community) in bringing about change (Gillies, 1998; Lamptey and Gayle 2002; Campbell, 2003).

There is much support for this in the partnerships literature, with many compelling reasons provided for the centrality of *community participation* in resolving long-term health and development-related challenges within local contexts. Philosophically, communities have the democratic right to contribute to the issues and services that affect them. Practically, the health and development related problems that affect communities cannot be realistically resolved by any one person, community or organisation on their own, since these problems are usually complex and interrelated and beyond the capabilities of one entity acting alone (Jewkes & Murcott, 1998; Lasker and Weiss, 2003; Kreuter, Lezin and Young, 2000; El Ansari and Philips, 2004). Grassroots participation in finding collaborative solutions to community based challenges has the potential to garner the support, acceptance, and credibility of programmes being facilitated in the target community (Kreuter et al., 2000), ensure community ownership of the project, shared responsibility of local health and development problems (El Ansari and Philips, 2001a; Fawcett et al., 1995), and contributes to the sustainability of community interventions for this purpose (Altman, 1995). Hence, ignoring *community perspectives* and downplaying their involvement can jeopardize more top-down and technocratic interventions (Kreuter et al., 2000). Instead, strategies that engage with community stakeholders and incorporate their competencies and strengths have had some of the most significant health related success stories (Kreuter, Lezin and Young, 2000). The World Health (WHO) organization has basically rubber stamped 'community participation' as a central strategy for health promotion globally (Jewkes & Murcott, 1998; WHO, 2008). In summary, putting community members at the centre of collaborative partnerships is vital to the long-term health and welfare of grassroots communities (El Ansari and Philips, 2004; Provan, Veazie, Teufel-Shone and Huddleston, 2004).

Aside from the literature reviewed, which highlights the value of community participation and partnerships, I present three bodies of research on partnerships which I believe is most directly relevant to the partnership study presented in this

thesis. 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), the 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, highlighting the need to supplement surveys with more qualitative research (El Ansari and Weiss, 2006). The Entabeni case study locates itself within this gap in presenting a longitudinal qualitative case study of the challenges facing an HIV and AIDS-related partnership aiming to strengthen local responses to HIV and AIDS in a rural community.

The second body of relevant research is that on *municipal-community partnerships* in South Africa, which discusses some of the complexities of promoting partnerships between local municipalities or local government as they are often referred to, and communities in the area of poverty alleviation. In South Africa, local municipalities, which are the closest sphere of government to communities, have been mandated to fulfil a *developmental role* in communities (White Paper on local government, South Africa, 1998, 17) by responding to the challenges of HIV and AIDS in a sustainable manner and thus improving the quality of life of its citizens. This new developmental role is based on the basic tenets of *strong leadership*, *transparency* and the creation of *effective partnerships* with stakeholders from communities, the public and private sector in responding to HIV and AIDS (Swartz and Roux, 2004). However, studies also highlight huge internal resource and capacity challenges as key obstacles to responding to the epidemic and building successful partnerships (Cranko and Khan 1999; Fourie, 2006; Swartz and Roux, 2004; Van Rooyen, 2003). In one of these studies, which assesses the impact of a municipal HIV and AIDS project in South Africa, recommendations were made for them to receive an injection of capacity from other government departments, to form co-operative ventures with the private sector and other partners and to strengthen their home-based care programmes (Swartz and Roux, 2004).

The third 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. In this study she highlights some of the complexities of implementing the

ideals of community participation and partnerships in real life, including power differentials between community stakeholders and project managers, a mistrust of project researchers by the community stakeholders, a lack of accountability between project stakeholders and project beneficiaries, poor communication between stakeholders, personality clashes and conflicts of ideology and project co-ordination. Based on this study, Campbell (2003) developed a framework highlighting five features of an effective partner: a *commitment* to HIV and AIDS management and the partnership, the *conceptualisation* of HIV and AIDS as a social development issue, the *incentives* to participate in the partnership and mechanisms for partner accountability to target communities, and the 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. I make reference to and incorporate this framework in the analysis of the findings from the Entabeni partnership study, discussed in Chapters 5, 6 and 7 of the thesis.

3.3.2. Partnerships as a process of networking and relationship building

“The collaboration inherent in a partnership is more than a mere exchange—it is the creation of something new, of value, together” (El Ansari and Philips, 2001b:232). The creation of these collaborative partnerships is considered to be an emergent, dynamic and multifaceted process (Gray, 1989; El Ansari and Philips, 2004), requiring considerable investments of time and material resources (DeFillipi and DiSorbo, 2006), and needs nurturing in order to grow and develop (Gardner, 2005; Vangen and Huxham, 2003). Hence, the notion that partnership-building is entrenched in *trusting relationships* (Lasker, 2000; Putnam, 1995; Nelson, Prilleltensky and MacGillivray, 2001), that provides both the *glue* and the *lubricant* for partnership functioning- a basic requirement for facilitating and holding partnerships together (Bryson, Crosby and Stone, 2006). El Ansari and Philips (2001b), contributes to the assertion that partnerships are synonymous with relationships, i.e. *formal structures of relationship* between individuals and groups that work together for a common purpose. It goes without saying then that fostering real partnerships needs huge investments of time in building relationships based on trust between stakeholder partners, throughout the lifespan of the partnership (Kreuter, Lezin and Young, 2000). *“Trying to leapfrog past the important phase of building trust with key stakeholders*

risks damaging or significantly delaying even the best intentioned initiatives” (Potapchuk, Crocker and Schechter, 1997:39).

Being a process, partnerships graduate through progressive developmental stages that can be interrupted or enhanced by internal and external forces which may in turn impede the cycle of the partnership process. An understanding of these developmental phases and the circumstances that necessitate its progression through these phases can increase ones understanding of partnerships, thereby improving the likelihood of building successful collaborative relationships between partners (Gray, 1989). These developmental phases, while variously described in the literature and differentiated by the context within which they are implemented, share common and generally applicable characteristics and principles (Wildridge, Childs, Cawthra and Madge, 2004). Some of these descriptions of process include McLaughlin’s (2002) observation of the partnership process as moving through a continuum, beginning with *isolation*, progressing to *encounter*, *communication*, *collaboration* and finally *integration*.

Bryson et al. (2006), provides a comprehensive description of the partnership process based on an extensive review of the partnership literature. They focus on six aspects which they identify as common to partnership processes:

- *forging initial agreements* around the problem definition and purpose of the partnership;
- *building leadership* by allocating formal and informal leadership positions to participating partners;
- *building legitimacy* of the partnership as a form of networking organisation with local and external stakeholders;
- *building trust* through relationships which is an ongoing requirement for successful partnerships (discussed above);
- *managing conflict* which primarily revolves around issues of power and should therefore involve tactics to equalize power among partners; and
- *planning* within partnerships may be deliberate and emergent as may occur with mandated partnerships or emergent as is often emphasized in non-mandated partnerships.

Gray (1989) adds to the body of literature that defines partnership as a process, by providing a very useful but concise summary of a three stage process through which partnerships progress.

- Phase 1 begins with *problem-setting* – defining the problem and committing to partnerships as a strategy for addressing the problem; choosing appropriate stakeholders and establishing levels of individual stakeholder participation; identifying the facilitator or convenor of the process and the resources needed.
- Phase 2 moves to *direction setting* – establishing ground rules which include mutual respect and openness; deciding on an agenda, the process of collaboration and what must be done and then moving on to exploring various options available; obtaining information and finally reaching an agreement.
- The final phase is *implementation* – obtaining agreements from the constituents of each participating organisation and acquiring external support; putting in place the required structures and changes needed; monitoring all activities and ensuring compliance.

I incorporate the general principles and characteristics of these accounts of the partnership-building process in my analysis of the research questions mentioned in Chapter 1 of the thesis (partnership process, challenges and enablers), but lean more towards El Ansari and Philip's (2001b) description of the partnership process, since their model is based on research undertaken with partnership interventions in South Africa, involving the collaboration of community and professional stakeholders around the issue of community health challenges. I also incorporate the partnership model developed by Kreuter et al., (2000), who similarly describe partnerships as progressing through four phases (mentioned below), but adds on a *pre-formation* stage, which precedes the *formation* stage, as described by El Ansari and Philips (2001b) below. I reflect largely on this body of work when synthesizing and describing the results of the Entabeni partnership process in Chapters 5, 6 and 7 of the thesis.

El Ansari and Philips (2001b) description of the developmental stages of partnership process begins with:

1. the *formation stage*, where funding is secured and committees are formed. During this stage, organisational participants come together and identify a common purpose and issues to be addressed by the partnership, appoint a leader and mobilize resources, signifying the formation of the partnership.
2. This then gives way to the process of *implementation*, which involves an assessment of the constituency's concerns and a development of intervention plans.
3. The *maintenance* phase involves a process of supporting the life of the partnership, monitoring and continuing with partnership activities.
4. The *outcome* stage encompasses the impacts made by the partnership.

As already indicated, Kreuter et al., (2000), add a *pre-formation stage* to the partnership process described above. This involves an initial needs assessment, as done with the Entabeni project (reported on in Chapter 2), the collection of relevant data and the convening of planning groups. They also note that while partnership processes are often described as progressing through a sequence of stages, there is often considerable overlap between these stages. For example, while most of the programme planning may occur during the maintenance stage, the need for planning may surface during the formation stage as well. This concurs with the findings in the Entabeni partnership study, which responds to research question 2 (see Chapter 1) and is discussed in detail in Chapters 4, 5, 6 and 7 of the thesis.

3.3.3. Factors inherent to partnership success: what are the enablers, what are the challenges?

Having extolled the virtues and value of collaborative partnerships in responding to the major community health and development challenges that confront us today, in this section I present a review of the many challenges and possible enablers in building effective partnerships. This feeds into and contributes to my analysis and discussion of research questions 3 and 4 (see Chapter 1), which is discussed in Chapters 5, 6 and 7 of the thesis.

Evidence confirms that many partnerships fail in their first year of life, and if they do survive beyond this, they often experience major challenges in implementation or the pursuance of development plans (Kreuter et al., 2000; Lasker et al., 2001). Some

attribute this to the challenging but essential focus on a process of relationship building and trust between partners, together with work strategies and structures that are unfamiliar and different to that which individuals and organisations are accustomed to (Lasker et al., 2001; Gray, 1989), highlighting the care needed in planning and implementing successful partnerships.

The interconnectedness of issues like health, which were previously considered narrowly but are now being redefined in broader, more all-encompassing terms, to include economic issues, migration policy, education, welfare, etc., is a disconcerting notion not easily embraced by traditionalists. The adoption of partnerships as a necessary and new strategy for service delivery is even more disconcerting and challenging; hence attrition rates in partnership processes tend to be high. The partnership-building process is also costly, and documenting improvements in community health is difficult (Lasker, 2000; Kreuter et al., 2000). Boudreau (in MacGillivray and Nelson, 1998) articulated these challenges well when he said that “*partnership is a solution that comes with many problems.*”

What follows is a focused summary of the factors, as highlighted in the literature that could contribute to partnership success if they are incorporated into the process of partnership-building. I also mention possible challenges to the path of partnership success, drawing lessons primarily from the three bodies of literature which, as already mentioned, are considered to be most relevant to this study – the research on municipal-community partnerships’ in South Africa (Cranko and Khan 1999; Fourie, 2006; Swartz and Roux, 2004), Campbell’s (2003) Summertown project in a mining community in South Africa, and the works of El Ansari and his colleagues (2001; 2001a; 2001b; 2001c; 2002; 2003; 2004; 2005; 2006). I also make reference to other relevant empirical studies sighted in the academic literature on partnerships. It is important to note that while I discuss these factors under separate categories for the sake of clarity, they are interrelated and feed into one another in determining how each partner responds to and displays the qualities and criteria highlighted as necessary for achieving partnership success:

3.3.3.1. *Representation* within the partnership, its composition and diversity, who is recruited, who stays, who attends meetings and what they bring to the partnership in terms of resources, skills, power and credibility will influence the process of

development of the partnership and the achievement of partnership goals. It is said that a fair representation of all stakeholders that are closest to the problem/issue (in this instance HIV and AIDS management in Entabeni), will facilitate support among partners through a sharing of strengths and capabilities (El Ansari and Philips, 2001a; Lasker, 2000; Popay and Williams, 1998; Walker, 2000; McLaughlin, 2002), and contribute to project sustainability. “*Wide representation of all stakeholders and a strong membership base is critical as a means to increase the critical mass behind the partnership, to build trust and enhance relationships, and to invoke citizen participation and advocate for participants interests*” (El Ansari and Philips, 2001a:123). Chapters 5 and 6 of the thesis present a detailed description of who the representatives were in the Entabeni partnership study and the value they added to the achievement of partnership goals.

3.3.3.2. A long term *vision* and *clear objectives* of what the partnership hopes to achieve is valuable for giving direction to, and clarifying the process of partnership-building and goal achievement, contributing to transparency and aligning the expectations of partners (Salmon, 2004; Roussos and Fawcett, 2000; El Ansari and Philips, 2001c; Gray, 1985; Boex and Henry, 2001). Organisations will also be more likely to be involved and committed to the process and clear objectives may maintain a sense of equity among partners (El Ansari and Philips, 2001a). This process often occurs at the very beginning of the partnership development process.

3.3.3.3. A *sense of ownership and commitment* to the partnership must be instilled in partners from inception, through the process of mutual involvement in the creation of the partnership (El Ansari and Philips, 2001a; Salmon, 2004), and shared decision-making and ownership of the partnership’s triumph’s and failures. This sharing may lead to a greater understanding of and *commitment* by partners to the process of partnership-building (El Ansari and Philips, 2004; Campbell, 2003; Gray, 1985), ensuring its durability and the achievement of partnership goals; hence partnerships are more likely to persevere and remain intact if the commitment of their members to the partnership is strong. However, levels of commitment among partners often differ and fluctuate according to the nature of the partner (paid/volunteer), the support each partner receives from their employees or organisations (Lasker, 2000; Campbell, 2003; Kanter, 1994), and other factors specific to each partner (El Ansari and Philips,

2001c). This often results in a variable investment of time, effort and resources by partners (Campbell, 2003; El Ansari and Philips, 2001b; DeFillipi and DiSorbo, 2006), and differences in the sense of enthusiasm shown towards the partnership, which is reflected in their behaviours and beliefs about the partnership (Dowling et al., 2004).

3.3.3.4. The stability and growth of a partnership arrangement depends substantially on the *capacity* of partners to make meaningful contributions to the partnership (Campbell, 2003), and benefit from the diversity of partners in achieving objectives that cannot otherwise be accomplished (El Ansari and Philips, 2001a; Lasker, 2000; Fourie, 2006; Swartz and Roux, 2004). One of the key benefits accrued to individuals and organisations participating in partnership processes are the chance to learn through ‘knowledge transfer’ between partners, and through the creation of knowledge over time, achieved through the process of change facilitated by the partnership (Hibbert and Huxham, 2007).

3.3.3.5. *Incentives* for participating in partnership processes are very closely linked to all the other factors discussed above and below, and are, to a huge extent, the ‘make or break’ of a partnership, since these largely determine the motivational drive behind individual and organisational participation (El Ansari and Philips, 2004). Incentives must be assessed from an individual, as well as organisational perspective, since a partner’s participation in the partnership is driven by the need to satisfy/meet individual level goals as well as organisational and partnership goals (Lasker, 2000; Campbell, 2003). As elaborated by Walker (2000:29), “...every organisation must get something out of the package of agreements and tasks”. Thus, collaborative activity between organisations and communities must have built in incentives for both individuals and organisations to motivate them to participate (Rugg, Novak, Peersman, Heckert, Spencer and Marconi, 2004).

3.3.3.6. As elaborated on earlier, building *relationships* based on trust and respect for one another and facilitating *social capital* among partners is crucial to inter-organisational collaboration (Salmon, 2004; Lasker, 2000; Campbell, 2003; El Ansari and Philips, 2001a; Gray, 1985). Closely tied to relationship building is *effective communication* between partners and participating organisations, a central tenet to

collaboration (Walker, 2000; El Ansari and Philips, 2001a; Salmon, 2004). Poor communication or a breakdown in communication between partners can radically affect partnership relationships (Salmon, 2004). Since efforts to foster respect and trust between partners and facilitate the development of social capital can be very challenging, effective protocols and explicit policies to facilitate inter-organisational communication, and the sharing and exchange of information, can enable the process to partnership success (Walker, 2000). This will not only reduce their feelings of isolation, but create greater awareness around issues that affect them (El Ansari and Philips, 2001a). Keeping partners in the loop through direct and frequent communication that is accurate about the information needing to be communicated, and using a combination of methods of communication (oral communication, newsletters, reports, etc.) goes a long way in contributing to improved networking, healthy communities and partnership success (Gillies, 1998). These factors, including those mentioned previously and below, were fundamental to the Entabeni partnership-building process, and is discussed in the analysis of process, challenges and enablers (research questions 2, 3 and 4), and fed into research questions 1, 5 and 6, which is discussed in Chapters 5, 6, 7 and 8.

3.3.3.7. Defining what *accountability* means within the partnership and holding partners accountable is crucial for achieving goals and partnership success (Blagescu and Young, 2005; Campbell, 2003; Dowling et al., 2004; Roussos and Fawcett, 2000). In a mutually beneficial, equitable partnership, partners need to monitor their accountability to one another, to their employees and to the community. Accountability is said to increase when stakeholder partners participate actively in the partnership-building process, since the *lived experience* not only enhances partner skills and equitable decision-making, it also fosters respect and a sense of accountability (Blagescu and Young, 2005; Couros, 2003).

3.3.3.8. *Power* dynamics and *conflicts* between partners are critical to an understanding of why partnerships work or fail. These power imbalances among collaborating partners, as already elaborated on in the social capital literature (Bourdieu, 1986), can pose one of the biggest challenges to attaining effective partnerships (Huxham and Vangen, 2005; El Ansari and Philips, 2001b; Campbell, 2003; McLaughlin, 2002). Differences in the status, power, organisational culture,

norms and traditions of participating partners and organisations, or threats to the professional status, autonomy or control of some partners (Diamond, 2002; Glendinning, 2002), are just some factors that may cause tension or conflict in a partnership. Ignoring or downplaying these differences and conflicts, inherent to partnership processes, may lead to difficulties in the development of good working relationships among partners or in meeting partnership objectives. The issue of *power* is taken up in the discussion of findings relating to the role of the community partners (Chapter 5) and the external partners (Chapter 6).

3.3.3.9. Finally, *leadership*, the role often assumed by the facilitator of the partnership, (Lasker, 2000), is another factor that is crucial to the success of the partnership (Dowling et al., 2004; Bryson et al., 2006; Carter, 2000; El Ansari and Philips, 2001a), and in facilitating community and systems change (Roussos and Fawcett, 2000). Huxham and Vangen describe leadership as “...*what makes things happen*” (2005:202). In this thesis, I refer to the leader as the external change agent or facilitator, the role assumed by the author of this thesis (see Chapter 7 for a detailed discussion of the role of the external change agent in the Entabeni partnership). The leader is often the person responsible for bringing individuals and organisations together in a partnership-building process, facilitating negotiations in the partnership and ensuring that progress happens. According to Walker (2000:28), “*Without such a person working in its heart a fledging collaboration is likely to make slow progress, if any at all*”. Hence ‘leadership’ requires a high level of skills and tenacity, since the complex nature of partnerships makes the process of facilitation and relationship building a formidable task (Gardner, 2005; Nair and Campbell, 2008).

As already mentioned, in Chapters 5, 6 and 7 of the thesis, I draw largely from the above literature in analysing the findings of the Entabeni partnership, guided by the research questions. I highlight similarities between the Entabeni study and the reviewed literature, but feed into and add a whole new dimension to the factors mentioned based on the findings from the Entabeni partnership-building process.

3.4. Conclusion

Due to the pioneering efforts of James Coleman, Robert Putnam and Pierre Bourdieu in establishing the idea of *social capital*, few people in social science circles need

convincing of the importance of *trust-based relations* in social and economic life. The cohesive quality of trust and the opening up of opportunities and mutual support through *social networks* is now seen as a form of capital that all societies need to promote. While there is acceptance that *bonding* social capital needs to be tempered by *bridging* and *linking* social capital to foster relations between and within social groups, a focus on *bridging social capital* can be used as leverage by resource-poor communities to *access resource-rich social networks* to generate increased stocks of social capital for the purposes of managing HIV and AIDS in their communities. This is facilitated through the process of collaborative partnerships, a strategy heralded as a new and more effective way of delivering health and social development services globally as well as in Sub-Saharan Africa (El Ansari and Weiss, 2006; Lasker et.al, 2001; Gray, 1989; Lord, 1998; Campbell 2003; Wagner and Mleck, 2004).

In the HIV and AIDS field the general thrust of the partnership approach is that traditional individualistic approaches (Heenan, 2004; Campbell, 2003) have failed to tackle the epidemic and reduce the spread of HIV. Hence partnerships between marginalised communities and support agencies from within the public, private and civil society sectors that have access to economic and political power and essential resources is key to HIV and AIDS management (Campbell, 2003; Clay and Lee, 2002). However, while the benefits of partnership are generally far reaching and particularly beneficial to their participants, such alliances are also notoriously difficult to promote and sustain. Thus, much remains to be learned about the 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). The Entabeni partnership study situates itself within this gap in facilitating a community-driven process for HIV and AIDS management within the resource-poor community, Entabeni.

A review of the academic literature on social capital, partnerships and HIV and AIDS suggests a Northern bias to available documented empirical studies within an African or South African context. This becomes particularly evident in a search for academic guidance materials to support HIV and AIDS partnership interventions within a South African resource-poor community context. This leads to the conclusion that if partnerships are to play a key role in supporting resource-poor communities to

develop AIDS competence, there is an urgent need for the systematic documentation of evidence-based partnership approaches that shed light on why partnerships are important for HIV and AIDS management in resource-poor settings, the processes involved in facilitating such partnerships and the factors that are most likely to enable or hinder the path to partnership success (El Ansari and Philips, 2001c; Campbell, 2003; Shisana, 2007).

Chapter 4

Research Methodology

4.1 Introduction

The thesis is based on my experiences and observations, and those of the research team, and the research participants who participated in the Entabeni partnership project. Formal fieldwork for the thesis took place over four years, between 2004 and 2007, but the totality of my field experience actually spans the time I entered the community in 2003 to facilitate a formative research study (discussed below), and continues to the present.

This chapter describes:

- i) the research design and framework used to guide the research process, the data collection tools adopted to capture the information required, and the method of analysis used to un-bundle and report on the complex nature of the subject under study (partnerships or bridging social capital);
- ii) the research process followed to ensure methodological and ethical procedures were adhered to, while gathering the data required to answer the research questions posed in the study.

4.2 Research Design

As noted previously, there is a paucity of research on partnerships for HIV and AIDS management within a South African context from which one can draw parallels, or use as guidelines in facilitating a project of this nature. Studies considered relevant to a South African resource-poor context have used largely quantitative, cross-sectional methodologies (El Ansari, Philips and Hammick, 2001; El Ansari, Philips and Zwi, 2002; El Ansari, 2003), highlighting the need to supplement surveys with more qualitative research (El Ansari and Weiss, 2006). The qualitative methodology adopted in this thesis locates itself within this gap – presenting an in-depth longitudinal case study of the challenges facing an HIV and AIDS-related partnership aiming to strengthen local responses to HIV and AIDS in a deep rural resource-poor community. In the words of El Ansari and Weiss (2006:177), “*The full potential of qualitative research has yet to be realized in the health field, especially in*

partnership work....” The value of the qualitative methodology for partnership research is that, “*It can assist in understanding the meaning of an intervention, participants’ beliefs about and expectations of the outcome and the impact of the context and the process of the intervention*” (El Ansari and Weiss, 2006:177).

My choice of the qualitative longitudinal case study methodology was therefore guided by the research aim, research questions and the nature and requirements of the subject of research (Silverman, 2000). The methodology was therefore dependent on ‘what we were trying to find out’. In this instance, the aim of the study was to explore the factors (*enablers, challenges*) that were inherent to the Entabeni partnership-building *process* for the purpose of providing evidence from one detailed case study to the research questions detailed in section 1.1. (Chapter 1).

However, and as elaborated by Denzin and Lincoln (1994:210), “...*the qualitative researcher is very much like an artist at various stages in the design process, in terms of situating and re-contextualising the research project within the shared experience of the researcher and the participants in the study.*” In many ways, due to the dictates of the local situation and the intervention oriented aims of the project, the approach adopted approximated ethnography, although this was not introduced at the outset of the project. I responded to and took the lead from the local community/partnership participants who demanded an extremely close and sustained involvement from me. Thus, although not designed as an ethnographic study, I often feel that this was what we (the research team) were doing through our total immersion in the life and unfolding processes in the community, and partnership group. This is captured in the following quotation from Denzin and Lincoln (1994:210), “*The design serves as a foundation for the understanding of the participants’ worlds and the meaning of shared experience between the researcher and participants in a given social context*”.

The basis of enquiry and information gathering in the partnership study was a process of *long-term field-work* (Fetterman, 1998; Hammersly and Atkinson, 1983), focusing on one *case study*, the Entabeni partnership process. I spent many hours in the field (40 to 80 hours a month, depending on the phase of the research process), between 2003-2007, meeting with community and external stakeholders, attending community events, visiting people in their homes, joining partners for breakfast or tea to chat

about concerns, bounce off ideas, or just ‘hang out’; participating in seminars and workshops that focused on the subject under research, and sometimes merely being an observer within the study context.

The process began with formative research in 2003-2004. I have called this the *pre-formation* stage of the partnership process (see Chapters 2 and 5), since it was not initially intended to be part of the process, but on hindsight I realised the value and necessity of this phase in feeding into and supporting the development of the Entabeni partnership (discussed in detail in Chapter 5). This phase of the process allowed me the opportunity to familiarise herself with the Entabeni community and develop an understanding of the dynamics and issues (needs, challenges) relevant to the community, enabling the research team to work together with community stakeholders in planning a way forward (discussed below).

I was a vital part of the process, adopting the worldview of Hammersly and Atkinson (1983:25), who said that, “...*we are a part of the social world we study...*” Hence, this became the basis of enquiry in the Entabeni partnership study, supported by the use of a range of sources and data collections tools, including in-depth, semi-structured and unstructured *interviews* and informal conversations with various community and external stakeholders, key informant interviews, participant observation, focus groups, meetings and workshops, consultation with the partnerships and social capital literature, and photographs. The availability of other textual materials to provide historical data on the Entabeni community and their interactions with external stakeholders, as well as insights into the way of life in the community and the institutions that participated in the study were virtually non-existent; hence most of these insights had to be gleaned through discussions with various community stakeholders and service-provider organisations in the area. A detailed discussion of the data gathering tools and methodology adopted follows after the following discussion of the phases of the research process.

4.3. The Research Process – Stages of Fieldwork

4.3.1. Phase 1

Pre-formation- Gaining Entry into the Study community: Beginning the process of relationship building (July 2003-November 2004)

A crucial first step in qualitative research is gaining entry and access to the community or research participants, since this has implications for how the research process unfolds (Upvall and Hashwani, 2001; Denzin and Lincoln, 1994). Often entry can be a long process, fraught with many challenges and obstacles (Upvall and Hashwani, 2001; Huxley, 1998). Fortunately, for the research team⁸, this process was easily negotiated with the assistance of a university colleague who lived in the community and who invited the research team to facilitate an HIV and AIDS research and management process in the community. Consequently, this set the stage for the research team's total *immersion* into the dynamics of the Entabeni community.

And so began the story of the Entabeni partnership study, a process that was initiated in July 2003 when the research team entered the Entabeni community as part of an initial brief to conduct case studies of community responses to HIV and AIDS in KwaZulu-Natal, South Africa (see 2.5. in Chapter 2). The traditional chief or iNkosi as he is referred to in the community, welcomed the research team into his community by introducing the team to various community stakeholders at a public gathering in the community. This gained the team immediate acceptance and credibility within the Entabeni community. The approval of and acceptance by the community's iNkosi was a non-negotiable requirement to entry into this rural community. In rural Traditional Authority areas in South Africa, the iNkosi is considered the paramount decision-maker and authority figure whose approval has to be sought for almost anything that happens in the community (weddings, funerals, meetings, celebrations, projects, etc.) (Mokvist, 2003; Mufamadi, 2000).

The iNkosi also arranged for the research team to meet the community health worker leader (Mr Nxumalo), who was also a traditional leader. Mr Nxumalo, who was well

⁸ The research team is also referred to as the HIVAN team. It was comprised of the author of this thesis doubling up as researcher and team leader together with two field-workers who had over five years experience in field research (see Chapter 5)

known and highly respected in the community, became the team's lifeline. He introduced the research team to key community stakeholders (religious organisations, CBO, women's group, gardening group, traditional leaders, schools, etc.), who subsequently participated in the formative study undertaken in the community. This introduction into community life by the 'right people' was of huge significance to the research team, who benefited from a 'halo effect' (Huxley, 1998) throughout their time spent in the community. This became more pronounced over time as positive changes were observed in the community as a consequence of the research process. Hence, the strategies I adopted (extensive field-work combined with the ability to listen, reflect, empathize and focus on strengths and unconditional acceptance), initiated what was to become a long-term relationship based on trust and mutual understanding between the author of the thesis and the research participants (see Chapter 5).

The Formative Research (survey phase of the research process)

The formative study or survey phase (Fetterman, 1998) entailed a detailed case study of the context of HIV and AIDS management in Entabeni, involving 60 in-depth interviews and focus groups with a wide range of local people, as well as health and welfare professionals, missionaries, NGO workers and business leaders in the surrounding region (all within the radius of one hour's drive from Entabeni); observation of community life; detailed fieldworker diaries, document review and a search for archival and secondary data that would assist in formulating a picture of the community and shape the study design and formative theory (LeCompte and Schensul, 1999). The research methodology and findings from the formative research, conducted a year prior to the formation phase of the partnership study, is discussed in Chapter 2 of the thesis and in Campbell, Nair and Maimane (2007).

During this phase, I mingled with the people, getting to know the community and external stakeholders through a 'wide-angle' view of events (Huxley, 1998), then narrowing the focus to obtain a more microscopic view of community interactions and networking with external stakeholders as required in the partnership study. This phase of the project contributed to the crucial first step of the partnership study (reported on in Chapter 5), which involved building relationships based on trust, becoming familiar

with the context of the study – its people, their culture, customs and ways of doing things – and initiating the selection of research participants.

4.3.2. Phase 2

Formation – Negotiating relevance – Dissemination of formative research findings and stakeholder consultation (2004- 2005)

The next stage of our engagement with the community and external stakeholders took the form of a series of research-dissemination and stakeholder consultation workshops on the way forward. This phase of the process overlapped with the *pre-formation* and *formation stage* of the partnership process. It incorporated elements of what is described by Kreuter et al., (2000) as *pre-formation* (discussed in Chapter 2), where the team collaborated with key community stakeholders in conducting a community needs assessment (formative research), and recruitment of partnership participants, a process that usually occurs in the *formation stage* (discussed in chapter 5 and 6) of partnership-building (El Ansari and Philips, 2001a).

The workshops organised to disseminate the formative research findings doubled up as a platform for facilitating debate and dialogue among workshop participants around the issue of HIV and AIDS, and community responsibility for facilitating and managing change processes (see chapter 2). The research team adopted a strengths based approach when facilitating these workshops with nine groups of local community residents: health volunteers, religious leaders, traditional leaders, traditional healers, school learners, young people out of school, members' of a local sewing group, teachers, and a local development group.

A 10th dissemination workshop brought together volunteer health worker representatives, local community leaders and a group of potential 'partners' from the public, private and civil society sectors located closest to the community, most of whom had participated in the formative study. The core group of local representatives (home-based carers, traditional, religious and community leaders) that had already been recruited by the community health leader (Mr Nxumalo.) to assist with the formative research study, were primarily responsible for presenting the formative

research results to the workshop participants (see Chapter 5). Aside from the dissemination of formative research findings, the workshop provided the opportunity to introduce the idea of a mutually beneficial partnership between the Entabeni community and key service-provider stakeholders in responding to and managing HIV and AIDS in the community. Thus, and following research protocol, the results of the formative research and outcomes from the dissemination and consultation workshops with research participants, informed the design and facilitation of the partnership study (see Chapter 2 for details).

Selection of research participants

The process of recruitment of the community partners during the *pre-formation* stage of the partnership-building process is discussed in detail in Chapter 5 of the thesis. During the *pre-formation* phase and the *formative* phase, beginning with the research-dissemination workshops, I, with the assistance of a few community and external stakeholders, scoured the local district for potential project partners, identifying key community stakeholders, a local CBO and six agencies who were keenly interested in participating in the Entabeni partnership. The choice of research participants was influenced by the aim of the study.

Research participants included representatives from the local government departments of health and welfare, the local municipality, a philanthropic business-funded NGO, a counselling NGO and an HIV and AIDS training NGO (details in Chapter 6 of thesis). Each welcomed the opportunity to work in partnership with such a remote community, saying they had previously lacked contacts, access and the capacity to engage with rural communities. The author of the thesis therefore planned to use her extensive networking skills and contacts to facilitate bridge-building between the community and these agencies. Mobilising these agencies to partner the Entabeni community stakeholders in a long-term process of networking and collaboration for the purposes of achieving concrete HIV and AIDS management goals in Entabeni, has been both daunting and fulfilling. This process forms the focus of this thesis.

4.3.3. Phase 3

Facilitating the partnership-building process (2005- 2007)

The next phase of the process began early in 2005, with the very first partnership meeting. This phase incorporated the second part of *formation*, but incorporated elements of *implementation* and *maintenance*. I therefore discuss all three phases of the process in this section. Since Chapters 5, 6 and 7 describe the dynamism of the Entabeni partnership building process that resulted in these major overlaps between the different phases of the process (Gray, 1985; El Ansari and Philips, 2001a), below I merely provide a summary of the process.

The multi-faceted role's assumed by the author of the thesis (team leader, co-facilitator of the partnership-building process and external change agent – discussed in Chapters 5, 6 and 7), demanded much observing, interviewing, recording of observations in detailed field-diaries and reflection on the data gathered. I rotated between field-visits – withdrawing from the field for short periods to analyse and reflect on observations made and information gathered, and returning to the field to test hypothesis developed – continuing the flow of the research process through this continuous reflection, analysis of data gathered, and returning to the field. I focused on relationship building during this phase, nurturing and building on the relationships initiated with research participants at the beginning of the research process. These relationships became the cornerstone of the partnership process, and efforts to build trust between the partnership participants (see Chapter 5 and 6).

The focal point for observations, informal discussions and individual and group interviews were *formal partnership meetings* (eight), which were conducted to facilitate discussion and debate around the achievement of partnership goals, and foster changes in networking patterns and collaboration between the partnership participants; *sub-committee meetings* (thirty nine) held with smaller groups of external and community stakeholders to discuss and plan around matters arising in the larger group meetings; and, *community events* (graduation ceremonies for trainees, youth rally, opening of hospice, opening of outreach centre, etc), which were an outcome of the research process and organised and attended by research participants (discussed in Chapters 5, 6, 7).

Towards the end of 2006, and after much introspection and analysis of the data gathered, I, together with the other members of the research team, agreed that enough data had been gathered to describe and report on the process of multi-stakeholder partnership-building between the Entabeni community and external stakeholders. Clear patterns could be identified and sufficient evidence had been gathered to support significant findings on the subject under research (Fetterman, 1998). It was also time for the partnership participants to begin to assume full responsibility for the facilitation of the partnership process and ensure its sustainability. The team therefore decided to begin the process of withdrawal from the field. During this time and even before, the *implementation* of the partnership continued, but *maintenance* had already begun (discussed in Chapters 6 and 7). For the purpose of this thesis, the beginning of the *maintenance* and withdrawal process will be incorporated into the discussion in Chapter 7 of the thesis, with the reporting process ending in December 2007. It is noted, however, that the partnership process is still continuing into 2008 because of the generosity of the funder of the project, but the input of the research team into the process will officially come to an end in December 2008.

4.4. Triangulation

Triangulation is a method often used by qualitative researchers to establish validity and reliability (see 4.7) of research results and to counter the negative influence of bias in the research process (Hammersly and Atkinson, 1983; Denzin, 1978).

I incorporated several types of triangulation in the implementation of the partnership study, and in the process of data gathering. These include methodological triangulation (the convergence of data from multiple data collection sources), data triangulation (the convergence of multiple data sources), and investigator triangulation (use of several or different investigators) (Denzin, 1978).

4.4.1. Investigator triangulation

In the partnership study, while I was the primary tool or mode of data collection, systematically observing, interviewing and recording what was seen, heard and done, she also drew from the observations, and experiences of the other *research team members*. These included *a trainer* responsible for facilitating HIV and AIDS related training with community stakeholders and who was recruited from one of the

potential partner organisations in the formation phase of the process; and an *external evaluator*, contracted by the research team for a fixed period to provide a non-participant, possibly more objective view, of the process and outcomes of the project. The IsiZulu speaking fieldworker that continued working with the research team after the formative research study always accompanied me during field-visits. She conducted independent observations, assisting with interviews with participants who preferred to converse in IsiZulu and transcribed and translated all recorded interviews.

The trainer, who often lived in the community when conducting training workshops, documented her experiences and observations during the training sessions, and made these available to the research team. The external evaluator, on the other hand, who through the process of evaluation interviewed the partnership participants and community stakeholders to assess the impact and value of the partnership to the community and participating external organisations, wrote a detailed report based on her observations and analysis of the interviews. This was incorporated into the analysis of the findings from the partnership study.

4.4.2. Data triangulation

As indicated previously, various data collection tools were used to gather and corroborate data from the study. They are described below.

Participant Observation

“The most important element of fieldwork is being there, to observe, to ask seemingly stupid but insightful questions, and to write down what is seen and heard” (Lao Tzu, 1998:9).

The focal point for data gathering was field-work, interviews, direct participation, observation and a whole lot of introspection. I was both an insider and outsider in the partnership process, trying to glean an insiders perspective of the contextual dynamics influencing and determining the direction of the process, while adopting a ‘Martian perspective’ by standing back, looking at the process with an outsiders lens, and analysing the study context as a foreigner would (Genzuk, 2003; Babbie, 1999).

The insider role enabled me to feel the frustrations, triumphs and challenges that the research participants experienced in their interactions with each other, and in their

attempts to meet the goals set by the group. However, while accepting the need to become a part of the group process in order to describe and reflect upon the process from an insider's perspective, I chose not to live in the community or become a full participant in the lives of the partnership participants. Instead, I visited the community at regular intervals and my participation in this research process was largely demand driven, influenced by the dynamics within the context.

Brainstorming sessions with the research team were followed by a return to the field to test and retest hypothesis. In this way, certain patterns and themes were observed over time in the communications and behaviours of research participants, which fed into the findings reported on in Chapters 5, 6 and 7 of the thesis.

Participant observation became a very useful technique in observing and recording information that could not be captured via the interviewing process. It provided rich data on the networking and interactions that took place during partnership meetings and community events, and clearly mapped out the gradual change in relationships that occurred over time between the partnership participants. These observations were carefully and meticulously captured in photos (see Appendix 3), and detailed field-diaries (see Appendix 4).

Meetings

An introductory workshop was held with key stakeholders in December 2004 (including local community representatives and service-provider stakeholders in the region), to kick-start the partnership-building process. Twenty six employees from various service-provider institutions attended, many of whom became key research participants in the partnership study. The findings from the formative study formed the basis of the plenary and small group discussions that were held with workshop participants to assess their understandings and views on collaborative work, and gauge their levels of enthusiasm and commitment to working in partnership with the Entabeni community. Small group/focus group discussions were guided by an interview schedule developed by me, and administered by elected group participants. During these group interviews, I played the role of observer and facilitator of the process. Group participants completed evaluation questionnaires at the end of the workshop. The information gleaned from these questionnaires, and the ensuing

discussions around the way forward is what precipitated the first formal partnership meeting between the community and external stakeholders in January 2005. This process is discussed in detail in Chapter 5 of the thesis.

Throughout the process, *formal partnership meetings* and *sub-committee meetings* were used as a means to facilitate change processes around networking and collaboration between research participants from within the community and external service-provider stakeholders. Early on in the process, an agreement was reached among the research participants that formal partnership meetings and sub-committee meetings would be the primary means for communication, discussion and debate among partners. It therefore became the primary platform for participant observation and group interviews, yielding rich data on networking patterns and factors that enabled and hindered networking and collaboration between partners for the purposes of managing HIV and AIDS in the Entabeni community. As already mentioned, between January 2005 and December 2007, eight formal partnership meetings and 39 sub-committee meetings were conducted. Sub-committee meetings were held between smaller groups of partners in order to work together on matters arising from the formal partnership meetings. This often involved attending to tasks associated with partnership goal achievement, or resolving issues between partners that were hindering collaborative activities, e.g. meetings were held between senior managers from the Department of Health, my-self and local community representatives to discuss and find ways to translate their verbal commitment of support and participation in partnership goal achievement (like the provision of gloves and home-based care kits for the home-based carers), into reality (see Chapter 7).

Formal partnership meetings followed the normal meeting procedure, with an agenda for each meeting (negotiated among partners), minutes, and a chairperson. The proceedings of these meetings were always tape recorded and transcribed. At the beginning of the process, I chaired and hosted the meetings, but external partners soon assumed responsibility for hosting meetings, and on some occasions, chairing the meetings. Local community partners were encouraged to take on key positions in the meeting (chairing and secretarial), which they assumed with my assistance (see Chapters 5, 6 and 7).

Interviews

Various forms of interviews were conducted with research participants throughout the research process, based on the circumstances and the nature of the information required. These included *in-depth open ended* and *semi-structured* interviews, *unstructured* or *informal* interviews, as well as *focus group* interviews (LeCompte and Schensul, 1999; Fetterman, 1998; Hammersley and Atkinson, 1983). These interviews were used as a means to tap into local and ‘outsider’ views and perspectives and personal experiences of the partnership process, exploring the subject under study in depth and allowing for new information to surface, and evaluate the process at regular intervals from every angle possible. Again, my extensive experience of working with grassroots communities, and her initial training as a social worker with many years of experience in the field, contributed to the quality of, and style with which the interviews were conducted. The field researcher, who conducted a small number of evaluative interviews, also had many years of experience in interviewing and working with projects in grassroots communities. The questions posed in these interviews were constantly guided by the research questions, the theoretical framework and Campbell’s (2003) framework, which highlights five characteristics of an effective external partner in the context of community-led HIV and AIDS management. These include commitment, capacity, incentives, accountability to project beneficiaries and organisational infrastructure to link partners (discussed in detail below).

During the *formative research* phase, 27 exploratory interviews were conducted with potential partners and significant others to the process. The intention of these interviews was to provide baseline information for the partnership study, and expand my knowledge of the area and context of study (see Chapter 1 and 2 for details). Interviews were therefore conducted with various stakeholders from the Entabeni community, a local community based missionary, the nearest municipality (local government) office and their regional branch office, the nearest government primary health care clinic, the two nearest hospitals that have an HIV and AIDS clinic, the local branch of a national counselling charity, the nearest clinic that provides voluntary counselling and testing and support groups for HIV positive people, the Welfare Department who controls access to grants, a religious based NGO providing home-based care training and hospice services, an NGO co-ordinating development

oriented projects in the region and representatives of a philanthropic foundation funded by the regional Chamber of Commerce.

In Phase 2 (*formation*) and 3 (*implementation*) of the study, 125 interviews (semi-structured, unstructured or informal and group interviews) were conducted with research participants and key informants.

Semi-structured open-ended interviews were used to evaluate the partnership process and gain expert insights from key informants. Interviews with *key informants* were conducted with experts in the field, or people with active experience in facilitating and participating in multi-stakeholder partnership processes, and those responsible for formulating policy around the key issue of HIV and AIDS, and strategies advocating for partnerships or collaboration. These key informants included people from within the CBO sector, public sector and NGO sector (6).

The study, as indicated above, had an intensive monitoring and evaluation component, in the interests of generating guidelines for best practice, and lessons for future intervention and policy in the area of study; hence regular interviews were conducted with partners to *evaluate the partnership process* and give direction to the research process. In the initial stages of planning, I planned to conduct evaluative interviews with research participants every six months, but as the process evolved, it was obvious that research participants were experiencing interviewee attrition. Thus, the interval between interviews was adjusted, and yearly interviews conducted instead. Interview schedules comprised of six key questions (see Appendix 2), guided by Campbell's (2003) criteria for effective partnerships. This allowed for a comparison of the participant's responses over time, with adding on questions where necessary to allow for further probing based on the responses received. These interviews yielded rich data on the participants' perspectives of the partnerships process (research question 2), their interpretation of challenges (research question 3), the value of the partnership process to them as individuals, the community, and their organisations and lessons learnt from the process (research questions 1, 4 and 5). Questions were open-ended and flexible. The duration of each interview was between 45 minutes to an hour and a half, depending on the extent of, and type of, discussions that ensued during these interviews.

Most of these interviews were face to face interviews, while a few had to be conducted over the telephone due to the work commitments and time constraints experienced by mainly public sector participants; hence interviews had to be constantly juggled around the availability of the research participants, resulting in many interviews being conducted after hours, during lunch breaks or on weekends (discussed in detail in Chapters 6 and 7).

Group interviews (Fontana and Frey, 1994) or *focus groups* (LeCompte and Schensul, 1999; Nastasi and Borgati, 1999), as they are often referred to, were also used as a means to evaluate the partnership process and stimulate discussions, debate and the opportunity to listen to and interact with one another. Group interviews were conducted at two partnership meetings and were facilitated by the fieldworker and a research assistant. This afforded me the opportunity to observe interactions and networking among group participants, assess communication styles, leadership qualities, the ability and commitment of group members to collaborate with each other and the growth of group participants via their participation in the research process (contributing to research question 6). Group interviews were incorporated into partnership meetings to save on costs and maximise on the time and work commitments of group participants.

Numerous *unstructured interviews and informal conversations* (Huxley, 1998; Denzin and Lincoln, 1994) were conducted when the opportunity presented itself for a spontaneous conversation with a local partner, service-provider partner, or people external to the process (professionals from within the public sector or civil society sector working within similar contexts or with similar stakeholders), who could throw light on the subject of research or support my introspection and analysis of experiences and observations in the field. This often occurred throughout the three year process of the study and contributed to an abundance of rich data that supported and enhanced the data gathered through the implementation of other research methods (focus groups, observation). It also contributed to the process of building and nurturing relationships, a key element of successful partnerships (Eyben, 2006; El Ansari, 2003).

Creative strategies were used to draw interview participants into conversations that would yield unforeseen but crucial data on people's feelings and emotions, their fears, desires and hopes that often would not be possible to discover during a straightforward interview. In essence, it allowed for a human context to enrich the partnership-building process. In some instances, I would invite a member of the partnership committee to tea or breakfast, and during the course of the meal, I would strike up a conversation about the partnership process (contributing to research question 6).

These conversations yielded an abundance of material on the context of study, the interviewer's perceptions of his/her personal or organisational challenges that hindered their input into the partnership process, and the successes and personal accomplishments associated with their involvement in the partnership-building process. I was also able to glean insider information on institutional operations, leadership structures and gender dynamics within the community that impinged on the partnership process, all of which had implications for the findings of the study.

Early on in the research process, I identified two *key informants* (older male and young female) in the community whom I consulted constantly, in the quest to build a holistic picture of the community and their interactions with the external world; hence I would often pick up the phone or have face-to-face chat sessions with them about aspects of the dynamics in the Entabeni community that I encountered in the field, or to clarify the validity of certain research strategies or events planned for the community by the partnership participants. The selection of a young female (referred to as Gladys – see chapter 5) home-based carer and an older male (Mr Nxumalo) who occupied a key leadership position in the community was strategic-based on the gender dynamics that existed in the community (patriarchal system), the fact that they participated actively in community life and were familiar with the history, interpersonal relationships and the every-day life of people in the community (contributing to research question 2).

Recording the Data

Various methods were used to record the data gathered from interviews and observations, capture the events and life in the Entabeni community and the Entabeni

partnership process. In the three year life-span of the partnership process, over a thousand *photographs* (see Appendix 3) were taken to capture key moments which would highlight and clarify the process as it unfolded. These photographs were very effective in showcasing the partnership research process and putting the Entabeni community on the local and global map at policy and social science conferences, workshops and seminars. Copies of these photographs were placed in albums and given to all research participants at the last partnership meeting. For group participants, it was an affirmation of the change processes that they had participated in, and made the process a reality for themselves and the Entabeni community.

Four community events (graduation ceremonies, youth rally, opening of the outreach centre) were captured on *video*, to provide clarity and support to data collected via other methods used (observation, photographs) (Fetterman, 1998; Atkinson, Coffey et al., 2001). This was very useful in capturing community interactions and dynamics, and to gauge how this feeds into defining the Entabeni community and the partnership development process. The idea of using video-tape to capture the proceedings of partnership meetings was discarded early in the process, since it was assessed that this method would be intrusive, and would hinder free flowing communication among the group participants.

Semi-structured interviews (individual and group) were *digitally recorded* and transcribed to ensure crucial data was not lost, while unstructured interviews also followed the same process, except in situations where interviews occurred spontaneously and it was not possible to digitally record these interviews. In these instances, e.g. when the conversation occurred while I was driving a community partner to his/her home or to the nearest town to do their monthly grocery shopping, the contents of the conversation were recorded manually by the research assistant/field-worker who always accompanied me in the field. I later added to these recordings if necessary and contributed background data to the interview. Meticulous and detailed *field-diaries* (see Appendix 4), and *daily diaries* were utilized by the research team from the very beginning of the research process, to record and reflect on their experiences, observations and impressions in the field, and document the research process and contextual aspects that impinged on these processes (Hammersly and Atkinson, 1983; LeCompte and Schensul, 1999).

Interviews and procedures of meetings were *tape recorded and transcribed* (LeCompte and Schensul, 1999; Nastasi and Borgati, 1999), and wherever necessary (when people spoke IsiZulu, the predominant language spoken in the community), these transcripts were translated into English. Transcripts of partnership meetings were used to draw up minutes which were then distributed to all the partners and used as a benchmark to assess progress made in the achievement of partnership goals.

Research participants

As mentioned previously and discussed in detail in Chapters 5 and 6 of the thesis, research informants included partnership representatives from within stakeholder institutions (Department of Welfare, Health, local government, a CBO, NGOs and a private sector organisation), institutional managers, community partners (Traditional leaders, religious leaders, community leaders, home-based carers, youth, teachers), and key informants with expert knowledge and experience in collaborative and partnership work.

Consultation of the literature, review of the records, attendance at conferences and workshops

A comprehensive review of the academic and grey literature on social capital, partnerships and HIV and AIDS began in earnest prior to the study and continued throughout the process. This was instrumental in formulating the research design and formative research model that guided the research process. International and South African data on the issue under study was reviewed to trace similarities in contexts and research problems, assess and compare best practice strategies, record gaps in the literature, and reveal new and significant data sources to serve as a benchmark for this study. This literature was instrumental in guiding the continuous reflection and analysis of data gathered.

Feeding into this continuous process of reflection, analysis and evaluation, was the consultation of the various public sector policy and strategic planning documents that incorporated thinking and planning around the challenges of HIV and AIDS, multi-stakeholder partnerships and resource-poor communities. This interrogation of public sector policy also led to me making crucial input at workshops and seminars designed

specifically for scientific input from researchers and interventionists; hence I attended six policy related workshops in the final stage (2007) of the research process to contribute to, and influence, public sector policy on HIV and AIDS and multi-stakeholder partnerships, based on the findings from the study.

Framework for the operationalisation of the research data

In order to synthesise and analyze the data gathered via the research process, a framework developed by Catherine Campbell (2003) for effective partnerships was used as a benchmark. In this framework, she highlights five features of an effective partner: *conceptualisation* of HIV and AIDS as a social development issue, *agency capacity* to make a meaningful contribution (especially funding and appropriately trained personnel), *commitment* to HIV and AIDS management and the partnership process, mechanisms for partner *accountability* to their target communities, and *incentive* to participate in the partnership. In addition, a successful partnership should have access to the organisational *infrastructure* necessary to organise and host partner meetings and to co-ordinate partner efforts.

It will be noted that the nature of the data gathered in the study prompted additions to be made to this framework; hence the reporting of the data, while largely reflecting the above framework, broadened out and added to it when reporting the findings in Chapters 5, 6 and 7.

Analysis as a Process

Analysis was an interactive and ongoing process that began in the pre-formation phase, continuing over the course of the field work into the thesis writing phase, and feeding into and informing the research design, process and findings (Hammersly and Atkinson, 1983). The continuous and ongoing reflection and analysis of events as they unfolded throughout the partnership development process enabled the development of clarity and a progressive focus on the emerging issues that either challenged or supported the traditional conceptualizations of partnerships or bridging social capital, as described in the academic literature (see Chapter 3).

Comments and tentative interpretations were drawn throughout the research process and refined as more data was collected; hence continuous analysis allowed for the

testing and retesting of hypothesis developed, assisting as well in the choice of appropriate methods at various stages of the study (Fetterman, 1998).

Having followed a process of continuous analysis, the next step was the organisation of all the data collected via interviews, observations, etc., into a framework that was analysed using *thematic content analysis* (Flick, 2002). Thematic analysis focuses on identifiable themes that emerge through a careful reading and re-reading of the data. These themes then form the categories for analysis (Aronson, 1994; Fereday and Cochrane, 2006). In this study, Campbell's (2003) five characteristics for effective partnerships (discussed above), formed the basis of the coding framework that was developed, and guided the analysis of the data gathered.

Transcripts for each interview were reviewed, and insights, commonalities and differences documented. Participants responses were entered into a spreadsheet and analysed based on the research questions and Campbell's (2003) framework. Immersion in this material, together with my on-going reading of the social science literature on partnerships, led to the progressive refinement of the material into cross-cutting themes and categories, captured in a series of research memos using the thematic analysis technique (Lincoln and Guba, 1985; Aronson, 1994). These combined themes were then used as the basis for a selective re-coding of the interviews from which additional insights emerged. Themes were backed up and qualified by quotes from the transcripts in order to capture the participant's meanings and understandings of partnerships and the research questions posed in the study. These *themes*, which fed into the key findings in the study, were then combined with the academic literature (see Chapter 3) to form the basis of the findings of the Entabeni partnership process presented in Chapters, 5, 6 and 7 of the thesis.

4.5. Ethical considerations

Prior to the initiation of the research, an application was made to the University of KwaZulu-Natal (where the research team is based) ethics committee for ethics clearance in terms of standards set for field research (see Appendix 1). Throughout the process of the study, the generally accepted standards for informed consent, voluntary participation by respondents, confidentiality, and anonymity in data reporting were adhered to.

In the initial round of interviews done during the formative research, all respondents completed consent forms which authorised me to interview them and use the information gathered for research purposes and for facilitating an intervention in the community. Whenever interviews and group sessions were digitally recorded or photographs taken, permission was sought from the individual or group. Participants were always assured of their anonymity when reporting the findings of this study in journals, conferences and this thesis.

4.6. Limitations of the study

It is accepted that qualitative research is ideologically driven and is therefore not value or bias free, but it would be false to believe that any research is value free (Denzin and Lincoln, 1994). Hence in order to obviate bias in this study, I made a conscious effort to identify her biases earlier on, and be aware of these biases throughout the study in order to allow as little interference as possible in the process of the research, and analysis of the empirical materials gathered.

Participation in partnership meetings by public sector partners, and to a small extent other partners, were often hindered by work constraints, lack of resources (cars, telephones, faxes), and internal organisational challenges. Power differentials between the community stakeholders and ‘professional’ participants and gender dynamics (see Chapter 5) were also responsible for the limited participation by some group participants. However, these constraints were a reality of the research context and considered to be part of the key findings of the study, contributing to valuable lessons learnt when building multi-stakeholder partnerships within such a context.

When considering other barriers to the study, the use of *language* could have limited participation of community partners (predominantly IsiZulu speaking), to some extent at the beginning of the process. However, participants were constantly encouraged to communicate in the language with which they felt most comfortable, since this would be easily translated to English by the fieldworker who was always present, and other group participants. In time, when group participants became more comfortable with each other and the research team, language became less of an issue (see Chapter 5).

4.7. Reliability and Validity (Rigour in the Partnership study)

Reliability is generally concerned with the replicability of scientific data within similar settings, while validity is concerned with the accuracy of these scientific findings; hence scientific findings must be reflective of the true reality of the research context (LeCompte and Goetz, 1982; Babbie 1999).

In this study, several strategies were employed to ensure validity and reliability of the data:

Firstly, a year was spent in the community during the pre-formation phase to familiarize oneself with the study context (Lincoln & Guba, 1985), and to use the data gathered, in combination with the outcomes of the dissemination and consultation workshops, to build on and feed into the planning for the partnership study (see above for details).

Secondly, a triangulated method for data collection was utilised, ensuring the use of a combination of data collection tools, various data sources, and more than one observer in the field.

Thirdly, the project had a monitoring and evaluation component which ensured evaluative interviews were conducted with research participants at regular intervals throughout the research process. This, together with the continuous analysis and reflection of data, contributed to the adjustment of methods of data collection, and a continuous testing and re-testing of hypothesis developed. All this was done in consultation with research participants and key participants in the community (see above for details), and the meticulous records that were kept throughout the three year process of the study (daily diaries, field-diaries, tape-recorded interviews). In addition, the services of an independent external evaluator was sought to add to and confirm the accuracy of my findings. This was undertaken during the last phase of the study.

Fourthly, research results were continuously work-shopped and presented at various local and international conferences and seminars (14) at various stages of the study. The discussions, debates and questions that emanated from these presentations stimulated my thinking about the subject of research, providing crucial guidelines for

planning and design of the study. It also fed into and ratified the ongoing hypothesis developed by me, and guided by the academic literature on partnerships and social capital, allowing for adjustments to be made where necessary, while also confirming similarities with findings made by people living in and working within similar contexts.

4.8. Conclusion

This chapter has presented a detailed review of the research design (qualitative, longitudinal case study), the research process followed in facilitating the Entabeni partnership study, the data collection tools, the method and framework of analysis applied to the findings, reliability and validity issues related to the study, and ethical clearance procedures followed.

What follows in the next three chapters is an analysis of the data gathered over the three year research process, supported by detailed description and quotes gathered from the field-research and interviews that were conducted with the various research participants.

PART TWO

Findings: Discussion and Analysis of Data, Conclusions and Recommendations

Chapter 5

Laying the foundation: Collaborating with the Community stakeholders

5. 1. Introduction

This and the following two chapters (6 and 7) are structured to present data from the partnership study in terms of the stages of the partnership process (El Ansari, 2001a), while the analysis of data is guided largely by Campbell's (2003) framework for effective partners. However, two points must be noted:

- Neither of these models was adopted as a *blueprint* for the facilitation of the Entabeni partnership or the analysis of and presentation of the findings. Thus adjustments and additions were made, where required, and when necessitated by the continuous feedback from the study
- The presentation of findings within three chapters is an artificial division of a process that flowed and moved back and forth from one stage to the next; hence the noted 'repetition' of occurrences between the different phases and chapters.

The discussion and analysis in this chapter contributes to the research questions discussed in Chapter 1, through a focus on the initial stages of the partnership-building process, beginning with collaboration and relationship building with the Entabeni community stakeholders.

This phase, referred to by El Ansari and Philips (2001a) as the *formation* stage in the partnership-building process, was driven by the basic premise that partnerships to support grassroots responses to HIV and 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 collaborative work by outside professionals (Campbell, 2003). Hence, the external change agent adopted the model of *facilitating* change through the active participation of the Entabeni community partners (grassroots people). From the very beginning, change would come about through their active participation in the partnership (Gillies, 1998; Lamptey and Gayle 2002; Campbell, 2003), as opposed to the research team and other external partners *intervening* on behalf of the people in the community. In adopting this model of

facilitation rather than intervention, it was expected to be useful in *balancing power relations* between the community, the external change agent and the external partners.

To illustrate the findings during the formation stage, I focus on the process of recruitment of the community partners (Chapter 5), and external service-provider partners (Chapter 6), describing who they are, the value they added to the partnership (research question 2), and those factors that either hindered or enabled the process of partnership-building and the achievement of partnership outcomes (research questions 3 and 4). In this chapter, I contribute to the research questions by focusing my analysis around two key events that occurred during formation:

- the *formative research-dissemination workshop* for potential external stakeholder partners that occurred prior to the first official meeting of the Entabeni partnership committee, and,
- a *youth rally* organised by the community partners in collaboration with the newly recruited external partners (described in Chapter 6), which took place after the second formal meeting of the partnership committee.

I add to these discussions by making reference to other interactions and experiences with the community partners in order to enrich the analysis of data gathered during this phase of the partnership-building process.

It will be noted in the following discussions that while I make reference to, and am guided by El Ansari and Philip's (2001a) four stage model of the partnership process - involving a process of *formation, implementation, maintenance* and assessment of impacts and *outcomes* – the partnership developed a life of its own. Consequently, the process diverged somewhat from the sequence of stages or commonly occurring steps as described in the literature (Gray, 1989; Bryson et al., 2006; McLaughlin, 2002; El Ansari and Philips, 2001a), precipitated by the dynamism of the partnership-building process, and resulting in considerable overlaps between the stages. For example, the recruitment of partners began prior to the *formation stage* and continued through to the implementation phase. Similarly, the *implementation* of project goals began almost immediately in the formation stage, and continued throughout the project. *Maintenance* of the partnership, which involved a continuous monitoring of and support of the partnership, began during the formation stage, with an emphasis on

ownership and sustainability of the project being woven into all aspects of planning and capacity-building initiatives with the partners. The following table provides a bird's eye-view of the phases of the Entabeni partnership process, key challenges, outcomes and the external change agent's role in the process of partnership building as presented in the three findings chapters (5, 6 and 7).

Table 4: Time-line: Phases of the Entabeni partnership process, challenges, outcomes, key events and ECAs role

Phases of the Partnership	Time -line	Key events	Challenges	Outcomes	ECAs role	Chap
Pre-formation	July 2003- Nov 2003	Gaining entry; Relationship building; Formative research		Immersion into community; Acceptance of research team by community	Facilitating grassroots responses to AIDS	2, 4
Formation (1) Laying the foundation- collaborating with Community stakeholders	2004-2005	Recruitment- community partners; Research workshops; Youth rally	Power differentials; conflicting values & norms between ECA & community; varying capacity	Networking & relationship with external partners; 'Learning through doing- skills, confidence, trust, respect , 'common vision'; joint facilitation	Central convener, teacher; nurturer; mediator; facilitating rather than intervening	5
Formation (2) The External Stakeholder Partners-Who are they and what do they bring to the partnership?	2004-2005	Recruitment, collaboration with potential external stakeholder partners	Recruitment of private sector; Limited capacity, poor internal communication, work constraints	Morale-building, project planning; potential model of 'best practice'-local govt.	Multi-faceted, resource intensive-identifying partners, enabling & supporting participation	6
Implementation of the Entabeni partnership	2006-2007	Conferences, workshops, meetings, graduations, opening of out reach centre	Limited capacity; fluctuating commitment; poor accountability communication; lack of infrastructure & decision making powers, power differentials, inadequate incentives to support participation	Dynamic, 'fast-paced'; relationships based on trust, established networks, increased confidence & self-esteem; changing mindsets, growing commitment, willingness to embrace new strategies; institutionalization & formalisation of partnership; establishment of <i>outreach centre</i> ; ongoing training; employment	Harnessing innate strengths and existing skills of partners; appealing to their humaneness & responsibility in responding to the challenges posed by HIV and AIDS in the Entabeni ; <i>nurturing relationships & reciprocity</i> among partners	7

In Chapter 5 and 6, I base my discussions on several contacts I had with each partner: an initial one-to-one research interview; their participation in a workshop disseminating and discussing formative research findings; individual meetings between partner representatives and myself to discuss possible participation in the partnership; partner's participation in planning meetings to organise the youth rally and, where it occurred, the partners' participation in two preliminary partnership meetings.

5. 2. Beginning the Journey

At the outset of this discussion, I must mention some factors that in my view influenced the process to some extent:

- I am a trained and experienced development practitioner with a keen understanding of development principles which advocate for *community driven development* and the active participation of community stakeholders in social change processes in their community (Heenan, 2004; Dongier et al., 2002; Gillespie, 2004). I therefore drew from personal experience and popular literature (see Chapter 3), in allowing the unfolding partnership-building process to be led largely by the dynamics and nature of the interactions with the community and external stakeholder partners
- My past experience of working with marginalised communities, and a belief in the philosophy of *learning through doing* or that *experience is the best teacher* (Gillespie, 2004), underpinned my determination to mobilize community stakeholders, ensuring their participation in all aspects of the partnership-building process, from planning, to implementation and maintenance.
- The assistance of a IsiZulu speaking fieldworker (two in the pre-formation stage) with many years of experience in working with marginalised communities, who assisted with the co-ordination and facilitation of the partnership meetings and events organised by the partnership and who played a key role in observation and keeping detailed field diaries of her experiences and observations in the field
- The knowledge that the research team had been funded for a fixed period of time and would therefore need to plan for their withdrawal from the process by the end of the third year of the project.

Contact with the Entabeni community was initiated a year prior to the formal process of forming the Entabeni partnership; hence the process of *networking, collaboration and relationship building* with community stakeholders began a year prior to what is often described in the literature as the initial phases of the formal partnership-building process (Gray, 1985; El Ansari and Philips, 2001a). This initial process of entry and relationship-building was crucial to the way the partnership-building process unfolded, as the following response from a community stakeholder (to evaluate the partnership process) illustrates:

Community stakeholder: *“It is the way they (research team) entered the community. They followed the right entry channels in the community by introducing themselves to both the tribal council and the community as a whole. They showed lots of love and respect for the community.”*

I describe this as the *pre-formation* stage (Kreuter et al., 2000). During this phase, the research team collaborated with key community stakeholders in conducting a community needs assessment (formative research), discussed in detail in Chapter 2. At that point, my contact with the community stakeholders progressed spontaneously into the partnership intervention, a process initiated through the natural dynamism and continuous consultation and input from the community and external stakeholders, coupled with a commitment to allowing the process to unfold and be driven primarily by the partners. Since the results of the formative research is summarised in Chapter 2, and the initial entry process described in detail in Chapters 1 and 4, I focus below on the process of recruitment and description of the Entabeni partners.

5.2.1. Who were the community partners and how were they recruited?

The recruitment of community partners began in the *pre-formation* stage and was consolidated during the *formation stage*. As indicated previously, a primary representative (Mr Nxumalo⁹) in the community was allocated to the project by the iNkosi. The research team had to then work through him when recruiting community stakeholders to assist with the formative research. These stakeholders then, through a

⁹ It must be noted that the names of all the partners and research participants mentioned in this thesis have been changed to protect their identity; hence pseudonyms have been used instead

process of consultation and approval by Mr Nxumalo, progressed into becoming the key community representatives in the Entabeni partnership project. A local ‘reality’ in this patriarchal, tribal authority area was an acceptance of the fact that everything that happened in the community had to be negotiated with and channelled through the iNkosi or his representative (a male elder or traditional leader in the community), and approved of by them; hence every aspect of the research and intervention was negotiated with Mr Nxumalo first, since he was the ‘person in charge’, having been allocated to the project by the iNkosi. An ignorance of or defiance of this protocol, especially at this early stage in the relationship building process with the community could have jeopardised the project, or worse still, the research team could have been asked to leave the community – a common experience when working with rural communities in South Africa (Mufamadi, 2000; Ntsebeza, 2006). While the literature on partnerships mentions the need for community representatives to be truly reflective of their constituents (Gillies, 1998), at the point of recruitment of the community stakeholders, the *cultural and contextual dynamics* within the community compelled me to accept the community partners chosen by Mr Nxumalo to be a fair reflection of the community’s demographics.

However, Mr Nxumalo was open to suggestions made by me on possible criteria for the selection of community representatives, including a fair *representation* across gender, age and status in the community, their willingness to participate in the process and having a good grasp of community challenges and needs. The following conversation between me and Mr Nxumalo reflects the efforts made to establish whether the community partners adequately represented the community:

Researcher: “*Why do you feel the community partners adequately represent the community?*”

Mr Nxumalo (traditional leader): “*I should think the schools, through Lina (teacher), are represented. The religious groups, through Reverend M, and even myself are somehow represented. The home-based carers are somehow represented. The traditional leaders, through me and Reverend M are somehow represented, and some of the members, Wanda, Lina, are youth. So the youth are also represented.*”

Researcher: “*And Gogo? Whom is she representing?*”

Mr Nxumalo: “*She should be representing the elders*”. (September 2005)

Mr Nxumalo was a traditional leader, a community health worker and a confidant of the iNkosi. He was one of the few traditional leaders in the community that had completed his schooling and was fluent in the English language, having worked as an administrative clerk in a mining company in Gauteng for over ten years. He was basically the first friendly face that the research team encountered in the community and it was realised, on hindsight, that it was his acknowledgement and continued support of the research team and the project that actually facilitated the relative ease with which the project was conducted in the community (see Chapter 4). Mr Nxumalo's strong religious beliefs, his commitment to supporting the work of the volunteer home-based carers and facilitating development and health support in the community, are some of the key characteristics that guided his unwavering and intense participation in the project from the initial *pre-formation* phase (formative research), till the present.

Mr Nxumalo: *“My life is involved in so many things, like working with the home-based carers. Whatever they are benefiting, that is mine. I am benefiting as well. Whatever the community is benefiting, I feel it is me who is benefiting. I don't see myself as an individual. I am a community member”*.

However, he was constantly caught up in the often confusing and *conflicting values* of the culture in the community, and the 'community's expectations of his role as a traditional and religious leader in upholding and promoting the virtues of abstinence, while his role as community health worker compelled him to advocate for the use of condoms as an alternative to abstinence.

Mr Nxumalo: *“Our culture, good as it is, it does contribute negatively to the use of condoms. Our culture we all know says you wait up until your turn comes. So you don't find yourself involved in sexual activities. But now that the youth is already involved, then the condoms maybe one of the solutions, but our culture is completely against it. Some people feel that condoms encourage sex before and out of marriage. Some think condoms are only meant to spread HIV/AIDS as they are made and supplied by people of another race to eliminate another race. While all this is said,*

people are dying non-stop. Nevertheless, health workers in this area are doing their best in educating community members with HIV/AIDS.”

In a later discussion with Mr Nxumalo at a meeting to discuss the planning of a youth rally in the community, it is noted that Mr Nxumalo contradicts what he says above when he insists that the message of abstinence is promoted with the youth at the rally!

Reverend M was introduced to the team by Mr Nxumalo. He ‘wore many hats’, being the head of a church with a huge following in the community, a traditional leader, as well as a municipal (local government) councillor up until the local elections in 2006, when Mr Nxumalo assumed the position of municipal councillor.

KwaZulu-Natal M: *“You can call me a Reverend if you want to. You can call me pastor. You can call me councillor. I am just everything.”*

He was a humble person, willing to participate but constrained by the many roles he had to fulfil. During an initial interview with the research team, he revealed that he had personally experienced the impact of AIDS, since he cared for but finally lost his eldest son to AIDS. However, despite him discussing this openly with the research team, he refused to discuss this ‘personal tragedy’ in public for fear of reprisals from others in the community and in the church.

Reverend M: *“I would also like to say we are really disturbed about this disease, HIV/AIDS. What I am worried about is that most of our people, they do not agree, admit that this disease exists. If somebody is suffering from this disease, he will mention another disease. There is a belief that people are being bewitched. They do not admit that they are suffering from HIV. My son was also killed by this disease. He never told me the truth until the doctor told me that he died of that disease. We know the symptoms now as old people.”* (November 2004)

He was also clear about his views on sex and sexuality among the youth, believing as did many others in the community, that abstinence should be the only means of prevention adopted and promoted in the community, despite his knowledge of, and concern about the number of people dying in the community.

Reverend M: *“We church leaders are really disturbed. As church leaders, we don’t preach the gospel of condoms. We do not preach that gospel because it is ungodly. The gospel we preach is that people should abstain themselves from sex, especially the youth. The youth shouldn’t enjoy sex before marriage. That is a sin. That is what we preach. We don’t say anything about condoms. I believe that most of the religious leaders preach the same gospel as I am preaching. We also do pray for the solution. We need the remedy for this kind of a disease. We are very worried. Every weekend we have funerals, people who are dying of the same disease.”* (November 2004)

Gladys, Wanda, Dumi and Nellie are volunteer home-based carers who served under Mr Nxumalo (being the leader of the home-based carers), and whom he hand-picked to participate in the partnership process, since they met the criteria suggested by myself, being young, three of whom were female and having a deep understanding of the challenges posed by HIV and AIDS in the community as illustrated below:

Gladys: *“In this community there is a very high level of poverty. You would find that a young girl will have unprotected sex with an old man because he will provide her with her basic needs. I am also worried about women that act like midwives at home. They use their bare hands and un-sterilised instruments when delivering a baby. Some of the people are shy to talk about HIV in front of their children. They feel embarrassed. The couples blame each other when they find that one of them is HIV positive. Such people lack knowledge.”* (November 2004)

All three were fresh faced, enthusiastic but initially shy and afraid to participate freely at meetings. In initial contacts with them, they displayed unwavering support and respect for the authority in the community- represented by Mr Nxumalo and Reverend M in the partnership committee – and rarely communicated their views openly in their presence. They later admitted that they were also intimidated by the very important people from the public sector departments and NGOs, and the ‘white people’ who came to these meetings. I take up this point later in a discussion of the *power dynamics* within the community that impinged on the participation of some of the community partners. It is also noted that this changed somewhat through their participation in the partnership process, a process of becoming familiar with the partnership representatives and the role played by the external change agent in developing their levels of confidence and sense of empowerment.

Gogo and Lina were both teachers. *Gogo* was an elderly retired teacher who was well respected in the community for her contribution to education in the community, her voluntary work with the pensioner's group and participation in church activities. She often joked about having taught all the 'big men' in the community, including the iNkosi, Mr Nxumalo and Reverend M. She was a huge asset to the partnership committee, since she was familiar with the community's strengths and challenges, including the onset and impact of AIDS in the community, and had the ability to situate this discussion within a historical context. She was a constant source of inspiration to the partners and they drew from her wisdom, knowledge and guidance at partnership meetings. Unfortunately, midway through the implementation phase, she had to withdraw from partnership activities since she had become quite ill and began succumbing to age-related frailty (she was 80 years old in 2006).

Lina was a young female teacher who joined the partnership committee for a short time. She was also an asset to the committee because of her link to schools in the community. She had the ability to influence the mindsets of the youth and teachers at school and speak openly about the virus, in spite of the denial and stigma that existed in the community.

Lina: "The school community, that is the learners and the educators, they know of the HIV/AIDS thing and they agree that it kills, but the problem with them is they don't believe it is near them and it lives within them. They believe HIV/AIDS affect and infect people who live in far places, in urban areas, for what reason I don't know. When my elder sister died of AIDS, after her funeral I wore the same badge I am wearing now to school. When I got to school they were so amazed. They asked me, "Hey why all of a sudden AIDS awareness?" I said, "I am wearing this because I have realised". We didn't know my sister had AIDS. We knew when she was about to die. So I thought I should take that initiative of making people aware of the disease and so I wore the same badge." (November 2004)

Before she moved to her husband's home, situated outside Entabeni, and relinquished her ties with the partnership group, she contributed to the initial workshop with potential partners and was able to establish a strong link between the school she taught at and the partnership members. This helped establish the peer education

programme that was facilitated in this school by an external NGO partner (counselling NGO described in Chapter 6).

During the formation and implementation phase, four more female home-based carers (Imbali, Ntokoza, Mamage, and Thusi) were recruited by Mr Nxumalo to participate in the partnership committee as extended support members to the local partners. They had received training in home-based care and life-skills through the partnership programme and were enthusiastic to support the work of the partners in the community.

5. 3. Collaborating with the Community Stakeholders-Process, Challenges and Enablers

The process of *networking* and *relationship building* with the local community partners began at the inception of the contact between the research team and the community, and continued throughout the partnership-building process. In the *pre-formation* stage, the local community stakeholders, recruited by Mr Nxumalo, participated in the *formative research* (see Chapter 2) by making suggestions about potential research participants in the community, assuming responsibility for facilitating these interviews and directing the research team to mandated external service-provider organisations that they believed should form part of the research sample. This process of consultation with the community stakeholders was time consuming, requiring much effort to arrange in this rural community, due to the *lack of formal communication networks* (telephones, tarred roads, etc.), and the reluctance of some community members to participate in HIV and AIDS research. At the time of the formative research, HIV and AIDS was still a taboo subject in the community and many people were wary of being associated with anything to do with the virus for fear of being *stigmatised* by other community members. The following quote highlights this challenge:

Mr Nxumalo: “*We still get patients who are locked away from the rest of the family. On Tuesday I was told that a patient was put aside. The room was always locked. I was with Mrs Z (home-based carer) and we just went there. She was neglected and she died on the same day. We suspected she had been hit as she was crying when we came. We went into the room and there were no signs that someone had been there.*”

Usually you would find a bench or an ordinary mat, to show that someone had been sitting there". (March 2005)

The second stage to this process involved a series of formative research dissemination workshops (see Chapter 2 for details). The local partners again participated actively in facilitating these dissemination and consultation workshops with the community stakeholders and external service-provider stakeholders. Since I have already discussed the outcomes of this workshop in Chapter 2 and Chapter 4 of the thesis, I contribute largely to research question 2, which focuses on ‘*process*’ issues. I discuss their involvement in the preparation and facilitation of the workshop and the meeting held thereafter to evaluate the workshop.

5. 3.1. Facilitating networking, capacity-building, empowerment and ownership through community-driven development

In adopting the concept of *learning through doing* (see Chapter 3), the community partners were encouraged to assume *responsibility* for participating actively in building networks with potential external stakeholder partners and facilitating *collective ownership* and *joint management* of activities focused on addressing the challenges posed by HIV and AIDS in the community. I demonstrate the process of how this transpired through a discussion of two key events involving the community partners as primary facilitators and participants, with the external change agent assuming the role of co-facilitator, and providing constant support, guidance and encouragement. I discuss the process of planning for both events to demonstrate how the notion of *learning through the lived experience* facilitated a process of *capacity-building* and *empowerment* for the community partners and encouraged a sense of *ownership* of the project and the challenges of HIV and AIDS in the community (responds to research questions 2 and 4). The discussion highlights some of the *complexities and challenges* involved in working with resource-poor communities (responds to research question 3), where development *capacity is scarce*, resources unavailable and ‘*cultural norms and values*’ and codes of conduct constantly influence perceptions and the participation of women and youth in developmental processes.

5. 3.1.1. Preparation, facilitation and evaluation of the formative research-dissemination and consultation workshop with potential external stakeholder partners

At a meeting held to plan for the research-dissemination workshop with potential external stakeholder partners (November 2004), and subsequent meetings, the community partners were encouraged to assume major responsibility for communicating the community's challenges, needs and hopes to potential external partners (service-providers). It was hoped that this experience would initiate the process of *capacity-building* with the community partners, boost their levels of confidence and begin to acknowledge their personal and community strengths, as illustrated below:

Researcher: *“The important thing about this workshop on the 29th is for everyone to be able to let people out there know what this community is about, what their problems are, where you need assistance, because we are going to have the Department of Welfare, the hospitals and the clinics present, so they must hear from you.” “That is why I am saying, if you talk, talk from your heart so that they hear. Don't be shy because most of them are coming because I told them members of the community will be there”.* (Planning meeting for workshop with potential external partners, November 2004)

Researcher: *“Part of this is that you all need to get something out of this partnership as well. You need to develop your skills and get in contact with other people where you draw on them for other things. We need to sit and talk about that as well, because ultimately if that partnership does not work, we will have to depend on this group. We are going to try and see if we can draw them in but if it comes to a point where these partners are not very keen and feel that they are too busy, we can use them for the things that we need but ultimately we will have to depend on this committee here and develop them to take this project forward in the long term.”* (Planning meeting with community partners for first formal partnership meeting, March 2005).

At this planning meeting (held in November 2004), the community partners expressed a sense of isolation and helplessness in relation to the service-provider stakeholders, having become accustomed to being ‘ignored’ by public sector officials and

struggling to *network with or gain access* to them, let alone their support. Mr Nxumalo and the Lutheran missionary from the development NGO based in the community (referred to as Audrey – see Chapter 6), expressed their disappointment and *mistrust* of the Department of Health, who failed to attend the official opening of a fledging hospice that was set up by the NGO missionary, with the assistance of the community partners in the community.

Mr Nxumalo: *“We invited them (Department of Health). Actually we kept informing everyone else involved, but even on the day of the opening of the hospice, no one turned up. We even wrote a note to the director, Ms Msomi, but no one came and no apology. So, it is impossible to get hold of them but we know about them”.*

Audrey (NGO representative): *“I remember you telling me that people from the primary health clinic would come, but they were not here”.*

At a subsequent meeting held to evaluate the dissemination workshop, prior to the first formal partnership meeting, I mentioned the challenges experienced when attempting to contact public sector officials to invite them to the dissemination workshop. Mr Nxumalo again confirmed they have always struggled as a community in accessing the support of the Department of Health officials:

Mr Nxumalo: *Yolanda (referring to researcher), you are just witnessing what I have been telling Audrey about the Department of Health. I was actually thinking it is better to go there rather than talking over the phone. They are a problem really.”*
(March 2005)

It was therefore hoped that the dissemination workshop would provide the opportunity for community stakeholders and potential external service-provider partners to communicate directly with one another, establish the ‘community’s *credibility*’ in the ‘eyes’ of the external service-provider organisations and initiate the *process of networking and relationship building* between them.

On the day of the workshop, the research team was pleasantly surprised to see the community partners dressed in what was obviously their ‘Sunday best’, looking very nervous but also excited at the opportunity of being a part of ‘such an important

meeting'. Wanda commented later that this was probably the most exhilarating experience she had ever had in her young life-time. She danced around the room with Gladys, the silver dust on her outfit catching the light of the evening sun, reflecting the 'magic' that the day's events had initiated for them and the community of Entabeni (see Chapter 6 for details of external partners participation in the dissemination workshop).

5.3.1.2. Planning, facilitation and evaluation of the Youth Rally

At a meeting with community stakeholders in March 2005 to evaluate the dissemination workshop with external stakeholders, and, to plan for the first formal partnership meeting, the community partners were sidetracked from the agenda for the meeting. They were concerned about the impact of HIV and AIDS on youth in the community and needed to discuss this urgently. These concerns were shared by the NGO representative who suggested a gathering for youth in order to 'get the message across' and encourage youth participation in HIV and AIDS programmes in the community.

Reverend M: *"The youth especially do not attend meetings. I had a big gathering on Saturday at the Tribal Court. I think 25 percent of the youth was there but mainly it was the old people. We need to convey the message about HIV/AIDS wherever we meet. Even on Sundays when I preach. I don't forget that, especially the youth because we have mainly the youth in our churches. They must understand how they should abstain from all this. I really agree with what Ms M is saying. We need to have that message going straight to the youth. Those are the people who are really affected. They are buried every weekend."*

Audrey (NGO representative): "It is a natural thing for people to want to have sex with the one they love. Otherwise you will have many frustrated people around here. I think people have to be told the correct information, that the condom does not bring AIDS. Another cultural thing I see is the role of a young person when there are adults present. They are not supposed to say anything. Is that right? They are supposed to be quiet. So I think it is important if you are going to talk to the youth there must only be the youth there so that they feel free to talk. It should be a youth gathering and all the oldies must stay away, and have a dynamic young person to talk, like that teacher who

was present at that workshop (with external stakeholders). I was very impressed with her. I don't remember her name but she spoke so well and her sister had died, and she was very involved. This is the kind of person that gets the message across, not the elderly people. You are settled in your families.”

There was unanimous agreement from all the other community stakeholders present that a youth rally would be the most appropriate way to introduce a programme focused on educating the youth about HIV and AIDS. In acknowledging the principles of community-driven development (Mansuri and Rao, 2004; Platteau, 2004), the external change agent went with the flow of the discussion, acknowledging their need to begin the process of responding to the challenges posed by HIV and AIDS immediately. Their decision to begin the process of a partnership response to the challenges of HIV and AIDS with a youth rally was supported and used as an opportunity to encourage community ownership and capacity-building of the community partners. They were therefore encouraged by the external change agent to take the lead in organising and planning the youth rally with the NGO representative, while the external change agent assumed an advisory and supportive role in the process.

The concerns raised at the meeting with the community partners, the external change agent and the NGO representative (Audrey), led to the establishment of a 10-person planning group (referred to as the youth committee), comprised of youth representatives from a local school, out-of-school youth, Reverend. M, Mr Nxumalo, a local teacher and three of the home-based carers represented on the partnership committee.

The external change agent was initially concerned about the small representation of two school-aged youth on the committee, especially since the inclusion of youth in planning the rally was one of the issues discussed at the previous meeting. This confusion about who represented youth was soon clarified by Mr Nxumalo and the other community partners, who confirmed that both the health workers and the teacher on the committee were between the ages of 21 and 35 years, and were considered youth in the community! It is also noted that the National Youth Commission Act of 1996 in South Africa defined youth as persons in the age category 14 to 35 years.

At the time of planning this event, the community partners had already met with potential external partners from within the public service departments (Health, Welfare, local government), the private sector and NGO sector, which is discussed in detail in Chapter 6. Two formal partnership meetings had been convened and the community partners and researcher decided to use this as an opportunity to present the idea of the youth rally to the committee, motivating for this event to be one of the first joint ventures facilitated by the partnership committee. There was much support for this idea from the external stakeholder partners, who offered not only material assistance but creative ideas and promises to attend and assist the community partners in facilitating the event.

May (primary health care nurse): *“About the youth rally, we can also contact Cora FM maybe they can give help. This is the local radio station.”*

Lina (teacher from community): *“Ya, we thought of Cora. I think if I am not mistaken, Reverend M promised to speak to the Nxumalo guy”*

Reverend M: *“I can see him after this meeting.”*

May: *“I can also provide posters.”*

Researcher: *“What kind of posters will you provide?”*

May: *“They are HIV/AIDS posters and then we also have small pamphlets. I think we have to liaise with Naledi (counselling NGO psychologist) and see what we have got.”*

Hence, while planning for the youth rally was the primary responsibility of the youth committee, the value of collaborating with the partnership stakeholders on this event was also acknowledged. The input of the external partners was therefore continually fed back to the youth committee, who then made the final decisions regarding the event.

This process of planning for the youth rally was fraught with many complexities which were exacerbated by the conflicting and contradictory *norms and values* of myself (researcher) and community stakeholders, and often between the community stakeholders themselves (between the older men, women and youth respectively), as illustrated below by the discussion about condoms. My view was that young people

were not adequately represented on the youth committee, a view fuelled by evidence from the formative research, including interviews and focus groups with the very types of young people targeted by the rally. Hence I believed that the so-called community representatives on the committee were not indeed representative of the relevant constituency. Adult men on the youth committee dominated discussions, alienating the women and youth represented on the committee. This resulted in the external change agent having to gently intervene on many occasions to negate the *power* wielded by the older men on the musical bands, singing and dancing, a talent contest, motivational speeches by PLWAs, competitions and a presentation of prizes by dignitaries invited to the event (religious leaders, traditional leaders and healers).

NGO (Audrey): *“Now I wanted to say, thank you. I was going to agree that this was a great day and I think we can all be proud of what we did and I am glad it happened. I think we can do it again and we have to learn from this and the next one will even be better and bigger.”*

Mr Nxumalo (in excitement): *“Let’s clap hands!!”*

At a post evaluation meeting with the youth committee committee, encouraging participation by all the committee members and ensuring that everyone’s voice was heard.

Reverend M and Mr Nxumalo were initially unanimous that the aim of the day should be to promote sexual abstinence by young people. Whilst I am strongly in favour of sexual abstinence as an HIV-prevention strategy for those who are likely to adopt it, given the reality of the high levels of youth sexual activity in the community, I also felt that it would be beneficial to offer young people a range of options for avoiding HIV: abstinence, monogamy or condoms. In the formative research study, young people repeatedly indicated that abstinence messages had no resonance with the reality of their own lives and norms, and that they perceived them as irrelevant and meaningless. This view was conveyed to the planning committee, with emphasis that this was supported by the formative research findings. However, and in line with the commitment to the partnership project being community-led and community-owned, the external change agent had to stand down when it became evident that no other

committee member was willing to openly support this view. These kinds of interactions highlight again the differing *norms and values* of the external change agent and some community members (especially older men), and the need to be cognisant of the ways in which it may impinge on partnership process.

The partnership meetings provided a novel opportunity for these and other issues to be *discussed and debated* within an open forum. In effect, it also afforded community partners the opportunity to hear alternative perspectives and understandings on issues like the use and availability of condoms to youth, while providing the platform for other voices in the community (women, youth representatives) to be heard. In these instances, I often played devils advocate by making provocative suggestions with the intention of facilitating debate and introspection, thus subtly influencing and contributing to a shift in mindsets, as illustrated in the following conversation about condoms at the 2nd partnership meeting which focused on planning for the youth rally (June 2005):

Sally (counselling NGO director): “*Condoms?*” (*Laugh*)

May (primary health care nurse): “*There is this school we go to? Each time we go there we come back with nothing.*”

Naledi (counselling NGO psychologist): “*But they play with the condoms.*”

May: “*As long as they take for the friends or whoever, the fact is they take them.*”

Naledi: “*They take them but they play with them.*”

Lina: “*I am the supplier of condoms at my school. They just take them and inflate them. They play with them.*”

Researcher: “*Don’t you think it is better to have them available than not?*”

All: “*Yes.*”

Wanda (home-based carer): “*In my area I distribute them. I just put them in shops and also at Ezinqobele.*”

Gladys: “*Kids get information from outside and bring it home. My son asked me how to use a condom and why people should use condoms.*”

Despite the above discussions, Mr Nxumalo and Reverend M were still keen that the main message for the event should focus on abstinence:

Mr Nxumalo: *‘The information is to know your status, abstain. We will be getting motivational speakers. One of them, I am made to understand is positive. So she or he will be saying, ‘I am positive. This is how I live, but abstinence will be the priority.’*

Reverend M: *‘I would like to say, we as pastors, we have a role to play as far as that is concerned. In fact abstinence is very good. To have children before marriage is a sin. People must know that. God doesn’t like that. So we play a big role.’*

However, on the day of the youth rally I observed the home-based carers casually handing out condoms to all those present at the youth rally and arranging condoms in an attractive pattern almost at the centre of the soccer field where the rally was being held. This challenged the *values* and popular view often held by older men in the community that abstinence should be *the* prevention strategy promoted in the community! Our involvement in the youth rally reflects some of the complexities of outside agents working with local people to further community-led programmes, where the *values* of community representatives appear to be at variance with my values and between different sectors of the community as well. It also challenges the popular definition of social capital by theorists like Francis Fukuyama (1999), who described social capital as the existence of a certain (i.e. specific) set of informal *values or norms shared* among members of a group that permit cooperation among them. In this instance, the conflicting values of my-self and often older men in the partnership and between some of the community partners themselves did not deter cooperation, but actually allowed for an acceptance of and tolerance of each others *values and norms* within an environment of respect, *trust* and openness to learning from each other (*reciprocity*). Thus, the community partners felt encouraged to incorporate the alternative views expressed by the external change agent about abstinence, condoms and planning strategies for the youth rally, while the external change agent reciprocated by acknowledging the community partners views and interpretations on these issues and on the success of the youth rally (discussed below). This encouraged the community to take the lead in decision-making around the planning and implementation of community events like the youth rally.

The youth committee, despite their lack of experience in planning such events and the many challenges encountered during the planning process, managed to *work in*

collaboration with various community and external stakeholders in facilitating what was considered by them to be a very successful youth rally. Thus, the committee rallied the support of the Department of Health in supplying them with condoms and pamphlets to distribute to the youth on the day of the event, while the counselling NGO (see Chapter 6) was present at the youth rally and assisted with the distribution of pamphlets and general organisation. The Entabeni development committee contributed funds for the hire of portable toilets for the day and worked tirelessly, with the assistance of community partners and home-based carers, in preparing and distributing food to the approximately 800 community members who attended the rally. The research team also pitched in by arranging for a group of youth from Durban to perform a sketch based on the theme ‘HIV and youth in rural communities’ – a drama seeking to facilitate AIDS-awareness. It was later learnt, from a discussion with the community partners, that this was very well received by those present, generating a lot of discussion and laughter at the identified similarities between the sketch and their experiences of how HIV and AIDS was perceived within their community. The community partners, youth committee and home-based carers took responsibility for organizing other events for the day, including members, it was assessed that being involved in organising such a large and complex event had been a steep learning curve for virtually all the committee members, including myself, with fast and effective *experiential learning about planning, networking with outside organisations* (including a radio station and the drama group), and *collaborating* with community representatives of various ages, experiences and perceptions. The following two conversations between those present at this meeting reveal some of the lessons gained (*capacity*) from organizing and participating in the planning and implementation of this event.

Conversation1

Gladys (home-based carer): “*I think the organising time was too short.*”

Researcher: “*You mean you needed more time to plan*”?

Gladys: “*Yes.*”

Researcher: “*Why do you say that?*”

Gladys: “*I am saying that because transport was not available. People waited at Umlalazi Bridge for transport to pick them up but there wasn’t any.*”

Mr Nxumalo: *“I agree with what she said. Some of the youth were coming from very far. They needed transport. Maybe she is right, everything was somehow late. Unfortunately people (sponsors) did not respond to the many letters we wrote. Only two responded.”*

NGO representative: *“As far as I can see or hear, we really have two issues here. One is the time we had to plan such a big thing. It was short. The other thing is transport, because it is money. If there is no money there is no transport. So we are really facing two issues here. If the transport issue had been raised in the committee, maybe we could have handled it already then. That is not necessarily the time. It is knowing that if we are having a rally, we need to have transport. That is what we have got to learn from this.”*

Conversation 2

As indicated, the process of collaborating with the community stakeholders in planning and facilitating the youth rally was definitely an eye opener for me, since I believed that the inadequate representation of youth at the rally, and the obvious presence of older people and children, hindered what was supposed to be an awareness programme targeting youth only, again illustrating a conflict between my *norms and values* and those of the community stakeholders. The euro-centric criteria adopted by myself in assessing the outcomes of the youth rally was basically thwarted by the positive feedback from the community partners, who were obviously exhilarated about the achievements made, and unanimously adamant that the day was a resounding success!

Dumi (home-based carer): *“In my point of view, I don’t see any problem with mixing youth with adults because they usually mix. As long as the youth came, I would say mission accomplished. You can’t separate adults from the youth in the community because they enjoy everything together. As long as the youth came, there is no problem.”*

Gladys (home-based carer and youth): *“The women concentrated a lot when they watched drama on HIV/AIDS.”*

Dumi: *Whilst the youth were chaotic, the adults concentrated on what was happening. They came closer to listen*

.

Wanda (home-based carer and youth): *“Ya, I think the day was nice and I don’t see anything wrong with the adults. They also learned something they could go back and teach their children.”*

Researcher: *“What I am hearing from the committee members is that while it was supposed to be a youth rally you are saying that it wasn’t a bad thing that there wasn’t only youth there. It was very good that there were parents and older people because they were listening to the message and in a round about way they would be able to educate the youth about what they heard that day and to also make them think about the issues that came out of the drama. So that is basically what you are saying?”*

Mr Nxumalo: *“Yes.”*

Having described the process and factors that influenced and impinged on the first phase of *formation* of the Entabeni partnership, involving the recruitment of and relationship building with the community partners, below I supplement these discussions with an analysis of the process of partnership-building, using Campbell’s (2003) criteria for effective partnerships.

5. 4. An Analysis of the *formation* stage of the Entabeni partnership with community stakeholders

In applying Campbell’s (2003) criteria for effective partnerships as a framework for the analysis of *partnership formation* with the community partners, it is acknowledged that these criteria have thus far only been applied to an analysis of external service-provider partners within a partnership process (Campbell, 2003). However, I contend that these criteria have value for and are applicable to an analysis of a partnership process involving community stakeholders, as the discussions below indicate. I also add to this analysis by extending the interpretation of these criteria (from the original interpretation highlighted in Chapter 1), based on the data gathered in the first phase of the Entabeni partnership.

In terms of the *capacity* of community partners to make a meaningful contribution to the partnership and to HIV and AIDS management in the community, the levels of *capacity* among the community partners varied. Mr Nxumalo and Reverend M generally possessed more skills to facilitate their active participation in the partnership and in social change processes in the community, both having received training to perform their various roles as community health worker (Mr Nxumalo), and municipal councillor (Reverend M) in the community. Their ages and years of work experience contributed to their ability to participate actively in partnership discussions, make innovative and creative suggestions about strategies for encouraging service-provider participation in the partnership, and contribute ideas around possible joint ventures to be implemented in the community by the partnership.

However, as with the other community partners, they lacked planning and facilitation skills and the confidence to communicate with outsiders or advocate on behalf of the community for service provision or adequate support of community initiatives (home-based care programme) and community aspirations (support of a hospice to be established in the community, training of youth and other community stakeholders, support for PLWHAs). This however, changed gradually through their participation in the partnership meetings and activities and the key roles and responsibilities they were encouraged to assume by the external change agent (chairing of meetings, recording minutes, planning events like the youth rally, attending and participating in meetings with partner organisations), in the formation and implementation phases of the Entabeni partnership.

The four home-based carers (Wanda, Dumi, Gladys and Nellie) came into the partnership with very few skills aside from their existing knowledge gained through their lay experiences as home-based carers in the community. Some of them even indicated that prior to their involvement in the partnership process, they lacked in confidence and self-esteem and could not see themselves progressing as women and youth in the community, or contributing to social change processes in the community. However, this changed with their involvement in the partnership and their participation in the numerous training courses arranged by the research team initially and subsequently by the service-provider partners (counselling NGO, Dept of Health)

in the implementation phase of the partnership. They benefited tremendously from these various training programmes as home-based carers, as partners, and as social change agents in the community.

The *learning by doing* strategy adopted from the very beginning of the partnership process was instrumental not only in facilitating skills transfer, but heralded a steep learning curve for community partners, who began reaping the benefits of their involvement even in the early stages of *formation*, as the following quotes illustrates:

Wanda: *“One day Sally (director – counselling NGO) said knowledge is power. I am today proud because of the knowledge and wisdom I have got through this partnership. I can now stand in front of a large crowd and talk confidently. I am now able to share the knowledge I have with other people.”* (September 2005)

Gladys: *“I have gained a lot from this committee. When I was still at school, I had a vision. I saw myself as a doctor or as a radio presenter or something great. I have always wanted to be a leader and to have my own business. It is unfortunate that in the meantime I got married. I started having children. I thought of going back to school. I failed biology. I could not cope. Now that I am involved in home-based care and HIVAN has come into my life, things are beginning to have meaning for me again. I am not like a person who is sitting at home doing nothing. I am now able to give advice to people. I am also a role model to some people. People who have been looking down upon home-based care are now starting to think otherwise. They have seen us graduating. They see many things happening in the community.”* (September 2005)

Gogo and Lina, for the time that they were with the partnership, contributed their skills as trained educators and the knowledge that they had acquired in the community through their work with youth (Lina), the church and elders (Gogo). They also benefited from their participation in the partnership and were able to disseminate this knowledge to other groups in the community.

At the point of partnership theoretically progressing into the *implementation phase* of the process, it is noted that while capacity-building and empowerment of the

community partners was initiated, and shown to have contributed to the growth of the partners and the partnership, I felt that they still had 'far to go' before they would be able to assume full responsibility for the facilitation and co-ordination of the Entabeni partnership. Hence, the development principles of *community owned and community-driven* had to be tempered with an acceptance that I would need to continue to partner with the community stakeholders in facilitating the Entabeni partnership, and, indeed, assume major responsibility for the administration (writing of minutes of meetings, sending out invites and reminders to meetings), etc.

This situation was aggravated by the lack of *infrastructure* and essential resources to support the work of the community partners. They did not have: i/access to telephones (except cellular telephones which were expensive to maintain), faxes or computers (access to email) to contact partners to arrange meetings; ii/access to adequate and reliable transport to get them from one point to the next, or access to transport to enable them to travel to the offices of the service-provider stakeholders (see Chapter 2). The only means of communication (telephone, fax) that existed in the community was situated at the tribal court, but none of the community partners 'dared' request the use of these facilities since it was presumed to be the property of the iNkosi (traditional chief and leader), despite it being known that the technical operation of tribal courts in rural communities in South Africa was subsidized by the South African government.

In order to assist with and work around this challenge, the research team often transported community partners to meeting venues (outside the community), or arranged for partnership meetings to be held in the community to allow for their easy access to meeting venues. In the initial stages of the project, the research team was reluctant to contribute funds directly to the community partners, for fear of this interfering with the notion of *community ownership* and *sustainability* of the project, as experienced by other projects facilitated in rural communities in Africa (Gruber and Caffrey, 2004; Pfeiffer, 2003). However, during the *implementation phase*, the research team made a decision to provide minimal stipends to all home-based carers that worked in the community in a parallel project being facilitated with HBCs in the community (see Chapter 2), because of the high levels of poverty in the community and to support their care of PLWHAs. This included many of the community partners

as well (Mr Nxumalo, Dumi, Gladys, Wanda and Nellie). I was therefore able to transfer the responsibility of contacting and maintaining contact with external partners to the community partners for arranging meetings and joint interventions in the community (see Chapter 6 and 7).

What the community partners lacked in capacity and infrastructural support, they made up for in their enthusiasm and motivation to participate in what they saw as a 'god-send to the community'. A major *incentive* for them to participate in the partnership process, as discussed above, was the value their participation in the Entabeni partnership had for them *personally* (capacity and empowerment discussed above), and for the *community*. The perception was that this value arose from the partnership interventions (discussed in Chapter 6 and 7) planned and facilitated in the community by the Entabeni partners, as well as through the *networking and access to external service-providers and trusting relations and reciprocity* that was facilitated through this process, as illustrated below:

Gladys: *'The community is gaining a lot from this partnership because in most cases, the community does not have much information about the service-providers. Personally, if I didn't volunteer to be a home-based carer and then in the long run meet people from HIVAN, I wouldn't have got so much information and knowledge today. I wasn't even motivated to go and get information anywhere. I see this committee as very important because we go out and get information and then bring it back to the community. We tell people about what we have seen and heard about. Most of the people we visit are poor and lack information. They cannot get out of this community. It is therefore important for us as a committee to go and find information for these people. It also makes me feel responsible. There is a lot this committee can do for the community.'* (September 2005)

Mr Nxumalo: *One would always be on the positive side because we are looking for the positive side. Between the municipality and the community, because otherwise, besides this partnership team, I wouldn't be knowing Mr D (municipality). The only person I would know is the councillor of the ward, which is Reverend M or someone else. With the partnership I now know people from the Welfare, municipality. It is now easier for me to go straight to the person in the department about the problems in the*

community, unlike if there was no partnership, because I wouldn't be knowing about Matron N (local hospital). In future I will be knowing people from Catherine Booth Hospital. (September 2005)

Researcher: *So you feel that the partnership has helped you to form alliances.*

Mr Nxumalo: *Yes. Thank you for opening doors that have been closed.*

Their *conceptualization* of the partnership as facilitating networking and access to the essential information, resources, services and support needed by the community from external service-provider partners, and the value that their participation in the partnership had for them personally is what sealed their *commitment* to the partnership and to the interventions planned for facilitating HIV and AIDS management in the community (discussed above and below).

Gogo especially benefited from the *reciprocal* support that she received from the partners (research team and community partners), and the *trusting relations* that were built and continuously nurtured between the partners. At an end of year group evaluation session and celebratory lunch with the community partners and the research team, I noticed that Gogo was un-characteristically quiet and withdrawn. On enquiry, she indicated that she was tired and 'not very hungry'. However, she soon announced to everyone present that she had a 'confession' to make to everyone present since she 'felt close enough to everyone present and trusted them'. Her announcement came as quite a shock to everyone present.

Gogo: *"My daughter is HIV positive. My daughter has AIDS!"* She then broke down, her body racked with spasms of uncontrollable sobbing!

The immediate response of everyone present was stunned silence and confusion about how to respond since Gogo was a person they all looked to for advice and support. However, as soon as I, a trained counsellor, reached out to her and hugged her, allowing her to cry and unburden herself, the community partners present took up the cue by whispering quiet words of support and reassurance.

The above compelling example of the value that the Entabeni partnership had for Gogo and the other community partners was what continued to drive their participation in the Entabeni partnership in the *formation, implementation and maintenance phases* of the partnership process. However, a major *disincentive* was the lack of access to material resources to enable them to assume responsibility for certain tasks essential to the facilitation of the partnership (discussed above). This was therefore pursued in the implementation phase, where minimal financial support was given to the community partners.

5. 5. Conclusion

The initial stages of the Entabeni partnership-building *process (formation)* involved the recruitment of the community partners and heralded the beginning of *networking and collaboration* (e.g. planning and implementation of the youth rally) with potential external service-provider partners around identified partnership goals. Even at this early stage of the process, the community partners confirmed that this process of collaboration and networking was of *value* to the community. It signified the beginning of ‘mending’ their relationship with the public sector that was previously based on *mistrust and suspicion* because of their long history of the battling to gain public sector support in addressing community challenges, and in accessing basic health and welfare support.

Other ways in which community partners *benefited* from their participation in the partnership process included the opportunity for them to *develop their skills* and levels of *confidence* through fast and furious *experiential learning* (learning through doing), and using these skills to benefit the community. Community partners attended almost all of the research meetings with external partners and did not have unrealistic expectations of what the partnership project would achieve, placing an extremely high value on each of the very small steps that the partnership formation process achieved. This illustrates one of the benefits of adopting the process of *facilitating* rather than *intervening* (Campbell, 2003; Lamptey and Gayle, 2002), giving control and space to project participants to formulate small steps in line with what can realistically be achieved in terms of existing capacity (both within and outside the community), and allowing the process to be driven largely by the partners and the unfolding dynamics of the partnership process. Partners were therefore able to appreciate the achievement

of small gains and ‘quick wins’ as described by Butterfoss, et al. (1993), rather than continually striving to achieve grandiose and externally imposed goals, and in the process, losing sight of the significant but small developments along the way (Alinsky, 1973; Wieck, 1984) I discuss this point further in Chapter 7.

The process also highlighted *challenges* (research question 4) associated with the issue of *power*, a factor highlighted by Bourdieu (1986) in the social capital literature, and by many authors in the partnerships literature (Huxham and Vangen, 2005; El Ansari and Philips, 2001b; Campbell, 2003; McLaughlin, 2002). However, these conceptualisations often describe *power differentials* as that which exists between people in communities in relation to organisations and people with economic power, professional status or resources outside of their immediate environment or community. In this chapter, the findings highlight the *power differentials* that existed between the older men and women and youth in the community, illustrating how this *cultural norm* interfered with and hindered their (women and youth) participation at partnership meetings and in the partnership process. I highlight this to draw attention to the potential *hindrance* that this could pose to partnership initiatives in particularly rural, traditional communities such as Entabeni if they are not accounted for and dealt with appropriately. In this instance, the external change agent utilized the relationship built with community stakeholders and the respect earned for the input made in the community (see Chapter 2) in assuming the role of mediator, and intervening at meetings and other events to ensure that the voices of these *less empowered* partners were heard. This was one of the roles that the external change agent had to assume throughout the partnership process, especially when intervening in conflicts or other relational outcomes due to power differentials between the community and external stakeholders (see Chapter 6 and 7).

Another *challenge* encountered during this phase related to conflicting *values and norms* between the external change agent and particularly older men on the partnership committee, and between the community stakeholders themselves. An example of this related to the issue of condoms and the call from older men represented on the partnership committee to promote abstinence as the only prevention strategy amongst youth in the community, while the younger representatives on the committee, the home-based carers and the external change

agent felt otherwise. These differences in opinion and values, encountered often in this phase of the process, did not hinder cooperation among the partners or between the partners and the external change agent, since it was often negated by the levels of *respect* and *trust* (the cornerstone of collaborative relationships and social capital), that had developed between the community partners and the external change agent. This challenges the notion of the social capital literature which generally purports ‘common values’ and ‘shared norms’ as the basis for building ‘trusting relationships’. Instead, a familiarisation with each others beliefs and values, a respect for each other and an understanding and acceptance of the culture and contextual dynamics within the Entabeni community contributed largely to the development of a ‘*common vision*’, purported to be necessary to partnership-building over time between the partners and the external change agent (Salmon, 2004; Roussos and Fawcett, 2000) (contributes to research question 6).

In terms of the factors that *facilitated the process* (research question 3), the relative *ease of entry* into community life by the research team; the process of *relationship building* that began in the *pre-formation stage*; the research team’s *acceptance of the dominant cultural practices and norms* that existed in the community (patriarchy, gender and political hierarchy), and the ability to work around these practices rather than against them, contributed to the ease of entry and the warm *relationships based on trust and respect* that developed between the research team, the community partners and other stakeholders in the community (traditional leaders, iNkosi, home-based carers, religious leaders). This, in turn, fed into how the rest of the process unfolded. The process of entry into the community was negotiated with the iNkosi and it was accepted that the recruitment of community stakeholders to participate in the partnership would be done via a traditional leader allocated to assist the research team in the community.

The community partners contributed to this process through their *existing skills and knowledge*, their *willingness* and *commitment* to participating in the partnership process for the purposes of achieving the personal goals of *capacity-building and empowerment*, and the community goals of gaining *access* to information, knowledge, service provision and support from the external stakeholder partners. As indicated above, the focus on the *joint facilitation* of the partnership and the involvement of the

community stakeholders in all aspects of the partnership-building process contributed to the *strong bond* that developed between the research team and the community partners, resulting in what can only be considered to be a consolidation of *trust*, as illustrated by Gogo's 'confession' about her daughters HIV positive status to the research team and community partners.

The next chapter presents a discussion and analysis of the second phase of the *formation stage* of the Entabeni partnership process. I highlight the process of recruitment of the external service-provider partners, the challenges encountered and factors that facilitated the process of collaboration with the external partners.

Chapter 6

The External Stakeholder Partners: Who are they and what did they bring to the Partnership?

6.1. Introduction

This chapter follows on from Chapter 5, which discussed the recruitment of and collaboration with community partners from Entabeni. Here I present an analysis of the second part of the *formation stage* (El Ansari and Philips, 2001a), the process of recruitment and collaboration with potential external stakeholder partners. The data presented continues to focus on and contribute to the five research questions highlighted in Chapter 5.

I reiterate the practical aims of the Entabeni partnership to situate the process followed, and findings discussed, in this and the following chapter. These included the need to: (i) support the work of the home-based carers and community partners; (ii) enable them to facilitate community members' access to resources and services needed for the effective care and support of people living with HIV and AIDS, especially grants and skills building; (iii) develop service-providers' understanding of the community's challenges and needs; and (iv) secure the external partners' commitment, however small, to contributing time and resources to meeting practical goals developed by the partnership committee.

The recruitment of potential external partners began in earnest at the time of implementation of the formative research and dissemination workshop held with external stakeholders in the region (discussed in Chapters 2 and 5). Six key agencies were interested in participating in the project. These included district government offices of health and welfare and local government, a private sector philanthropic organisation, and the civil society sector (see below). In preliminary meetings, these agencies were visited by the external change agent and representatives of the Entabeni health volunteers (Mr Nxumalo, Gladys or Wanda) and invited to participate in a partnership seeking to achieve the four aims outlined above. Every potential partner welcomed the opportunity to work in partnership with such a remote community, saying that work of this nature resonated strongly with their agency's goals, thus serving as a strong incentive to work with the Entabeni community and the research

team. They said they had previously lacked contacts and access to engage in effective partnerships with remote and hard-to-reach communities. The Entabeni partnership project would provide them with the types of access and contacts they usually lacked, but which would be of benefit to them and the community.

Their initial participation in the dissemination workshop revealed that while they were mandated to work in Entabeni, few had previous knowledge of its existence and virtually none of them had ever visited the community. The workshop therefore played a vital role in bringing the existence of this remote community to their attention, and giving Entabeni residents the opportunity to present and discuss the needs and challenges of the community with them.

I discuss the process of recruitment of the six agencies that emerged as potential project partners in the two years of formative research, dissemination, stakeholder consultation and formation of the partnership (research question 2), highlighting briefly the *challenges* encountered (research question 4) and the *factors that facilitated the process* of partnership-building during this phase (research question 3), placing emphasis on the *enabling role played by the external change agent* in this process. I provide an analysis of this data through a discussion of Campbell's (2003) criteria for effective partnerships.

6.2. Who are the service-provider partners and what do they bring to the partnership?

“By bringing people with different perspectives together, partnerships have the potential to identify new and better ways of thinking about health issues. By linking the contemporary skills and resources of diverse people and organisations, partnerships have the capacity to plan and carry out comprehensive actions that coordinate a variety of reinforcing services, strategies, programs, and systems” (Lasker, 2000).

In the Entabeni partnership, recruiting partners to ensure a comprehensive *representation* (El Ansari, 2001a) of external stakeholders on the partnership committee, and taking these partners through the process of introspection and commitment to participating in the partnership process, was a major task fraught with

many challenges. I outline some of these *challenges* through a discussion of the entry and exit of partners, who stayed, the nature of their representation and how this impacted on the development and outcomes of the partnership-building process. I also highlight some of the factors that facilitated this process, including the role played by the external change agent (lead partner) in translating rhetorical representation to realistic participation of partners in the partnership-building process.

Within the *public sector* there were three distinct partner groupings:

1. The Department of Health (including hospitals, a local clinic, and a local primary health care facility),
2. Department of Welfare
3. The municipality (local government).

One partner was drawn from the *private sector* (the philanthropic wing of the regional Chamber of Commerce), and the final two partners represented *civil society*: the local social development committee spearheaded by a Scandinavian missionary (CBO), and the regional branch of a national counselling charity (NGO).

6.2.1 Potential public sector partners

As discussed in the previous chapter, the formative research and subsequent contacts with the community partners pointed to numerous ways in which Entabeni residents were failing to access government health and welfare services. They also expressed frustration at their many failed attempts to network with government officials, especially from the Department of Health.

Mr Nxumalo. “*So, it is impossible to get hold of them but we know about them. So we are just lost. We are in a lost community as far as the Health Department is concerned*”. (March 2005)

Mr Nxumalo: “*If you can keep praying for the Department of Health to come closer, because all the home-based carers are busy doing the health work in the community and the department is not recognising them. There will always be a gap between the people on the ground and the department. I will always request you to make them come closer*”. (September 2005)

It was therefore anticipated that the Entabeni partnership would provide a channel through which public sector agencies could inform community members about their services, and through which community members could, in turn, feed back information about problems they had in accessing services, and point to gaps in service provision. It was hoped that 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 community outreach strategies of this nature.

The concept of responsive public services is part and parcel of a decentralisation agenda that attempts to make services more democratic and accessible for the poor (Blair, 2000; WDR, 2004). This is seen as a two-way process; strengthening community voice will improve public services, and creating responsive public services will create stronger community voice (Goetz and Gaventa, 2001; Niksie, 2004).

As stated in the discussion on the research process in Chapter 4 of this thesis, in the formative research-dissemination and consultation workshop and earlier meetings, every potential partner expressed enthusiastic and unconditional support for the partnership – saying it could play a key role in assisting them to provide more effective services, particularly to remote communities of this nature which were particularly hard to reach.

Based on this and the policy mandates of potential public sector partners (see Chapter 3) to engage with communities and other organisations in responding to the challenges of HIV and AIDS, it was assumed that:

- they shared ideologies for service provision and were committed to working in partnership with underserved populations
- each participating organisation could deliver on some AIDS programme component which another organisation could not.

- This commitment, coupled with individual organisation strength, apparently promoted collaboration and coordination among the organisations with less threat of competition.

Below I provide an overview of the external partners and discuss some of the obstacles encountered in turning this principled commitment into action.

6.2.1.1. Department of Health

The most obvious partners were public sector agencies charged with responding to HIV and AIDS in various ways. Entabeni lies at the boundaries of three hospital catchment areas. Hospitals play a key role in treating people with AIDS-related opportunistic infections, and, at this early stage in the process, were still to be involved in the roll-out of antiretroviral drugs as these gradually became available to remote rural residents. With few roads, and transport limited by combinations of inaccessibility and un-affordability, many Entabeni residents found it difficult to access hospitals at all. For those who got there, the AIDS services were difficult to find. I spent 30 frustrating minutes following the yellow feet that were supposed to lead to the AIDS clinic in one hospital, only to end up walking around in circles!

In interviews and meetings, hospital superintendents showed a strong appreciation of the potential value of outreach partnerships of the kind represented by the Entabeni project, saying that proper channels of communication with remote communities would increase their ability to offer them effective medical care.

However, due to resource constraints, they battled even to provide basic conventional medical services, let alone engage in more complex and unstructured activities such as building bridges with hard-to-reach patient communities. Thus, whilst senior hospital managers supported the project in principle, they tended to send nursing sisters to represent the hospital at partnership meetings. Over the course of the first two partnership meetings, it became clear that these nursing sisters lacked the types of decision-making power they would have needed to be effective partners. They said there were no channels to feed back information from project workshops to more senior managers – and that whilst they would gladly deliver any letters that I cared to write to senior hospital officials, they had no influence over whether they would be

read or acted on as the following comment by the private sector representative illustrates:

Private sector representative: *‘In terms of resources they (public sector representatives) are not in a position where they can say we can do this or we can do that. They still have got to go back and speak to their managers and get approval and get authorization and then somewhere along the line that information gets lost. So the key players, those who actually make the decisions, they are the ones that actually need to meet with the people and the community members. Like you know the nursing sisters that were there can contribute in terms of expertise and so on but when it comes to commitment to resources they are not able to give that go-ahead. Then I just feel they can go back and give feedback, but the message is lost.’* (2005)

The second potential public sector partner involved in health service delivery was the primary health care nurse allocated to the Entabeni community. She travelled around with a mobile clinic that visited all the areas served by a large district hospital. Her role was explicitly defined as supporting local home-based carers. She had in fact already set up monthly meetings with the health volunteers, at which she collected written reports of their work over the past month.

Many health volunteers battled to compile these written reports, given their low levels of literacy, and their limited access to pens and paper, and in our early research interviews they complained bitterly that they had never received any feedback on these reports. The primary health care nurse said that she filed away these reports in her office, and at regular intervals summarised their content and passed this on to her supervisor. She said she had never received any feedback or comment from her supervisor on them. When I suggested to her that she might discuss the content of these reports with the health volunteers, and give them feedback on how to address the numerous problems they reported on, she said that such a course of action had never occurred to her, but that she would consider doing this in the future.

Researcher: *“I am saying this because when we did our initial research in the community, one of the things that the volunteers said was that they don’t get feedback*

from their reports so they don't know what is happening with the information. It would therefore help for you to give them feedback on their reports".

Primary Health Care nurse: *"Ah yes. This is a very good idea. Thank you for telling me."* (August 05)

In this and many of our other contacts with public service officials, it became increasingly clear that they had *no formal community liaison skills*, and that they *lacked both the training and the channels to communicate with their target communities*, and also with their own supervisors. In this early stage of the partnership-building process, I began the process of devoting time and energy to working with the primary health care nurse to develop strategies for more effective support of health volunteers, resulting in the nurse giving more regular feedback and guidance to the health volunteers. I also became a go-between for the nurse and her supervisor, liaising with the supervisor to reassure the nurse that her supervisor approved of these new developments.

The third potential Department of Health partner identified by me through her communication with the hospitals and primary health care nurse was the *district office* located in the nearest big town. It was assessed that contact with this office was essential since they were responsible for the overall co-ordination of health services in the region and communication between the managers of this office and the health services (hospitals and clinics) departments that 'reported' to them was 'extremely poor'. The supervisor of the primary health care nurse as well as the hospital manager informed me that communication from 'outsiders' would be much faster and easier than communication between the 'insiders' of the department.

Supervisor of primary health care nurse: *"....the best thing for us to do is to go to the hospital, because from there we must go to the district. I can't phone Ms M (district office manager). She is a big boss".*

Hospital manager: *"I think the best thing is to get hold of Ms M, and probably Ms L (HIV and AIDS coordinator from the district office) and try and facilitate a meeting between yourselves and them".*

This office paid a small stipend to the leader (Mr Nxumalo) of Entabeni's health volunteers. On hearing that he had not had formal contact with the district office the external change agent suggested he visit them to discuss some problems the health volunteers were facing, and to seek their advice. His visit to this office was greeted with hostile incredulity. The agency official expressed shock that a humble community representative should take the initiative to approach the office. She berated him, saying that if the office had anything to say to him, they would initiate contact. She refused to engage in discussion, saying he was wasting department money by being away from the community where he was paid to work. As he left, she shouted that she would ensure his monthly stipend was reduced to penalise him for wasting the day!

6.2.1.2. Department of Welfare

The regional Department of Welfare (DOW) faces a strong national policy directive to implement social development approaches to HIV and AIDS. Despite this, its local office has responded in a minimal fashion, dispensing welfare grants to community members who have the skills to access them. Many people lacked these skills, and some who had them were unable to afford transport to the welfare office some distance away. Those who managed to gather the necessary documentation and fill in the necessary forms often waited for years before grants materialised. The process of seeking out possible DOW participants for the partnership resulted in me practically 'running around in circles'. Several telephone calls were made to DOW to secure an appointment with the head of the department to discuss the possibility of a partnership, and when an appointment was eventually made, the head of department was not available and could not be located. A senior social worker at the office was apologetic after I refused to leave without some form of explanation for his absence. She also agreed to chat briefly to me about the department's role in the region. Five months later and with a new head of department in place, I managed to meet with the designated social worker for the Entabeni community and his senior to discuss their possible role in the Entabeni partnership.

The following quote from this meeting illustrates their initial reluctance and inability to understand and accept that they had an important role to play in the community, instead deflecting the attention to other public sector departments:

Mr Nxumalo (Community partner): *“Some of the people heard that I was going to the department because I haven’t been here for sometime, and they said please mention this. They said if I am going to the office, I must mention some of the issues they had tried to solve and failed. I have got some of them with me here. So, all in all, I am asking the Welfare Department, if possible, to come as closer to the people as possible, because we have got a crisis.”*

Welfare representative (Mr Nongoma): *“It seems everything revolves around the Department of Social Welfare. What about the other department’s as well?”*
(November 2005)

He and fellow social workers were trained in traditional one-to-one counselling and welfare grant allocation strategies – and in the face of the huge demands of poverty and ill-health, they had little time for anything else. Whilst he appreciated the potential value of the project, he initially did not see any way of fitting project participation into his current way of working. I had to engage in on-going discussions with him about ways of interacting with the community, and attempting to get hold of his supervisors to discuss DOW involvement in the Entabeni partnership. This was an endlessly time-consuming process, involving on-going attempts to telephone, email and fax DOW officials to organise a meeting and secure a commitment from them.

6.2.1.3. Municipality (local government)

I initially had high hopes of the local municipality (the local development planning wing of the provincial government).¹⁰ They were the closest sphere of government to rural communities and a senior municipal official (Mr Dennis) whom the research team and representatives initially met, quickly grasped the opportunities that the project offered the municipality 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 the dissemination workshop for service-provider stakeholders and later revealed that this was the first opportunity he had of mixing

¹⁰ The provincial Department of Local Government and Traditional Affairs is the closest sphere of government to communities. They have district municipalities that are responsible for development planning in communities. These are further sub-divided into local municipalities, one of which services Entabeni, and it is this body that we refer to as ‘the municipality’.

with other organisations and community stakeholders in the region at a workshop of this nature. My observations revealed that he was initially uncomfortable and unable to interact with the other workshop participants. He was the only white male attending the workshop and was obviously not accustomed to this scenario, where the majority of participants were black females! However, during the small group discussions that formed part of the workshop, he gradually began to relax and eventually began participating quite animatedly in the discussions and debates that ensued. When evaluating the workshop, he mentioned that the workshop had been quite an eye-opener for him.

He subsequently attended early partnership discussions, making insightful contributions – saying that the project could serve as a municipality model of best practice for HIV and AIDS work in resource-poor communities in the region.

Mr Dennis (municipal manager): *“What we could do is to use this committee as a pilot for the rest of our councillors so that we can get the same type of structured committee going in each of our 26 wards and we will all be talking the same language. Your programme will then have gone from one ward to 25 other wards as well and that would be planting the seed for growth. We would then know that, that committee then does have direct links with the iNkosi in the area, with the iNduna in the area and with the community, because without that linkage, nothing is going to work.”* (March 2005)

Having the vociferous support of a well-informed and senior official, with a sound and articulate appreciation of the value of partnership working was a positive boost for the project’s morale in its early stages. However, as time passed, it became clear that his ability to act was hindered by resource constraints combined with the huge geographical area the municipality is expected to support. After numerous unsuccessful phone calls to contact him for a particular meeting, his secretary told us he was ‘drowning in work’, having been allocated 60 new projects to manage in the next year, with no extra personnel. Furthermore it became clear that his ability to help a single innovative project was limited by the competitive nature of the local councillors (politicians) he had to answer to. Many councillors resented his suggestion that resources be devoted to a project in a single community – irrespective of its

potential value as a pilot project developing transferable models. They insisted that any assistance given to one community should be given to all (discussed in detail in Chapter 7). The following quote from an interview to evaluate the municipality's participation in the partnership illustrates some of these challenges:

External Change Agent: *“From your point of view, I know you are very busy but what would you think would hinder your participation in this partnership?”*

Mr Dennis (municipal manager): *“Ya, it would be lack of capacity. You find us doing all sorts of things and we haven't been given more staff. The present staff has to double everything they are doing. As you can see it is a massive area. So I would say financial constrains. I think politics play quite a big role as well. You know, we think differently. We think about people. Politicians think about votes. I always have to work around that.”* (August 2005)

In discussions between the external change agent, community representatives and Mr Dennis to discuss these limitations, Mr Dennis offered the assistance of an official that would be based at his office, but appointed to the municipality by the United Nations Development Programme (UNDP). I discuss the input made by this official, who entered the partnership process during *implementation* and who will be referred to as Lennie, in Chapter 7.

The project's contacts with the municipality has usefully highlighted the limited role that Entabeni's elected councillor had been playing in accessing municipality support and resources, and feeding community views into municipality meetings. However, the project turned this insight to good effect for the community and health volunteers when Mr. Nxumalo stood for elections and became the new municipal councillor representing the Entabeni community in 2006.

6.2.1.4. Building partnerships with the public sector?

These experiences with the Entabeni partnership process suggests that resource-poor communities like Entabeni are constrained by an institutional context that actively works against effective grassroots community empowerment. In my role as external change agent, every aspect of my 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 (discussed in detail in Chapter 7).

While senior civil servants welcomed the project in meetings with them, due to the pressure of work, they directed the team to the more junior officials directly responsible for Entabeni. These officials lay along a continuum. On the one hand there were skilled and talented individuals offering services in almost impossible conditions with little supervision or support. On the other hand, there were those who were underemployed or disorganised, lacking the training and motivation to address the pressing social problems that crowded in on them from day to day. Thus for example, the community was home to a full time worker paid by a government poverty-alleviation programme. However he said he seldom worked for more than two hours a day, not knowing what to do, and without an accessible supervisor.

Even the most effective junior official was hampered by red tape and bureaucracy. Many found it impossible to get permission to attend the Entabeni partnership meetings. Thus for example, the nursing sister in a regional clinic responsible for voluntary counselling and testing was keen to attend partnership meetings and to include Entabeni residents in her programme, but could not do so without the permission of her district manager – to whom she had no direct access. It took me six months, ten phone messages and eight emails to get a response from the manager's office. When it was faxed to my offices, the fax contained an error, granting permission for this nursing sister to participate in an unrelated project. Even those officials who managed to get permission to attend partnership meetings often had limited access to agency cars – without which they could not access this remote area.

Limited lines of communication between more junior and more senior civil servants also made it difficult for juniors to incorporate partnership participation into their existing job descriptions (elaborated on in Chapter 7). There were few times or places at which such meetings might have taken place. Senior officials were often too busy to talk. But most importantly there appeared to be an institutional culture that did not allow for the possibility that junior staff members might have anything of value to say. There appeared to be very limited opportunities for new ideas to move up the

power hierarchy. Given that it is invariably more junior staff that interacts with grassroots communities, and is best placed to report the views of communities back to public sector agencies, the way in which agencies operate limits opportunities for grassroots views to be heard in the health or welfare sector.

Junior health representative: *“I think the success of the partnership is on the commitment of each and every member of the partnership. If a person can commit him or herself on whatever he/she can contribute to the partnership, sometimes you will find that a person is not in power to offer something without going via somebody else. So it is difficult for that person because you may find that I can say to you I will offer this but to offer you that I must go and get authority from somebody else who might say no.”* (September 2005)

Overall there appeared to be a climate of demoralisation and hopelessness amongst the civil servants we encountered in the face of the scale of the problems facing them and their lack of skills for addressing these – in a context where institutional constraints limit peoples’ ability to innovate or respond to their target communities. These issues are discussed in detail in Chapter 7.

6.2.2. Potential private sector partnerships

In the international development arena there is currently much rhetoric about developing the role of the private sector to serve as partners in social development programmes (UNAIDS, 2006; Haider, 2003; Nishtar, 2004; Richter, 2004). Entabeni’s geographical remoteness located it some distance from regional towns and businesses. However, I made an initially promising link with the manager of the philanthropic wing of the regional Chamber of Commerce. At the early stages of the project I had hoped that they would assist us with stipends for some health volunteers (home-based carers). The manager was extremely positive about the project, attending the formative research-dissemination workshop and early partnership meetings, participating actively and making several offers of assistance, as the following quote illustrates:

Manager – Private sector: *“No, that’s fine. I promise you we will be there. It will be two or three of us. I will try others within the community so we can see all the areas*

where we can assist. I'm sure we can help with some form of garden services for the people training them as well as if they need extra training. We can help with that as well."

However, she resigned shortly afterwards. Subsequent contacts with her colleagues suggested she had not discussed these offers with her organisation. We were told that the group lacked the resources to support such a remote community, and that they had a new and fairly rigid five-year funding plan, which made it impossible for them to take on unbudgeted commitments. They also indicated that they did not have the resources to address 'more than a drop in the ocean' of the AIDS problem and that their brief was to prioritise areas immediately surrounding their own town.

Private sector representative: *"We have got our set of deliverables already set out for next year so in order to commit to additional services would require time and manpower as well and the distance away from us is also a factor"* (March 2005)

However, prior to their withdrawal from the partnership process, they introduced an NGO (offers counselling and training services in the region) to the partnership who they believed would add more value to the partnership than they would at this stage. This NGO partner has since proven to be the most active and committed partner organisation on the committee (discussed below).

These experiences suggest the need for a high dose of realism about the theoretical potential of the private sector to contribute directly to development particularly in geographically remote areas which often face the most pressing challenges. In weighing up the pros and cons of pursuing private sector input, and taking into account the scarcity of time, funds and capacity available to the Entabeni partnership-building process, a unanimous decision was made by the community partners and the external change agent to abandon this pursuit in favour of investing scarce resources to developing and building on the current partnership structure for partnership goal achievement.

6.2.3. Non-government organisations

There has been a long history of NGOs working with and supporting social development programmes in remote rural communities. Many of these have been top-down, replicating public sector programmes and not facilitating grassroots mobilisation. However, others have been successful in supporting communities in roles such as advocacy and service delivery in these remote areas (Desai, 2002). To date, the most promising partners in the Entabeni Project have been two NGOs (one situated in the Entabeni community). Both are small, under-funded and run by deeply committed individuals.

6.2.3.1. Entabeni development committee

This group is coordinated by a Scandinavian missionary who raised a small grant, and has spent several years in Entabeni, working closely with local people to set up a crèche, community gardens, craft projects and most recently a hospice for terminally ill 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 (referred to as Audrey) works painstakingly slowly out of her deep commitment to facilitating community ownership of the project, and takes no personal control or 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 what others might describe as impossibly difficult conditions.

Her input has been a tremendous asset to the partnership in many different ways. She has frequently made financial contributions to small-scale project activities (e.g. to buy meat or rice for large project events) and has actively participated in the implementation of project activities (see pictures in Appendix 3) and the achievement of partnership goals. The project has made use of her infrastructure – especially her home and buildings – for various partnership meetings. With her keen understanding of the principles of bottom-up social development, she has been an on-going source of insightful and practical ideas in project planning and debates. For example, she and the community partners (discussed in Chapter 5) conceptualised and facilitated a very successful youth rally to publicise a schools-based peer education programme that the

project was planning to launch at the time. She has made her vehicle and driver available for the project to transport young people to attend skills training in distant locations. Most of all, her enthusiasm and motivation have served as a constant source of inspiration to me and to other partners (see Chapter 7).

6.2.3.2. Lifeline – a counselling NGO

The second very effective service-provider partner has been the local branch of a national counselling NGO, Lifeline. This NGO has been operating for decades, offering suicide counselling, but has recently redirected its focus towards AIDS counselling, training and support as the need for AIDS services has grown in South Africa. The regional director (Sally) is a former business woman who relocated to the rural area for family reasons, and lives in a nearby town. She raises her own funds, draws a minimal salary, and is dynamic, articulate and confident.

From the early stages of the project she has attended project meetings, listened carefully to the community's accounts of their needs, and almost immediately volunteered to provide training courses for health volunteers, monitoring and support services for trainees, as well as working with local people to set up an outreach centre in a disused building loaned to the project by a local leader, which she has furnished and equipped (see Chapter 7 for details). She delivers on her commitments, seldom misses a meeting or project function, and is a constant source of useful ideas. She also has a wide network of contacts in the region – and many of her contacts have been useful to the project at various stages. The following quote from an early meeting with the director of Lifeline and community partners reveals her immediately committing her organisation to collaborating with the community partners in rendering essential services in the community:

Sally (director of counselling NGO): *“Perhaps what we could do is to look to establish a satellite centre here where we would start training the local volunteers. We would do a screening, train up local people and see how dedicated they are to the idea and start to run services and start to acquire premises, a place where we could meet. Eventually we would want to be there everyday. It would also be a place to do mentorship and supervision of your home-based care workers.”*

6.2.3.3. Short-term and ad-hoc NGO members

As noted by Gray (1985), the configuration of a coalition or partnership is dynamic, thus the inclusion of stakeholders must be a continually adaptive process. Hence, while the above discussion focuses on six key partners who were recruited during *formation*, other potential partners joined the partnership via the recruitment efforts of the local community partners and service-provider partners throughout the partnership-building process. While some remained as ad-hoc members, others withdrew from the partnership, based on their perception of the potential benefits or drawbacks to themselves or their organisations, e.g. an NGO rendering training to youth expressed an interest in joining the partnership since it would afford them the opportunity of gaining easy access to a rural community where they could implement training programmes with learners and out of school youth, thus broadening their geographical output. However, they were not in a position to fund this venture, and therefore requested financial compensation for their trainers from the external change agent. Since this request could not be met, they decided to withdraw from the partnership. Yet another promising link was made with an NGO focusing on HIV and AIDS training primarily with rural communities. They joined the Entabeni partnership through the recruitment efforts of Mr. Nxumalo (a community partner) and remained with the partnership for ten months. During this time they availed their trainer to conduct two consecutive training sessions with home-based carers on HIV and AIDS. However, during their time with the Entabeni partnership, they struggled to secure funding to keep their organisation afloat, and eventually closed offices after ten years of being in existence. Their trainer, who had the opportunity to network with and develop a relationship with the counselling NGO – Lifeline, during her time with the partnership, was eventually employed by them and continued to render HIV and AIDS training to various stakeholder groups (traditional leaders, iNkosi's wives, youth, religious leaders, women's groups, men) in the Entabeni community.

In addition, and despite the disappointing and rapid entry and exit of a few more NGO partners during this and the implementation phase of the process, the partnership has benefited enormously from the input of an NGO (National Hospice Association) that joined the partnership as an ad-hoc member. Their representative (Amiela) was enthusiastic to join the partnership after hearing about the Entabeni project at a public forum hosted by the research team (HIVAN) for the purposes of disseminating the

results of the formative research and introducing the Entabeni partnership project. Amiela saw the partnership as an opportunity to contribute her skills to a rural community through the training of the volunteer home-based carers in palliative care and in assisting with the establishment of the hospice¹¹ in the community to render quality care for PLWHAs and other terminally ill patients. While the Entabeni partnership facilitated their input in the community, their participation at partnership meetings was minimal, since their mandate was specific to rendering palliative care support; hence they interacted primarily with the community partners, the Entabeni development committee and the home-based carers in the community. Their *incentive* for participation, which was realised during this and the implementation phase, was the opportunity to network with and establish relationships with a resource-poor rural community requiring training and support in palliative care and hospice support. An added benefit to them was the opportunity afforded to them to network with other local organisations in setting up joint projects of a similar nature in other communities.

Hospice representative (Amiela): *“You are doing wonderful work. It is so marvellous to have this community input too. I am very encouraged by it. Hospice association also encourages networking and partnerships and we definitely look forward to a partnership with the government departments as well”*. (2005)

6.2.3.4. Sustaining the inputs of local NGOs?

Small NGOs of this nature are flexible, fashioned around being immediately responsive to local needs. The staff often works for little or no payment, motivated by personal dedication and drive and inspired by a vision of a better world. The organisations operate on tight budgets, and rely heavily on the inputs of individuals.

¹¹ The community partners, together with the Scandinavian missionary (Audrey) from the Entabeni development committee, were attempting to establish a hospice in the community to care for the sick, based on requests from the community. Audrey had raised enough funds to construct a building in the community for this purpose, but did not have adequate support or knowledge on how to progress further. The representative from the national hospice association has, since joining the partnership committee, been rendering support, supervision and training to the Home-based carers and members of the NGO in establishing the centre as a fully fledged hospice with trained personnel.

The challenge at this point was how to make this work sustainable over the long term – a key project goal – to move from formation to implementation, maintenance and outcomes. 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 may often depend heavily on non-durable resources such as the dedication of individual staff members (who might leave the organisation), and on unstable sources of funding, as the discussions above confirm, and the quote below illustrates:

Director (Sally), counselling NGO: *“At Lifeline we are always controlled by our financial position. As long as we receive funding, we receive finance to keep our operations running. Together with our outreach centre’s we obviously can stay fully active, but it all depends on our finances because we are an NGO.”*

The goal of institutionalising the Entabeni partnership and handing over work of this nature from dedicated, relatively affluent individuals with a view of a better world, to paid civil servants battling with the stresses of poorly paid jobs and difficult working conditions, remains a great challenge.

6.3. An analysis of the ‘*formation*’ stage of the Entabeni partnership-building process with external stakeholders using Campbell’s (2003) criteria for effective partnerships

I have provided a detailed description and analysis of the key service-provider stakeholders from the public, private and civil society sectors in the region that were recruited during the *formation stage* of the partnership-building process. At each stage of a partnership-building process, there are certain factors that may be relevant and important to enhancing the functioning of the partnership, and lead to the partnership progressing from one stage to the next (Butterfoss, Goodman and Wandersman, 1993). In assessing the factors that *enabled* the process (research question 3) of partnership formation, and a progression into the next phase of the process (implementation – see Chapter 7), and the factors that *challenged* it (research question 4), I utilise Campbell’s (2003) framework for effective partnerships to briefly analyse and present the data gathered during this phase.

In early interviews conducted with ‘potential partners’, and at the formative research-dissemination workshop, each partner (public, private and NGO sector) *committed* themselves fully to participating in the partnership project, as the following quotes illustrate:

Primary health care nurse: *“Working in partnership is good, convenient to us as the Department of Health as it involves all other departments and the community. It’s bringing the services to the people, which is our main objective. The partnership avoids duplication of services. The community participation and involvement is tops and it helps that we learn to know one another as departments and as the community. It makes people grow and helps to enlighten them. I am 100 percent dedicated to this programme.”* (2005)

Mr Dennis (municipal manager): *“Ya, I would like the community to see us facilitating this. We do have political power to do this, and if we can help, we will.”*

In terms of *conceptualisation*, partners appreciated the complexity of the HIV epidemic, acknowledging 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. At the initial partnership meeting and a subsequent workshop to evaluate the partnership process, partners displayed a lucid understanding of the requirements for successful partnerships as the quotes below indicate:

Social worker – Mr Nongoma (Department of welfare) *“I think firstly it is the sharing of ideas and working together and also trying to cooperate with all what is being done in that partnership.”* (2005)

Municipal representative (Mr Dennis) *“Working in partnerships means, as much as we are sharing ideas, we share resources and discuss resources that we have. It means saving on what we have for the benefit of the community and it means less duplication and optimising service delivery.”* (2005)

In terms of *incentives* for participation, every partner spoke of their agency's principled commitment to targeting isolated rural communities for HIV and AIDS management work, and using community outreach and social development strategies; hence identifying a *reciprocal advantage* to their participation in the partnership in meeting organisational goals as well.

Senior health official (district office): *“The value is that we are happy that the partnership is going to help us make sense out of our vision for the Department and the mission statement as to why we are existing as Dept Health. Our KwaZulu-Natal Department Health vision is to achieve optimum health status for all in KZN and the mission statement for KZN as a whole is to develop a sustainable, co-ordinated, integrated and comprehensive health system at all levels, based on the primary health care approach through the district health system. At the district office we do have our mission which is aligned with the provincial one and I'll just mention our vision – to excel in the provision of quality district health services for all the people in the district. That is the value and good of being in partnership with Entabeni Health Partnership and HIVAN – its achieving our mission statement and vision.”* (2005)

Despite these commitments made and an acknowledgement of the incentives and benefits of partnering with Entabeni in responding to the community's challenges with HIV and AIDS, pre-existing challenges within partner organisations surfaced continually and became especially constraining during *implementation* of the Entabeni partnership. I discuss this in detail in Chapter 7, but mention it briefly below since implementation began during the formation phase of the process.

Aside from the two NGO partners, who had a keen appreciation of the benefits of working closely with communities, and were generally responsive, 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 and AIDS in conditions of poverty.

In the following chapter, I provides a detailed analysis and discussion of these factors, highlighting the particular challenges presented in facilitating partnership-building and in achieving partnership goals through the crucial role played by the external change agent – both in working with the community and service-provider partners in developing their capacity, as well as in changing mindsets to think and work in ‘partnership’ with each other. Below I touch on the enabling role played by the external change agent (research question 3) in facilitating *partnership formation* and highlight some of the challenges encountered (research question 4) in fulfilling this role.

6.3.1. The enabling role of the external change agent in the formation of the Entabeni partnership

Whilst the role of external change agents is frequently discussed in the community development literature (Van Klinken, 2003; Chambers, 1983; Mansuri and Rao, 2004), I have been unable to access literature which discusses this role in relation to HIV and AIDS management. However, there is general agreement that a central convener or facilitator is necessary to the success of any partnership intervention (Lasker, 2000; Walker, 2000; El Ansari and Weiss, 2006; Bryson et al., 2006). Early on in the Entabeni partnership process, partnership participants agreed that I, with the assistance of the other team members, was best placed to assume the role of facilitator or convener. Gray (1989) in her discussion of the collaborative process emphasises the significance of the partner organisations’ perception of the legitimacy and skill of the convenor in the initial and ongoing success of a partnership. In many ways the research team were unusually qualified to carry out this role – a three-person team with high levels of academic, practical, community development and networking experience, backed by 12 months of prior research and dialogue with local residents and potential external partners (conducted in the context of formative research, dissemination and community consultation prior to the formal initiation of the project). In addition, the team belongs to an organisation situated within the well reputed University of KwaZulu-Natal, noted for its academic excellence and long-term establishment in South Africa; hence contributing to the credibility and influence of the external change agent. I examine the role played by the author of this thesis as research team leader (researcher) and external change agent in the formation of the Entabeni partnership.

The external change agent's role has been multi-faceted (discussed more fully in Chapter 7), consisting of identifying potential external partners, persuading them to participate, and enabling and supporting such participation in any way possible. Support took a variety of forms. These include: helping agency staff to get the necessary permission from senior supervisors to participate; working with them to identify how they might fit community outreach activities into their job descriptions and daily working schedules; working with them to develop nuanced understandings of the impact of AIDS on the Entabeni community and of the health volunteers' resources and limitations; beginning the process of building external partners' confidence to contribute effectively to AIDS management by helping them identify the skills and resources they might bring to the partnership; keeping in regular contact with partners to keep their commitment to the partnership process alive; and, providing empathy and encouragement to them when the challenges of partnership working appeared overwhelming.

Administratively, the process of recruiting external stakeholders and ensuring their commitment to participating in the Entabeni partnership has been a mammoth task. For example, several public sector partners 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 the external change agent attempted to ring them, the switchboard operators were unable to connect us. Contact fax machines didn't always work. One key nursing sister was too busy to talk on the phone during the day and was only contactable at home after 9.30pm.

In performing all these roles, the external change agent's primary motivation was that of facilitating grassroots community responses to AIDS through equipping the external partners to provide the best possible support to the health volunteers and community stakeholders, and through advancing the interests and capacity of the health volunteers in every way possible. The health volunteer team had been battling along in the community for many years prior to the external change agent's contact with the community, doing sterling work in embattled households. However, they felt that they lacked the training, influence, contacts and support (both within the

community and externally) to enable them to optimise the impact of their considerable efforts. At the time of the formative research, they expressed feelings of physical and mental exhaustion and demoralisation, saying that they were desperately in need of support and development. The external change agent has involved the community stakeholders in every way possible (see Chapter 5) in the partnership process, consulting them constantly, ensuring that they play a key role in every project decision, and taking community partners to nearly all of the face-to-face meetings with external partners.

6.4. Conclusion

The first stages of the partnership process (formation) involved the mobilization and recruitment of community partners (Chapter 5), followed by the recruitment of external stakeholders (Chapter 6) for the purposes of facilitating supportive external networks.

This chapter has reported on the first two years of a four year project, with the second two years reported on in Chapter 7. The findings indicate that even at this early stage of formation, the partnership has *achieved substantial progress* in terms of networking, and initiating the process of collaboration and external support for the community's challenges with HIV and AIDS (see Chapter 5 as well). The research team in partnership with the community stakeholders were successful in mobilising effective NGO support, with two NGOs specifically investing time and scarce resources to support the work of the partnership. Much positive groundwork was done with some public sector partners as well and with time and persistence, these relationships would start bearing fruit (see Chapter 7). The external change agent made progress with some public sector partners around morale-building and assistance in thinking through ways in which they might respond more effectively to community needs, e.g. social work representative from the Department of Welfare. The primary health care nurse initiated a process of feeding back information to the home-based carers on a monthly basis with the blessing of her supervisor. A senior municipality official (Mr Dennis) has become 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. However, the recruitment of the private sector has been a bit more challenging, revealing that remote communities like Entabeni may lie beyond

the reach of the private sector. The reality of this situation resulted in the public sector, NGOs and community partners being the key representatives on the Entabeni partnership.

The process of partnership formation also met with many *challenges* (research question 4) in the recruiting external partners for participation in the Entabeni partnership. Some of these challenges related to the lack of or limited capacity of partners to engage in partnership-building and community development, poor internal communication within organisations, and work constraints (discussed in detail in Chapter 7). The external change agents role during the process of formation was challenging, requiring endless investments of time, energy and tenacity in embracing the challenge of identifying and mobilising potential partners, convincing them of the rationale and potential value of partnership working, negotiating between junior and senior staff in the public sector to encourage participation in partnership activities and keeping in contact with partners over time.

In this chapter and in Chapter 5, I have outlined the process of *partnership formation* in Entabeni (research question 2), those factors that enabled this process (research question 3) and the factors that challenged the process (research question 4). She has also briefly highlighted the value the partnership process has yielded thus far for HIV and AIDS management in Entabeni (research question 1). The longer-term outcome of these efforts will be discussed in detail Chapter 7. However, I can say with confidence that without my role as external change agent, little or any of the networking outlined in Chapter 5 and this chapter could have happened. Having said this, if HIV and AIDS management experts are to continue to advocate partnerships as a key strategy for HIV and AIDS management, I believe there is a need for much greater acknowledgement of the resource-intensive nature of *partnership formation*.

Chapter 7

Implementation of the Entabeni Partnership

7.1. Introduction

This chapter provides an analysis of the second phase of the Entabeni partnership, *implementation* (El Ansari and Philips, 2001a), involving an assessment of the constituency's concerns and a development of intervention plans.

The nature of the partnership process was dynamic and driven primarily by the needs expressed and the pace set by the partnership committee, and the need to ensure ownership and sustainability were instilled in the mindsets of partners from the very beginning of the process. Just as the formation phase was bound to have elements of the other phases of the partnership-building process, this phase overlapped with what El Ansari and Philips (2001a) describe as the *maintenance* phase, involving a process of supporting the life of the partnership, monitoring and continuing with partnership activities, and the *outcome* stage, which encompasses the impacts made by the partnership. Thus, while I refer to this phase as implementation, it is noted that it incorporated elements of the *maintenance* and *outcome* phase.

The analysis of data and structure of reporting in this chapter responds to all six research questions (see Chapter 1) within a framework that incorporates Campbell's (2003) criteria for successful partnerships (see Chapter 4). However, adjustments and additions were made to this framework, necessitated by the findings from this phase of the study, and supported by the partnerships literature (El Ansari and Philips; 2001a, 2004; Lasker, 2000; Swartz and Roux, 2004; Salmon, 2004; DeFillipi and DiSorbo, 2006; Fourie, 2006). Hence, it will be noted that the constructs within which the findings are discussed often redefine and re-conceptualise Campbell's (2003) criteria for successful partnerships in order to find the 'right fit' for the analysis and description of data gathered during *implementation*. These five key constructs include:

- Conceptualization of partnership
- Capacity and empowerment

- Commitment
- Accountability
- Incentives and benefits

It is hoped that these constructs serve as a benchmark for academics and partnership practitioners attempting to facilitate partnerships for HIV and AIDS management and other community development or social science related projects.

The presentation of findings is an analysis of the *process* followed (research question 2), the *challenges* encountered (research question 4), and the *factors that enabled* the achievement of partnership goals and outcomes (research question 3). The pivotal role played by the external change agent in turning these challenges around by harnessing the resource capabilities of partners and focusing on their inherent strengths and existing capacities, is emphasised throughout. Data that responds to the other three research questions (1, 5 and 6) emerges out of this analysis. It is noted that some of the challenges encountered during *formation* carried over into implementation; hence the overlaps and what may appear to be ‘repetitions’.

The discussions incorporate data gathered during two years of the partnership-building process (2006- 2007), and includes four formal partnership meetings, twenty five sub-committee meetings (planning or negotiation meetings involving the external change agent, community partners and specific service-provider partners), two evaluations of the partnership involving interviews and focus group discussions, four community events planned and implemented by the partners (three graduation ceremonies for training implemented by partners and the official opening of an outreach centre in the community by the iNkosi), numerous telephone calls, emails and faxes. The meetings, interviews and focus group discussions were tape recorded and transcribed, while community events were captured on camera (see Appendix 3). Detailed field-diaries were kept by the research team and some of the local partners (see Appendix 4 for sample).

7.2. The Process of implementation: what were the challenges, what were the enablers?

The process of *implementation* was driven largely by a sense of urgency and excitement. The community partners, and, to a smaller extent the service-provider partners, were impatient to ‘get things going’ and continue with the pace set during *formation*. They felt inspired by the small but *quick wins* (youth rally, initial training and graduation of volunteer home-based carers) of the first phase of the process, achieved through the collaborative efforts of several of the partners (see Chapter 5). It motivated them to focus their energies on the continued achievement of concrete partnership outcomes. The following discussions highlight the rapid pace at which the partnership development process proceeded during *implementation* in order to continue to yield quick outcomes (Butterfoss, Goodman and Wandersman, 1993).

Throughout this process, and in tandem with current development discourse which advocates for community-driven development¹² and the active participation of the community in social change processes (Heenan, 2004; Dongier et.al.2000), partners were encouraged to participate actively in the planning and implementation of activities planned for partnership goal achievement, despite their capacity constraints (discussed in this chapter). Again, the notion of the lived experience (discussed in Chapter 5) shaped the capacity-building and empowerment initiatives for partners that were so necessary for the assumption of ownership and sustainability of the project.

The implementation phase was closely monitored and regularly evaluated by the research team. The data from these evaluations served two practical purposes, aside from feeding into the research process. It guided the planning of interventions for partnership goal achievement, and allowed for a process of introspection and learning by the partners. They were able to assess the achievements made through their collaborative efforts and the adjustments and additional effort required of them and

¹² Community-driven Development - broadly defined - is an approach that gives control over planning decisions and investment resources to community groups and local governments. CDD programmes operate on the principles of local empowerment, participatory governance, demand-responsiveness, administrative autonomy, greater downward accountability, and enhanced local capacity

their organisations to ensure partnership goal achievement. Towards the latter end of this phase the services of an external evaluator was sought by the research team, to provide an outsiders perspective of the partnership, and to corroborate the validity of the findings from the partnership study (see Chapter 4). The data from this report was immensely useful in guiding the external change agent and partners in strategising and planning for current partnership interventions and the sustainability of the partnership.

I begin with an analysis of the way in which Entabeni partners conceptualised partnerships, highlighting the gap between the *rhetoric* and the *reality* of these conceptualisations.

7.2.1. Conceptualizations of partnership

Current development thinking focuses on ‘partnership’ as a logical and reasonable response to HIV and AIDS, especially within resource-constrained communities battling with the added challenges of poverty, gender based discrimination and poor access to essential services (El Ansari, 2003 and 2005; Szreter and Woolcock, 2004; Subramanian, Lochner and Kawachi, 2003; Campbell, 2003; Woolcock and Narayan, 2000). Partnership approaches to HIV and AIDS management also underpin health policy (NSP, 2007-2011) and development planning (The Reconstruction and Development Programme, 1994; The White Paper on Local Government, South Africa, 1998; Department of Social Development, Republic of South Africa: Annual Report, March 2006) in South Africa.

The findings in this study challenge the notion that these policy and planning rhetoric, which advocate partnership approaches as a central tenet to the realisation of policy goals, actually reflect the reality of service provision in South Africa. The following discussions (linked to the data in Chapters 5 and 6), is indicative of individuals and organisations entering the partnership without a clear conceptualization or reality based understanding of what partnerships actually mean for them and their organisations. During partnership formation (Chapter 6) external partners supported a partnership approach to HIV and AIDS management in Entabeni, seeing it as a logical response to the complex nature of the challenges posed by the epidemic, and committing themselves and their organisations to participating actively in the partnership. However, it soon became apparent that these *rhetorical verbalizations* did

not automatically translate into the *reality* of a commitment to the sharing of resources and time to participate actively in partnership meetings and activities, or the assumption of joint ownership for the responsibilities and risks (El Ansari, 2005; Heenan, 2004; Roussos and Fawcett, 2000) associated with the partnership-building process. This prompted me to question whether they (the service-provider partners) had entered the partnership with ‘their eyes wide open’ or ‘their eyes wide shut’?

The process of implementation uncovered various factors which contributed to their inability to translate their *rhetorical conceptualizations* to the *reality* of their active participation in the partnership. I discuss this in the following sections in this chapter.

7.2.2. Capacity and empowerment

A key enabling factor to the growth of the partnership was a general acknowledgement among partners that their participation contributed to individual goals of *personal growth and development*, the partnership goal of *reciprocity*, and the organisational goals of realising their vision of *community development* and *collaborating* with communities and other service-provider agencies in responding to HIV and AIDs. However, there was also acknowledgement that this was unfamiliar territory – something they were unaccustomed to doing. For service-provider partners, it was a new way of thinking that challenged their often traditional, individualistic approach to service delivery. While some partners were prepared to take the leap into the unknown and embrace new strategies for community engagement and service delivery, others were a bit more reluctant to do this. I discuss this in relation to the service-provider and community partners, highlighting those aspects that challenged their participation in the partnership, the opportunities provided to them for growth and interaction (7.7.7.1), and the role played by the service-providers in capacitating community stakeholders (7.2.2.2).

7.2.2.1. Creating opportunities for interaction and learning

While the implementation phase heralded much interaction between the partners, and a *focus on relationship building*, the participation of some partners was hampered by issues of language (most partners first language was Zulu) and the lack of prior opportunities to interact with people of other race groups, class or professional status. This challenged and often undermined their confidence and self-esteem.

It must be noted that working within a multi-racial and multi-cultural context is a fairly new phenomenon for many people in South Africa, especially those living and working in a more isolated rural geographical context (majority previously disadvantaged and predominantly black population) where the partnership was situated. Service-providers were accustomed to seeing themselves as superior to lay people in communities, as evidenced by the community partner's experiences with managers in the Department of Welfare and Department of Health (discussed below). For some of them (service-providers), it was their first opportunity to sit together, as equals, at a table with 'lay people' from communities or the consumers of their services. The external change agent therefore had to consciously create an atmosphere where equality and fairness reigned and where partners felt comfortable to *relate to each other as equals*. Incorporating these principles into the *relationship building process* contributed, to a large extent, in achieving amicability between the partners. The partnership also created a unique opportunity for service-providers and service-users to meet, interact, share information, acquire new ideas, shape policies, learn about the community, identify and respond to community needs, and debate the pros and cons of different styles of working.

Ms Carter (welfare manager): *“Well for me as the new district manager it was quite an exciting experience. First of all it was the first time that I went to Entabeni and I did not even know the area and I met a number of people and important stakeholders and community members for the first time and I was able to talk to them and get a better understanding of that area and also of the problems they are experiencing.”*

Primary health care nurse: *“I'm getting ideas from individuals that I've never thought of and it's really making me grow, working hand in hand and making it easier for us”.*

Local government representative/UNDP (Lennie): *“Yes, it is valuable to us as a municipality because we get to learn what the community needs are. We also get to learn how the communities think and what they want, so we can then respond to the needs of the community. It also helps us to shape or make the policies that we develop as government to assist the communities in any way. The partnership is helping me in*

a way because I know that for that particular community I have got partners I am working with in terms of service- delivery in that area. I'm also learning how to develop such partnerships for some of the areas that I am serving. I also replicate what we are doing here in other areas".

Community partner: *"I have benefited a lot. I used to be shy and passive and would not speak my mind. I would end up supporting those I felt were powerful even though I could contribute something better. I am now confident and speak my mind. I am not even afraid to speak English and I think it has improved. I'm convinced that with the information I have I can make things happen now! I now prepare myself thoroughly prior to doing presentations. I am really growing in the partnership."*

For some partners, embracing new approaches to service delivery was particularly daunting. For instance, the social worker representing the Department of Welfare on the partnership committee indicated that geographical distance was a major hindrance to the community accessing general welfare services and welfare grants, but was unable to suggest how he or his organisation could bridge this gap between themselves (Department of Welfare) and the Entabeni community. He was also initially reluctant to accept a suggestion made by the community partners and external change agent to pilot a programme requiring him to be based in the community for short periods of time (two days in a month) in order to facilitate community access to welfare services.

Welfare representative: *"So I think at the present moment I am trying to beat backlog although I am not doing it correctly by allowing people to come here (community centre) and interview them here. If I do it here, it is just like I am doing it in the office".*

The external change agent soon realised that his reluctance was also related to his 'fear of venturing into the unknown', and his *lack of confidence* in his capacity and training in community development work, as the following quote illustrates:

Welfare Representative: *"I have not yet been involved so much in community work. It will be new to me".*

To provide him with the moral support he obviously needed, he was promised the assistance of two home-based carers who would screen clients that came to the community office for social work services, thus ensuring order and structure. He feared that he would be inundated with clients if people knew that he was at the community office. In return for this assistance from the volunteer home-based carers, it was suggested that he *reciprocate* by training the home-based carers on how to screen clients prior to his coming to the community office. This *reciprocity* in the form of knowledge transfer to the home-based carers was highly pleasing to him since he was, to some extent, contributing to meeting their organisational mandate of passing on knowledge and developing the capacity of community stakeholders (Department of Social Development, 2006).

The process of shifting his rigid mindset to think more flexibly about his input into the community required two formal meetings with him and his superior and several informal telephonic discussions before this could be initiated. Throughout this process, the external change agent strategically focused on *nurturing his strengths*, identified as a cornerstone of *relationships based on trust* (Nelson et al., 2001). The external change agent also presented him with a clear plan of how the process would unfold, while continually motivating him through a discussion of the value (*benefits*) it would add to the community (accessible welfare services), himself (new skills and capacity development) and his organisation (in meeting their goal of partnering with communities for innovative service delivery) (Department of Social Development, 2006). The following conversation between the external change agent and the welfare representative refers:

External Change Agent: *“I think people have really appreciated your coming here. I have heard people in the community saying, ‘Oh Mr. Nongoma is coming to the outreach centre’ ”.*

Mr Nongoma (welfare rep.): *“Ya, it is working because if I am here and I have seen four people, it means next Wednesday we are going to open children’s court cases and it goes on like that.”*

External Change Agent: *“And Gladys (home-based carer) is here. She can help you. There are also other lay counsellors that have been trained. They can help you screen the people that come to the centre.”*

The process of implementation also revealed a general *lack of confidence and capacity* among some public sector partners (welfare representative, primary health care nurse), created by their lack of training and opportunities afforded to them to assume key roles within their job contexts. This initially hindered their input at partnership meetings and their ability to take on leadership roles (Bryson et al., 2006), like that of chairing meetings, recording and drawing up minutes, facilitating meetings, etc. Nevertheless they were encouraged to assume these roles (e.g. chairing meetings) on a rotational basis and host and jointly plan for partnership meetings with the support of the external change agent. Again, the community development principle of *learning by doing* was adopted and implemented (Gillespie, 2004). Creating these opportunities for the partners and encouraging them to act on their individual strengths was one way of boosting their confidence, self-esteem and enthusiasm to assume these key responsibilities required of the partnership-building process, e.g. the primary health care nurse hosted two partnership meetings and agreed to take the bull by the horns and chair the second meeting that she hosted, albeit anxiously. She received much congratulatory comments and clapping at the end of the meeting and confessed that she felt empowered.

Primary Health Care nurse: *“Thank you Y... (external change agent). I would like to thank you guys for giving me this opportunity and for making it easy for me to chair the meeting and for being so well behaved (laughingly and with a huge sigh of relief)! Thank you so much”.*

7.2.2.2. Contributing to community capacity and empowerment

In spite of the challenges outlined, the ‘joint-working’ efforts of the partners, and the enabling role played by external change agent in the partnership was instrumental in the major breakthroughs made in achieving the partnership goals of *capacity-building and empowerment* in the Entabeni community. The partners (Health, hospice association, Lifeline, HIVAN) conducted HIV and AIDs and general skills training programmes (health care services – VCT and hospice care, training on management of

alcohol and drug abuse, training on strategic planning and board governance for partners and volunteer home-based carers) with various stakeholder groups in the community (see previous discussions), while the other partners (municipality, welfare) were instrumental in information giving and sharing (welfare grants and funds for development projects, legal aid services, how to plan and draw up constitutions, etc.).

The focused and continued training of volunteer home-based carers facilitated enormous growth in the confidence and capacity of the home-based carers. This filtered down to benefit others in the community through a cascade system of training where the home-based carers conducted workshops, informal training and discussions with family groups, neighbourhood youth, learners, church groups, gardening groups, people waiting at pension points and patients waiting to be attended to at mobile clinics in the community; hence *facilitating a process of community education and information transfer* to those requiring access to crucial health and welfare services as well as general HIV and AIDs education. In interviews with home-based carers to evaluate the training conducted with them over a period of time by the service-provider partners, they had the following to say:

Gladys (home-based carer and community partner): *“This training has really helped me to deal with problems in the community. If something bad has happened to me I always want a way to get rid of it. Since I received training on personal growth, I am now able to deal with problems in a positive manner. I have learnt to talk openly about issues.” “I regard myself as a very experienced health worker now because I have been trained and have done workshops in the community”.*

Imbali (home-based carer): *“I really liked this training because it made me a better person. I am now able to go out and talk to the community about the issues concerning them. I can even visit schools and talk to the learners like a teacher. The teachers are also very cooperative”.*

Wanda (home-based carer and community partner): *“I have been trained that before I visit a certain group, be it a church group or people sitting and drinking alcohol, I should prepare and think critically because their way of understanding issues is not*

the same. When I visit learners in schools, I know how I should talk with youth.” “I am now armed like a soldier and I can stand any challenge that comes my way. What I have learnt is that if I don’t know something, I shouldn’t be afraid to say I don’t know it”.

The following comment by a religious leader, who lives in the community and who provides religious guidance to a huge number of Lutheran worshippers in Entabeni and KwaZulu-Natal, adequately summarises the contribution made to Entabeni residents and home-based carers by the partners in terms of *capacity-building, empowerment and changing mindsets*:

Reverend Gary: *“I just want to say that one of the biggest achievements of this whole partnership is to enable people, these women, to stand up and to take the responsibility as they are doing and leading something that they probably, when it started would have never even tried to accept, but now they are doing it. To change the mind of people is a huge achievement, maybe even bigger than things like the outreach centre because that can go on forever. Even if this might not go on but you have changed the people’s minds and you have brought them together, they know where to go and whom to approach when they need help. So I think that is a huge achievement. Now they know the possibilities. They know what is possible, not just to wait and wait but to stand up and do something.”*

7.2.3. Commitment

The commitment of partners, reflected in their investment of time, effort and resources (Campbell, 2003; El Ansari and Philips, 2001; DeFillipi and DiSorbo, 2006) in the partnership, varied and was often hindered by underlying contextual factors associated with resource constraints, internal organisational challenges and the inconsistent support of individual participation by senior management within participating organisations.

In a planning meeting between partners, focusing on partnership goals and possible interventions to achieve these goals, some partners expressed the need for more certainty and clarity around each partner’s commitment to contributing to the achievement of partnership goals:

Director, Lifeline: *“The first thing I think is that partners should actually display their commitment by trying to bring in ideas and services. We are all hearing what the needs are. We all know what the needs are. We still need to find out more but I think that the partners need to demonstrate their commitment by coming forward now and telling us what they can do and how they can do it. We are going to start working on the programme and we are going to work out a three to six months programme in advance so that we are running different things to help all the different sectors of the community. There are different types and kinds of needs. That will help make a difference”.*

It was also established during the implementation phase that the rhetorical commitment made by each partner to participate in the partnership-building process during formation (see Chapter 6), was often hindered by various individual and institutional challenges, and highlighted in the discussions below.

7.2.3.1. Department of Health’s fluctuating attendance at meetings and questionable commitment impacts on relationship building and goal attainment

The attendance at partnership meetings by some of the public sector partners was highly erratic. Often, partnership meetings were attended by different employees from the Department of Health. On enquiry, they indicated that their fluctuating work commitments prevented them from committing one person to attend all partnership meetings. This had a ripple effect on the partnership. It hindered the steady flow of communication between partners at meetings and the process of report back to other officials within their department about decisions made at partnership meetings. This in turn resulted in commitments made by the varying employees from the department, often not being honoured. For example, a senior member of the department, after attending two partnership meetings, promised to train a group of youth in Entabeni in methods to document the challenges of people in their community ‘through the lens of youth’. She had received training for this from the Japanese government via an agreement between them and the Department of Health, that she would use these skills to benefit grassroots communities like Entabeni. However, she failed to ‘follow through’ on this ‘commitment’. On enquiry by the external change agent about a possible future date for the training, she indicated that she was busy but would ‘still

like to do it'. This has yet to materialise! The community partners were especially disappointed at this 'lost opportunity' for skills transfer to the youth in the community.

Junior health employees represented on the partnership (primary health care nurse, hospital representatives) were also distressed at the general lack of support to volunteer home-based carers in Entabeni by the Department of Health, especially since they (home-based carers) played a pivotal role in realising their (Department of Health) mandate to providing care and support for PLWHAs in often hard to reach communities like Entabeni (see Chapter 2). In addition, and ironically, the social worker from the Department of Welfare mirrored the dismay felt by other partners towards managers at the regional Department of Health, and their apparent lack of acknowledgement of the crucial role played by the partnership in facilitating health care and HIV and AIDS management in Entabeni:

Social worker (Department of Welfare): *"It is difficult to say because in most cases people always talk about other commitments and that there is no time available. I always notice this from the Department of Health. They keep sending different people to meetings. They talk about being busy and doing their work, as if this partnership is just an extra commitment which is not part of their work. They don't realise that what is done by the home-based carers is actually what should be done by the health workers from the department"*.

7.2.3.2. Status and decision making ability of partner's influences commitment

The position, status or rank of the partner within the organisation had direct implications for their decision making powers, their ability to make binding decisions for their organisation, as well as their levels of commitment (see Chapter 6). This situation was especially challenging during implementation, with community partners advocating for quick wins in a context where HIV and AIDs presented additional burdens within an already challenging community context (see Chapter 2).

Despite the external change agent and community partners lobbying for senior staff members to be represented on the partnership committee, public sector organisations continued to send junior employees to partnership meetings. These employees

struggled between the urge to commit themselves completely to the partnership, and their inability to make binding decisions on behalf of their organisation, as illustrated by the following quotes:

Social worker, Department of Welfare: *“My main challenge has been in not being able to make decisions on behalf of the welfare department. I had to give them feedback first and then wait for a decision. Another challenge is that I can’t stick to what has been agreed on, like going to the outreach centre twice a month. At times I don’t have transport or I have to deal with something else that was not planned”*.

Junior health representative: *“I think the success of the partnership is on the commitment of each and every member of the partnership. If a person can commit him or herself on whatever he/she can contribute to the partnership, sometimes you will find that a person is not in power to offer something without going via somebody else. So it is difficult for that person because you may find that I can say to you I will offer this but to offer you that I must go and get authority from somebody else who might say no”*.

Often, the inability of public sector management in conceptualising and embracing the Entabeni partnership or partnerships in general as an innovative strategy for facilitating service delivery, realising organisational mandates and handling demanding workloads, resulted in employee participation in the partnership being considered as an individual commitment to be pursued outside of their official work schedule.

Health representative – hospital: *“I can say I can do that, but when I go to my manager and say that I have committed myself to do that, she will say, on whose time, because you know that you are fully employed here. So sometimes you find yourself trapped in between, not knowing what exactly it is that you can do. Sometimes you have to write a letter to my manager saying we request so and so to come and present to us or to the community of KwaMzimela on a topic on diabetes or hypertension. I need to have authority especially because KwaMzimela is not my area of work. So I can’t just go there without authority more especially during working hours”*.

Hence, the commitment of public sector individuals participating in the partnership was often hindered by the many absent voices of senior management or politicians, who did not *directly* participate or fully comprehend the value of the partnership for their organisation, but whose voices determined the level of partner commitment to the partnership.

Local government representative (Lennie): *“As a municipality, in terms of time, most of you will know that municipalities are governed by politicians so in terms of time it is 100 percent divided so I’m allocated 3.8 percent of my time to Entabeni”*.

In support of the belief that the status and decision making ability of the representative partner matters, the two key NGO partners, who were represented by their directors, displayed high levels of commitment to the partnership. This was reflected by their unwavering and regular participation at partnership meetings, their contribution of resources and time to the achievement of partnership goals, and their sense of accountability to the partnership and the community. NGO partners did what they said they would, without much coaxing from other partners or the external change agent. They followed through on their verbal commitments, as illustrated by the following quotes

Director, Lifeline: *“I will have to start because it is easier for me because we have committed ourselves totally to this partnership by establishing an arm of our main centre at this outreach centre by employing somebody as a supervisor to run it. So you have our total commitment in making a success of the outreach centre and the partnership and all the skills and resources that are available from us”*.

Director, Lifeline: *“Lifeline’s role in the project is to endeavour to ensure sustainability because HIVAN wanted to leave something in the community when their project funding came to an end”*.

7.2.3.4. Commitment was narrowly interpreted by public sector partners

Public sector organisations participating in the partnership often tended to have a narrow and traditional view of commitment. Thus, they were often adamant that their ad-hoc commitment of material resources and available capacity was adequate and all

that was required of them as members of the partnership. One such example is that of the Department of Health, who focused on the commitment of VCT services for the community, and gloves, home-based care kits and once off training programmes to support the work of home-based carers. While this contributed to concrete outcomes for the partnership and the community, their understanding of their role in the partnership did not extend to an acceptance of and understanding of the prescribed *norms of cooperation and commitment* in a partnership (Salmon, 2004; Campbell, 2003; El Ansari and Philips, 2001a). Their participation in the process did not include a simultaneous commitment of individual and organisational time, the sharing of risks and responsibilities associated with the partnership, or the need for accountability to the community and the partners – factors identified as key to ensuring the sustainability and ownership of the partnership (El Ansari and Philips, 2004).

This traditional interpretation of participation in and commitment to the partnership was also mirrored by the local government representative (Lennie) on the partnership committee. In Chapter 3 of the thesis, I highlighted the role of local government (municipality) in community development. They are the closest sphere of government to communities and have a clear mandate for facilitating community development through sustainable partnerships (The White Paper on Local Government, South Africa, 1998). However, public sector partners, including local government, struggled to conceptualise of, or accept the ‘reality’ of partnerships as fitting within a continuum of service provision, instead of being an ‘either/or’ response, as the following quote illustrates:

Local government representative (Lennie): *“As a community development representative for Umlalazi, I think my future involvement is going to decrease. I must say I will continue with the support of availing the hall, conference rooms and boardrooms and sometimes attending the meetings if I’m available. My time is going to be taken up”*.

The following quote basically summarises the author’s sentiment regarding public sector participation and their levels of commitment to the partnership. It was accepted that within the current reality of their conceptualisation of partnership, and their

internal organisational challenges, they would do only what they believed was possible.

Sally (Director – Lifeline): Yolanda (*external change agent*) *I think we have to appreciate that it is very difficult working with the government departments because they can make commitments and not fulfil them. Take Mr Nongoma (social worker) for instance, he can make a commitment and not be able to stick to it, the same as the Legal Aid Board. They are obliged to do certain things and when other things come up, they pull down. There is nothing they can do about it. It is unfortunate for us, but I do understand. As frustrating as it is, I do understand the problem. We can only try our best to ask them to stick to a certain day each month.*”

7.2.3.5. Unsustainable funding sources challenges NGO commitment

While the unwavering support and commitment of the NGO partners to the partnership was a key contributory factor to the relationship-building process and the attainment of concrete partnership outcomes, their long-term commitment to the process was challenged by unsustainable organisational funding (see Chapter 6). This impacted on their ability to commit to financing training initiatives or sustaining structures (e.g. outreach centre, hospice) that they, together with the partners, had succeeded in establishing in the community.

For partnerships to secure the total commitment of privately funded NGOs, and ensure their continued participation in the partnership and its projects, much work needs to be done in influencing and changing the mindsets of funders to promote the concept of collaboration. If this is achieved, the resources necessary for the ‘time-consuming nuts and bolts work’ of collaborative processes will be provided, and the sustainability of collaborative projects in resource-poor communities like Entabeni can be achieved. As OSCEP's Angela Jarvis Holland put it, "*Funders support this model but aren't realistic about the resources and energy necessary to make it work. I don't see any allowance made for the amount of work it entails if I want to network, if I want to get to know people, if I want to work collaboratively*" (Smock, 1999:19).

One of the key outcomes of the networking between partners, facilitated through the partnership-building process (many sub-committee meetings between the partners),

was the support given to the Entabeni development project (NGO partner) by the regional branch of the Hospice Association of South Africa (ad-hoc member of the partnership – see Chapter 6). During the implementation phase and after several sub-committee meetings between the partners (see pictures in Appendix 3), the hospice association committed themselves to providing regular, monthly financial support to the Entabeni hospice since other funding sources to sustain this essential service in the community was no longer available. Aside from this, they (hospice association) provided training for the home-based carers who worked at the hospice (see Chapter 6) and were arranging for the hospice to acquire professional nursing assistance.

7.2.4. Accountability

The literature on partnerships emphasizes the importance of accountability in achieving partnership success (Campbell, 2003; Dowling et al., 2004). For many of the service-provider partners, accountability was a vague concept, often not perceived as a binding commitment to their organisation or service beneficiaries. Most certainly, for many of the public sector partners, the ethos of accountability to one's organisation, the community, and to some extent the partnership, was practically non-existent. While it existed on paper and was talked about at length by senior managers within public sector institutions that participated in the partnership, what was actually implemented in reality was a far cry from institutional or policy expectations (The White Paper on Local Government, 1998; Department of Social Development, 2006; National Strategic Plan for HIV/AIDS and STIs in SA, 2007-2011; The White Paper for Social Welfare, 1997).

7.2.4.1. Public Sector managers did not promote or practice the ethos of accountability

Senior managers were certainly not the ideal role models for their junior peers who participated in the partnership. On more than one occasion, managers from public sector organisations represented on the partnership would arrange to meet with Entabeni community partners or the external change agent at a specific venue, time and date. However, on arrival at the meeting, it was often found that they were not available, nor would they make prior arrangements to have the meeting cancelled. An apology for their absence was also never forthcoming. Getting to the meeting venue would involve the external change agent driving for approximately two hours from

Durban to fetch community partners, before arriving at the venue, most often at a government department situated a distance away (approximately 30km away) from Entabeni, only to find that the manager with whom the meeting was arranged was not present! The following excerpt from the field-diary of a research team member describes briefly the scenario of a meeting arranged with the district manager of the Department of Welfare in the region:

24 November 2005

'Nxumalo (community partner), Sindy and Yolanda (research team) arrived at the Department of Welfare as per arrangement. Ms Carter (district manager) had promised to be present as well, together with Mr. Nongoma (social worker). When the team arrived, they were instructed by the receptionist to take seats in the conference room, as Nongoma was still busy. He would be joining the team soon. They waited for Nongoma for thirty minutes, not knowing what else to do. When he arrived he apologised and said everybody had left and left him to man the department. He brought with him Zodwa whom he later introduced. Ms Carter was not available, though she had agreed on the date. Apparently she had to attend another social security meeting. It was disappointing that she wasn't available. Nongoma apologised on her behalf.'

In a discussion with Bongi, an independent consultant contracted by the National Department of Health to do training for home-based carers in several provinces in South Africa, she confirmed that this experience was not unique to the Entabeni region or to any one public sector department:

Bongi (trainer contracted to the Department of Health): *"What I usually do is I make an appointment about a day before and in the morning of that meeting, I phone. It is not at Entabeni only. I work at Sisonke and in the Eastern Cape. It is the same. You drive for six hours and you get to the Eastern Cape, Engcobo, nobody is there. So you phone the day before and you phone in the morning of that appointment."*

In two separate planning meetings with representatives of the Department of Health, managers from the department committed themselves to providing accredited home-based care training for the home-based carers in Entabeni. The home-based carers had

been informed that this training, facilitated by the Department of Health, was necessary if they were to qualify for a minimal monthly stipend from the Department. The home-based carers were really excited and enthusiastic about the impending training. They had been struggling for years to acquire training endorsed by a government department so they could qualify for a government stipend. However, these trainings never fully materialised, nor did the department managers deem it necessary to apologize or inform the home-based carers of their inability to follow through on their commitment. This became a pattern of interaction between the community and the public sector institutions, requiring the external change agent to constantly intervene on behalf of the community partners to ensure that commitments made were actually fulfilled. This persistence resulted in the home-based carers finally receiving three sets of training from the Department of Health, an ongoing supply of gloves, home-based care kits and a protein feed for PLWHAs. Some of the partners grabbed the opportunity to discuss this issue with a senior manager of health, who subsequently made a rare appearance at a partnership meeting. When presented with these challenges, she apologised and referred the partners to her locally based colleagues:

Mpanza (Senior Manager-Department of Health): *“I was there during the graduation of the home-based carers. We gave the kits and Ms Thoko is our HIV/AIDS programme coordinator. Sorry that she is not here. Could you please use me as your contact and I will try my best. I hope I won’t chase you. If I am not around, please get to know my colleagues on a local level. Mrs Monza, since you are in her catchment area, is always there. If you don’t see a face from the district office Mrs Monza and the health people around that area, may represent the district office, not that we are running away. Whatever you want from the district office, please talk to the local health providers of that area. That is our support from the district office, because they are our extensions of the district office. From the district office, I am also available for you as long as I am allocated in this area. Because these top guys are not always there, you make appointments with them and they even forget to let you know, sorry for that.”*

Unfortunately, the very same manager went on to break all the promises made to the members of the partnership who were present at this meeting, i.e. of continued support and time allocated to the partnership.

These kinds of interactions between senior public service officials and partner representatives did not do much to mend the previously poor relationships that existed between the community and public service-providers (see Chapter 2 and 5). It was also not helpful in building *trust* (Gray, 1989; Heenan, 2004; Gardner, 2005), identified as pivotal to redeeming these damaged relationships and building partnerships between the community and service-providers, as illustrated below:

Nxumalo (community health worker): *“We are busy progressing, we think, with the health related project in the tribal authority, but if this were to somehow fail in the future, it will really be because of the Department of Health. They are just nowhere to be contacted and nowhere to be found. We really think, as she was saying, that the stumbling block is the Department of Health. We tried all the means to get them to come closer to us. We even approached them by going there. I was once chased away and booked absent just for going there, because I had to go there just to find out what was happening and they said because I came there I had to be booked absent. That was Ms Makaza (district manager – Health). So how do you approach them because I don’t want to be booked absent? Who will ever go there and be booked absent for the health related problem?! So I will repeat. If it were to fail it will be because of the Department of Health”.*

7.2.4.2. Inadequate monitoring systems and internal communication channels hinders accountability

Often internal monitoring and accountability systems within external partner organisations appeared to be inadequate, hampering their ability to hold employees accountable for their time spent on partnership or other work outside of the office. This kind of situation was aggravated by poor channels of communication within and between the various departments offices (e.g. Department of Health), resulting in a lack of transparency between employees and an ignorance of the work that each of them were involved in doing. In a strange way, the partnership meetings became a platform for facilitating communication and debate among employees from within

these organisations, a practice apparently unfamiliar to them, as the following communication between a senior health representative and her junior colleague (the primary health care nurse) at a partnership meeting illustrates:

Mpanza (Senior Manager – Department of Health) *“I have a concern about the report of the outreach programmes, community health workers, home-based carers and volunteers. Most of the time, they do not reach me as the representative at province level. Most of the time, you colleagues (referring to partner organisations) call me and say, ‘hey we have got the home-based carers getting this and that.’ I fail to say thank you to them for their good work because I don’t know what they have done. Just look, they have identified this mobile point (mobile clinic). I am only getting to know that now in this meeting because ‘comprehensive report’ just mentions a new mobile point has been identified. By whom, whether by induna (headsman) or community I don’t know? And these people who are our extensions feel, ‘ooh, it means they are looking down upon us’. If you (junior colleague) could please, don’t just file them (reports) nicely. Send them to me also. I will also communicate with Mrs M (head of primary health care). Those monthly meeting’s, please invite me”.*

Similarly, within the local municipality, the municipal manager (Mr Dennis) was not aware of the contribution made by his junior representative on the partnership committee (Lennie), nor was he informed of when Lennie attended partnership meetings, or the time he spent on planned partnership interventions. In fact, Mr Dennis was pleasantly amazed when informed by the external change agent of the input made by his colleague in assisting the community partners to draft a constitution for the partnership committee and then facilitating the formal registration of the partnership committee.

The apparent lack of functional monitoring and accountability systems within these organisations, and its implications for the assumption of ownership and sustainability of the partnership, presented the external change agent with the arduous task of initiating a process of instilling a sense of accountability into the mindsets of partners. This, through ongoing discussions and negotiations with organisational heads and individual partners, suggesting alternatives to existing monitoring and accountability

systems, and ways in which these could be incorporated into daily work plans. The following discussion with the municipal manager and community partners refers:

External Change Agent: *“I just want to talk about the future involvement of the municipality. You said you are employing someone and that person is going to be working with all the desks and the AIDS desk is one of that. My worry is, how much input that person is going to make, specifically with regards to AIDS related issues. The other thing is, if you look at Lennie (municipal employee), the way he operated, there was no system of accountability at all. So Lennie might have said he was coming to the partnership meetings or he was going to be in the community, and so many times he phoned and said ‘I am on the way. I am just around Ging or wherever.’ We would start the meeting and finish, and no Lennie. So my biggest concern is that this is not only with local government. I am talking government departments generally. The system of accountability is non-existent, and that is the biggest problem that NGOs and communities like Entabeni Tribal Authority face with government officials. I don’t know what suggestions to make to you or how this is going to work but I am saying that it is something you need to take into account when that person is being employed because there has to be very close monitoring and constant evaluation so that that accountability does exist.”*

It is noted that while functional internal organisational monitoring and accountability systems are crucial to the functioning and sustainability of a partnership, it must be accompanied and executed by skilled, responsible and informed personnel. If not, accountability will continue to be a ‘vague concept’, manipulated by service-provider employees to justify their wavering levels of commitment and accountability to the community, the partnership and their ‘organisational mandates’.

7.2.5. Incentives and benefits

The motivation that drives the participation of an individual or organisation in any partnership arrangement is largely dependent on the incentives or benefits accrued to them. El Ansari and Philips (2004) define ‘incentives and benefits’ as the ‘make or break’ of a partnership. By implication, partnership arrangements between organisations and communities must have built-in incentives for both individuals and organisations to encourage effective participation and collaboration (Campbell, 2003;

Lasker, 2000). Additionally, and as I have learnt, the facilitator of the partnership needs to be particularly sensitive to the needs of individual partners as well and ensure that the value of their input into the partnership is regularly acknowledged by the partnership.

7.2.5.1. Organisational benefits and incentives

From an organisational perspective, partners were clear about the benefits for participation in the partnership-building process. Public sector partners cited the following benefits:

- meeting policy mandates which proposed multi-sectoral partnerships and community engagement as a key strategy for facilitating HIV and AIDS management;
- meeting strategic planning mandates for increased inter-organisational networking and collaboration;
- learning about the services provided by other stakeholder partners;
- enhanced community engagement and understanding of the needs of their target community's;
- facilitating community capacity-building and community access to their services, and;
- building organisational capacity.

Social Worker – Department of Welfare: *“I used to work as an individual but now we work as a team! There are now people I work with – sometimes even the information I would otherwise have not been able to access, through HBC and other stakeholders is now possible. Although I worked in the community before HIVAN (external change agent) but there was no outreach centre to work from and my visits to the community were not structured. Now the community knows that Mr. N will come on such a date! Sometimes when I go to the community I already know who I would be seeing because the home-based carer would have done the ground work”*

Meeting the policy goals of participating in a partnership-building process with other organisations and engaging with communities as equal partners was probably the biggest incentive for public sector partners. However, while acknowledging the

benefits accrued to their organisation through their representation on the partnership committee, they did not relate this to the need for *them* to have shared equally in the toil and time taken to achieving these partnership goals, e.g. a senior health representative was adamant that the research team submit reports to their department on the achievements made by the partnership since it was important for them to have it on record. The very same representative indicated that she was a very busy person and could not attend all the partnership meetings or participate in tasks allocated to partners for the achievement of partnership goals!

For the NGO partners, the partnership was a means of providing easy access to a rural community and satisfying religious convictions of contributing to the capacity-building and empowerment of community stakeholders (see Chapter 6). Networking with and receiving the support of other partners in achieving these goals, and facilitating community development and social change processes was an additional incentive.

Audrey (Entabeni development committee): *“We have wanted this kind of cooperation among the people and the partnership has brought in important people that play a role in the lives of people. We have put ourselves on the map. We have brought the Department of Health and Welfare into the partnership. That is what the partnership is all about. The Department of Health is a tremendous achievement. We must remember that.”*

Amy (hospice association): *It’s been really great for us to be able to be a part of this. I did not have to struggle to get into the community or meet with the hospice people. I have now committed myself to working with the home-based carers and the hospice committee in making sure that they can function as a proper hospice”.*

For the community partners, their participation in the partnership facilitated changes in the way they were thinking about HIV and AIDS, improving community access to services, increasing their ability to mobilize around a development issue and contributing to social change:

Mr Nxumalo: *“Things are happening in the community, the organisation itself is growing enough. We are seeing things changing – the attitudes of the people, the traditional leaders and more especially we are seeing the attitudes changing of the ordinary people. We are experiencing a large number of people who are exposing themselves, which is good for the community – they are HIV positive. Most of the people are going for testing, there’s a certain percentage still afraid but a good percentage is coming up, it’s great for them to say that I’m HIV positive and going for testing. We have people working in the community that were not as active as previously because the partnership, especially the home-based carers, but they are going all over work-shopping the people but doing it as part of the partnership. We are seeing people changing the community gardens. Before they couldn’t use gloves, it was discriminatory but the community is gaining a lot, we have trained traditional leaders and they are looking for gloves, we are supplying them with the gloves. Everyone is becoming educated now. The community knows, not 100 percent, but they know what’s happening.”*

Gladys (home-based carer and community partner): *“I am taking this partnership as the root sucking water, bringing it to the stalk and to the flowers. Participating in the community, bringing the service-providers to the community helps the community and also the local partnership. I think this partnership is the root helping the stem and the trees to make their food.”*

7.2.5.2. Individual benefits and incentives

During the formation stage and part of the implementation phase, service-provider partners indicated that they had personally benefited from the process through their enhanced capacity-building skills, increased confidence, a recognition of their personal strengths and a general boost in self-esteem (see Chapter 6). However, and as the partnership progressed further into the implementation of partnership projects and the facilitation of partnership goal achievement, it became apparent that *personal recognition* and the *acknowledgement of personal contributions* by partners in realising partnership goals, became a key driver for participation in the partnership by some partners. For instance, the local government representative who made great strides in working with the community partners in developing a constitution to facilitate the formal registration of the partnership repeatedly mentioned this at

partnership meetings and saw it as a personal rather than an organisational contribution to meeting the goal of formalizing, and therefore sustaining the partnership.

Lennie (Municipal representative): *“This is a brief report. It is mainly on the workshop that I came and did with the committee in terms of registering the NGO as an NPO. We also developed with them a constitution. So that is what we mainly did with the committee last year but it is something that we did before the meeting. That is why Yolanda, I was a bit cross that the committee member did not report that at the last partnership meeting because that activity was actually done before the last meeting in October, but I am happy that Gladys has reported on it today. If you are registered as a non-profit organisation, it makes it easier for international funds to go through your organisation. Once the certificate is there you can proceed with application for that.”*

I recognized his need for acknowledgement and consciously made a note of constantly highlighting the value of his contribution to the partnership and the community.

External Change Agent: *“Thank you Lennie for your valuable input into the partnership. I know that the community, especially, really appreciates the time and effort that you have invested in ensuring that the partnership is registered with a constitution and are now able to apply for funding. We would not have known how to do this without your assistance”.*

For the community partners, aside from the partnership being recognised as a community achievement, they benefited enormously as individuals. Thus their incentive for participation in the partnership during implementation, included benefits accrued to them as individuals, through the *opening of doors* and the *opportunities for networking and interacting with service-providers* in the region at partnership meetings, community events, and meetings with service-provider organisations. They had opportunities for learning and networking, through their assumption of key leadership roles on the partnership committee and at partnership meetings, and through their attendance at workshops and local and international conferences. A

‘once in a life-time opportunity’ was their presentation of a project paper at the 3rd South African AIDS conference held in Durban in August 2007, an experience later described by one of them (religious leader) as the most *‘wonderful experience of my life’*.

The following quotes reflect their gratitude and understanding of the opportunity for growth afforded to them through their participation in the partnership:

Mr Nxumalo: *“In isiZulu there is a saying that means “a person learns everyday of his/her life” so as long as you’re alive you’ll be learning something new. Working in this partnership as a member has given me a lot of experience, though I am growing still in experience, but I would say I’m gaining more than enough experience.”*

Dumi (home-based carer and community partner): *“Thanks each and everyone for your contributions and also the success of the partnership. I would say Lennie (municipality) is doing a wonderful job on this application (formalisation of the partnership), and also I can see that we are heading in the right direction now. I will say each and everyone must work harder than before because the ball is on our court. I am also very impressed with Lifeline and also to see that they have prepared a plan for the year. You cannot do anything without a plan. We now have the direction and they know where they are going. I also want to thank the HIVAN team for encouraging us to do things ourselves because as we are happy to achieve this registration, even ourselves, we are so proud because we were a part of it, unlike to be waiting for them to spoon feed us. We are also gaining more experience from each and every department who are participating in the partnership. Thank you very much from all of us. You are so great. Keep up the good work.”*

7.2.5.3. Organisational challenges are a disincentive for partnership participation

What was noted, especially with public sector partner’s, is that incentives and benefits accrued to individuals did not necessarily translate into enthusiastic, regular and ongoing participation in the partnership, as expected by me. In fact, participation at meetings and partnership activities were erratic and irregular, often requiring concerted input from the external change agent to motivate partners to ‘put their money where their mouth is’ in terms of the benefits accrued to them and their

organisations. The social worker from the Department of Welfare, who continuously highlighted the benefits of participation to him and his organisation, was constantly late for meetings and had to often be ‘coaxed’ into actioning his verbal commitments. In these ‘trying times’, when the external change agent felt particularly fatigued in pursuing the role of nurturing, supporting and encouraging partners to endure and persevere despite personal level challenges, the NGO partners often ‘took over’ this role. They encouraged other partners to focus on strengths and possibilities rather than challenges, as the following conversation demonstrates. Audrey, from the Entabeni development committee, took on the role of *nurturing relationships* between the community and the Department of Welfare and encouraging the welfare representative (who was again lamenting the difficulties of ‘bringing’ social work services to the community), to accept the assistance of the community partners in doing this.

Audrey (Entabeni development committee): *“You can’t please everyone as you say. I think it is very important if somebody can come at least once a month, whatever the schedule will be. The important thing is to come that one time and then everybody will know for sure you are going to come that one day and everybody will come that need to talk to Mr Nongoma at that one time than not be able to because that is worse for the people because they get so disappointed when they come and nobody is here. It is though they are being fooled in a way, if I can use that expression. It is really important to decide that we will make it once a quarter if that is all that can be done, but that is very important to come then and pass the word around that Mr Nongoma is going to be here.”*

External Change Agent: *“Thanks for saying that Audrey. I think that is basically the crux of the problem. Mr Nongoma, I absolutely understand all the challenges that government is facing now, especially in the Social Welfare Department as well, because there is a huge turn-over of social workers. I think that is basically the problem that civil society has with public service, is that when they say things, they never follow through and there is an increasing mistrust of public servants now because of that. It comes down to basic things that Audrey was saying, that if you are saying you are going to be here and you are not here, then again, people are saying, ‘can we ever trust them?’ We may not see it that way but that is how people see it as*

well. It is like being let down as a child. And the more often it happens, the more disillusioned you become with government. So I think Mr Nongoma, what Audrey is saying, and I absolutely know what you are talking about and I empathise in a lot of ways because I know also what you are saying about politicians saying things and raising people's hopes and they don't know what people on the ground are doing, so I understand that huge gap in communication, but like Audrey is saying, try at least to be there once a month so that people start developing their confidence in the Department of Welfare or your services. I am appealing to you at that level and at the same time I am saying we absolutely know the major challenges the government is going through at the moment. I am going to leave that difficult task to you Mr Nongoma and I am hoping that Gladys can work together with you with that. What we are saying is that they will give you all the help that you need. We said that to you before."

In attempting to unravel the seeming lack of motivation of some individuals, reflected in their erratic participation in the partnership, I concluded that partnership participation was closely tied to the levels of support individuals received from their organisations, as mentioned by Walker (2000), and confirmed by the findings, which allude to the lack of support of especially public sector employees participating in the Entabeni partnership from their organisations.

The lack of infrastructural and individual support (cars to attend meetings, allocation of resources and time for partnership activities, training of employees in partnership work, decision making abilities), from external partner organisations proved to be a *disincentive* for participation in the partnership; hence, partners often *counted the costs* of time spent in partnership activities rather than the benefits accrued to them and their organisations.

Social Worker, Department of Welfare: *"From my side, I am doing my utmost best but the thing is that I won't be able to satisfy each and everyone at the same time. About the politics of the ministers, I don't want to comment on that because they are there and they come and say different things. Recently our minister preached that there is a shortage of social workers. It is a known fact that we are short staffed. Even the cars, we don't have. Sometimes I have a problem of a car"*.

Public sector managers, in explaining the assumed ‘lack of support’ of, and commitment to the partnership, identified *inadequate funding* to support partnership work as a key disincentive for them as managers of public funds and programmes. A senior health manager indicated that despite HIV and AIDs policy (NSP 2007-2011, NSP 2000-2005) which advocated for multi-stakeholder partnerships and continued community engagement, they were inadequately funded for this type of work. Thus funds could not be allocated for the support of health personnel participating in partnership activities, nor could additional resources be set aside to support partnerships within specific communities. Hence the apathy associated with prioritizing partnerships as a key strategy for service delivery in the public sector, as illustrated by the following quote:

Senior manager, Department of Health: *“What I need to explain is that the Department of Health doesn’t have a bank, or doesn’t work with Tito Mboweni (Head of reserve bank). We really don’t have money. We have allocations and we run things according to budget, so we are different from the whole of Uthungulu as a district. Last year a lot of funding was spent on training communities. Personnel and facilities were left out. We are having major gaps”*.

This statement and previous discussions (see Chapter 6) on the role of the public sector in supporting communities to manage HIV and AIDs, begs one to again question the link between public sector manager’s conceptualisation of partnerships as a service delivery strategy, and the (lack of) creation of an enabling environment that supports partnerships with communities for this purpose. Do they conceptualise partnerships within a continuum of service delivery that is then automatically incorporated into the service delivery budget? These are some of the questions and points that need to be considered by public sector managers if employees from within their organisations are to be provided with the incentives necessary for their total commitment and eager participation in partnership for HIV and AIDs management and general community development.

7.2.6. The enabling role of the external change agent during the implementation of the Entabeni partnership

The complex nature of partnerships makes the *process* of facilitation a formidable task that requires a high level of skills and tenacity (Gardner, 2005; Gray, 2008). Predictably, therefore, within the context of the partnership-building process, outcomes were closely tied to the pivotal role played by the external change agent in facilitating the process of change and development and the achievement of partnership outcomes, which began in the *formation* phase of the partnership and continued into *implementation*. The *implementation* phase heralded a process of the external change agent *being influenced* by the unfolding dynamics and outcomes of the partnership and in turn *influencing* the process of collaboration to effect change and facilitate positive partnership outcomes by:

- nurturing and encouraging the development of *relationships* based on *trust* between partners;
- encouraging *reciprocity* and strengthening *networks* between the community stakeholders and the external service-provider partners;
- encouraging dialogue and the exchange of ideas at partnership meetings and events;
- facilitating the process of partners sharing and listening to each others challenges and aspirations;
- empathising with partner representatives and supporting and nurturing their personal growth potential, and;
- mediating in unequal power relations and supporting the voice of the powerless (more often community partners) on the partnership committee through moral support and advocacy, and by *strengthening the capacity and empowerment of the community partners*.

The external change agent also continued to intervene in and address the challenges encountered with external partners in the implementation of the partnership (especially in relation to the public sector), while focusing on the strengths and abilities of partners to enable partnership-building and goal achievement.

7.3. Conclusion

The presentation of findings in this chapter describes the process of *implementation* of the partnership (research question 2), the *challenges* that intervened (research question 4), those factors that *enabled* the process (research question 3), and the *value* of the partnership for participating individuals and organisations, and HIV and AIDS management in Entabeni (research question 1).

It is noted that the *process of implementation*, similar to the other two phases (pre-formation and formation), was dynamic and ‘fast-paced’, moving beyond the assessment of the constituency’s concerns (accomplished during pre-formation and formation) and the development of intervention plans (El Ansari and Philips, 2001a), but to the actual implementation of partnership activities, while simultaneously monitoring and supporting the life of the partnership (maintenance). This phase of the process also yielded many partnership outcomes, both subtle (relationships based on trust, established networks, increased confidence and self-esteem of partners, etc.) and concrete, which are mentioned below (outcome stage).

The structure for the analysis and presentation of data diverged slightly from that which was adopted in Chapter 5 and 6. Whilst incorporating Campbell’s (2003) criteria for the analysis and presentation of data, adjustments and additions were made to the framework. Thus, constructs utilized for the presentation of findings often redefined and re-conceptualised these criteria to blend in with the data gathered during the *implementation* of the partnership.

Many of the *challenges* encountered during this phase of the process related to public sector participation, including limitations in individual and organisational capacity, the fluctuating commitment of time to work with other partners in realising partnership goals, poor systems of accountability and communication, a lack of infrastructure, power differentials between partners, the lack of decision making powers assigned to junior officials representing public sector organisations, and inadequate organisational incentives to support the participation of employees in partnership work. These challenges often eroded the *trust and relationships* between partners. However, the external change agent played a pivotal role in turning these challenges around by harnessing the innate strengths and existing skills of partners

and appealing to their humaneness and responsibility in responding to the challenges posed by HIV and AIDS in the Entabeni community. This largely contributed to the changing mindsets of partners, their growing commitment to 'take a leap into the unknown', and their willingness to embrace new strategies for community engagement and service delivery through their participation in the partnership.

The external change agent's involvement in the implementation of the partnership has reversed my naïve initial interpretation of the community as the problem and the service-provider partners as the solution. Over time it has become clear that the community stakeholder partners had the will to learn skills and mobilise energetically to address the challenges of the epidemic. Most often it was the external partners – particularly those in the public sector – that lacked the capacity or skills and organisational systems that would enable them to support community responses to HIV and AIDS. This 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, I 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.

The reality of these challenges with service-provider partners, and the need to plan for the *sustainability* of the partnership and eventual withdrawal of the external change agent from the project, largely influenced the concerted drive to capacitate and empower community stakeholders to assume primary responsibility for the long-term facilitation and sustainability of the project, in their role as *internal change agents*. This was an ongoing process, implemented through their participation in all aspects of the partnership-building process and through the continued training provided to them by the external partners. Thus, the process of preparing the community stakeholders to assume the roles of facilitator and internal change agent involved a 'learning through doing' philosophy, the unconditional and ongoing support of the external change agent, and the provision of extensive networking opportunities provided through:

- their attendance at conferences and workshops focusing on HIV and AIDs and community development;

- their presentation of discussion papers on the Entabeni project to a wide range of external stakeholders both internationally and locally;
- facilitating their access to, and attendance of meetings with service-provider organisations, and;
- consolidating these networks through a process of institutionalising the partnership within a permanent government structure (the local municipality).

The process of networking and collaboration (*building social capital*) between the partners, and the investment of time and effort by the external change agent in *nurturing relationships* and *reciprocity* among partners, contributed not only to the partnership-building process, but to the partners mutually benefiting from one another. This, through the learning and knowledge gained from their interactions with one another, the sharing of resources and information, and their *access* to ‘otherwise difficult to reach’ *networks*. This in turn facilitated a process of service-provider partners realising their organisational mandate of engaging with rural communities and enhancing their capacity, while community partners *reciprocated* by supporting the work of the service-provider partners in the community, providing them with moral support and the information they (service-providers) needed to facilitate service delivery in the community.

The process of sharing and joint working yielded many other concrete partnership *outcomes* during the implementation phase, also ensuring the sustainability of the project. These included:

- The *formalisation of the Entabeni partnership* committee. With the assistance of the municipal representative (local government) on the partnership committee, the partners were able to put together a constitution for the partnership, apply for and be formally registered as a community based organisation (CBO). This enabled them to apply for and receive funds from donors within government and the private sector to facilitate general community development and health related projects in the community of Entabeni. The executive committee of the newly formalised Entabeni partnership are represented by the community partner’s. They have been

trained by Lifeline on ‘organisational development’ and other skills necessary for managing a CBO and facilitating development related projects in the community.

- The establishment of an ‘*outreach centre*’ in Entabeni that was supervised by the NGO partner, Lifeline, with the assistance of Gladys (home-based carer and community partner). She was trained by Lifeline and received a nominal stipend from them for managing the centre. The centre serves as a place where community members can access information and lay counselling services (Gladys and other youth in the community were trained by Lifeline to provide lay counselling), or be referred to service-providers (health, welfare, etc.) for more intensive and professional services. The centre is also used by the partners as a meeting venue and by the social worker from the Department of Welfare to provide accessible social work services to the community once a month;
- Extensive and ongoing HIV and AIDS training, based on the train the trainer¹³ programme with home-based carers, religious leaders, traditional leaders, traditional healers, learners, out of school youth, youth groups (churches), women and men in the community, iNkosi’s (chief) wives, community partners. The volunteer home-based carers used their training to facilitate training workshops, discussions and debates with a wide range of ‘hard to reach’ people in the community. Some of the components covered in these training sessions included a general overview of HIV and AIDS, modes of transmission, stages of the virus, the immune system, antibody testing, the association between TB and HIV and AIDS, HIV testing, home-based care, fears associated with AIDS, caring for people with AIDS, gender and HIV, designing and running a workshop, communication skills, writing project proposals, etc.;
- Employment opportunities for community partners (Gladys employed at the outreach centre; the Tugela AIDS project trainer is now working for Lifeline; home-based carers received minimal stipends for the service they provided in the community), together with the provision of funding for the partnership committee to facilitate community development projects in the community

¹³ Each person that was trained was equipped with skills to facilitate similar training workshops or discussion groups with their peers, family members or people in their neighbourhood

(through the local government partner) and for the Entabeni Development NGO to manage the Entabeni hospice (through the Hospice Association of South Africa);

- Towards the tail end of the implementation phase and at the end of 2007, the Entabeni project was *institutionalized* within the local government department (municipality) represented on the partnership. This came about through the long-term efforts of the community partners, the external change agent and the local government representative on the partnership, who advocated for and lobbied management and the political structures within the municipality to accept the 'Entabeni partnership project' as a designated municipally supported and registered project.

These collaborative achievements, despite the many challenges outlined, support Evan's (1997) contention that even within challenging Third World contexts like Entabeni, state-society synergy¹⁴ or partnerships between the public sector and civil society is constructible and capable of yielding valuable outcomes for all partners.

¹⁴ Synergy refers to joint work and cooperative action which occurs when the result is greater than the sum of the parts. Synergy is created when things work in concert together to create an outcome that is in some way of more value than the total of what the individual inputs are.

Chapter 8

Lessons learnt, Recommendations and Concluding remarks

8.1. Introduction

HIV and AIDs is the leading cause of adult mortality in Africa, its effects being compared to the Black Death in medieval Europe (Barnett and Clement, 2005). In South Africa, the epidemic continues to be one of the worst in the world and shows no evidence of declining (UNAIDS, 2006). Responses to the epidemic thus far have been largely biomedical or behavioural and have failed to reduce the spread of HIV. Within the health and social development sectors globally and in Sub-Saharan Africa, partnerships are, however, increasingly being heralded as a new and effective way of responding to the epidemic (Sanders and Baisch, 2008; DeFillipi and DiSorbo, 2006; Snape and Taylor, 2004; El Ansari and Weiss, 2006; Wagner and Mleck, 2004; Campbell 2003).

In South Africa, where wealth and access to public services is skewed despite measures by government to 'level the playing fields' in terms of development and access to essential services post 1994, the majority of South Africans continue to live in poverty, and continue to be the victims of an imbalance in access to essential services like health and welfare. In rural communities like Entabeni, this is pronounced because of geographical isolation, limited infrastructure (tarred roads, transport) and the lack of supportive networks with service-providers that can foster their access to these essential services. Bourdieu (1986) believes that a limited access to networks of socially advantageous inter-group relationships, which he defines as social capital, plays a key role in perpetuating poverty and social disadvantage, thus hindering people from improving their life circumstances. Despite the existence of a policy environment that encourages public, private and civil society partnerships in responding to developmental challenges like HIV and AIDS, the political will and administrative support to enable this interaction is lacking. Service-providers have functioned largely independently in their response to HIV and AIDS, but with the increasing prevalence of HIV, the public sector is now challenged to do more with

fewer resources and be accountable for achieving results often beyond their control due to transformational, capacity and work load challenges.

These contemporary realities provided the backdrop for the partnership between the Entabeni community stakeholders (including home-based carers, traditional leaders, a municipal councillor, a religious leader, teachers and youth), and representatives from the public (welfare, health, municipality) and NGO sector (Lifeline and Entabeni development committee). The broad philosophy underpinning the Entabeni partnership strategy was based on the recognition that:

- the failure of current strategies to stem the tide of the AIDS calls for the adoption of creative strategies that are relevant to the current health and developmental challenges facing resource-poor communities like Entabeni;
- the HIV and AIDS epidemic is too big a challenge for any one constituency to deal with on its own; hence forming alliances with a wide range of constituencies that allow for the pooling of resources, manpower and creative ideas is more effective in dealing with the current manifestations of the epidemic, i.e. ‘the whole is greater than the sum of its parts’;
- for resource-poor communities, developing bridges or vertical networks through collaborative partnerships with influential actors from the public, private and civil society sectors will facilitate access to the support, capacity and resources needed to maximize their own efforts in promoting health, and initiating general community development.

The partnership literature, (confirmed by the findings in this study), indicate that partnerships as notoriously difficult to promote and sustain. Hence the need for evidence-based research and interventions to guide the process of partnership-building, and map out the conceptual and practical terrain between policy rhetoric, and the reality of facilitating multi-stakeholder partnerships. However, the available literature on partnership emanates largely from generally well-resourced Western contexts, with a dearth of locally published (South African) research on HIV and

AIDS partnerships, and virtually none, to my knowledge, based in rural contexts. The Entabeni partnership study responded to this empirical and academic gap.

I used a qualitative, longitudinal methodology to guide the research process, which focused on one case study, the Entabeni partnership (see Chapter 4). A general survey of the literature revealed a bias towards quantitative, cross-sectional methodologies in facilitating partnership studies. This study, again, located itself within this empirical gap through the in-depth qualitative study of the Entabeni partnership. The value of the qualitative longitudinal method (QLR) for this study lay in its ability to investigate and interpret the nature and process of change over a period of time, allowing for an observation of the relationships that developed between the partners, the challenges experienced and the outcomes that joint working yielded, despite the challenging context within which the partnership was facilitated.

In terms of *generalisability*, while the study focuses on a single case study within a specific context, I believe the findings will be invaluable to social researchers and development practitioners in serving as a benchmark for ‘what to strive for’ or ‘what to look out for’ when facilitating partnerships within similar contexts, and with the same or possibly other developmental needs.

Campbell’s (2003) criteria for effective partnerships largely guided the ongoing evaluation and analysis of the partnership process, while El Ansari and Philips (2001b) four stage model of partnership-building — involving a process of *formation*, *implementation*, *maintenance* and assessment of impacts and *outcomes*, directed the process of planning and development of the partnership.

The study drew insights from two related bodies of literature, *social capital* and *partnerships* in establishing a conceptual framework for guiding the intervention and analysing the research process (see Chapter 3). In addition, insights were drawn from a review of the published literature on the historical and current drivers of the AIDS pandemic in South Africa, and the transformational processes that the country is currently undergoing to ‘level the playing fields’ and ensure equitable development (see Chapter 2).

In this final chapter, I draw on the findings of the Entabeni study through a summary of the key lessons learnt. I also make recommendations based on these lessons learnt and end with a discussion of the conclusion reached and the way forward.

8.2. Lessons Learnt and Recommendations

The eight key lessons learnt are:

1. Context matters. Partnerships are embedded in and influenced by the contexts within which they are located.
2. Stakeholder organisations must create an enabling environment to encourage and sustain partnership participation.
3. Capacity-building and empowerment of partners is crucial for ensuring ownership and sustainability of the partnership.
4. Partnerships within resource (human and physical) poor contexts like Entabeni, where skills and resources are scarce, require the services of a dedicated, skilled facilitator or external change agent.
5. Partnership-building needs to be guided by regular monitoring and evaluation and a systematic documentation of the process.
6. Relationships based on trust are a central pillar of partnerships.
7. Partnerships are as much about individuals as they are about communities and organisations.
8. Partnerships can and do work, in spite of the many challenges that may be encountered.

8.2.2. Context matters. Partnerships are embedded in, and influenced by, the contexts within which they are located

The research, supported by popular literature on partnerships (El Ansari, 2005) and community development (Gillespie, 2004) supports the notion that partnerships for HIV and AIDS are embedded within and influenced by the broader macroeconomic, socio-political, historical and cultural *contexts* within which they are located (Chapters 2 and 3). Several contextual dynamics determined the course and facilitation of the Entabeni partnership.

Hence, contextual peculiarities and the unfolding dynamics of the partnership necessitated the constant adaptation and creative adjustment of:

- i/ strategies for partnership-building, to incorporate community norms and values as well as the needs, opinions and levels of experience and exposure of the community and external partners to alternative ways of thinking and behaving;
- ii/ the four stage model adopted to guide the partnership-building process (El Ansari and Philips, 2001a). An additional phase, *pre-formation* was added on and preceded the *formation* phase, to cater for the crucial process of ‘community entry’ and community engagement (see Chapter 5). The *dynamism* of the partnership also precipitated considerable overlaps between the stages of partnership-building, and a deviation from a stringent pattern of progression from one stage to another (see Chapter 5, 6, 7).

The location of the Entabeni partnership, within a *rural, African community*, steeped in tradition and bound by stringent cultural norms (see Chapter 2), influenced the process of entry, community engagement, and the subsequent interactions and relationships that developed between the research team, the community, and community stakeholders represented on the partnership. Complying with the required protocols for entry into Entabeni secured the research team’s acceptance in the community, and contributed to their long-term *relationship, based on trust*, with the community and ‘potential’ community partners (see Chapters 2, 4 and 5).

It was clear that the cultural practices of *patriarchy*, male dominance in the community, and the acceptance of the iNkosi as the paramount chief and ultimate decision-maker, spilled over and perpetuated *power differentials* between male elders or traditional leaders represented on the partnership committee, and women and youth representatives. It often undermined and restricted the latter’s participation in discussions and debates at partnership meetings. This (contextually based) representation of *power* and the role it plays in influencing partnership relationships is of significance to partnership practitioners and academics who have pondered on this interplay of power in partnership relationships. These include social capital theorists like Bourdieu (1986), and academics who have contributed to the literature on partnerships, e.g., Huxham and Vangen, 2005; El Ansari and Philips, 2001b; McLaughlin, 2002. They have often focused on *power differentials* between

‘oppressed’ people in communities in relation to organisations and people with economic power or professional status. While this form of *power* did emerge in partnership relations (see Chapter 7), it is the unacknowledged impact of the power of often older men over women and youth in the community that is particularly significant since it carried over into the Entabeni partnership. If the intention is to build effective and equitable partnerships by giving voice to and encouraging the participation and empowerment of all partners, this form of power cannot be ignored.

Another aspect of note for interventionists and researcher’s, is the possibility of differing values and norms between themselves and the research participants. In the initial process of collaboration between the community partners (mainly the older male representatives on the partnership) and external change agent, there was conflict between the *values and norms* of the external change agent and some partners around the issues of youth sexuality, abstinence and the promotion of condoms (see details in Chapter 5). However, the possibility of a breakdown in the relationships between the external change agent and older male partners, due to these conflicting beliefs and values, was negated by the *mutual respect and understanding* and the strong bond that already existed between the external change agent and community partners. This outcome challenges *social capital literature* (Fukuyama, 1999), which highlights ‘shared values or norms’ as the basis for building trusting relationships. The findings support the notion that partnership relationships can negate the possible negative implications of conflicting norms and values among partners if, as with the Entabeni partnership, much effort is invested in building trust between partners from the very beginning of the process. This, by respecting or embracing community values, norms, beliefs and cultural practices, *working with the community* rather than for them, and respecting and valuing the contribution of local interpretations and local knowledge on issues concerning them.

Recommendation

There is no ‘best way’ to implement partnerships (Roussos and Fawcett, 2000). Instead, partnerships should be allowed to develop through an *organic process* where *flexibility* underlies responses driven by environmental determinants and the perceived needs of stakeholder partners within that specific context. Development practitioners intending to build AIDS competence through partnerships must focus much of their

efforts on understanding and embracing the factors typical to that particular social context to ensure that their strategies are appropriate to the context.

8.2.3. Stakeholder organisations must create an enabling environment to encourage and sustain partnership participation

The findings confirm that the intervention by the research team provided the Entabeni partners with their first opportunity to interact with or participate in collaborative relationships across professional and economic statuses. As with any project of this nature, it was inevitable that there were conflicts of interests and collaborative challenges due to the ‘newness’ of this experience for the partners. In the Entabeni partnership, the *key challenges* encountered (see Chapters 5, 6, 7), revolved primarily around a public sector environment that more often constrained rather than supported the participation of their employees in the partnership. Hence, the scenario was one where public sector representatives struggled to engage with prescribed policy changes to service delivery which recommended traditional, individual responses to HIV and AIDS be complemented with partnership approaches involving a commitment to community engagement and cross-sector collaboration. This is largely due to contradictions between a public sector policy environment that prescribes partnership strategies for addressing HIV and AIDS that is not reflective of the dearth of fiscal, managerial and political support available for and essential to enabling the translation of ambitious national policy rhetoric into the reality of individual and organisational participation in multi-stakeholder partnerships (see Chapters 6 and 7).

Often leadership within public sector departments, e.g. Department of Health, is accompanied by a hierarchical structure and poor internal communication (see Chapter 7), that often stifled and inhibited individual employees from making decisions on behalf of their organisations, thus hindering their efforts to make innovative and creative contributions to the achievement of partnership goals and slowing down the progress towards partnership goal achievement.

Recommendations

Partnership-building should be a *core function rather than an optional extra task* for service-provider organisations, and incorporated into program planning for general service delivery.

Organisational leadership must be enabling rather than controlling and provide the necessary support required for employees to participate easily in partnership activities.

A requirement for '*partnership participation*' should be written into the *job-descriptions* of specific employees and accompanied by the necessary infrastructural and managerial support to enable them to fulfil these job requirements to the best of their ability. This includes an adequate allocation of *material* resources (vehicle to travel to meetings and participate in partnership activities, money for employee subsistence), dedicated *time* during working hours for participation in partnership activities, and the ability to make decisions on behalf of their organisation.

Organisations must identify a minimum of two representatives, preferably an employee at managerial level and an employee at implementation level, who are adequately trained and able to use their skills in facilitating and participating in partnership-building efforts on behalf of their organisations. By identifying more than one employee to be dedicated to partnership work, including a senior staff member, it will reinforce their efforts and *protect against lost knowledge* should one person leave the organisation. It can also garner the support needed from management for their employee's participation in such activities. Internal organisational arrangements should also be put in place for employees participating in partnership activities to share their learning and experiences with other colleagues at meetings and workshops. This ensures that knowledge gained benefits a broader group of employees who may then be encouraged to incorporate a partnership strategy into their daily service delivery framework. This is especially crucial in public sector organisations in South Africa (see Chapter 7), where staff turnover is generally high and individual workloads often unmanageable.

Organisations must have *inbuilt incentives and accountability systems* which give recognition for and reward the achievements made by employees participating in partnership activities. Employees must also be simultaneously accountable to the partnership committee for contributing to the achievement of partnership goals, their organisation for time spent on partnership activities, and the community for delivering

on organisational mandates for the joint management of the challenges posed by HIV and AIDS.

Personal incentives that have partnership appeal and which encourage employees to embrace partnership strategies, must to be incorporated into service delivery frameworks. At the same time, these incentives should be creative and suitable to what is possible and do-able within the limitations and status quo of each organisation, e.g. a job promotion, an increase in salary or personal recognition in the form of an award.

In terms of accountability, instilling a sense of transparency and accountability to communities or service-users', is especially important for public sector institutions with a mandate to participate in or facilitate multi-stakeholder partnerships within a context like Entabeni, due to a history of mistrust between the community and public sector stakeholders. An innovative approach to building trust and encouraging transparency and accountability among public sector institutions is through the participation of community stakeholders and civil society organisations (NGOs, CBOs) in national and regional public policy-making and strategic planning and budgeting for service delivery programmes. This must be accompanied by measures that encourage a process of civil society monitoring of public service delivery. Ultimately, partnership processes must have built-in mutual accountability mechanisms between the community and service-provider stakeholders. This will ensure community stakeholders are able to monitor service-provider actions, decisions and performance over time, and vice versa.

Participation in partnerships must be accompanied by *strong institutional capacity* and appropriate individual skills that enable their long-term participation and commitment to the achievement of partnership goals. To make this a reality, training for employees must include community development and outreach work involving an engagement with a multitude of stakeholders. Ideally, capacity-building should be regular with *on going training and mentorship support* provided to employees.

Finally, for partnerships to be *sustained*, it should ideally be anchored within *existing institutional frameworks* (e.g. the local municipality or Health Department) and

processes, even though these may be less than perfect. In the Entabeni partnership, measures were put in place from the beginning, through a conscious process of networking and relationships building (building social capital) between the community stakeholders and public sector partners, to encourage this absorption of the Entabeni partnership into current or future programmes of public sector organisations. The local municipality, who had always expressed an interest in replicating the Entabeni partnership model into other areas of their work (see Chapters 6 and 7), eventually, and at the tail end of the four year process, registered the partnership with their organisation. The partnership is now receiving funds from them to facilitate development-related and HIV and AIDS management projects in Entabeni.

8.2.4. Capacity-building and empowerment of partners is crucial for ensuring ownership and sustainability of the partnership

The findings in the study and popular literature on partnerships (see Chapter 3) confirm that capacity is pivotal to the development of successful partnerships and their sustainability over time. However, capacity-building with partners takes time and requires the dedicated input of resources. In the Entabeni partnership, a *learning by doing* culture (learning by making mistakes and by the achievement of successes), was the primary means of capacitating partners with the skills essential for partnership participation, goal achievement and the long-term sustainability of the partnership. This approach (see Chapters 3, 5, 6, and 7) values adaptation, flexibility, and an openness to change at all levels. Its value for the Entabeni partners existed in its ability to facilitate their empowerment and ongoing capacity-building. Both external service-provider partners (see Chapter 7) and the community partners confirmed that their participation in the partnership afforded them the opportunity to *develop their professional and partnership skills* and boost their levels of *confidence* through rapid *experiential learning* (learning through doing). This, together with the additional skills acquired through the extensive training they received from external partners (see Chapter 7), enabled the community partners to use these skills to benefit various other community stakeholders through their facilitation of a ‘train the trainer’ programme (see Chapter 5), advocate for services on behalf of the community, and generally network with and strengthen ties with service-provider stakeholders (see Chapters 5, 6 and 7).

Enhancing the capacity of community stakeholders within Entabeni and creating an opportunity for these skills to ‘trickle down’ and benefit the rest of the community, was important not only for achieving the overall project goal of facilitating an AIDS competent community (see Chapter 1) and ensuring the sustainability of the partnership (see above), it was especially important within a context where external service-provider support was limited and constrained by resource, capacity and transformational challenges (see above).

In the long-term, strengthening the capacity of community stakeholders through the partnership will and did begin to create bottom-up pressure on local service-providers, ensuring that they become directly involved in shaping the enabling environment within which the partnership can flourish. This notion is supported by Gillespie (2004:37) who confirms that “*In the medium and long run, sustained bottom-up demand from organized community groups is probably the best way to maintain the commitment of both policymakers and service-providers.*”

For the service-provider partners, especially those from the public sector, their participation in the process was a beneficial and proactive means of ensuring that partnership approaches to service delivery be incorporated into current ways of thinking and acting, rather than waiting for a time in the future when service-providers are ready and able to embrace and incorporate reality-based partnerships approaches into their daily service delivery frameworks, accompanied by the appropriate implementation capacity.

Finally, and as confirmed through discussions with experts at local conferences and policy seminars in South Africa, it is acknowledged that partnership programmes and participation in partnership activities are a relatively *new phenomenon* for many stakeholders (public, private and civil society) within South African contexts.

Recommendation

Aside from the ‘learning by doing’ approach and other strategies adopted, and discussed above, development or partnership practitioners should acknowledge the newness of people working together, possibly for the first time in their lives. They should therefore ensure that training and support programmes for partners emphasise

mutual understanding, an acceptance of each other's strengths and weaknesses, a commitment to working together and overcoming differences, and an openness to a mutual learning experience (see Chapters 6 and 7).

8.2.5. Partnerships within resource-poor contexts like Entabeni, where skills and resources are scarce, require the services of a dedicated, skilled facilitator or external change agent

The role of the external change agent or external facilitator, the role assumed by the author of this thesis with the support of the research team, was central to the functioning and achievements of the partnership. The literature on partnerships acknowledges the need for a dedicated facilitator to ensure the success of partnership interventions. A key objective of the study was to ensure that the partnership was a community and partner driven process. However, the limited capacity of partners, and the newness of their experience with partnership and development processes and community engagement (for external service-provider stakeholders) resulted in the external change agent initially assuming the role of principle facilitator, while the community and external partners assumed the role of secondary facilitators. But, as the process of learning through doing unfolded and began to yield positive capacity outcomes for the partners, they became co-facilitators of the partnership with the external change agent (see Chapters 5, 6, 7).

Thus, in facilitating the partnership, the input of the external change agent was time consuming and resource intensive, requiring the external change agent to play multi-faceted roles, including:

- mobilizing community stakeholders and recruiting external service-provider partners with the support of the community partners;
- driving the process of relationship building between partners;
- assuming the role of *nurturer* when partners needed a 'shoulder to cry on';
- affirming the inherent skills and knowledge of disempowered community partners and resistant external partners;
- *advocating* for the community partners who often felt powerless to represent their needs and demand service delivery from public sector institutions;

- *fostering dialogue and co-operation* between partners at partnership meetings and sub-committee meetings; and,
- *mediating in conflict* situations between partners and turning these conflicts and diversity into working relationships based on mutual understanding and an acceptance of differences in opinions and ways of thinking and working.

The resource and fiscal challenges experienced by the Entabeni community and organisations represented in the partnership also necessitated the external change agent to assume major financial responsibility for the funding of the partnership-building process and planned activities throughout the life span of the study, with sporadic efforts of material support from the local municipality and the Entabeni development committee.

Recommendation

I recommend that development and research practitioners attempting to facilitate partnerships within resource-poor environments like Entabeni acknowledge the capacity, resource and governance challenges they will encounter, and which necessitates the input of a highly skilled, appropriately trained and dedicated external change agent to facilitate the networking, collaboration and relationship building so necessary for partnerships.

8.2.6. Partnership-building needs to be guided by regular monitoring and evaluation, and a systematic documentation of the process

The study had an intensive monitoring, evaluation and feedback component which served the following purposes:

- it influenced and gave direction to the research process,
- it served as a learning process for partnership participants,
- it was used as a benchmark for assessing the value and limitations of the partnership, and,
- it generated valuable data that was systematically documented to serve as guidelines for best practice and lessons learnt for partnerships in South Africa.

Monitoring indicators were based on partnership objectives that were collaboratively developed and refined at every partnership meeting. Being mindful of the need to use the data gathered from evaluation to inform and improve partnership strategies and processes for the benefit of all involved and for the achievement of partnership goals, I initially planned for regular evaluative interviews to be undertaken with the partners at six month intervals. However, as the partnership evolved, it became evident that research participants (partners) were experiencing interviewee attrition. I had to therefore adjust the period between interviews and instead conduct evaluative interviews annually instead of bi-annually. Often these interviews and feedback sessions were done in conjunction with a partnership meeting, or conducted within a focus group session to prevent partners having to adjust their already tight work schedules and time constraints to make time specifically for evaluation. The ongoing evaluation and continuous feedback with partners allowed for a critical reflection of the process, serving as a useful source of learning for the partners and allowing them to assess what works and what does not. It also helped to redirect efforts where necessary and celebrate *small wins* or successes achieved through their joint working efforts. This contributed to increased motivational levels and a working momentum throughout the process. In addition to the regular internal evaluation facilitated by myself, an external evaluator was employed by the research team during the implementation phase (see Chapters 4 and 7). This served as a valuable outsider perspective of the partnership process, corroborating the validity of the findings and guiding the decision for changes made to partnership strategy.

Throughout the life-span of the Entabeni partnership, meticulous records were kept of observations, interviews, events and other field experiences through daily diaries, field-diaries and transcriptions of tape-recorded interviews (see Chapter 4). This recorded data was systematically analysed and continuously work-shopped and presented at various local and international conferences and seminars (14) at different stages of the study to ensure transparency of the process, share 'lessons learnt' and increase the validity and reliability of the study through the process of sharing, and incorporating feedback from a broader audience. The discussions, debates and questions that emanated from these presentations fed into and ratified the ongoing hypothesis developed by me and guided by the academic literature on partnerships and social capital. This allowed for necessary adjustments to be made to the project,

while also confirming similarities in experiences between the Entabeni partnership and other projects facilitated by people living in and working within similar contexts. It also provided the opportunity for a wide-scale dissemination of the research results and a contribution to public policy on AIDS and development in South Africa. In the latter half of the study, I attended six policy related workshops for the purpose of contributing to and influencing public sector policy on HIV and AIDS. The idea was to motivate for an enabling policy and planning environment that reflected the contextual reality of a community engagement and multi-stakeholder partnership strategy in responding to the current challenges posed by HIV and AIDS in South Africa.

Recommendation

Partnerships need to be monitored and evaluated at regular intervals to guide the process and achieve partnership goals. The value and importance of sharing experiences and lessons learnt from evidence-based partnership processes, especially where such information is scarce or non-existent, cannot be emphasised enough if partnerships are to hold the promise of innovation and empowerment.

8.2.7. Relationships based on trust are a central pillar of partnerships

Much time and effort needs to be invested by all partners in building relationships and nurturing trust reflected in their *commitment* to the partnership, *reciprocity* through an exchange of knowledge, material resources, moral support and expertise, and *accountability* to the partnership, the community and their employees. Organisations need to recognize that building strong, *durable* and *sustainable networks* between stakeholder partners is a long term process based on trusting relationships. The findings in the Entabeni study indicate that the *continued interaction* over time and the development of familiarity between partners allowed for misconceptions and myths to be dispelled, differences to be respected and personal bonds that foster *equitable communication and collaboration*, to develop. However, a lack of commitment by some public sector partners, demonstrated by their inability to follow through on promises made, eroded the trust between themselves and the other partners, negating the efforts made by the external change agent in building relationships based on trust between the partners. It is therefore crucial for partners to introspect on those aspects of their behaviours and actions that hinder trust and

damage partnership relationships. This is especially important within contexts like Entabeni where there is a legacy of mistrust between civil society and the public sector, created by their perceived lack of service delivery and community engagement.

8.2.8. Partnerships are as much about individuals as it is about communities and organisations

Often individuals participating in the partnership on behalf of their organisation or the community bring with them their personal life experiences, personalities and unique skills that influences their input and adds to the dynamics of the partnership. In a partnership situation, it is important to recognise this and manage contradictions that may arise, where some individuals begin to focus more on meeting individual needs rather than organisational/community or partnership needs and goals, or when introverted personalities that have valuable contributions to make tend to be overshadowed by more dominant individuals in the partnership (see Chapters 5 and 7).

8.2.9. Partnerships can and do work, in-spite of the many challenges one will inevitably encounter within a context like Entabeni

Public sector input accompanied by strong NGO support, a motivated and mobilized community stakeholder base and the services of a skilled and dedicated facilitator or external change agent was fundamental to the many and crucial goal achievements made since inception of the Entabeni partnership.

Despite the many challenges encountered, the partnership achieved the goals of *facilitating networking* and interaction between service-provider organisations and the community, creating *mutual awareness and understanding* of each others challenges, needs and roles in managing HIV and AIDS and general development, and *collaborating* to achieve various concrete and discreet partnership goals (see previous discussions and Chapter 7). This collaboration also contributed to the *increased capacity* of external partners and community stakeholders and many *concrete outcomes* including the establishment of an outreach centre and the formalisation of the Entabeni partnership (discussed previously).

8.3. Concluding remarks and recommendations

HIV and AIDs is only one of the very many development challenges in South Africa. While there are many examples of what works in achieving development goals, much of the literature comes from first world contexts. In such contexts problems are generally more specific (not inter-laced with many other interlinked challenges), less severe and sometimes affect smaller numbers of people. However all the literature, while itemising specific requirements essential to achieve outcomes and objectives, do also emphasize context specific strategies and requirements. Arising out of this study, the following are some of the context elements that I conclude are necessary and can be used as a benchmark in achieving planned outcomes and objectives in poorly resourced contexts characterised by low educational levels of people, high incidence of poverty and illness, a lack of basic infrastructure and poor access to essential health and welfare services:

- A partnership-building strategy that is non-prescriptive, creative, flexible and adaptable to the context and dynamism of the process
- Research tools and methodologies that mirrors local priorities
- An acknowledgement of the *newness* of this experience for partnership stakeholders (public, private and civil society) and an acceptance that there will be many teething challenges
- A recognition of and support of local strengths
- The need to strengthen the capacity and skills of all the partners through training and by adopting a learning by doing approach
- The need to empower, support, and ‘open doors’ for local actors
- Linkages with local organisations also providing services in the area
- Investing in relationship building processes and the development of trust between partners
- The need for a skilled, dedicated and motivated external change agent
- The necessity for a commitment, from the external change agent, of resources and time to support the partnership
- The commitment of all role-playing partners
- In-built incentives and accountability system for all partners
- Planned and programmatic resource allocation by government departments. It is accepted that public sector bureaucratic actors in the first world have more

time, resources and an actual number of people involved in development projects. However with more political will, resource allocation, training and accountability, we should be able expect much more than that which is currently achieved by this sector in all its spheres of activity in such communities.

- Changes in attitudes and mindsets of bureaucratic role players in the public sector. A relevant observation is that it is telling that government departments who have been in the area for a very long period of time achieved less than the project staff and its partners in a relatively short time frame!
- An important aspect of this mindset change is the recognition by the public sector that partnership initiatives cannot be driven by purely top-down management. The value and success of the Entabeni partnership is largely attributable to the recognition and acceptance of the importance of bottom-up, locally owned and jointly managed partnerships.

This study provides a model that did work in this context, may work similarly in similar contexts and which can certainly be adapted for context specific needs.

The Future

The study has questioned the certainty of AIDS policy rhetoric which promotes partnership as a central strategy for service provision in South Africa. The findings reflect individuals and organisations entering the Entabeni partnership without clear conceptualizations or reality based understandings of what partnerships actually mean for them and their organisations in terms of an input of time, resources, capacity and the necessary institutional and leadership support. The present challenge for AIDS policy and planning is in bridging the gap between policy rhetoric and the reality of implementing partnership projects for HIV and AIDS management in a less than ideal situation.

What is required is the implementation of empirical partnership processes at various levels and within different contexts, accompanied by an innovative exploration of the reality of what works or not in partnerships for HIV and AIDS management in order to contribute to and build the evidence base for partnership interventions in South

Africa. My hope is that the findings, conclusions, lessons learnt and recommendations made in this study:

1. are used as a benchmark by researchers, policy makers or development practitioners involved in partnership-building processes in South Africa
2. serves as a foundation to build on and add to in ways that allow for partnership processes to feed into and become anchored in national HIV and AIDS policy frameworks, embedded within the social, cultural, and institutional fabric of the country, and filters into practical steps that ensure partnerships can and will indeed become a part of the process for service delivery.

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ANNEXURE 1

ETHICS APPLICATION AND CLEARANCE

- 1. Ethics Application**
- 2. Ethics Clearance**

UNIVERSITY OF KWAZULU-NATAL

**ETHICAL CLEARANCE APPLICATION FORM
(SOCIAL SCIENCES AND HUMANITIES)**

Inquiries:

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SECTION 1: PERSONAL DETAILS

PRINCIPAL INVESTIGATOR

- 1.1 **Full Name & Surname of Applicant :** Catherine Campbell (Prof)
1.2 **Title:** Adjunct Professor of Industrial, Organisational and Labour Studies, UKZN
International Fellow of HIVAN (Centre for HIV/AIDS Networking), UKZN
Professor in Social Psychology, London School of Economics, UK
1.3 **Staff Number :** 52818
1.4 **Discipline :** HIVAN (Centre for HIV/AIDS Networking)
1.5 **School :**
1.6 **Faculty :**
1.7 **Campus :** King George V Ave, Durban
1.8 **Existing Qualifications :** PhD

PROJECT CO-ORDINATOR

- 1.1 **Full Name & Surname of Applicant :** Yugi Nair (Ms)
1.2 **Title:** Senior Researcher
1.3 **Staff Number :** 52818
1.4 **Discipline :** HIVAN (Centre for HIV/AIDS Networking)
1.5 **School :**
1.6 **Faculty :**
1.7 **Campus :** King George V Ave, Durban
1.8 **Existing Qualifications :** MA (Development Studies)

2. Contact Details

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3. SUPERVISOR/ PROJECT LEADER DETAILS

NAME	TEL. & FAX	EMAIL	DEPARTMENT / INSTITUTION	QUALIFICATIONS
3.1				
3.2				

SECTION 2: PROJECT DESCRIPTION

Please do *not* provide your full research proposal here: what is required is a short project description of not more than two pages that gives, under the following headings, a brief overview spelling out the background to the study, the key questions to be addressed, the participants (or subjects) and research site, including a full description of the sample, and the research approach/ methods

2.1 Project title

Facilitating local community responses to HIV/AIDS: a study of the psycho-social and community-level processes that mediate the impact of community participation on HIV/AIDS management in a rural community.

2.2 Location of the study (where will the study be conducted)

Entabeni, Uthungulu Municipal District, Northern KZN

2.3 Objectives of and need for the study

(Set out the major objectives and the theoretical approach of the research, indicating briefly, why you believe the study is needed.)

Summary: This research focuses on an intervention to facilitate local community responses to HIV/AIDS in a remote rural area in northern KZN. The research investigates the psycho-social and community-level processes underlying the impact of participation on health, through examining a real-life application of participatory development for health.

History of Research: Campbell has 10 years of experience in the design and evaluation of HIV/AIDS management programmes in South Africa. She has published widely in this area, including a single-authored book (*Letting them die: why HIV/AIDS prevention programmes fail*) and more than 80 peer reviewed articles, focusing on various aspects of the social context of health. This academic work feeds into the research outlined in this proposal. Nair has worked in the community development field in KZN for 20 years and comes to this research with a wealth of practical experience in community mobilization and partnership building. She has also been conducting research in this area for two years, and is fast building up a list of publications in this area.

For the past 18 months we have been conducting research into local community responses to HIV/AIDS in the Entabeni community, in partnership with the local chief and a cadre of 80 local community health volunteers. This research was part of a three-year study for which we were given ethics clearance by the then University Ethics Committee, chaired by Prof Martin Prozesky, on 20 August 2002. This research has resulted in a number of academic publications (listed at the end of section 2.3), and best practice manuals.

For the purposes of this proposal, the key outcome of this research has been an intervention (which will formally be starting in July 05, although much preparatory work has already been done) which arises out of detailed discussions which HIVAN and Entabeni residents have conducted about ways in which our research findings can be used to implement a community-led intervention.

Objectives of research: The objectives of the research are to examine those psycho-social and community-level factors which support or hinder a community-led intervention seeking to facilitate local community involvement in HIV-prevention and AIDS-care in Entabeni.

Why is the study needed: Despite growing evidence for the role played by social environments in shaping peoples' responses to HIV/AIDS, as well as the growing emphasis on the role of local community relations as mediating between social environments and individuals – much work remains to be done in conceptualizing what constitutes a health-supporting social environment, and in developing psycho-social and community-level strategies for promoting such an environment. We seek to contribute to this area through investigating the processes involved in implementing a community-led HIV/AIDS management intervention.

Theoretical approach: Both the intervention and the proposed research are guided by the conceptualization of the 'AIDS-competent community' that has emerged from our research and reading since the project began (see e.g. Campbell, Nair, Maimane and Sibiyi, 2005b, submitted for publication; and other publications listed below). By this we mean a situation where community members work collaboratively to support each other in achieving: sexual behaviour change; the reduction of stigma (a key obstacle to effective HIV/AIDS management, often deterring people from accessing prevention and care services); support for people living with AIDS and their carers; co-operation with volunteers and organisations seeking to tackle HIV-prevention and AIDS-care; and effective accessing of health services and welfare grants, where these exist.

According to our definition, an AIDS-competent community has five dimensions: (i) community members have the knowledge and skills necessary to avoid HIV-infection, and to provide the best possible care and support to people with HIV/AIDS; (ii) people have opportunities to discuss HIV/AIDS with peers in face-to-face settings in the interests of translating health information into action plans in their own lives; (iii) people have a sense of 'ownership' of the problem, and a sense of responsibility for contributing to its solution; (iv) people believe they have the capacity – as individuals and in groups - to make an effective contribution to tackling HIV/AIDS; (v) people work to build 'bridging' relationships with networks and agencies outside the community (public sector, private sector, civil society) who have the political or economic power to facilitate effective local community responses to AIDS.

Publications to date:

Published:

1. Campbell, C, Foulis, CA, Maimane, S and Sibiyi, Z (2005a) "I have an evil child in my house": stigma and the struggle against youth HIV/AIDS in South Africa. *American Journal of Public Health*. 95: 808-815. 5 May 2005.
2. Campbell, C, Foulis, CA, Maimane, S and Sibiyi, Z (2005b) The impact of social environments on the effectiveness of youth HIV prevention: a South African case study. *AIDS-Care*. 17(4), 471-478. May 2005.
3. Campbell, C, Nair, Y, Maimane, S and Sibiyi, Z (2005a) Home based carers: a vital resource for effective ARV roll-out in rural communities? *AIDS Bulletin*, 14(1), March 05, 22-27.
4. Campbell, C. and Foulis, C. (2004) Creating contexts for effective home-based care of people dying of AIDS in South Africa. *Curationis*. 27 (3), 5-14
5. Campbell, C and Foulis, C-A (2002) Creating contexts that support youth-led HIV prevention in schools. *Society in Transition*, 33 (3).
6. Maimane, S, Campbell, C, Nair, Y and Sibiyi, Z (2004) The role of volunteer community health workers in a rural setting. Monduzzi Editore (Eds) *Proceedings of the XV International AIDS Conference*. Bangkok, 2004.

In press:

7. Campbell, C (2005, in press) HIV/AIDS prevention in South Africa: politics and inter-group relations. In Ratele, K (Ed) *Intergroup psychologies*. Cape Town: Juta/ University of Cape Town Press.

Submitted for publication:

8. Campbell, C, Nair, Y, Maimane, S and Sibiyi, Z (2005b, submitted) Beyond interventions: creating HIV/AIDS competent communities.
9. Campbell, C, Nair, Y, Maimane, S and Sibiyi, Z (2005c, submitted) Building contexts that support effective community responses to HIV/AIDS: a South African case study.

To be submitted by September 05:

10. Campbell, C, Maimane, S, Nair, Y and Sibiyi, Z (2005d, in preparation) The context of HIV/AIDS management in a deep rural area in South Africa: what networks exist to support community responses?
11. Campbell, C (2005, in preparation) The impact of grassroots leadership on the effectiveness of HIV/AIDS management in South Africa.
12. Nair, Y and Campbell, C (2005, in preparation) Building partnerships to support community-led HIV/AIDS management in a rural community in South Africa: prospects and challenges.

To be submitted by December 05:

13. Campbell, C, Nair, Y, Maimane, S and Sibiyi, Z (2005e, in preparation) Dying twice': the challenges of stigma for HIV/AIDS management in a rural community in South Africa.
14. Campbell, C, Sibiyi, Z, Nair, Y and Maimane, S (2005f, in preparation) 'Dissemination as intervention': the dissemination of HIV/AIDS research findings to members of a deep rural community in South Africa.

Best Practice Manuals:

Campbell, C, Foulis, C, Maimane, S and Sibiyi, Z (2004) *Supporting youth: broadening the approach to HIV/AIDS Prevention Programmes*. Durban: Centre for HIV/AIDS Networking (HIVAN).

Campbell, C, Nair, Y, Maimane, S and Sibiyi, Z (2005g) *Understanding and challenging stigma*. Durban: Centre for HIV/AIDS Networking (HIVAN).

2.4 Questions to be answered in the research

(Set out the critical questions which you intend to answer by undertaking this research.)

What are the factors which facilitate or hinder the project's attempts to facilitate the development of each of the five features of an AIDS-competent community (outlined in 2.3 above).

2.5 Research approach/ methods

The research will use three methods:

- i) **Weekly fieldwork/project diaries** kept by the project manager and the two project fieldworkers.
- ii) **Focus groups** with core project participants. These will be conducted at the beginning, middle and end of the project including: local community health volunteers, traditional leaders, religious leaders, church groups, women's groups, youth in school, youth out of school, teachers, carers of people with HIV/AIDS.
- iii) **Individual interviews** with key project partners (from public sector – including health, education and welfare; private sector – including local businesses; and civil society – including volunteer groups such as LifeLine, and TAC reps).

Topic guide for interviews and focus groups.

- Informants' factual description of their view of project activities;
- Their perceptions of project strengths and triumphs;
- Their perceptions of challenges and obstacles to project success;
- Their perceptions of ways in which project activities might be reformulated in the light of successes and problems;
- Their perceptions of the extent to which the project is succeeding in contributing to the five dimensions of an AIDS-competent community as outlined above.

2.6 Proposed work plan

Set out your intended plan of work for the research, indicating important target dates necessary to meet your proposed deadline.

STEPS	DATES
Fieldwork/ project diaries	Weekly throughout duration of project
First set of focus groups and interviews as outlined in 2.5	Months 1-4
Second set of focus groups and interviews as outlined above.	Months 5-8
Third set of focus groups and interviews as outlined above.	Months 9-12

SECTION 3: ETHICAL ISSUES

The UKZN Research Ethics Policy applies to all members of staff, graduate and undergraduate students who are involved in research on or off the campuses of University of KwaZulu-Natal. In addition, any person not affiliated with UKZN who wishes to conduct research with UKZN students and / or staff is bound by the same ethics framework. Each member of the University community is responsible for implementing this Policy in relation to scholarly work with which she or he is associated and to avoid any activity which might be considered to be in violation of this Policy.

All students and members of staff must familiarize themselves with AND sign an undertaking to comply with the University's "Code of Conduct for Research".

QUESTION 1.

Does your study cover research involving:	YES	NO
Children	x (high school learners)	
Persons who are intellectually or mentally impaired		x
Persons who have experienced traumatic or stressful life circumstances		x
Persons who are HIV positive	x	
Persons highly dependent on medical care (most people have little access to medical care)		x
Persons in dependent or unequal relationships	x (women)	
Persons in captivity		x
Persons living in particularly vulnerable life circumstances	x (poverty)	

If "Yes", indicate what measures you will take to protect the autonomy of respondents and (where indicated) to prevent social stigmatisation and/or secondary victimisation of respondents. If you are unsure about any of these concepts, please consult your supervisor/ project leader.

After 18 months of working and researching in this community, we do not anticipate that our study will lead to the stigmatization or victimization of project participants. We are well aware (indeed our own research in other areas has shown) that it is often the case that people are stigmatized by virtue of having any association with a project that is associated with HIV/AIDS. We will make every effort to guard against this in our work. Whilst our intervention aims at enabling local community volunteers to lead an accelerated campaign for more effective HIV/AIDS management, our starting point is that every single community member needs to be involved in this campaign. The intervention is aimed at community members in general – and all project participants will go to great pains to emphasise that involvement in the project does not necessarily mean that a participant or his/her family members or friends are HIV-infected.

This research is carried out as part of the evaluation of a community-initiated and community-led initiative, so in this respect community members will have an unusually high sense of 'ownership' of the intervention and the research. All participants in the project will be volunteers, no pressure will be put on anyone to participate, and our experience over the past 18 months suggests that people have participated willingly and enthusiastically in a project that they perceive as important and necessary in the community.

We will require participants in the research to sign the consent form (inserted into this proposal application – see below), which will be translated into Zulu. Many of our participants will not be literate, and fieldworkers will take care to set aside time to read out and discuss each point on the consent form before asking participants to sign in whatever way they choose to. Emphasis will be laid on the freedom of prospective participants to withdraw from any group or discussion if they wish to. However, as already said, this is a project which is run by local volunteers – our past experience suggests that people have been more than willing to participate very enthusiastically in discussions, focus groups and interviews.

A key goal of our work is to train and support youth leaders to play a key role in the project. We anticipate that these will be young people of 16 or older, rather than 'children'. To date, we have conducted focus groups with such youth in school classroom settings, with the support of the school principal and teachers. Youth have participated willingly and openly, and we do not envisage that their participation in this research will pose any ethical problems.

In a community where more than 40% pregnant women are HIV-positive, and where anecdotal evidence suggests high levels of illness and death in the general population, it is inevitable that HIV-positive people will be amongst our research informants. However at no stage will they be singled out as a group, and in no case will we ever ask anyone to identify themselves as HIV positive in any focus groups or discussions.

Obviously it may be the case that people voluntarily identify themselves as HIV-positive. In this case we will respect their confidentiality and anonymity in all the usual ways that researchers do. In addition to this: a key aspect of the intervention that we will be researching includes facilitating access to supportive counseling and advice for those who need it. A key partner in the intervention is the NGO Lifeline, who specialize in providing counseling to people with AIDS. Other partners include representatives from the local health and welfare departments. If

anyone did in fact inform us that they were HIV positive in the course of the research, we would take pains to facilitate their access to counseling and services if they were not already aware of these.

QUESTION 2.

Will data collection involve any of the following:	YES	NO
Access to confidential information without prior consent of participants		X
Participants being required to commit an act which might diminish self-respect or cause them to experience shame, embarrassment, or regret		X
Participants being exposed to questions which may be experienced as stressful or upsetting, or to procedures which may have unpleasant or harmful side effects		X
The use of stimuli, tasks or procedures which may be experienced as stressful, noxious, or unpleasant		X
Any form of deception		X

If "Yes", explain and justify. Explain, too, what steps you will take to minimise the potential stress/harm.

QUESTION 3.

Will any of the following instruments be used for purposes of data collection:	YES	NO
Questionnaire		X
Survey schedule		X
Interview schedule	X	
Psychometric test		X
Other/ equivalent assessment instrument		X

Semi-structured topic guides for interviews and focus groups will explore the following five areas:

- Informants' description of project activities;
- Their perceptions of project strengths and triumphs;
- Their perceptions of challenges and obstacles to project success;
- Their perceptions of ways in which project activities might be reformulated in the light of successes and problems;
- Their perceptions of the extent to which the project is succeeding in contributing to the five dimensions of an AIDS-competent community as outlined above.

As is the case with semi-structured interviews, detailed questions will not be formulated in advance. Our two project fieldworkers are already well-trained in non-directive and open-ended interview techniques. These involve asking informants to comment on the points raised in the above bullets, and then non-directively 'probing' for further information through asking informants to expand on any information they might provide.

QUESTION 4.

Will the autonomy of participants be protected through the use of an informed consent form, which specifies (in language that respondents will understand):	YES	NO
The nature and purpose/s of the research	X	
The identity and institutional association of the researcher and supervisor/project leader and their contact details	X	
The fact that participation is voluntary	X	
That responses will be treated in a confidential manner	X	
Any limits on confidentiality which may apply	X	
That anonymity will be ensured where appropriate (e.g. coded/ disguised names of participants/ respondents/ institutions)	X	
The fact that participants are free to withdraw from the research at any time without any negative or undesirable consequences to themselves	X	
The nature and limits of any benefits participants may receive as a result of their participation in the research	X	
Is a copy of the informed consent form attached?	X	

If not, this needs to be explained and justified, also the measures to be adopted to ensure that the respondents fully understand the nature of the research and the consent that they are giving.

CONSENT FORM: TO BE TRANSLATED INTO ZULU

**'COMMUNITY RESPONSES TO HIV/AIDS' PROJECT
HIVAN, UNIVERSITY OF KWAZULU-NATAL**

Aim of research: To understand those factors which are most likely to help or hinder HIV/AIDS management projects of the kind that currently being implemented in Entabeni.

Project members: Catherine Campbell (Adjunct Professor), Sbongile Maimane (Fieldworker), Yugi Nair (Senior Researcher) and Zweni Sibiyi (Fieldworker), HIVAN (Centre for HIV/AIDS Networking, University of KwaZulu-Natal, King George V Ave, Durban)

Contact details: Telephone: 031-260 2279. Monday to Friday 8am to 4pm.
Email: nairy3@ukzn.ac.za

1. The aims of the study have been explained to me, and I have been given the chance to answer any questions I have about the study and its goals, about the researchers and about what will be done with the findings.
2. I understand that I will not derive any personal gain or assistance from participation in the study.
3. I understand that the interview will be tape recorded, and that it will be transcribed and translated at some later stage at the University of KwaZulu-Natal. No one will have access to the tape recording apart from members of the research team.
4. I understand that any information that I provide will be treated in confidence. In any discussions, reports or papers resulting from this study

no reference will be made to my name, or my address, and no information will be included which could be used to identify me.

5. If I choose not to answer any of the questions asked by the interviewer, I am free to say so.
6. If at any stage of the interview I decide that I do not want to participate any longer, then I am free to say so, and the interview will be terminated.
7. I freely consent to participate in the interview, on the conditions laid out above. No one has put any pressure on me to participate.

Signed:

Name:

Date:

Interviewee category:

In cases where interviewee is not able to read:

I declare that I have read this form to the informant, at a slow speed. I have stopped at the end of each of the 7 points to ask them (i) if they have understood what I have said, and (ii) to encourage them to ask any questions that they have about each of the 7 points.

Fieldworker signature:

Name:

Date:

QUESTION 5.

Have efforts been made to obtain informed permission for the research from appropriate authorities and gate-keepers (including caretakers or legal guardians in the case of minor children)?	YES x	NO
---	-----------------	-----------

SEE DISCUSSION OF YOUTH PARTICIPATION IN OUR RESPONSE TO QUESTION 1 ABOVE. WE WILL NOT INTERVIEW ANYONE UNDER THE AGE OF 16, AND WE WILL DO THIS ON THE SCHOOL PREMISES, WITH THE PERMISSION OF BOTH THE RELEVANT TEACHER AND SCHOOL PRINCIPAL.

If not, this needs to be explained and justified.

QUESTION 6.

How will the research data be secured, stored and/or disposed of?

Interviews and focus groups will be translated and transcribed into Word files. These will be circulated amongst the four project workers (Campbell, Nair, Maimane and Sibiyi), as will the fieldworker diaries. No one else will have access to these data, which will be stored on computer files that can only be accessed with personal passwords. Once the data analysis and write-up are complete, master copies of the interviews will be kept by Campbell and Nair. Maimane and Sibiyi's copies will be deleted.

QUESTION 7.

In the subsequent dissemination of your research findings – in the form of the finished thesis, oral presentations, publication etc. – how will anonymity/ confidentiality be protected?

In all our work to date we have disguised the name of the community, and its precise location. It is only identified as a 'remote rural area in KZN'.

In citing quotations from interviews and focus groups we identify research participants very vaguely, e.g. **Focus group - men**, or **Interview with religious leader**.

Wherever there is any potential danger of the informant being identified, we disguise their identity. Thus for example, in our area of interest there is only one religious missionary working. For this reason identifying her as **Interview with religious missionary** could potentially identify her to people more closely associated with the project. In such a case we might, for example, disguise her identity by referring to her as **Interview with outside community development worker**. Or **Interview with overseas aid worker**. Clearly there is some loss of rigor in this strategy. However given that the potential success of our intervention depends on the levels of trust that we establish with local people, we have no choice but to make such a sacrifice.

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SECTION 4: FORMALISATION OF THE APPLICATION

I have familiarised myself with the University's Code of Conduct for Research and undertake to comply with it. The information supplied above is correct to the best of my knowledge.

.....
.....
SIGNATURE OF FIRST APPLICANT
DATE

.....
.....
SIGNATURE OF SECOND APPLICANT
DATE

DATE:

SIGNATURE OF SUPERVISOR/ PROJECT LEADER
:

RECOMMENDATION OF FACULTY RESEARCH COMMITTEE

FULL NAME : _____ **(CHAIRPERSON)**
DATE :

SIGNATURE : _____

RECOMMENDATION OF UNIVERSITY RESEARCH ETHICS SUB-COMMITTEE
(HUMANITIES AND SOCIAL SCIENCES)

FULL NAME : _____ **(CHAIRPERSON)**

DATE :

SIGNATURE : _____

ANNEXURE 2

DATA GATHERING TOOLS

- 1. Interview Schedule for 'Partnership' Interventionists**
- 2. Mzimela Health Partnership Group Evaluation**
- 3. Partnership Evaluation Questionnaire (Individual)**

INTERVIEW SCHEDULE FOR 'PARTNERSHIP' INTERVENTIONISTS

Name:

Date:

Organisation:

1. Where do you work and what is your role in your organisation?
2. What is your experience of working with projects that focus on facilitating multi-sectoral partnerships? (between CBOs, NGOs, Public sector, private sector)
3. What are some of the **key challenges** that you/your organization has encountered when working together with all the above sectors in trying to facilitate collaborative working relationships?
4. What are some of the **enabling aspects** that you have encountered during the process of attempting to work in partnerships (from public sector, NGOs, CBOs, communities, private sector, etc.)?
5. What do you believe are some of the key criteria that are essential for partnerships to work within a South African or African context?
6. Do you think that 'partnerships' is a good working strategy in meeting key social challenges like HIV and AIDS within resource poor community contexts in an African or South Africa context? Elaborate
7. Do you have any specific recommendations for communities or organisations attempting to facilitate multi-stakeholder partnerships for the purposes of responding to social challenges like HIV and AIDS, within an African or South African context?

Thank you for your time and input into this study.

Mzimela Health Partnership Group Evaluation

DATE: 20 June 2006

Purpose of Discussion: Evaluate the partnership process thus far, the level & type of commitment of the partners & assess its future direction

1. What is your understanding of 'working in partnership'?
2. Why is it valuable/good for you & your organization to work in partnership with the Mzimela community/service provider organizations?
3. How much of your time, skills & resources can you commit to achieving the goals of the Mzimela partnership committee?
4. What will prevent/hinder you from participating more actively on the partnership committee?
5. How/what do you see your future involvement in the Mzimela partnership committee & the Mzimela community as being?

ii/ for you personally

iii/ for your organization

6. What do you think are the key issues to ensuring that a partnership is successful?

7. What recommendations do you have for the way forward?

8. Where do you see yourself/your organization in relation to the Mzimela Health partnership in the future?

We thank you for your input and wish you well in the future.

HIVAN

ANNEXURE 3

**PHOTOS OF THE ENTABENI COMMUNITY AND ENTABENI
PARTNERSHIP BUILDING PROCESS**

The Entabeni Community



The Geographical area of Entabeni



Subsistence farming done by women



Traditional chores for boys

Pre-formation

Community engagement- Community consultation & Relationship Building



Traditional Leaders & elders



Young Learners in School



Research team at Community meeting



Group of Volunteer HBCs



Engaging with women in Entabeni



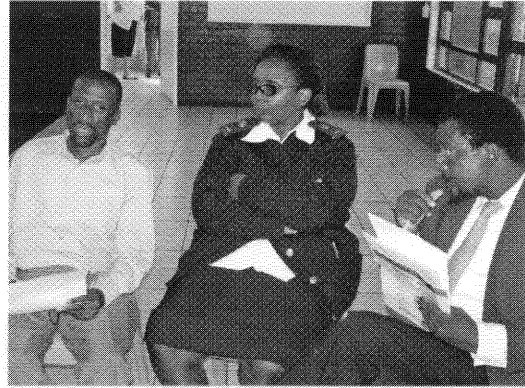
Consulting Community Partners

Formation

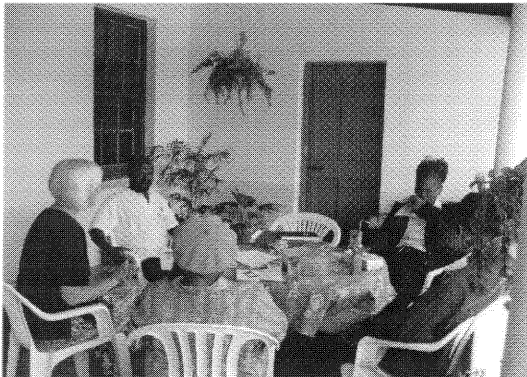
Networking with External Partners



Primary Health care



Hospital and Social Welfare



NGO- Endlovini Committee



Ad-hoc NGO partner



Ad-Hoc NGO partner



NGO- Life-line Staff

Implementation, Maintenance, Outcomes



Training workshop with HBCs



Training workshop with Learners



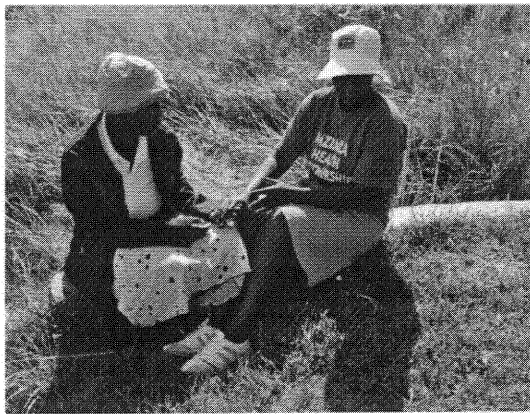
Workshop with Out-of School Youth



Workshop with ordinary women



Trained HBC comforts PLWAs



Trained HBC councils a carer

Partnership Activities



HBC graduation-note academic gowns!



Jubilation of HBCs at graduation



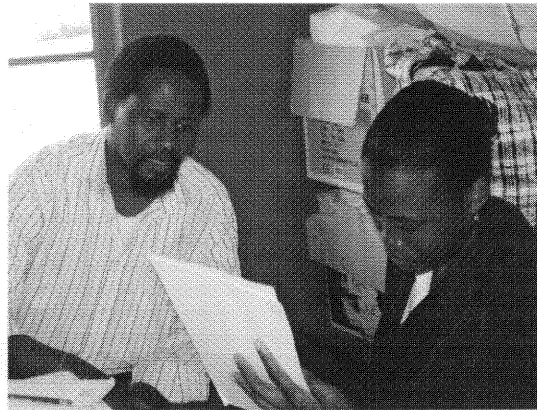
HBCs receive HBC kits



Gladys & Wanda- partners



Partners interact over tea



Planning for partnership meeting



Partners with the iNkosi at the opening ceremony of the Outreach centre



Youth Perform - Outreach centre



Youth Perform – Youth Rally



Animated audience at Youth Rally



Planning with community partners



Partnership meetings & sub-committee meetings



Networking and Relationship Building among Partners



Partners Socialise over Tea after a Meeting



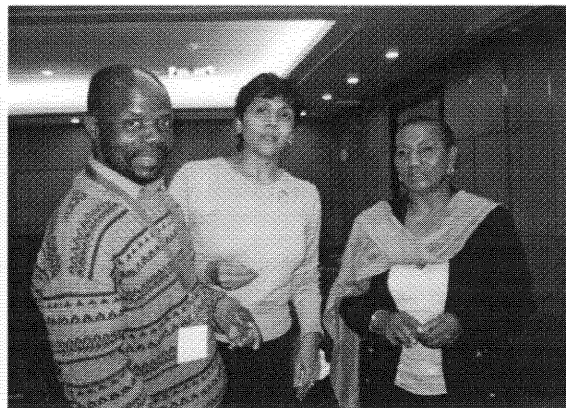
Breakfast with a PHC nurse



Evaluation with community partners



Year end lunch

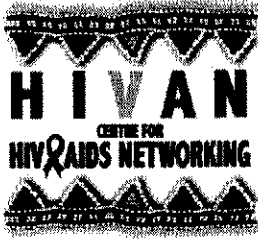


Partner networking at conference

ANNEXURE 4

DATA FROM THE FIELDWORK AND PARTNERSHIP MEETINGS

- 1. A Partnership Meeting agenda**
- 2. Minutes from two Partnership Meeting**
- 3. Field-Diaries by Researcher and Fieldworker**
- 4. A Daily Diary**
- 5. Records of a Year End Evaluation with Partners (Achievements)**
- 6. A Letter to the Department of Health**



Centre for HIV/AIDS Networking

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King George V Avenue, Durban, South Africa
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Email: nairy3@ukzn.ac.za



Mzimela Health Partnership

Date: 31 August 2007

Time: 10.00 am -12.30pm

Venue: Endlovini Lutheran Mission, Mzimela Tribal Authority Area

This is a friendly reminder to inform you that the next partnership meeting will take place, as discussed at the previous meeting, on the 31 January 2007 (see details above).

The tentative agenda for this meeting is as follows:

- Acceptance of minutes from previous meeting
- Confirmation of agenda & additions
- Report back on activities & achievements since previous meeting

- Inputs from:
 1. Sue Stevenson, Life-line
 2. Local Partners
 3. Department of Health
 4. Department Of Welfare
 5. Umlalazi Municipality
 6. HIVAN

- Open discussions & general evaluation of the partnership process
- Target for next meeting

Please feel free to contact me via email or telephone (see letterhead) for more details about this meeting. We hope to see as much representation as possible from stakeholder organisations.

RSVP for attendance of meeting by 29 January 2007.

Thank you

.....
Mzimela Health Partnership Committee Facilitator

**MZIMELA HEALTH PARTNERSHIP
MINUTES OF 3rd MEETING**

Date: 21 September 2005

Venue: Mzimela Development Centre

Present: Ms Yugi Nair (Chair), Ms Sbhongile Maimane (HIVAN), Mr Nene (Department of Welfare), Mr Nkosinathi Ngema, Winile Dlamini, Goodness Dlamini, DC Mngadi, (Local partnership representatives), Sue Stephenson, Nqobile Mthiyane (Lifeline) June (Ikhayeletu), Mam Dlamini, Councillor Nxumalo, Siphoshe Shobede (Traditional council), Marti Zulu (Primary Health Care, Eshowe), Nondumiso Dlamini (Local volunteer-nurse), Vicki Doesler, Wendy Forbes (Interact), Edward Masondo (TAP)

1. Welcome and Apologies

Yugi Nair welcomed everyone to the meeting. Apologies were accepted from Mr Diaz, Matron Ngcobo, Rev Mbokazi, Linda Malembe, Astrid and Thokozani Yimba. Sister Ntshangase was on leave.

2. Confirmation of Minutes and Review of Items for Action

These were approved with the following amendments:

Thoko Luthuli was referred to as Thoko Ntuli. Yugi thanked Marti Zulu for the correction.

Yugi then gave a brief run down of the purpose of the partnership, stating that it was intended to encourage networking and sharing of resources and information amongst partners.

3. Report back from previous meeting

Although Mr Nene had not attended the previous meeting, he had met with Yugi and Sbhongile at his offices and was familiar with the minutes. Mr Nene explained the structure of Child Welfare and the role it played in the community. The subject of grants for HIV positive community members was discussed and Mr Nene was asked to meet with his Department to discuss the dissatisfaction at the long waiting period for grants.

Mr Nene will liaise with Ms Champion who is head of the Department and give feedback at the next meeting.

Sue suggested that the Department makes its services accessible to the community. Sue then gave an update on the activities of Lifeline, Zululand. They had attended a youth rally where literature about HIV/AIDS was distributed, Nqobile started training lay counsellors and Lifeline also held meetings with HIVAN and did a presentation, along with Yugi and Sbhongile, at the Tribal Authority, Tribal Court.

The role of volunteers came under discussion. The solution to the problem of volunteers finding paid employment and moving on once trained is to create an infrastructure where you have a society of people who are employed but can also volunteer their services.

Yugi proceeded to explain that the main goal of the partnership was to try and get the volunteer home based carers a stipend but this was proving problematic.

Winile gave feedback on the Youth rally held at Indlovini Soccer Ground, saying that it was very successful. The aim of the day was to educate the youth on HIV/AIDS but older people and families also attended which was a great achievement.

Mr Masondo from Tugela AIDS Programme explained that his organisations role was to educate and train volunteers on peer education as well as training traditional leaders, councillors, amakhosi, farm workers. They will be running an additional home based care workshop on the 26th.

June from Ikhaya lethu Outreach indicated that their organisation is very short of money. They have 99 members (old age pensioners) who are taught various skills like sewing, knitting, woodwork. They are also taught the alphabet and encouraged to do some form of exercise. Food is supplied at a cost of R3.50. DC was shocked to hear of June's organisation and suggested they meet to discuss the possibility of working together.

Vickie described the work her organisation is doing in Uthungulu Municipality – finding out if the needs of the communities are met through service delivery in terms of HIV/AIDS. Wendy interjected by saying that there is a fund that Uthungulu Municipality has for HIV/AIDS programmes within the whole district. They are in the process of doing an audit to find out what is going on.

4. Items for Action

Training will continue with Lifeline – Sue and Nqobile will discuss how to move forward with the programme and report back at next meeting.

TAP is starting their training With home based carers & leaders on 26th and will also report back

DC and June will be meeting to discuss services for the elderly

Mr. Nene from welfare to arrange for the local partners & HIVAN representatives to meet with himself, the HOD as well as development social workers at the department Mr. Ngema, together with the 3 traditional councillors present, to give feedback to the traditional council about the meeting as well as outcomes from the 'partnership project' thus far

5. Roundup

Yugi commended everybody on the committee for their input and said that committee members had felt very positive about the progress made by the 'partnership committee'. It is hoped that by doing the capacity building in the community, they will in turn go and train other people in the community and at the end of the 3 year cycle, everybody will have some basic awareness and knowledge of HIV/AIDS, how it is transmitted, where to obtain help, how to get grants etc.

Yugi thanked everyone for coming and offered refreshments. She also reiterated the following:

"I think one of the things that we emphasise at every partnership meeting, is the need to make feedback to your organisations and other people in your community so that everyone else can also benefit from what has been discussed here as well. You may be surprised that they can also give you feedback as to what they can do as well."

6. Date of next meeting

This was set for 15 February 2006 at 10h30. The Primary Health Care clinic, Eshowe agreed to host the meeting.

MZIMELA HEALTH PARTNERSHIP

MINUTES OF THE 7TH PARTNERSHIP MEETING

DATE: 15 – 02 – 07 @ 10.00

VENUE: INDLOVINI LUTHERAN CHURCH

CHAIRPERSON: VUSI DUBE

Present: Vusi Dube (Chair), Sbongile Maimane (HIVAN), Mathie Zulu (PHC Eshowe), Eugene Mthiyane (Lifeline), Bathobile Khumalo (HCBC), Thanda Mgwaba (PHC), Makhosazana Gumede (HCBC), Nompumelelo Dlamini (HCBC), Goodness Dlamini (Outreach Centre), EN Ngema (Co-ordinator), Yugi Nair (HIVAN), Rev T Mbokazi (Local Partner), Andy Gibbs (HIVAN), Sue Stephenson (Lifeline), Rev S Gensicke (Lutheran Mission) and Lwazi Fihlela (UNDP/Umlalazi Municipality)

Welcome and apologies

Yugi welcomed everyone and then introduced Andy Gibbs to the partnership, who would be with HIVAN for ten months.

Ammendments and corrections

Sue said the correct name was 'Rock of Hope' not of Life.

Yugi said we were still waiting for money from the municipality, not from Lwazi. She apologised for personalising Lwazi.

Acceptance of Minutes

The minutes were accepted by Mr Ngema and seconded by Sue Stephenson.

Matters arising

Yugi mentioned that **Mrs Hlongwane was going to enquire from the Dept. about training on PMTCT and stipend for home based carers.**

Report back

1. Before the reports were given, Yugi explained to the partners that this was **HIVAN's last year in the Mzimela Tribal Area** and that HIVANS focus would be to empower the **local partners to take ownership of the project.**

2. Mathie's report:

Objectives for the year- To supervise HBCs and DOT supporters;
To work in collaboration with local support groups and NGOs.

Training for the newly deployed HBCs on the 19th and 23rd.

Training already taking place in KwaMzimela Area at KwaSigodo, run by KZN-PPHC. It is on nutrition and children and home visits.

Training for ARVs for HBCs, conducted by Mathie from 22nd – 26th Feb.

12th of January representatives from the Health Dept. visited Mzimela area to discuss a mobile point (Mathie, Mbokazi and Magwaza. It was approved and would start operating on 2nd March and every first Friday of the month and will include VCT. Environments Officer, Ndlovu, visited the Outreach Centre and inspected the building.

Home based carers now called 'home and community based carers – those being paid.

Action:

Mathie to find out the new name for volunteers that used to be called 'home based carers'

Yugi to send report on achievements to everyone.

Ngema to give Mathie list of names for more HBCs to be trained.

3. SUE:

Still no furniture in the Outreach Centre.

Visit by national finance manager (Lifeline). He was impressed with the centre and was going to look at how he could help with furniture or even a computer.

An attorney would come out once a month to the centre

Action:

Eugene to communicate with the attorney to set up a programme.

Eugene to inform Mr Ngema when the attorney would start so that he could tell the home based carers to pass the message on to the community.

Sue to put up a notice board at the centre.

Revs Mbokazi and Gensicke to announce information about the attorney.

Sue to communicate with ABET person she had spoken to about mobilising local teachers to give off some of their time.

EUGENE:

Peer education programme to start again at Eziqobele Secondary School – group of 20 learners to train as peer educators. Arrangements already made with the principal and a life orientation teacher.

Action:

Eugene to start peer education classes next Tuesday and to continue going to the school every Tuesdays of the week.

Eugene to find out from the legal aid person if he would come to the Outreach Centre.

Eugene to get date for the graduation of previous group of peer educators and out of school youth.

Ngema to approach the inkosi for the date – the principal of the school has also offered his school hall for the graduation.

Eugene to see to it that peer educators that have been trained are training other learners in the school.

Eugene to prepare certificates for the graduation.

GOODNESS:

VCT was offered at the Outreach Centre for the first time in November. The attendance was not good. One person came.

Inspection of the Outreach Centre by representatives from the Dept of Health. They said they were interested in running an educational programme in Lindelihle Primary School. Goodness is still waiting for a report.

“Sixteen Days of Activism’ on the 7th of December and the attendance was not good due to short notice. Local businesses donated R100. Brown’s Store donated pasta and mince soup and Lifeline donated R500

Goodness again informed the partnership about a visitor from Lifeline national office. The Outreach Centre has received 201 clients from June last year, most of whom have been females.

Goodness and her colleagues conducted awareness programmes on farm workers in Amatikulu. Sue explained that as part of their income generating project for Lifeline, they go out to businesses or wherever and do HIV awareness.

Goodness then presented her programme for the year.

Goodness read and approval letter for registration of the local partners as an NPO.

Yugi thanked Lwazi for that.

Yugi said getting an NPO number was a big achievement because a lot could happen now in terms of applying for funds. She was also amazed at how many people have visited the Outreach Centre and thanked Sue for the work Lifeline was doing at the centre.

Vusi encouraged each and everyone to work even harder now since the organisation has been registered.

LWAZI:

Lwazi reported on the workshop he did with the local committee in terms of registering the organisation as a NPO and the development of the constitution. Lwazi was not happy that this was not reported at the previous partnership meeting as it was done before that meeting. Lwazi then explained what it meant to register as public benefit organisation. He encouraged the partnership to apply for this once they get the certificate.

Lwazi informed the partnership about the call for funding from National Lottery. He asked if Lifeline could assist because if the Outreach Centre were to apply, they would need them to have a sister organisation that would be more experienced and could look after their funds.

Lwazi then informed the meeting about the grant making meeting he attended for all big companies in Uthungulu district. He said it was frustrating that the municipality was not moving fast enough in implementing some of the requests put forward. Lwazi said he had put a new proposal to the portfolio committee for the furniture at the Outreach Centre. He had been moving backwards and forwards with this issue and was now hoping it would be solved. He was also concerned that it was becoming very difficult to get funding for newer CBOs as the minister had to approve.

Lwazi said he was the only one doing outreach work without any assistance. He talked of budgets that had been unspent.

Lwazi also informed the meeting that it had been very difficult to try and ask ESKOM to connect electricity at the centre as they said for the next ten years they were only installing metered electricity in rural areas because people had been abusing the card system electricity. This would be very expensive for the centre. It would cost R5000. He encouraged the committee to open a bank account, should they get funding from the municipality.

Sue raised her concern about the centre not having got any funding after promised were made a year down the line. Sue used Lifeline's budget for the security at the centre and was concerned that her financial year was ending in February and the municipality had not reimbursed her.

Rev Mbokazi suggested that Mr Ngema invites Mr Powell who is the chairperson of the portfolio committee to visit the Outreach Centre as he had a big influence in the municipality. Ngema agreed that there were problems in the municipality. He assured the meeting that the request for funding for the Outreach Centre would be approved.

Lwazi said UNDP had had to pay for everything that the municipality should have paid for e.g. site visits (petrol), catering and so on. They were still waiting to vote so that they could start spending.

Lwazi then explained to Sue how UMEC was trying to structure itself and also the workshop on HIV/AIDS strategic plan that took place. Unfortunately the report was not yet available.

GENSICKE:

Rev Gensicke report on a successful meeting he had with the youth of his church in December. Theresa was invited to come and do a workshop with them and all went well.

Gensicke then reported a person who came to the pension pay point and asked people to register for his medical fund and made them pay R60. He suspected this was a scam and he needed to be reported to the police.

Action: Rev Gensicke to call the medical fund man and pretend to have more people who want to join and in the meantime ask someone to call the police.

Rev Gensicke wanted to know how he could have old people that are looking after the orphans register for grants. He was advised to ask them to go to Mr Nene when he is at the Outreach Centre. Lwazi explained 'ilimo' to the meeting and that if there was a need for this, a proposal could be made. **Lwazi to action this.**

Lwazi talked about the Department of Welfare restructuring. He said KwaMzimela will now fall under Eshowe Welfare Office. He asked Ngema if he could ask for a district office in Mtunzini as it would be nearer. **Ngema to action this.**

VUSI:

Amra from the Hospice Association was supposed to conduct a workshop with the home based carers that work at the hospice but could not come on a specified date. Mr Ngema was communicating with her to arrange another time. He also reported on the training that Mathie had already reported on.

NGEMA:

Ngema reported that he was communicating with Amra about the workshop and that she requested reports from home based carers in terms of how many patients they see who suffer from cancer and HIV/AIDS.

Ngema said there were still unresolved issues with the Welfare Department, like outstanding grants. He then said on the 26th, there would be an organisation, ULUDA from Durban, coming to the community to interview people about grants. Ngema also talked about the invitation for home based carers by the Health Department to attend the 'Awareness Day.' Transport was organised for them. Ngema said he had invited the environmental health inspector to come to the partnership meeting to present a report on the Outreach Centre he had gone to inspect. Unfortunately he did not come.

Ngema then requested that Ms Mngadi be released from the local partnership committee as she was getting too old and frail.

Ngema then requested counselling from Sue and the reverends for the home based carers that work at the hospice as their work involves dealing with dying patients.

Action: Sue to organise that home based carers get counselling

Mr Ngema reported the visit by "Umhlaba Development Agency" an agency delegated by the Human Rights Commission to look at government service delivery, in the community. They interviewed thirty people consisting of traditional leaders, religious leaders and home based carers. Yugi added that together with the EU, they are looking at what kinds of projects they could set up in the community.

Action: Mzimela Health Partnership to come up with ideas of what projects this agency could set up.

Yugi told the meeting that there is a draft report from this agency but it is not finished yet. She showed concern that people that were interviewed did not seem to know what

had been done in terms of the project and about HIV/AIDS in general. She said we needed to interrogate this report and find out what led them to give that information.

Sue reported that Cancer Association was opening office in Richards Bay.

Action: Sue to find out about their programme and how they can assist Mzimela community.

Action: Eugene to find out if counsellors from other areas could come to the Outreach Centre rather than local counsellors to counsel local people.

Action: Local Partnership to ask that mobile clinic also makes a one stop at the Outreach Centre when it comes to the community.

Action: Goodness to find out why Mr Nene did not come to address the home based carers and if he was still going to come twice twice a month to the Outreach Centre.

Action: Mrs Hlongwane to tell us about a ten-day course on HIV/AIDS.

Action: Sue asked for a hailer to call the community. Yugi suggested Businesses could donate one.

Yugi reported that she had attended a conference in New Zealand where she presented a paper on partnerships. She then told the partners that we had applied for some of them to attend the 3rd SA Conference in Durban in June but were still awaiting acceptance. The organisation would be able to pay for two people only if no one get a scholarship. They would present a paper if the abstract is accepted.

Lwazi asked that the Mzimela Health Partnership be put on HIVAN's database as a CBO because they are community based.

Yugi then told the partnership that Andy would be with HIVAN for ten months writing a book on the project. Sue wanted to know if the partnership would get royalties from the book.

Yugi then told the partnership about the external evaluator who would come and evaluate the project. She asked people to let her know if they knew of anyone. Lwazi suggested 'Interact'.

Yugi asked if anyone knew of someone who could train the local partners on committee skills.

Action: Sue to communicate with someone she knows who can do the the training for local partners.

Yugi again raised concern about Theresa's trainings that went very badly last year. She said the focus this year would be to see to it that the home based carers took their training and go out and train other people.

Rev Mbokazi and Rev Gensicke reported that Theresa came to their churches at different times to conduct workshops with the youth (Gensicke's church), and with the congregation (Mbokazi's church.)

Action: Goodness to run a workshop with the teachers at Lindelihle Primary School on ARVs.

Next meeting to be on the 18th April

Field-diary (Second Partnership Meeting)

Date: 23 June 2005

Venue: Primary Health Care Clinic (Eshowe)

Diary by Researcher

Sbo & I set off early, having made arrangements with the local partners to meet us in the town of Ginginlovu since we definitely did not want to encounter the problems we did for the previous partnership meeting (getting stuck in a ditch)! On our way there, we telephoned Mr. N to confirm where exactly we were to fetch them from. He indicated that he was still trying to find transport to get there but Mrs. Mngadi (DC) & Goodness had left already. He was not sure about Winile but Reverend Mbokazi would meet us at the clinic.

When we arrived in the town, we drove down the main road & managed to spot Winile & Goodness. They were not aware of DCs whereabouts. We finally managed to locate DC through her cell phone. She was waiting at the local garage with Linda (teacher). They had traveled from the area with Linda's car! I found this puzzling, especially since Mr. N was struggling to get to Ging & Goodness & Winile had traveled by bus to the town. They could have all fitted very comfortably in Linda's vehicle if these arrangements were made, or if Linda had been generous enough to offer them a lift! Sbo felt that she had probably not done this. I decided that I would try & unravel the mystery of this strange arrangement with Mr. N at a more appropriate time.

DC was engrossed in her newspaper while Linda, who got off the vehicle to come & greet us, looked very trendy in her black leather skirt, mohair jersey & slick new hairstyle. My impression of her was that she was a typically young, ambitious person who was in this for what she could get out of it for herself (exposure, networks with 'people of importance', opportunity to have a day off school) rather than what she will be doing for the community. Her previous responses & need to distance herself from the community by referring to them as 'they' (at HIVAN presentation, Partnership workshop) convinces me that she also sees herself as superior (encouraged by

community as well) who did not share the same 'issues' (poor hygiene, ignorance, lack of assertiveness) as the rest of the people.

Since Mr. N had not arrived, I telephoned him to establish where he was. He indicated that since he could not get public transport, he had to make arrangements to travel by car & that he was half an hour away. Unfortunately, I had to ask him to make his own way to the clinic since we would be late if we waited for him. He agreed to do this so we set off on our way to Eshowe. Linda agreed to follow us in her own vehicle but when we were about half way to Eshowe, she decided to speed of like an over exuberant teenager who was trying to impress his new girlfriend!

Fieldworkers DIARY OF 17 – 18 OCTOBER

TUESDAY: 17TH OCTOBER

VENUE: OUTREACH CENTRE

The partnership meeting was to take place on Wednesday the 18th but we decided to leave on the 17th because we had to meet the out of school youth who had not been willing to help Goodness at the Outreach Centre. Yugi was to meet with the local partners to discuss the agenda for the partnership meeting and also to talk about the challenges that have come up in the community.

When we arrived, there were only four out of school youth that were waiting for me. When they started training with Lifeline, they were 22 and the number kept going down until 7 of them remained.

When we started the discussions, the main concern was to find out why the youth that had been trained were not coming to the centre to volunteer their services. This question opened a string of dissatisfactions the youth had about the management of the centre and the way they were expected to work there. They complained that Goodness does not give them enough time to prepare to go and work in schools or at the centre. They said she only phones them when there is a crisis and she wants them immediately. They said she gets offended when they tell her they have other commitments.

The youth also said they would appreciate it if Goodness could draw up a roster so that everybody would know when they were supposed to be at the centre. They also said they were concerned that Mr Ngema calls them bad girls because they don't go to the centre. They also felt they should have regular meetings with people from Lifeline. They said Goodness did not consult with them but took her own decisions and then instruct them to do what she had already decided without them. They said her decisions were not always the best.

Goodness walked in just before we finished our meeting. She had been attending the local partners meeting with Yugi in another room. When she came I asked her to join us since the discussion also involved her work with the out of school youth. I informed her of what we had been discussing and that the out of school were not happy with her leadership. Goodness said she was aware that some of the youth were not happy. She said she was also not happy with Lifeline because they did not give her support. She said to communicate with the other youth, she had to use her cell phone and she found it difficult to claim money from Lifeline as she would be asked a thousand questions and end up not being reimbursed. Goodness said she found it difficult to communicate with Sue as she had to go via Eugene, who is her co-ordinator.

Goodness said she does not blame the youth for not coming to the centre because Lifeline does not provide them with even a glass of water. She said the least Lifeline could provide was at least tea and a loaf of bread. She said at times she had to fork out money from her pocket because she could not stand to watch other people sitting at

the centre and doing the work without anything in their stomachs. She didn't seem to be enjoying her work anymore. She said she felt torn apart because HIVAN expected her to work in the community and Lifeline is also taking ownership of her.

Eventually Goodness said she would make a timetable for the other youth so that they know exactly when they are supposed to be on duty.

Nompumelelo requested the other youth to also take the initiative to come to the centre. They shouldn't wait to be called by Goodness. She said at times she also does not come to the centre as she is from a poor family. When she hasn't eaten anything, she feels she cannot be in a position to deal with other people's problems when she has her own problems herself.

Bathobile said it would be very bad if the centre closed down because people were not willing to volunteer their services. She said inkosi offered the building for the use of the community. She said if one day he felt like driving to the centre and found it locked, as this is what happens at times, he would be very angry and demand that it be closed down.

Finally I encouraged the youth to learn to work together and not always to look for faults but to build each other. When I left, they were going to set a date when they would meet with Lifeline to discuss their grievances.

Personally I felt this was one of the many challenges we are going to find ourselves being asked to deal with and I am not too sure how far our energies would take us. Goodness has got a problem with Lifeline and the volunteers have a problem with Goodness. The list goes on and we need to be able to face these challenges as they come or run away as fast as we can!!!

Wednesday 18th October

This was a rainy day. We had slept over because of the partnership meeting that would take place on this rainy day. The first thought that came to my mind was that this meeting would be cancelled because the road to the venue, Indlovini Mission, would be inaccessible. When we went down to have breakfast Mr Ngema phoned Yugi to say the weather was very bad and the road to the mission was slippery. He said he was looking at the cars that had already got stuck. The next step was to cancel the meeting and inform the other partners not to bother to come. This would have been a waste of time, money and energy but on the other hand, this is one of the realities of fieldwork.

After giving this some hard thinking, I said to Yugi maybe we should have this meeting at the Outreach Centre as it would be easier for the partners that were coming from outside the community. As for the local partners, those who would be able to walk to the centre could be encouraged to come. Another problem was going to be the lunch that Astrid had already prepared at the mission. Anyway, we all agreed that the meeting should be moved to the centre. Cheryl got on the phone to tell everyone about the change of venue.

When we arrived at the centre, we didn't think many people would turn up, especially the local people as they had to walk a very long distance. To our surprise, Astrid had managed get out of her muddy driveway, picked up all the local partners and drove to the centre. This was a miracle. She also could not explain how she got out of the mud.

Amra and her husband attended the partnership meeting as she was later going to run a workshop with the home-based carers that worked at the hospice.

Mrs Hlongwane, from the Department of Health, was one of the many representatives we have had so far. Yugi said it was a pity that the department could not send the same person all the time as this took the meeting backwards because of the explaining that had to be done for the new person to understand. She also said representatives are delegated with some tasks and if they don't come to the next meeting, the new representative does not know what the previous representatives was tasked with. Hlongwane said this was something we had to live with, as the department was very busy at the moment with the transformation taking place.

Vusi was supposed to chair this meeting as he is now a chairperson of the local partnership committee. We had discussed this at a previous meeting and Ngema later thought he should chair the meeting and Vusi should watch him. We thought Ngema had enjoyed chairing the previous meeting so much that he wanted another chance. Yugi was not amused by Ngema's lust of being a chairperson twice in a row. The compromise was that both Ngema and Vusi would chair the meeting and take turns in doing so. Vusi also made it a point that Ngema did not override him. He chaired most of the time and proved to be very good and humorous. He made jokes here and there. The danger in empowering people is that once they have been empowered, you cannot set boundaries for them as to how they should use that empowerment. Ngema is one such person that is now beginning to use the empowerment to suit his own ego at times.

The venue for this meeting was a bit too small to accommodate all the people that were there, including the home based carers that had come for the workshop afterwards. The plastic chairs also continued to crack and fall apart due to the weight they carried. They are not strong enough anyway. Someone has to donate proper chairs for the centre.

It was nice to see Mr Nene after he had been hospitalised. He looked weak but well. He said coming to the community twice a month has made his work lighter and would appreciate it more if the home based carers gave him more information that is relevant to his work.

Astrid also said she was looking forward to the day when the hospice got registered. She was pleased that Amra had come to do this workshop with the home-based carers and to give them guidance.

Eugene from Lifeline gave a report of what he and the volunteers are doing in one of the schools in the community. When asked about the learners he was doing peer education with last year, he said they had integrated them within the Life Orientation Programme in the school. It was arranged with the teacher concerned to use them as educators. He didn't seem to have gone back to monitor how it is going.

Sue said money for the furniture at the centre had not been made available. In the meantime she is using money from her organisation to put up burglar guards on windows and doors.

Goodness gave a very good picture of the way the centre is operating. She said people are using it. She kept praising HIVAN for the training and the uniform given to all the home based carers.

Thanda, the home based carer was dozing away at the corner. She could not concentrate. Each time she woke up from her sleep she would open her eyes wide and smile at me across. At the end of the meeting Yugi asked her next time to write down what was being said at the meeting because she would have to give a report at the home based carers meeting. She suddenly woke up and remembered she had been given a piece of paper she never used. She asked Goodness what she must write down.

All in all the meeting was a huge success though the weather was bad. Hlongwane left before the end of the meeting as she was rushing back to the office.

Astrid had made sandwiches, tea and cool drinks. They were all wiped out. Unfortunately when she started her bakkie to go back home, it wouldn't. Eventually we had to take Ngema with us to find a mechanic he knew in the community. It didn't seem to be anything major as it didn't take the mechanic a minute to sort it out. We then all went to our different directions.

DAILY DIARY- Fieldworker (August 2005)

1 AUGUST 2005-08-01

- Arranged a meeting with Mr Masondo of Tugela Aids Project. To meet him on Wednesday 3rd August at Eshowe. He said he is very eager to work with us.
- Phoned Marti to invite her to meet with us and Mr Masondo. Left a message. She was out with the mobile clinic.
- Phoned Nqobile to let her know Yugi and Sbo would be coming to the satellite centre to witness registrations of out of school youth.
- Marti phoned to say she and Dorothy would attend the meeting with Mr Masondo.

2 AUGUST 2005-08-02

- Off to Mtunzini to monitor out of youth registrations
 - Mr Ngema phoned us on our way to check where we were.
 - Mr Ngema and Rav Mbokazi were standing outside when we arrived.
 - When we went inside Nqobile and Sipho had already started the registrations. There were about eighteen youth ready to be interviewed.
 - Ngema and Mbokazi said they will let more youth know so that another registration day (Friday) could be set.
 - Ngema phoned Linda to ask about parents meeting
 - Linda said she would mention it to parents
 - Asked Ngema to go with us to TAP meeting
- Meeting with Diaz at Umlalazi Municipality.
- Linda phoned re: parents meeting

3 AUGUST 2005-08-05

- Ngema phoned to say Mr Masondo of TAP had postponed the meeting to 11.00 instead of 10.00
- Ngema phoned again to say he was already at Eshowe
- Met Marti, Dorcas, TAP secretary, TAP trainer and field worker and project manager

4 AUGUST 2005-08-05

- Met Amra Chakravarti from Hospice Palliative Care Association.
- Spoke to Sbongile Dubazana of HIVAN McCord who would like to get into contact with Astrid, who has started a sewing group in our area of research.

5 AUGUST 2005-08-05

- Spoke to Ngema re: parents meeting to which he agreed to take part
- Spoke to Ngema about CHWs uniform – said he had a meeting with them, about 80 and discuss colour of uniform. Said he would meet with them again today to discuss the change of the colour of the shoes.

8 AUGUST 2005-08-10

- Somebody phoned looking for employment and enquiring about what we do.
- Themba also walked in asking if we don't have any vacancies as he is very interested in the work we do.

10 AUGUST 2005-08-10

- Phoned Ngema to find out about parents meeting (He could not attend)
- Ngema said he is still compiling a list of CHWs sized for uniforms
- Ngema said when he went past the satellite centre he noticed a number of out of school youth who had come for interviews. He could not go there himself.

11 AUGUST 2005-08-11

- Phoned Sipho (Lifeline) to find out about training. He said on Friday 20 youth came and 13 were selected. The previous week 17 came and 7 were selected.
- Confirmation that training for out of school youth would start on 16th August.

12 AUGUST 2005-08-12

- Phoned Nqobile and discussed out of school training that would start on 16th.
- 6 males and 14 females in the group.
- Booked car for 16th.
- Yugi received e-mail from Nqobile informing her about the training that would start on 16th August.

16 AUGUST 2005-08-18

- Monitored 18 out of school training course.
- Spoke to Mr Ngema re: uniforms for 68 CHWs
- Spoke to Nqobile, Sue, Fikile and Siphho about the training.
- Interviewed all 18 youth before and after the training.
- Met one CHW and spoke to her about numbers.

17 AUGUST 2005-08-18

- Meeting with Lifeline people (Sue and Nqobile) at Community Responses office. (planning peer education)

18 AUGUST 2005-08-18

- Phoned Mr Ngema asking him to attend Ngwelezane Hospital meeting with us on 19th August

19 AUGUST 2005-08-22

- Attended a meeting at Ngwelezane Hospital with about 20 people where we talked about our work in the community

22 AUGUST 2005-08-22

- Talked to Theresa of Tugela Aids Programme to confirm meeting for the following day.

23 AUGUST 2005-08-23

- Phoned Ngema about meeting at Eshowe – cancelled
- Spoke to Ngema again informing him of the youth meeting on the 7th September in Durban

24 AUGUST 2005-08-24

- phoned Nqobile about youth training the previous day. Could not get her
- Phoned Ngema to ask if he managed to fax the list of CHWs to Matron Ngcobo. Still busy with it. Complained that he has to take time to go to time only to fax. I suggested he must talk to Khohli (Tribal Court) if he could use the equipment in their tribal office as he is doing work for the community. He was pleased to hear that suggestion.
- Ngema told me Goodness told him the youth training went well.

25 AUGUST 2005-08-25

- Phoned Theresa to ask when their problems would be solved. She said they have financial problems that might take three months or more. She said if we can pay her something she can still continue with the training. I said to her we would discuss that and come back to her.
- Phoned Marti to organise a meeting. Left a message for her to phone me. She had gone with the mobile clinic
- Phoned Ms Champion to organise a meeting. Told she was at Ulundi. Left a message.
- Zweni wanted two booklets but got discouraged when I asked him to pay for them.
- Nqobile phoned to say the training was going well.
- Informed Nqobile about the meeting with the principal of Eziq

26 AUGUST 2005-08-26

- Phoned Mr Ngema informing him about our coming on Tuesday to meet with Theresa
- Ngema phoned to ask for Matron Ngcobo's phone number as he wanted to fax her a list of home based carers the matron had asked for, about 68
- Ngema said on Wednesday he would have a monthly meeting with Marti from Primary Health Care.
- Phoned Ngema to ask what ward is Mzimela Tribal Authority. Didn't know
- Phoned Umlalazi Municipality to ask for the ward number.

29 AUGUST 2005-08-29

- Phoned Ms Champion of Dpt of Welfare to arrange a meeting with her. Said she would delegate a chief social worker to attend our partnerships meetings as she is very busy.
- Phoned Marti to arrange a meeting. She said we could meet her on Tuesday as she would have another meeting on Wednesday.
- Marti phoned to ask if we could attend the meeting she would be having with home based carers. This was not suitable for us. We then confirmed a meeting for Tuesday afternoon at Eshowe Primary Health Care.

30 AUGUST 2005-09-01

- Met with Theresa of TAP
- Met with Nqobile at the satellite centre – 16 out of school youth present for the training.
- Met with Mr Nene at Esikhawini Welfare Department

FIELDVISIT

Annual Evaluation of Partnership achievements

Date: Tuesday, 3 October 2006

Present: Reverend Gensicke, Astrid, Nompumelelo, Mr. Ngema, Tanda, Makhosazana

Apologies: DC, Vusi, Goodness

Researchers Notes

(Read in conjunction with taped discussion)

Key achievements/concrete outcomes:

- **Opening of the Outreach centre (+100 attended people from the community, Inkosi & partners attended)**
- **Training of various stakeholders in the community** (Inkosis wives, traditional leaders, traditional healers, youth, learners, religious leaders, ordinary men & women, home based carers) -trained
- **Getting people to start talking about the issue of HIV/AIDS** in the community (Gensicke)
- **Bringing recognition of & respect for the role of the HBCs** from the community (Tanda)
- **Mr. Nene bringing SW services to the outreach centre.** He is based at the outreach centre twice a month & clients see him there rather than having to travel to Esikhawini
- **Department of welfare addressed 80 HBCs & out of school youth** on procedures & requirements to access welfare grants, accessing funding for development projects in the community & information on general support services offered by the department
- **Department of Health (Eshowe primary health care) did training with 60 HBCs on 'Nutrition & ARVS'**
- **HBCs were finally provided with gloves & HBC kits** by the Eshowe Primary Health care clinic after a meeting with the hospital manager at Eshowe.
- **HBCs were provided with uniforms & stipends (R200 per month)** by HIVAN
- **VCT to be available at the outreach centre** from this month (17 November). This is an outcome of discussions with the Eshowe primary health clinic, a partner on the committee
- **2 Graduation ceremonies (+400 attended) & Inkosi's recognition** (stamp of approval) of the project as playing a crucial role in terms of development & change in the community
- **'Putting the community on the map' & facilitating networking** between the community & service providers-major achievement for this community (Astrid)
- **Pele (Dept of Health) inviting the HBCs & community (Eshowe) to an Health awareness day** in Eshowe (October 06). She also arranged for a bus to transport them to the venue. **Approximately 80 people attended from the community**
- **HBCs attended a body mapping workshop** arranged by HIVAN in Durban (**5 attended**)

- **HBCs** are attending a 10 day **training** course attended by HIVAN in Mtinzini-HBC-November 06 (**10 attending from community**)
- Goodness & other women from the community are **catering** for the workshop in Mtinzini-November 06
- **3 formal partnership meetings** held for the year (in all, **approximately 70 people attended the workshops**)
- **Lifeline** has trained out-of-school youth (**approximately 15**) in lay counseling & have brought in **SANCA** to run a five day workshop with the HBCs & out of school youth on Alcohol & drug abuse (**approximately 60 attended**). They also recruited a **Legal Aid** representative from the Legal Aid board to render legal advice services at the outreach centre once a month
- Lifeline ran a **Board Governance** workshop for the local partners as well as HBCs & other committees (pottery group, etc) in the community to provide them with skills & information 'how to run committees'. **Approximately 35 people from the community attended**
- Goodness & two out-of-school youth (since completing the Life-line training course) are currently running a **life-skills training programme** every Tuesday (**five classes-300 children**) at one of the primary schools in the area at the request of the school principal. Goodness has also been recruited to be on the governing body of the school.
- The Mzimela Partnership committee has drawn up a constitution for the purposes of **formalizing the committee**-assisted by Lwazi from the municipality. Lwazi has submitted so the committee can acquire an NPO (non-profit organization) number
- Several of the original local representatives on the partnership committee have secured some sort of **employment** that has bearing on the project & facilitating HIV/AIDS management in the community- Mr. Ngema was elected as a municipal councilor, Vusi was nominated to manage the hospice set up by the Endlovini development committee, Goodness was employed by Life-line to supervise the outreach centre, Winnie is working at the outreach centre & is paid a minimal stipend for this. She was also chosen to attend formal nursing training in Ulundi in order to lend this support at the outreach centre.
- Outreach centre has been getting a regular flow of people visiting the centre for advice, lay counseling & support, information since June 06 (**approximately 65 people per month on average have visited the centre**)
- Cascade training by HBCs have been reaching huge groups of people in the community (**gardening groups, families, PLWHAS, learners in schools, clinic attendees, grannies, soccer teams, stokvels, etc.**)were reached through these discussions & workshops
- **The Hospice association of SA** (introduced by HIVAN) has been lending assistance to the Endlovini development committee in setting up a hospice in the community-**3 meetings this year** to assist with drawing up their constitution & providing information & guidance on how to set up & run a hospice. A **workshop is scheduled for the 27 November** for hospice staff & local partners on 'strategic planning'- will be attended by **30 HBCs & local partners**



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20 February 2006

Dear Thoko

Further to my telephonic discussion with you on Thursday, 16 February at 7.30am, I am forwarding you this fax to confirm the following:

1. My records indicate that I have spoken telephonically with you once previously, on 20 January 2006, when I also talked with Ms Msomi.
2. I arranged to meet with you & Ms Msomi at your offices in Empangeni on 26 January 2006 at 8.00am. However, on arrival at your offices, I was told that both you & Ms Msomi had left to attend another meeting with Dr. Simelane. I therefore met with Ms Mkhonza & she agreed to get you to contact myself or Mr. Ngema from Mzimela tribal authority area to arrange for a suitable date for your team to meet with the volunteer home-based carer's in this community.
3. We (HIVAN & partners) had a 'Partnership meeting' on 15 February 2006 which was attended briefly by Sandra Hadebe who happened to be at the Eshowe PHC office at the time of the meeting. I informed her that we had not heard from your office since my meeting with Ms Mkhonza & we were therefore 'at a loss' as to which direction to proceed.
4. I subsequently received a telephone call from Ms Mkhonza & yourself on the morning of 16 February 2006. My discussion with you resulted in an agreement for you to meet with the home-based carers at the Mzimela Tribal Authority area on Wednesday, 22 February 2006. Further, you agreed to meet with me at the Mtunzini Garage (BP) on Old Main road at 10.00am & I would then escort you into the area.
5. I have informed the home-based carers of your impending visit this week. They are waiting enthusiastically to meet with you to discuss their challenges & their needs & to work out a way forward.

I can be reached at through the following contact numbers:

Cell- 083 640 7136; work- 031-2602279; email- nairy3@ukzn.ac.za

We look forward to this meeting.

Thank You

Yours Faithfully

Yugi Nair