Behaviour Change Theory in Practice: A Review of Four HIV Organisations.

Report Commissioned by JOHAP, Durban, South Africa

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November 2007

Introduction

The brief for this report was to produce case studies of behaviour change for HIV risk from Oxfam-partnered non-governmental organisations from the Limpopo province, in the 'far north' of South Africa. The research process aimed at locating behaviour change in social science theory and developing case studies of four organisations with a focus on the following issues:

- The nature of behaviour change used in the organisations' programmes
- Identifying where, when, how and with whom behaviour change strategies are used
- Development of behaviour change programmes in these organisations
- Examples from the organisations' work of effective and less effective strategies for behaviour change in an HIV context
- Lessons learned from the development of behaviour change programmes

Following ethical approval of the research from the University of KwaZulu-Natal, preliminary email contact and telephonic interviews with each organisation took place, followed by visits by the research team to the sites of each of the four organisations. Following processes of individual informed consent, interviews took place at the visits to each organisation. Interviews were conducted with respondents from the organisation to include all levels such as beneficiaries, community stakeholders, volunteer implementers, implementers employed by the organisation, coordinators and programme leaders, management representatives and community members. Interviews took place at the administrative offices of organisations and important service sites in the community such as several primary health centres (PHCs), a school, and community meeting places in rural villages. Volunteer interview respondents were identified by organisation members and participated either individually or in groups. Following individual informed consent, semi-structured interviews took place using individual or focus-group formats, contingent upon what was appropriate for the respondents. The option of an interpreter was made available to all respondents and

following the preferences of respondents the interpreter was in some cases an organisation staff member or in other cases one of the respondents from a focus group.

1. Literature Review: Theories of Behaviour Change

The challenge of changing risk behaviour for HIV/AIDS has been situated in theories that differ in terms of the implications of change for interventions, programme planning, and evaluation of change in intervention contexts (Parker, 2004). Theories of behaviour change may be grouped according to the targets of change proposed (such as individuals, groups, organisations, or communities), the expected outcomes of change (for example, increased help-seeking behaviour) and the timing of change (primary, secondary, and tertiary prevention) (Baskin, Braithwaite, Eldred & Glassman, 2005). Health risk behaviour has been theorised in terms of individual factors such as cognitive and interpersonal predictors of behaviour, and in terms of structural factors that include material, social, cultural and gender relations (Kelly, Parker & Lewis, 2001). Traditional theories have focussed more on the individual as the primary unit of intervention. These approaches have assumed that rational, cognitive processes will initiate individual behaviour change, an assumption that neglects the non-rational mediators of health behaviour and the social, material and discursive contexts of health behaviour (Bennett & Murphy, 1994). Integrative approaches to behaviour change have been developed in response to the critiques of theories which focus on individual behaviour alone (Kelly et al., 2001). Ecological approaches favour interactive, multiple levels of prevention that address behaviour change within social, cultural, political and economic environments that shape individual or group behaviours (Babun & Craciun, 2007; NCI, 2003).

Research has suggested that HIV prevention programmes are more likely to be effective if based on theories rather than intuition (Kalichman, Simbayi, Cain, Jooste, Skinner & Cherry, 2006). Theory-informed interventions are helpful for programme design as theories (1) provides a conceptual framework for interpreting the situation, (2) may guide the design of interventions, (3) provide strategies for change appropriate for

the unit of practice (for example, individuals, groups, organisations or communities) (Kalichman et al., 2006; NCI, 2003). Applied in situation-specific ways, theories may be considered a resource for programme design in defining assumptions about the behaviour change problem to be addressed, targeting strategies for local needs and setting up effectiveness criteria for programme evaluation (NCI, 2003). Behaviour change theories may also counter the tendency towards 'technologising' preventions such has microbicides, antiretroviral treatments and circumcision which may be uni-dimensional if implemented without addressing social, material and behavioural contexts of HIV infection (Kippax, 2004).

1.1. Individual theories of change and their implications for HIV programmes

A range of behaviourally informed theories have been developed and applied to various health behaviours and conditions, including HIV/AIDS. The Health Belief Model, Social Cognitive Theory, the Theory of Reasoned Action and the Stages of Change Model are commonly cited theories that have been applied in the field of HIV prevention in developing countries (King, 1999; MacPhail & Campbell, 2001).

The Health Belief Model (HBM) is a typical example of an individually focussed theory, and will be used to demonstrate such individually focussed theories. The HBM suggests that individual risk or protective behaviour is a function of various factors including: (1) the individual's perceived personal vulnerability to the health risk ("Am I likely to be at risk of contracting HIV/AIDS?"), (2) the perceived severity of the risk ("Is HIV/AIDS a serious or treatable condition?") , (3) the costs and benefits of reducing risk behaviours ("What am I going to gain and/or lose by changing my behaviour?") (4) the perceived self-efficacy, or personal competence, to carry out protective behaviours ("Do I have the skills and competence to carry out these protective behaviours e.g. condom use or refusing sex?") , and (5) internal and external cues for action ("What triggers initiate my risk or protective behaviour?") (FHI, 2004; King, 1999). In terms of this model individuals may have the same knowledge of HIV risks, but will have markedly varied health risk behaviours on the basis of differences in perceptions and influences on

action. While limitations of the HBM, and other individual theories, will be discussed, a benefit of the HBM may be its framework for understanding subjective factors such as expectations, beliefs and perceptions in influencing health risk and health protective behaviours.

Box 1: Social Marketing and the Love Life Programme

Social marketing is not a theory of behaviour change as much as an approach to communication for change. It is an approach to health behaviour promotion that adapts commercial marketing strategies (such as formative research, product development, pilot-tests of marketing messages, process and summative evaluation) to inform, influence and reinforce health behaviours of targeted groups (NCI, 2003). South Africa's Love Life programme is one of the largest HIV prevention efforts in the world today and is one which is largely based in a social marketing approach (World Bank, 2003). Targeting the youth of South Africa, Love Life's media campaign informs, influences and reinforces messages of condom use, risks of unprotected sex, decision making and responsibility sharing (MacPhail & Campbell, 2001; World Bank, 2003). Love Life also provides health messaging through edutainment awareness programmes in schools. The number of people who have been 'reached' through the media campaign and self-reported condom use have been cited by Love Life as a means of tracking programme outputs (Smith, 2002). Critics suggest that Love Life's media messaging is too generic, that the emphasis on condom use over abstinence, delayed sexual debut or faithfulness is unresponsive to preferred or cultural practices and that the sexual explicit graphics of its publications are inappropriate for local norms (Smith, 2002). It appears that Love Life has started to move beyond what appear to be top-down communication for change approach towards horizontal participation in programmes of youth initiatives and partnerships for change, for example, locating Love Life implementers at primary health centres. These process-orientated interventions move beyond cognitive choice-based approaches towards supporting 'enabling environments' for change and move away from delivering messages towards supporting partnership, dialogue and negotiation (Parker, 2004). In resource-constrained, high prevalence contexts it may not be helpful to separate behaviour change interventions from what Parker (2004) calls the 'broader continuum of HIV response' that comprises treatment, support, care, advocacy and social capital (Campbell, Williams & Gilgen, 2002).

Prochaska and DiClemente's Stages of Change Model (SCM) is based upon the assumption that behaviour change is not a once-off phenomenon, but rather that behaviour change progresses through various stages and that long-term sustainability of behaviour change is especially important. According to this model, the process of behaviour change involves a person or group moving through five stages of behaviour change: pre-contemplation, contemplation, preparation, action and maintenance (NCI, 2003). The SCM has been applied in HIV interventions in which strategies are varied and responsive to the informational needs of individuals or groups on the stages of change continuum (NCI, 2003; Philander, 2007). Although limited by its generic approach (the model was developed for smoking cessation programmes), SCM has merit in that it starts to look at the processes of reception, interpretation and responses to interventions that enables a more 'tailored' approach to the needs of individuals and groups (Bennett & Murphy, 1994). The model especially recognizes that the processes involved in sustaining risk behaviour might be very different to those involved in initiating behaviour change.

There are other related theories that are variations of the individually-focussed approaches. Examples include the AIDS Risk Reduction Model, now updated as the Modified AIDS Risk Reduction Model, the Theory of Planned Behaviour and Precaution Adoption Process Model (NCI, 2003). It may be argued that these approaches share some of the merits and limitations of the models already discussed, and similarly emphasise changing individual expectancies and beliefs.

According to Parker (2004), the three most important limitations of the traditional, individually focussed approaches outlined above are (1) the assumption of a linear relationship between knowledge and action that does not account for social factors that impact on risk or protective behaviour, (2) the neglect of contextual variables which may limit or influence an individual's behaviour choices and (3) the premise that risk behaviour decisions are based only on volitional, rational thinking. These models assume that cognition initiates behaviour, whereas health beliefs may be a less important influence on behaviour than social factors (Kelly et al., 2001). There is further

critique that these theories are inappropriate in resource-deprived developing world contexts, and recent literature supports the need for behaviour change interventions to move beyond the top-down emphasis on delivering health messages or changing individual beliefs and attitudes (valuable as these may be in some contexts) towards horizontal processes of supporting dialogue, negotiation and partnerships at local community levels (Parker, 2004). While there may be some merit in the traditional approaches, such as the integration of cognitive and conative processes, for the development of effective and sustainable interventions it may be more important to address behaviour change in an integrated way that addresses contextual factors or what may be termed the 'enabling environment' for change (Parker, 2004).

1.2. Models based on communication for change

The Diffusion of Innovation Theory (DIT) shifts the emphasis away from individuals to multi-level change processes, so dispersing health behaviour innovations throughout a social system, be it an organisation, community or society (NCI, 2003). Diffusion of innovation comprises the (1) the innovative idea, (2) formal communication channels through which the idea is disseminated, (3) informal social networks through which the innovation is diffused and (4) the timing of the innovation (NCI, 2003). A limitation of the DIT is that expert knowledge may be valued over local knowledge, and that the initial communication for change appears to be a linear flow from the more to the less-resourced (Kelly & van der Riet, 2001; King, 1999). Community participation approaches, on the other hand, may favour a horizontal transmission of information through partnerships, dialogue and negotiation (Parker, 2004). The DIT proposes multiple communication channels, units of change and timings of interventions, and is a process approach that may be more responsive to local needs than the traditional approaches (NCI, 2003). As suggested by Kesby et al's study (2003) of effective programmes with minority African communities living in the developed world, interventions to promote behaviour change within the social embeddedness of HIV need to work through the socio-spatial and cultural networks of communities in order to be effective and sustainable.

1.3. Gender-based interventions

The HIV epidemic in sub-Saharan Africa affects women disproportionately, with the spread of HIV influenced by cultural constructions of gender and the economic dependence of women on men (Buve, Bishikwabo-Nzarhaza & Mutangadura, 2002). The subordinate position of women in sexual decision making, hegemonic norms of masculine behaviour that endorse multiple sexual partners, and norms of non-refusal by women of sexual advances of men, create social conditions in which volitional control over sexual practices is impossible for many African women (Buve, Bishikwabo-Nzarhaza & Mutangadura, 2002; Hoosen and Collins, 2004). Research findings suggest the primacy of gender inequalities and problematic gender constructions as the substrate for sexual decision-making patterns, risk perceptions and patterns of disempowerment (Harrison et al., 2001). Gender-based models of risk behaviour change seek to address these complex difficulties with gender inequalities as the 'root causes of risk' (Harrison et al., 2001, p. 70). Strategies within these approaches may include access to women-controlled protective technologies (for example, microbicides or femidoms), creating conditions for shared responsibilities in relationships (Harrison et al., 2001), facilitating educator awareness, resource material and a language of gender equality in schools (Moletsane, Morrell, Unterhalter & Epstein, 2002) and facilitating gender-based behavioural change among men or boys (MacPhail, 2003).

Box 2: Transforming men's behaviour through participation

Targeted Aids Intervention (TAI) is an organisation that has facilitated specific social development projects, community-based interventions around gendered violence and HIV, peer education projects and condom distribution programmes (Targeted AIDS Interventions, 2007). TAI's Shosholoza Project is a peer education initiative that has worked with local soccer clubs to develop peer educators, agendas for the participation of young men and the implementation of gender-based interventions (Targeted AIDS Interventions, 2007).

Men As Partners (MAP) is a programme that has also used a gender participatory approach around issues of gender equality, violence prevention and the critical involvement of men in sexual and reproductive health (Siegfried, 2005). MAP has facilitated workshops in all nine provinces of South Africa to engage men's participation in sexual health promotion, developing skills for peer education such as street drama education, creating communication channels and networks with the aim of enhancing responsibility and equipping men with skills for participation in health promotion (Siegfried, 2005).

1.4. Integrative approaches to behaviour change

Following a meeting of The National Institutes of Health (NIH), Centers for Disease Control (CDC) and others in Atlanta in July 2003, the following recommendations were made for conceptual and methodological advancements in assisting persons living with HIV: (1) interventions should target multiple levels of prevention, (2) the sustainability of intervention effects is under-researched and (3) effectiveness studies are a high priority (Gordon, Forsyth, Stall & Cheever, 2005). These recommendations form a substantial rationale for the assumptions and strategies for 'integrative' approaches to behaviour change and the broader 'enabling environment' for change (Parker, 2004). Examples of such integrative approaches include participatory peer education models (Campbell,

Foulis, Maimane & Sibiya, 2005), participatory dialogue based on the work of Paulo Friere (Kelly & van der Riet, 2001) and community participation (Kesby et al., 2003).

The participatory peer education described by Campbell et al. (2005) seeks to indirectly promote behaviour change by addressing three dimensions of social context that facilitate or undermine HIV prevention efforts: the symbolic context (stigmatising, pathologising and stereotyping those affected or infected by HIV), the organisational or network context (the quality of partnerships and relationships among community, organisational structures and groups) and the material-political context (social problems, local and national decision-making, political participation, advocacy and policy-making participation) (Campbell et al., 2005). An emerging aspect of such interventions is that of 'bridging social capital', that is for collaborating organisations, programmes and communities to improve inadequate networking among organisations, health and education services, community leadership, civic bodies, organised groups and so on (Campbell et al., 2005). Such networking may be crucial for creating the enabling environments for bringing intentions for change to action (Parker, 2004; Kelly et al., 2001).

Participatory dialogue for critical consciousness, also moves beyond the distal influences on risk behaviour, such as cultural or gendered practices and looks to structural change (Kelly & van der Riet, 2001). Strategies from Paulo Freire's Popular Education approach includes the facilitation of spaces for identifying challenges and facilitating dialogue that leads to organised action (Amnesty International, 2006). As with other participation approaches, the emphasis on processes for change in this model lead to tailored interventions in which sustainability is possible through the dialogued decision-making that facilitates community ownership (Baskin et al., 2005).

Box 3: Problematising 'participation' and 'empowerment'

Participatory approaches are by no means a cure-all and can be problematised on several fronts (Kesby et al., 2003). The meaning of terms such as 'participation' and 'empowerment' should be used guardedly as referring to ideals that may be unrealisable in practice, for example there may be 'deep' or 'shallow' participation and the 'cognitive' empowerment of an individual in an organised and democratic forum may be quite different from the empowerment of a person to effect self-efficacious choices in the private, power-laden contexts of sexual activity (Kesby et al., 2003). 'Ideal' inclusive participation are time-consuming and may also be impossible within the resource constraints imposed within developing world contexts or be undesirable in situations where interventions are urgently needed. The sustainability of an empowerment outcome may be contingent upon the socio-cultural and socio-spatial contexts in which the re-performance of empowered identities occurs (Kesby et al., 2003).

Box 4: Community-based gender intervention: Stepping Stones

Stepping Stones is a training package developed in the early 1990s in a culturally diverse area of Uganda which has subsequently been adapted for local needs in several developing world countries (Welbourn, 2002). Stepping Stones produce and adapt materials developed for community mobilisation around gender issues that affect vulnerable people, especially women and the youth (Welbourn, 2002). The programme works collaboratively with local level structures and provides resources for providing participants with language and assertiveness strategies towards the aim of empowerment (Kesby et al., 2003). The programme involves four spokes that make up a 'wheel of change', the first is learning (facts and risk factors in the context of local knowledge), the second is sharing (fission and fusion processes such as community workshops, public meetings and peer group meetings), the third is caring (facilitating gender-inclusive care for affected and infected persons, involving boys and young men in care and support) and the fourth is changing (transforming local gender norms through experiential learning activities, dialogue and inclusive participation) (Welbourn, 2002). While there is merit in producing resource material that is adapted for local needs, the extent to which the aims and assumptions are emically or etically derived is unclear.

1.5. Conclusion

It has been argued that social and behavioural theories make an important contribution to the design and implementation of prevention programmes for HIV/AIDS. While traditional, individually or interpersonally focussed theories may contribute valuable components to HIV prevention, used in isolation they have major limitations as they draw on linear, cognitive models of action, a problematic basis for HIV interventions where social, economic and gender factors create contingencies and constraints for changing HRB. Integrative models of change, which give more attention to a range of factors impacting on HIV/AIDS, may require more groundwork and dialogue among target groups, community consultants or other agents of innovation, but have the merits of being designed with the concerns of participants foregrounded, integrates research and practice and is accountable through specified outcome and independent evaluation. However, it is unlikely that any theory alone can adequately inform interventions for HIV prevention. In developing country contexts, in particular, it is important to give careful attention to the range of individual, social, cultural and economic factors impacting the HIV pandemic. Ultimately, the decision to draw on one or a range of theoretical approaches, to define appropriate outcomes may depend upon the resources available, time constraints, available communication channels and the level of intervention appropriate for the context.

The following case study discussions will offer a descriptive account of the extent and type of theoretical influences in the four organisations' planning and application of their programmes. It will also seek to identify the factors that drive the adaptation of theory-based interventions in the case of each of the organisations' programmes.

2. Introducing the Organisations

2.1. Bela-Bela HIV and AIDS Prevention Group

The Bela-Bela group provides care and support services with the participation of people living with and affected by HIV and AIDS at all levels of the organisation. The access points for services are located at Department of Health facilities such as a primary health centre and the district hospital. The Bela-Bela municipality has an estimated HIV prevalence rate of 15% and a 60% unemployment rate. The openness about the HIV status of staff and volunteers living with HIV and AIDS is a characteristic of the organisation, as are its participatory consultation with community stakeholders including faith-based organisations, organised groups, community leadership structures, clinics and schools. The programme includes a number of components, such as prevention and awareness including VCT, home-based care and care for orphans and vulnerable children, psychosocial and treatment support groups for people living with HIV and AIDS, both on ARV treatment, not on treatment or awaiting treatment, and adherence training, counselling and support. The stated aim of the organisation was to provide access to quality prevention, care and support for HIV infected and affected individuals and the related objectives were providing holistic information and awareness of HIV in a range of community settings, integrated with VCT, home-based care including adherence and family support, support groups and capacity-building with partner communities and organisations.

2.2. Centre for Positive Care

The organisation was formed in 1993 as an awareness group for women and was registered as an NGO is 1997 with a service range within the Thulamela municipality. In partnership with JOHAP, the organisation has access points in Maniini on the outskirts of Thohoyandou and at Sinthumule-Kutama that is 30 kilometres from Makhado. Originally the Tshikota area was targeted for support interventions, particularly home-based care (HBC), however it was found that this was an area of

migration, with many people going back to their traditional homes when ill, therefore Maniini was identified as a new site. The targeted areas consist of peri-urban settlements located in rural areas and with high rates of unemployment and population mobility due to migration patterns and urbanisation. Community consultation, skills-transfer and capacity-building are hallmarks of CPC and the organisation has facilitated stakeholder meetings with thirteen community structures, both civil and traditional leadership and existing organised groups within villages. The stated aims of CPC have been to increase access to government HIV related services, including access to ARV 'roll-out', to increase capacity of young women to have control over their lives, to reduce STI and HIV prevalence rates and improve coping capacities among vulnerable groups, especially young women and orphans and vulnerable children (OVC). Also targeted are high-risk migrant labourers who are reached mainly through awareness campaigns and condom distribution at strategic sites. Agendas for interventions are decided through community consultation that includes organised groups, civic and traditional leadership, FBOs and traditional healers. A development within the organisation has been the initiation of sustainable resource centres for holistic OVC care. Although interventions and participation have been mainly focussed on women, a recent change in the organisation has been the increasing involvement of men at various levels of participation including programme coordination.

2.3. Phelang Community Programme

The Phelang Community Programme is located in Namakgale just outside Phalaborwa, and services the Namakgale and surrounding communities. The purpose of the programme is to use an effective HIV and Aids management system to reduce the impact of HIV and Aids in target communities (Palabora Mining Company, 2005). This is accomplished through educating communities to change social behaviour. The programme aims include providing quality care and support services for infected people as well as the reduction of stigma associated with HIV and AIDS. Prevention through education and awareness has been highlighted as a primary objective of the programme. The Phelang Community Centre offers an array of services to the

community through the support group, peer group educators, on-site VCT, adherence counselling, and vigorous education and awareness campaigns.

The programme, initiated in 2001, commenced with a baseline study to determine the impact of the pandemic in the area. Since, the centre has developed and sustained relationships with various stakeholders in the community including government departments, the South African Broadcasting Corporation, the local clinic and hospital, and the South African Police Service. Education, awareness and psychosocial support reach a wide array of target groups such as farms, villages, schools, taverns, churches, traditional health practitioners, the South African National Defence Force, the local mine, and prisons, through a dedicated peer educator group who visit high risk areas and the HIV positive-member support group who are valuable in achieving the objective of providing psychosocial support and reducing stigma.

In 2005, the centre received accreditation together with the local clinic to “roll-out” ARV therapy, which was previously only accessible at a hospital some one hundred kilometres away. This centre also serves as a non-medical site where community members can receive voluntary counselling and testing. The programme was the proud recipient of the Sowetan/Old Mutual Community Builder of the Year award for the corporate category in 2006, which served to recognise this programme as one of the most effective in the Limpopo province.

2.4. Thohoyandou Vicitim Empowerment Programme

TVEP was formed to target young people (especially ages 10-19) to be aware of their rights in relation to various aspects of HIV and AIDS, an aim which was initially focussed on the development of resource literature for schools. With processes of re-organisation and responsiveness to community needs, particularly those identified through baseline research conducted by external consultants, TVEP’s stated aims shifted and are now to ‘generate an attitude of zero tolerance towards sexual assault and domestic violence in the Thulamela district’ (TVEP brochure, 2004). The central

office is located in Sibasa and service access points include nine help desks located at primary health centres (PHCs) and fourteen villages with organised groups and safe houses that form the Zero Tolerance Villages Alliance (ZTVA) in the wider Thulamela municipality. In addition to the ZTVA (implemented by Advocacy Officers) and help desks, programmes have expanded to Positive Support, an integration of trauma counselling, victim support and HIV counselling through trained Survival Support Officers (SSOs). Positive Support is integrated with legal support including court preparation and court chaperones, and an extensive awareness campaign with activities such as a regular radio talk show, public events and community partnerships. TVEP developed from a Victim Empowerment Committee that was established in 1997 by the Thohoyandou Community Policing Forum and involved community and government department partners with the aim of providing support to survivors of domestic violence, rape and sexual assault (TVEP, 2004). In 2001, the first one-stop trauma centre was opened at a district hospital. Since its opening, the Tshilidzini Trauma Centre has assisted with a monthly average of 37 rape survivors and 70 cases of domestic violence (TVEP, 2004). It was realised that more was needed than victim support and in January 2002 the organisation was re-structured to provide advocacy, empowerment and the 'Break the Silence' campaign (TVEP, 2004). In 2004, a second trauma centre was opened at the another local hospital.

3. Behaviour Change Interventions: Analysis of Programmes

3.1. Comparative Aims of Organisations

All organisations worked from an integrated and multi-level approach to behaviour change in an HIV context, although they differed in terms of emphasis on certain aspects of integrated care, treatment and support. The mission statements of organisations tended to be statements of integrated prevention that were sufficiently inclusive for more targeted interventions to be developed under the umbrella aims of the organisations.

The different organisations shared a number of common aims, including: facilitating HIV awareness and prevention; providing continuous care and support to those on ARV treatment; treatment access and referral networks with primary health clinics and hospitals for medication-based interventions including PMTCT, post-exposure prophylaxis (PEP) and antiretroviral (ARV) treatments; psychosocial support, including positive living counselling, support groups and in some cases, couple counselling (particularly at CPC) and trauma counselling (particularly at TVEP). In terms of orphans and vulnerable children (OVCs), psychosocial support also included indirect interventions which impact upon the support networks of children, including providing support for caregivers and communities in creating resources for structured recreation, art, sport and social activities for children made vulnerable through HIV and AIDS (Family Health International, 2001). An example of such a programme is the resource centres for children set up by the Bela-Bela group and CPC. These centres provide a place for activities, supplementary nutrition and homework support for OVCs.

Although there were notable similarities across the four organisations in terms of aims there were also differences in emphasis. For example, sustainable capacity-building was one of CPC's emphasised aims, whereas the Bela-Bela group and the Phelang Community Centre focussed more on prevention through awareness of risks, protective behaviours and access to treatment.

Box 5: Integrated Aims at Bela-Bela

A developing view in the literature is that there is little merit in differentiating behaviour change intervention from any other form of HIV response such as care, support or advocacy (Campbell, Williams & Gilgen, 2002). This view appears to be well-illustrated by the integrated 'pragmatic' approach of the Bela-Bela HIV and AIDS group. Programme elements form an interlinked network of prevention at multiple levels, with aspects of each programme working in harmony with the objectives of other programmes. For example, Bela-Bela's Home-based Care programme provided a range of interventions that include building relationships with patients, mobilising family support, facilitating family coping skills with health education around tertiary prevention, facilitating treatment support and reminding patients on ARVs of the risks of non-adherence and re-infection. The support group programme similarly provided multiple levels of prevention, not only by the more obvious levels of peer support that would reduce relapse but also by providing a forum for empowerment, re-defining responsibilities in relationships and enhancing the social capital of persons living with HIV and AIDS.

3.2. Mechanisms for Determining Programme Aims

Across the four organisations, aims were developed through varying processes – CPC and the Phelang Community Programme emphasised baseline surveys and external research as an preliminary phase of problem identification that led to community consultation, whereas the Bela-Bela group focussed more on clinic statistics and requests from the community as a basis for developing programme aims through dialogue with community stakeholders. Many of the aims were developed or refined in response to the needs of communities which they served established through participatory processes, baseline surveys or community consultation. For example, TVEP's aims had developed from the initial focus on victim support to providing a continuum of empowerment that included integrated counselling, treatment access, service-monitoring, lobbying, awareness campaigns, advocacy and court preparation.

CPC's aims were aligned to its identified target groups such as vulnerable women and children, through independent research and consultation with community structures, partner organisations and other stakeholders.

Some of the differences among the organisations were questions of programme emphasis or community relevance. The characteristic approaches of the organisations also reflected the concerns of the relevant stakeholders such as partner organisations and funders in the process of deciding on the aims or objectives. For example, on the basis of trauma centre statistics and community consultation one of the organisations had planned a programme of behaviour change with young perpetrators of sexual abuse, a target group for HIV prevention. A further example of partnerships influencing programme aims was a partnership between TVEP and a local men's organisation called Munna Ndinnyi ('what is a man?') where aims between the organisations differed on some levels but common ground was established through meetings in which shared aims and objectives were discussed. Although there was organisational and community support, it appeared that there was no available funding for the programme to be initiated. The aims of interventions were also influenced by the available resources, so for example the Bela-Bela group had partner relationships with faith-based organisations in the area and benefited from being able to use church halls for awareness campaigns although this had necessitated working on common ground , so condom distribution was less emphasised than delayed sexual debut, faithfulness and abstinence messaging.

It was apparent that aims for behaviour change had shifted with the development of the organisations themselves. For example, TVEP initially facilitated awareness campaigns in schools but had subsequently widened its focus to and beyond victim support and advocacy. This development had occurred through processes of re-organisation, problem-solving, community consultation and skills acquisition. At the time of the study, TVEP was focussed on issues of empowerment, prevention, awareness and access to justice, and its aims for behaviour change in HIV were integrated with the various programme clusters such as help desk advice and victim

support. TVEP's behaviour change approach was embedded within an integrated programme of support, advocacy and multi-level empowerment which addressed HIV behaviour change both indirectly and directly. Although TVEP's integrated programmes appeared to be addressing multiple forms of disempowerment, survival and vulnerability, in the targeted contexts of sexual abuse, rape and domestic violence, HIV-related behaviour change was addressed directly and indirectly through the integration of services. It may be both difficult and undesirable to separate HIV-related behaviour change from contexts of these behaviours, the holistic enabling environment including the material and discursive environments, and the gendered or cultural power relations that underscore HIV risk in the local context.

Variation notwithstanding, it seemed that the four organisations designed and developed programmes in an integrated and 'data' based fashion. Varied sources of data were epidemiological clinical statistics or service use data or "data" reflected in the voices and preferences of partner organisations or community spokespersons. Programme design therefore was connected to the contexts of these organisations in these (and other) ways.

3.3. Recipients of Organisations

A broad range of target groups were the recipients of programmes run by different organisations (see Appendix Table 2). School-based learners, families and the 'community' were reported as being the primary recipients of programmes run by all organisations, however men in relationships with women, youth, orphans and vulnerable children, and faith-based organisations were also recipients commonly targeted by these programmes.

Each programme also tended to have a particular focus in terms of its primary recipients. For example, Bela Bela had more of a focus on men as partners, by identifying male partners as treatment supporters, involving men as awareness facilitators and running support groups for men and women together. and PCP more of

a focus on farm workers, miners and the military especially because of the mobility of these populations. Military personnel were at greater risk of infection through travel to other parts of Africa on peace-keeping missions and migrant mine workers were often displaced from partners increasing the likelihood of having multiple sexual partners.

Box 6: Targeting Victims of Domestic Violence in Ivhembe District

One of TVEP's targeted groups for change were women victims of sexual or domestic violence with the holistic empowerment of victims as the overall aim of the programme. One of the TVEP coordinators saw the organisation's strategies for change as 'learning with the process', a statement which captured the flexibility of this organisation in responding to the needs of its targeted groups. As the organisation developed its victim support programme, the need to facilitate enabling environments for victim empowerment became apparent, and so strategies broadened to encompass a continuum of support and advocacy for victims that included awareness campaigns, VCT and adherence counselling for survivors, a legal support component and the Zero-Tolerance Village Alliance, a programme for facilitating community-based resources to deal with domestic violence at a local level such that villages could allocate and run safe houses, that civic and traditional leadership structures endorsed a policy of zero-tolerance for domestic violence and for trained volunteers to provide support for vicitims of domestic violence.

While identifying and focussing on specific target groups was recognised as important, it was often noted as secondary to tailoring programmes to meet the interests of all stakeholders in the community. For example, the Bela-Bela group and the Phelang community programme prioritised organisational partnerships and regular stakeholder meetings as a means of keeping in touch with community needs.

Common to all four organisations was the focus on school-based learners for awareness and education interventions. Families were also a target for intervention, most often in terms of home-based care. Although home-based care programmes were supportive in emphasis, they involved direct and indirect interventions for behaviour change. At CPC, for example, direct interventions for behaviour change by home-

based carers included providing education and awareness to reduce stigma, prevent re-infection and promote protective behaviours including medication adherence. Indirect interventions were to address the enabling environment for sustaining healthy behaviours such as educating families on environmental hygiene and nutrition, mobilising family support, identifying problems of abuse and neglect followed by appropriate referrals and facilitating capacity for families to cope with HIV.

Box 7 Bridging Social Capital as Facilitating an Enabling Environment

Case study research in South Africa has noted that the concept of social capital should be foregrounded in any interventions seeking to change people's behaviour and sustain those changes (Campbell, Williams & Gilgen, 2002). An example was CPC's work of training self-supporting women's groups in targeted communities as a means to creating capacity through financial skills development and group-efficacy, similar to men's 'saving clubs' among migrant miners in Campbell et al's case study (2002). Social capital is a concept derived from economic and political science to refer to the reciprocal influence between individuals and community level networks and relationships (Campbell et al., 2002). Interventions which improve networks and community relationships as a means of indirectly impacting on individual health behaviour move behaviour change out of the arena of individual change to the community-level, a concept that fits well with the capacity-building approach of organisations such as CPC which works with facilitating networks of support (Campbell et al., 2002).

3.4. Target Behaviours

Despite a certain degree of homogeneity in terms of target behaviours, each organisation placed varied emphasis on the different behaviours targeted for change as well as on the manner in which programmes envisaged such behavioural change. In each of the four organisations there was a wide range of behaviours targeted for change, evidence for a holistic or multi-dimensional approach to behaviour change. Recent literature supports the notion of multi-level interventions for behaviour change that target behaviours beyond social-cognitive or cognitive-attitudinal models to address

the enabling and sustaining environment for behaviour change (Kelly et al., 2001; Gordon et al., 2005). The following target behaviours were explicitly stated across all four organisations: condom use, voluntary counselling and testing, preventing mother to child transmission (PMTCT), adolescent pregnancy, medication adherence, lifestyle and nutrition. Other target behaviours were a focus of one organisation only, for example, TVEP focussed on preventing secondary trauma for rape and abuse survivors through its integrated survival support programme, a focus of particular relevance to TVEP's targeted group of women and children referred to trauma centres.

Box 8: Targeting Abstinence and Delayed Sexual Debut

The Bela-Bela HIV and AIDS groups ran youth awareness programmes in partnership with Love Life representatives, schools and churches. As an organisation that works within a community-consultation approach, the agenda for these interventions were dialogued among role-players. In working from a common agenda, the programme emphasised abstinence and delayed sexual debut. This was a response not only to the interests of faith-based organisations that supported the organisation's role in the community through providing venues for awareness and stakeholder support, but also the position of school governing bodies who were reluctant about having condoms distributed at school sites. From these processes there emerged a programme that emphasised the abstinence and delayed sexual debut messages among the youth of Bela-Bela. The literature supports the idea of that networking and partnerships among Organisations, schools and health services is an important part of creating the social capital (or organisational context) for effective youth HIV prevention (Campbell et al., 2005). As such, flexibility around programme content may be necessary for sustainable social-organisational environments for change.

Among the organisations, TVEP had a particular emphasis upon HIV behaviour change within a context of victim empowerment. Unique to TVEP was a preventative strategy of reducing secondary trauma among survivors of rape, abuse and domestic violence. This was accomplished through an integrated multi-level approach of legal, psychosocial and medication support that included assisting victims in reporting cases

of gender violence and providing ongoing support through the often lengthy process of obtaining justice.

Box 9: Processes for Tailoring Programmes to Meet Local Needs

Each organisation targeted groups for behaviour change through various processes of participation, research, external consultation, community consultation and partnerships. One of the strategies for identifying target groups for change was through the needs assessment in a variety of ways. Needs assessments included consultation with relevant community stakeholders, so for example, TVEP advocacy officers conducted listening surveys in communities around issues that had been identified through baseline statistics from health and social services. One of CPC's strategies was the use of external research done by the University of Venda, antenatal and STI statistics from primary health centres and community requests in the initial phases of targeting vulnerable groups followed by agenda-setting through grassroots participation.

The Phelang community centre serves as a central point of distribution for male and female condoms (Palabora Mining Company, 2005). While promoting abstinence to youth was practiced during awareness campaigns conducted by staff at the centre, it was acknowledged that many youth are sexually active and that condom promotion is a crucial component of any prevention initiative. A staff member at the centre suggested that the community should develop a culture of encouraging sexually active youth to condomise instead of feigning ignorance regarding youth's sexual behaviours. It appeared that the proclaimed naiveté of parents and other adults simply serves to compound the problem of adolescent pregnancy, increased termination of pregnancies and increased HIV infection rates in young children, already identified as problematic in the area.

Box 10: Identities and Brands in a Social Marketing Strategy

The importance of tailoring programmes to specific target groups was highlighted with the Levis Condom Campaign. A condom survey conducted by the Phelang Community Centre found that that sexually active youth lacked knowledge on condoms and failed to use condoms consistently. While condoms are widely and freely available at several locations in the community, young people were still reluctant to protect themselves. An educational and promotional campaign with Levis condoms, targeted at youth, successfully managed to change attitudes towards condom use. Interviewed youth attributed the success of the Levis condom campaign in increasing condom use by youth, to its appeal to branding 'status' and a label-driven youth culture. In fact, government provided condoms were reportedly not used partially because male youth felt that they had certain image and status standards to uphold. The use of a brand label helped create and maintain status and repute for young men in relation to partners and social reference groups. The social marketing strategy was one that drew on the relationship between brands and social identities such as acceptable masculinity.

3.5. Interventions

Interventions varied according to the targeted units for change, working not only with individuals but also with groups, families, organisations, villages and communities.

Awareness campaigns occurred at local community level such as with door-to-door campaigns or special events at strategic sites in villages, clinics, schools, taverns and in the broader municipality, district or province such as using the print or broadcast media. The PCP and TVEP similarly used regular radio phone-in talk shows as a means of raising awareness. Organisations were innovative in the strategic use of resources for awareness. TVEP planned special events to coincide with the national calendar, such as the 16 days of Activism against Women and Child Abuse, and facilitated edutainment through youth drama groups and local musicians. TVEP, CPC and the Bela-Bela group ran daily or weekly awareness campaigns in primary health clinics as a means of raising

awareness at the local level. Producing posters and resource materials for the Life Orientation educators at local schools was another way that TVEP worked strategically to produce enabling environments of reduced risk. The Phelang centre and the CPC strategically ran condom distribution and health education at sites such as mobile phone outlets and drinking houses. Some of these creative strategies had unforeseen gains, for example recipients of the village awareness campaigns (TVEP) suggested that these events relieved stress and depression among community members. Despite the general finding in the literature that education and awareness alone do not produce change, the emphasis on awareness interventions in the context of these organisations appears to not only produce unintended positive mental health outcomes, but seems rather to fit well with the preliminary phase of community mobilisation and community preparation for broader change. The awareness strategies and programmes are well connected to a range of follow-up intervention activities and therefore serve to promote programme receptivity and to catalyse action. This reflects the functioning of the Integrated Model for Communication for Social Change (Figuero, Kincaid, Rani & Lewis, 2002).

Box 11: Skills-Transfer and Mentoring at the Centre For Positive Care

Training of volunteers was an important part of CPC's approach to community-capacity building as a means of enabling and sustaining behaviour change. Skills-transfer occurred through the training of pre-existing organised groups within communities, for example in consulting with community structures, a group that 'wanted to do something' might come forward and then CPC would enrol group members as OVC or Home Community-Based Carers. Initial training for these groups was updated with skills that were acquired through coordinators attending workshops or receiving external training. External training was also directly facilitated for the implementers through workshops run by government departments in collaboration with the centre. Mentoring relationships with implementers and organised groups were also a means for enhancing capacity and sustainability in communities. The objective of training was for volunteers to progress through the organisation with mentorship leading to a sustainable skills base for enabling behaviour change. Community respondents commented on the developing efficacy of the volunteers as an important part of the centre's effect within communities. Community capacity-building is an appropriate level of intervention if the locus for behaviour change is to be shifted beyond the individual and interpersonal levels to encompass the social-ecological level, or as Kippax (2004) suggests, prevention belongs in the community as much as in the clinic.

Support groups and peer group educators were also recognised as fundamental to the implementation of several initiatives and interventions such as door-to-door campaigns, awareness campaigns and condom promotions, among others. At both PCP and Bela-Bela groups, support group members, who were themselves HIV positive, made an impact as peer educators and speakers at awareness events.

Box 12: Peer Educators at the Phelang Community Centre

At the PCP, support group members who are themselves HIV positive, conducted 1187 visits to homes and visited eight schools, four churches, seven farms and two military bases in 2005 alone (Palabora Mining Company, 2005). Their provision of continuous psychosocial support and care to clients on ARV treatment is evidenced by the 98.5% treatment adherence. The thirty seven peer group educators service several high transmission areas, providing education on HIV and AIDS related issues to 6 117 males and 5 610 females at these sites in the same year (Palabora Mining Company, 2005). Peer education has been identified as an effective means to challenging risk-related social norms especially in the area of gender norms, where 'peer re-negotiation' can generate alternative norms for gender relations (MacPhail, 2003; Targeted AIDS Interventions, 2007).

Follow-up was seen as a both a challenge and a strategy at some of the organisations, for example, at CPC, TVEP and Bela-Bela maintaining an accurate service-user data-base (and other forms of service documentation) was seen as crucial part of effecting and sustaining behaviour change. It was difficult for CPC and the Bela-Bela Group to keep track of all the clients as both organisations worked with communities with population mobility due to labour patterns, unemployment, urbanisation and transnational migration.

The transfer of skills through workshops with specific groups was a strategy noted at all four organisations and was particularly emphasized at CPC, where workshops had taken place to educate traditional healers in safer practices of performing circumcision which took place at around age six among boys in the Venda culture. Other interventions included educating Zionist church leaders on risk reduction in ritual scarification practices, important as according to one of the respondents, an estimated 60% of households in CPC's service area were of the Zionist church, where practices include scarification for both genders, the rejection of condoms and polygamy.

3.6. Risks

The factors reported by respondents as placing people at risk for HIV infection were contextualised within social, economic, cultural and religious systems. Respondents cited multiple social and economic contexts for increased HIV risk, with the following factors emphasised: poverty, unemployment, contractual sex, gendered power relations, the subordination of women, rape and sexual abuse, and norms permitting men to have multiple sexual partners. Interestingly, both following and abandoning traditional and religious practices were also seen as contributing to risk of HIV infection. Following traditional or religious practices such as serial monogamy, polygamy, rejecting condoms as a means of protection, circumcision or scarification were cited as risk factors by some of the organisational respondents whereas community respondents, especially religious representatives and traditional healers, said that following cultural or religious norms reduced risk by supporting appropriate relationships in society.

Behavioural interventions within resource-constraint may be most effective when the context of social, cultural, political and economic systems are addressed through holistic interventions (Babun & Craciun, 2007; Kelly et al., 2001). Responses from community members at all four sites noted the need to develop holistic interventions to address HIV in contexts of poverty, unemployment, socio-cultural practices, rape and sexual abuse, gendered relations of power, population mobility, faith-based practices and substance abuse.

CPC's approach of participatory consultation was to start working with identified vulnerable communities through existing structures around limited issues of environmental hygiene and reducing STI prevalence. Over time and with the 'buy in' of community members and structures, CPC's interventions developed into more holistic programmes that addressed HIV behaviour change (among other objectives) directly and indirectly through community capacity-building, skills transfer and the career pathing of volunteers. It would appear that in developing integrated or 'socio-ecological'

models of intervention organisations may do so much as to move beyond being identified as working in the field of HIV only but as a community organisation that is responsive to local needs in a range of areas. A challenge for TVEP for example, was how to be responsive to community requests while remaining focussed on its original aims of addressing gendered violence.

Box 13: Integration of Programme Clusters in Thohoyandou

The Thohoyandou Victim Empowerment Programme took a holistic approach to empowerment as a unifying theme across various project clusters. Interventions for behaviour change were seamlessly integrated with all modes of intervention with TVEP's targeted groups of rape, domestic violence and child abuse survivors. This integration was exemplified in the multiple roles of the SSOs or survival support officers, who were often the first contact that beneficiaries had with the organisation. At the trauma centres SSOs provided "Positive Support" that included trauma debriefing, voluntary counselling and testing and victim support through the processes of reporting the case, medical examination and the completion of the J88 medical report form, medication support for ARV treatment, post-exposure prophylaxis or PMTCT as sequelae of rape, domestic violence and abuse. The role of the SSOs also extended to court preparation and the keeping of duplicate records of documentation, thus allowing for cases to be reinstated if records had 'gone missing', leading to the successful prosecution of perpetrators. While the link of these interventions with HIV-focussed behaviour change may not be immediately clear, it is suggested that the multi-dimensionality of TVEP's approach is such that the health behaviour change is promoted within a repertoire of interventions that is relevant for meeting the holistic needs of the target groups.

3.7. Criteria of Effectiveness

Whatever the source of HIV preventive interventions, it is important that the effectiveness of these interventions be evaluated. While it was outside the scope of this project to undertake rigorous evaluations of the interventions, we did attempt to elicit reports of subjective and anecdotal impressions of where these interventions had been most effective.

The criteria reported as indices of effectiveness ranged from direct measures such as research findings by funding organisations or tertiary institutions, case analyses, epidemiological statistics to indirect indicators such as observations, feedback and attendance at community meetings. For the organisations studied, community feedback is a crucial indicator of programme effectiveness. Examples of this include opinions of stakeholder groups and community members, active seeking of information by the community and visible sustainability in communities (such as the running of resource centres for orphans and vulnerable children, one of CPC's village projects), among others. Given that local communities are the primary target group of most of these programmes, it is not surprising that this feedback is often cited as an indicator of effectiveness.

It appeared that most organisations looked at combinations of effectiveness criteria including the following categories: (1) empirical indicators of effectiveness such as clinic statistics or data base statistics at Bela-Bela for example, this was the number of pregnancies among enrolled service users, (2) inter-organisational indicators, such as the numbers of cross-referrals with health or social services (for example, at CPC), or the invitations for training with or for other organisations (for example, at all four organisations) (3) cultural-communal criteria, in the sense that an organisation will 'know' it is accepted in the community or not if, for examples, stakeholders attend meetings, community requests are made or, in the case of TVEP, the establishment of a safe house in each targeted village is seen as a sustainability milestone and (4) informal

or qualitative indicators of success such as the 'talk on the streets' or, for example, feedback through the radio talk shows at TVEP or PCP.

Box 14: Participant Perspectives on Support Group Effectiveness

Support group participants in Bela-Bela identified the following effective aspects of support groups (1) facilitating acceptance of being HIV positive, (2) countering social isolation, (3) mitigating against risks through peer support of adherence and protective behaviours, (4) encouraging the responsibilities of men as partners and treatment supporters, (5) accessing information and services. In terms of the stages of change model, support groups may be effective in facilitating sustainable change through the intervention of peer support in the processes of reception, interpretation and response (Bennett & Murphy, 1994). As noted in the theoretical literature, the stages of change have limited usefulness in addressing all aspects of resource deprivation where addressing the enabling context for change needs to move beyond the efficacy of individuals and groups to the material and discursive realities as contexts for health behaviours (Parker, 2004).

From most organisations there was little empirical evidence available regarding the impact on attitudes and behaviours. The majority of effectiveness indicators were anecdotal, self-reported observations by implementers, beneficiaries and programme staff and management. Evidence for change at PCP, for instance, was observed in the high treatment adherence rate, the use of VCT services, increased condom use and the perceived reduction of levels of stigma, among other such indicators. A noteworthy indicator for the programme manager was that clients were accessing the VCT services at the Phelang site daily, despite the fact that marketing and promotion of the VCT clinic was yet to begin. A challenge in identifying and measuring behaviour change effectiveness is that many of the targeted behaviours are private or hidden, and that it may be only through indirect effects that the reduction of such behaviours may be inferred. At Bela-Bela, CPC and at the other sites, there was some speculation that the increased numbers of persons coming forward for VCT (particularly the increasing numbers of men) was due to the visible effectiveness of ARV treatment although this link was not empirically or qualitatively established. Among respondents from many

organisations, especially among implementers and beneficiaries, emphasis was placed upon ‘accepting’ HIV by individuals, families and communities. In unpacking what this meant, it appeared to be a holistic outcome of stigma reduction, overcoming denial of the individual vulnerability and a more accurate assessment of the risks of HIV, the need for treatment and support in addition to a process of cultural rejuvenation around stigma, dignity or conditions of worth.

3.8. Emerging Lessons

Several important lessons appear to have evolved through programme implementation. The benefits of involving HIV positive people in the organisation was strongly emphasised by interviewees at Bela-Bela and the Phelang Community Centre, where these ‘HIV ambassadors’ were identified as the “primary agents of change”. At Bela-Bela, it was strongly emphasised that persons living with HIV and AIDS were included at all levels of the organisation from management and programme coordination to volunteers and implementers. This strategy was perceived to be very effective in countering stigma, changing expectations on living with HIV, promoting the credibility of the organisation and encouraging sustainable efficacy of individuals and groups, especially in the context of implementers acting as exemplary role models within the community. The ‘community credibility’ of the organisation was a unifying lesson emerging from these organisations, where participatory processes of various kinds were valued as part of organisational identity. Where theoretical approaches or models of community participation were cited, it was clear that conceptual approaches were used actively by the organisations and adapted to meet local needs. These strategies were a means for organisational ‘self-efficacy’ that was sustainable through ongoing connection with local needs. This emphasis on community involvement and the importance of developing and sustaining relationships with community structures was resonated across sites.

3.9. Sources of Intervention Strategies

Respondents suggested that rather than a reliance on published behaviour change theories, models and strategies, the strategies and interventions decided upon and employed by programmes were developed through training, workshops and from external consultants, including other organisations. Before the initiation of the local ARV treatment programme, the PCP received training from staff at Bela-Bela. Some interventions were facilitated from a particular way of thinking, for example, TVEP coordinators had attended Training for Tranformation workshops at The Grail Centre in Cape Town and had introduced a strategic praxis based in Paulo Freire's conceptual approaches.

Box 15: Transformatory Praxis

The TVEP empowerment team adapted the six step Freirian approach for a variety of projects including school awareness campaigns and the Zero-Tolerance Village Alliance. The steps consisted of (1) presenting a community narrative through role-plays, vignettes, videos and so on, (2) asking the group to discuss their observations, (3) asking the group to discuss if the scene depicted happens in real life, (4) asking the group to provide examples of where it happens in their lives (5) facilitating group discussion about the reasons for these occurrences and (6) enabling the group to develop an action plan. Paulo Freire's Popular Education approach includes the following principles of critique, intersubjective meaning and holistic engagement with all aspects of human experience (Amnesty International, 2006). Its value position includes respect for human dignity and worth, the value of rational and non-rational ways of thought, treating persons as subjects not objects of change and aversion to totalising frameworks (Amnesty International, 2006).

3.10. Challenges

One of the most frequently cited challenges was the difficulty in keeping track of programme recipients. Examples included recipients not returning for follow-up visits or to collect medication and reasons cited were transport limitations for implementers, migrant labour patterns, migrant populations from other areas and urbanisation linked with rural poverty. The literature cites attrition as a frequent challenge in social and health programmes in general (Baskin et al., 2005). This challenge can be a 'catch-22' as recipients who are the most vulnerable to risks are often the most difficult to enrol and retain in programmes (Baskin et al., 2005). Another frequently cited challenge was that of recipients defaulting of ARV treatment, and this was attributed to medication or treatment literacy factors such as recipients not understanding the need for strict compliance, the strict timing of doses, medication side-effects and patients not continuing with treatment once they were feeling better. These challenges are endorsed in the literature on treatment support for HIV patients receiving antiretroviral therapy (Baskin et al., 2005; Safren, Radomsky, Otto & Salomon, 2002). Social factors related to poverty cited from CPC were that some recipients were unable to maintain adherence due to lack of adequate nutrition and that some deliberately stopped taking ARVs in order to maintain a CD4 count of below 200 in order to continue to qualify for a temporary disability grant.

A challenge given some emphasis across all four organisations was the reluctance of men to seek care, treatment and support although it was a perception that this was changing due to a variety of reasons associated with the perceived efficacy of ARV treatment (Bela-Bela), the impact of awareness initiatives (Bela-Bela), developing programmes that involved rather than alienated men (CPC) and involving men at all levels of the organisation (TVEP). Lack of attendance at stakeholder meetings was also a challenge for some organisations as low turnouts at meetings hampered attempts to work with all community structures. One of the primary challenges to behavioural change identified by the PCP was the lack of involvement of key stakeholder groups such as the white community. Given the emphases on community change and

community ownership adopted by the programme, a lack of involvement by any group is perceived as problematic and an obstacle to community level change.

Obtaining and retaining skilled staff was also cited at Bela-Bela, CPC and TVEP. This challenge is also noted in the literature, and the problem of securing and mainitaining qualified staff occurs particularly within resource-limited contexts (Baskin et al., 2005). Other expertise-related issues included the shortage of state social workers (CPC and TVEP) and the frequent rotations of magistrates which led to problems in finalising cases of rape and abuse (TVEP). A further problem was the loss of volunteers who had been trained by the organisations but had found better remuneration in state organisations or the private-sector. A response of CPC was to prioritise skills-transfer and career-pathing for volunteers to ensure that resources used on training were not depleted. Government funding for trained implementers was also suggested by several respondents in several organisations, as volunteer stipends were insufficient to retain skills within organisations.

The need for skills for dealing with the emotional and mental health needs of recipients was an emphasised challenge at CPC and was also noted at TVEP. Addressing mental health challenges, especially depression, through psychosocial support is an important predictor or treatment effectiveness among patients receiving ARVs (Safren et al., 2002). Baskin et al. (2005) note that programmes require skilled staff to deal with the complex challenges of persons living with HIV that include mental health and substance abuse. It is noteworthy that CPC had responded in a proactive way to this challenge by soliciting the assistance of the South African Anxiety and Depression Group (SADAG) in providing training on mental health issues for its staff and volunteers. A further programme development issue was the need to provide more interventions that targeted HIV negative people.

Key challenges identified as arising from the context of HIV were poverty, alcohol use, unemployment, gendered violence and cultural or religious practices. There is substantial support for the idea that the efficacy of persons in health promotion

behaviour is contingent upon the factors in the broader social environment such as poverty, substance abuse, unemployment and gender relations (Baskin et al., 2005; Campbell et al., 2005; Kesby et al., 2003). Organisations appeared to be responding to these challenges by integrating behaviour change in the context of enabling environments for change. Cultural or religious practices were cited as challenges for HIV behaviour change on a number of fronts. Behaviours that potentially increased HIV risk included scarification (both traditional African and in the Zionist church), circumcision, rejection of condom use (various churches), polygamy (both traditional and within the Zionist church) and resistance to shared decision-making in relationships (traditional practices).

Box 16: Conversations with Traditional Healers

In several organisations, traditional healers were interviewed, some as community members, beneficiaries or volunteers. The traditional healers generally expressed the view that healers were integral to the well-being of persons and communities, and that provided with diagnostic skills, could be an effective link between people living with HIV and health services. One of the traditional healers interviewed noted that one of the unique roles of healers was in providing ways for people to order relationships and cope with life transitions such as birth, death, marriage, illness and bereavement. This healer explained that cultural guidelines for relationships were effective in preventing unsafe sex, as unrestrained sexual activity was discouraged and periods of voluntary abstinence were encouraged such as in changing sexual partners or during pregnancy and after the birth of a child. Healers interviewed said that they encouraged people living with HIV and AIDS to seek medical treatment and would encourage their patients to continue with appropriate cultural practices.

4. Conclusion

These case studies of specific South African organisations working in the domain of HIV/AIDS provide an interesting set of illustrations of the issues and challenges faced by any attempt to effectively alter HIV risk behaviours.

Many of the risk factors reported in this analysis reflect the direct and indirect risks of HIV infection seen in most contexts. Among the direct factors are multiple sexual partners, high levels of substance abuse, stigmatization of HIV infected people and partner violence. Among the indirect factors are poverty, unemployment, the economic dependence of women and migration.

Most of the recipients of these programmes of intervention are black women and this can be understood in terms of the recognition of the way in which black women are disproportionately at risk of HIV infection and also carry the bulk of the HIV/AIDS burden in sub-saharan Africa. They inevitably carry the anxiety about HIV infection of themselves, their children and their partners, and are the primary care givers of HIV infected family members, as well as carers for orphans and abandoned children. It is no surprise that the empowerment of women, and legal interventions to assist women who are victims of domestic abuse, are important interventions in most of these organisations. It has been widely recognized that men are resistant to greater involvement in HIV prevention, but also that “men make a difference”. It is possible then that the focus on servicing the interests of women and children may, unintentionally, have neglected and/or marginalized men and their role in this highly gendered epidemic. Amongst these organisations, the growing concern about and attempts to involve more men as both service recipients and implementers and to make services more male-friendly, are especially important.

Overall, the programmes have been powerfully informed and highly sensitive to the needs of communities within which they operate, by other organisations and local knowledge and experience. This contrasts strongly with more academic recommendations such as the emphasis of Kalichman et al. (2006) on the importance of

explicitly deriving interventions from theory. Their intervention programmes have also been informed by culturally relevant issues, such as the inclusion of traditional healers and faith based leaders. However, one can see elements of some of the theoretical models implicit in some of their interventions. There are also many examples of the diffusion of innovation in the interventions by these organisations. Some of the novel findings may also be explained in terms of these theoretical models. The effectiveness of the Levis condom campaign, could for example be seen as a novel way of reducing the costs and enhancing the benefits of condom use, as described by the Health Belief Model, through the association of condoms with the status of Levis jeans.

HIV reduction is one of the major goals of all these organisations, and many of their programmes include elements of behavioural interventions to reduce HIV risk behaviours. Overall, these organisations report evidence that this is having some of the desired effect. One of the primary means of HIV reduction is through the transmission of information through awareness and education campaigns. Important as this might be, research in the area suggests that this can never be an effective intervention in isolation. However, investigation of these organisations shows that rather than only focusing on discrete individual risk behaviours, they are largely based on what was earlier termed, integrated, multi-level interventions. This is seen in the combinations of education, social support, empowerment of women and legal interventions. These programmes illustrate the way in which HIV behaviour change cannot theoretically and seldom does in practice occur outside of broader responses to health, social and community development issues, as argued by Campbell et al. (2002), Baban and Carciun (2007) and others. The programmes appear more through community connectedness than through the drive of theory to be organically implementing a sensitive blend of elements of individual level behaviour change programmes integrated with communication and direct service and support strategies. These are in turn finely contextualised in terms of local psycho-social, cultural and economic conditions.

One of the most striking aspects of these programmes is their responsiveness to community needs, their programmatic flexibility and adaptability in response to these

needs, and their inclusion of people living with HIV and AIDS at all levels of the organisations including programme implementation. Given the powerful negative effects of HIV stigmatization, this may yield important stigma mitigation effects. This inclusion also promotes programme effectiveness and acceptance by having implementers who speak from experience.

These case studies provide an account of HIV and AIDS programmes *in action in context* negotiating a blended path meeting individual change imperatives and pressing needs for service and the broader multi-dimensional contextual intervention priorities.

Whereas the programmes appear not to be *explicitly* theory-driven they are indeed *implicitly* consistent with dominant theories within the field.

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Appendix 1: Interview respondents across the four organisations

(n = 85)

14 Support group members
6 Traditional health practitioners
6 HCBC Integrated Prevention and care group members
5 School learners
5 Help desk advisors
4 Home based carers
4 Advocacy officers
3 Programme directors/coordinators
3 Programme staff
3 VCT and adherence counsellors
3 primary health care practitioners/representatives
3 Community members
3 Ministers
3 South African Police/Community Policing Forum members
2 Foster guardians
1 Programme officer
1 Support group coordinator
1 home based care coordinator
1 Help desk coordinator
1 Campaign coordinator
1 Orphans and Vulnerable Children outreach coordinator
1 Medical practitioner
1 Board member
1 Founding members
1 Orphans and Vulnerable Children caregiver
1 Transport implementer
1 Positive support team leaders
1 Empowerment services team leaders
1 Child sponsor
1 Senior legal officer
1 Hospital board member
1 Clinic committee member
1 Victim empowerment member

Appendix 2: Summary tables of content analysis results

KEY	
0	= not mentioned in interviews
1	= implied, but no direct mention in interviews
2	= explicitly mentioned in interviews
3	= strong emphasis in interviews

Table 1: Comparative aims of organisations

	BB	CPC	PCP	TVEP
Awareness (information and persuasion)	3	3	3	3
Prevention	3	2	3	3
Treatment support	3	3	3	2
Access to treatment	2	2	2	2
Psychosocial support	2	2	2	2
Health education (information only)	2	2	2	2
Empowerment	1	2	2	3
Reducing stigma and discrimination	1	2	3	2
Sustainable capacity-building	2	3	2	0
Service access and delivery	1	2	2	2
Justice access and delivery	1	1	0	3

Table 2: Recipients of organisations

	B-B	CPC	PCP	TVEP
School-based learners	3	3	2	3
“Community”	2	3	3	2
Families	3	2	2	2
Organised groups	2	3	2	2
Orphans and vulnerable children	2	2	2	2
Youth	2	2	2	2
Faith-based organisations	2	2	2	2
Sex Workers	1	2	2	3
Men in relationships with women	3	2	0	2
Private sector	2	1	2	2
Traditional healers	2	2	2	1
Victims of gender violence	1	1	2	3
Villages	1	1	2	2
Educators	1	1	0	3
Prisons	2	0	2	0
Mine workers	0	0	2	0
South African National Defence Force	0	0	2	0
Farm workers	0	0	2	0

Table 3: Target behaviours

	B-B	CPC	PCP	TVEP
Medication adherence	**3**	**2**	**3**	**3**
Condom use	**2**	**3**	**2**	**3**
Access to health and social services	**2**	**3**	**2**	**3**
PMTCT	**2**	**2**	**2**	**3**
Abstinence	**3**	**2**	**2**	**1**
Delaying sexual debut	**3**	**2**	**2**	**1**
VCT	**2**	**2**	**2**	**2**
Teenage pregnancy	**2**	**2**	**2**	**2**
Nutrition	**2**	**2**	**2**	**2**
Lifestyle	**2**	**2**	**2**	**2**
Empowering women	**1**	**3**	**1**	**3**
Faithfulness	**3**	**2**	**2**	**0**
Substance abuse	**2**	**2**	**2**	**1**
Holistic empowerment	**1**	**1**	**1**	**3**
Prevention of domestic violence	**1**	**1**	**1**	**3**
Enhance the legal process	**0**	**0**	**0**	**3**
Prevent secondary trauma	**0**	**0**	**0**	**2**

Table 4: Interventions

	B-B	CPC	PCP	TVEP
Awareness campaigns	3	2	3	3
Tracking and follow-up of beneficiaries	2	2	3	3
Drama groups	2	3	2	3
Door-to-door campaigns	3	2	2	2
Special events for awareness	2	2	2	3
Condom promotions	1	3	3	2
Support groups	2	2	2	2
Home-based care	2	2	2	2
Health education campaigns	2	2	2	2
Workshops	2	2	2	2
Peer group educators	2	1	2	2
Treatment literacy to communities	2	2	2	1
Road shows	0	0	2	3
Radio slots	0	0	2	3
Press coverage (newspapers)	0	0	2	2

Table 5: Risks

	B-B	CPC	PCP	TVEP
Women not empowered	2	3	2	3
Poverty	3	3	1	2
Sex for economic gain	2	2	2	2
Multiple partners	2	2	2	2
Following traditional practices	2	2	2	2
Unemployment	2	3	1	2
Gendered power relations	1	2	2	3
Coercive partners	1	3	1	3
Teenage pregnancy	2	2	2	1
Abandoning traditional practices	2	2	2	1
Population mobility	2	3	0	2
Lack of social support	2	2	1	2
Substance abuse	1	1	2	2
Rape and sexual abuse	0	0	2	3
Religious practices	0	2	0	1

Table 6: Criteria of effectiveness

	B-B	CPC	PCP	TVEP
Feedback from stakeholder groups and community members	3	2	2	2
Representation of various sectors of the community as stakeholders at meetings	2	3	2	2
Attendance at community meetings	2	2	2	2
Active seeking of information by community	2	2	2	2
External research findings	2	2	2	2
Service use statistics (example, number of enrolled beneficiaries)	2	2	2	2
Epidemiological statistics (example, STI prevalence at Primary Health Centre)	2	2	2	2
Awards	2	2	2	1
Visible sustainability in communities (for example, sustainable organised groups)	1	2	2	2
Public responses in the print media	0	2	2	3
Clinic statistics e.g.	2	2	0	2
Community turnout at special events	1	1	2	2
Invitations to train others	2	2	0	1
Adherence to ARV regimens	1	1	2	1
Positive living outcomes of HIV positive individuals	1	1	2	1
Feedback from community members via Community Radio Station	0	0	2	3
Communal and home-based vegetable gardens	1	1	2	0
Random visits to access sites	0	1	2	1
Prosecution of offenders	0	0	0	2
Case analyses (example, profiles of trauma centre cases)	0	0	0	2
Adolescent girls using dual methods of contraception	0	0	2	0
Stakeholder attendance at weekly reporting meeting	0	0	2	0
One-on-one discussions with beneficiaries	0	0	2	0

Table 7: Indicators of effectiveness

	B-B	CPC	PCP	TVEP
Perceived reduction in levels of stigma	3	3	3	3
Attendance at stakeholder meetings	3	3	3	2
Perceived reductions in misuse of social grants	2	3	2	3
Reduction of STI at Primary Health Centres	2	3	3	1
Use of VCT services	3	2	3	0
Uptake of PMTCT	3	2	1	2
Acceptance of HIV positive family member	2	2	2	2
Number of persons on treatment	2	1	3	1
HIV positive clients accepting their status	2	2	2	1
Collection of condoms at distribution sites	0	2	3	2
Reduction in adolescent pregnancies	3	1	1	1
Perceived maintenance of a healthy diet	2	2	2	0
Collection of ARV medication	1	1	3	1
Reduced number of cases reported of gender based violence	0	1	2	3
Qualitative indicators of positive living	1	1	2	1
Perceived reduction in substance abuse	1	1	2	1
Completion of ARV readiness assessment	1	1	2	1
Positive behaviour change is sustained	1	1	2	1
Adolescent girls using dual methods of contraception	0	0	2	0
Reported reduction in multiple sexual partners (how measured?)	0	0	2	0

Table 8: Sources of behaviour change strategies

	B-B	CPC	PCP	TVEP
Integrated 'pragmatic' approach	2	2	2	1
Information and skills-transfer	1	3	2	1
Community capacity building	1	3	1	1
Training for transformation (Freireian)	0	0	0	3

Table 9: Emerging lessons

	B-B	CPC	PCP	TVEP
Involving all community structures	2	3	3	3
Skills-transfer and capacity-building	2	3	2	2
HIV positive people in organisation	3	1	3	1
Integrating programmes	2	2	1	3
Updates and ongoing training	2	2	2	2
Adapting models for local needs	2	2	2	2
Partnerships with state, municipalities and other organisations	2	2	2	2
Communities "owning" process	0	2	3	3
Developing organisational structure	2	2	1	2
Developing management capacity	2	2	1	1
Working with existing organised groups	1	2	1	2

Table 10: Challenges in implementing interventions

	B-B	CPC	PCP	TVEP
Defaulting on ARV treatment	3	3	1	3
Keeping track of beneficiaries due to population mobility	3	3	1	3
Need for funding support from the government	2	3	2	3
Disclosure to negative partner for serodiscordant couples	2	3	3	2
Involving men at all levels	1	3	2	3
More women than men present for VCT	2	2	2	2
Low rate of men seeking help	3	1	1	3
Non-attendances at stakeholder or community meetings	3	2	0	2
Obtaining and retaining skilled staff	2	2	0	2
Trained implementers leaving for other work	2	1	0	2
Social barriers in reporting rape and abuse	1	1	0	3
Divisions in community leadership structures leading to consultation difficulties	1	1	0	3
Rotation or redeployment of state service professionals (examples, social workers and magistrates)	1	1	0	3
Widening requests from the community and putting a limit on what organisation can do	2	0	0	3
Shortage of state-employed social workers	0	2	0	3
Low participation from white community	2	0	2	0
Paucity of programmes for HIV negative individuals	0	0	3	0
Insufficient training in dealing with mental health issues (example, depression)	0	0	0	3
Sustainability of support groups	0	2	0	0

Table 11: Local risk factors and community challenges

	B-B	CPC	PCP	TVEP
Negative social reactions to HIV ('stigma')	**3**	**3**	**3**	**3**
Misuse of social grant benefits by relatives of beneficiaries	**3**	**3**	**2**	**3**
High prevalence of adolescent pregnancies	**3**	**3**	**3**	**2**
Population mobility (example, migrant labour or transnational migrant people)	**3**	**3**	**2**	**2**
Poverty as a social risk factor	**2**	**3**	**1**	**1**
Economic dependency of women upon abusive male partners	**2**	**2**	**0**	**2**
Educators and/or nurses not presenting for VCT	**2**	**2**	**0**	**1**

Appendix 3: Selected Diagrammes of content analysis results

Figure 1: Comparative Aims of Organisations

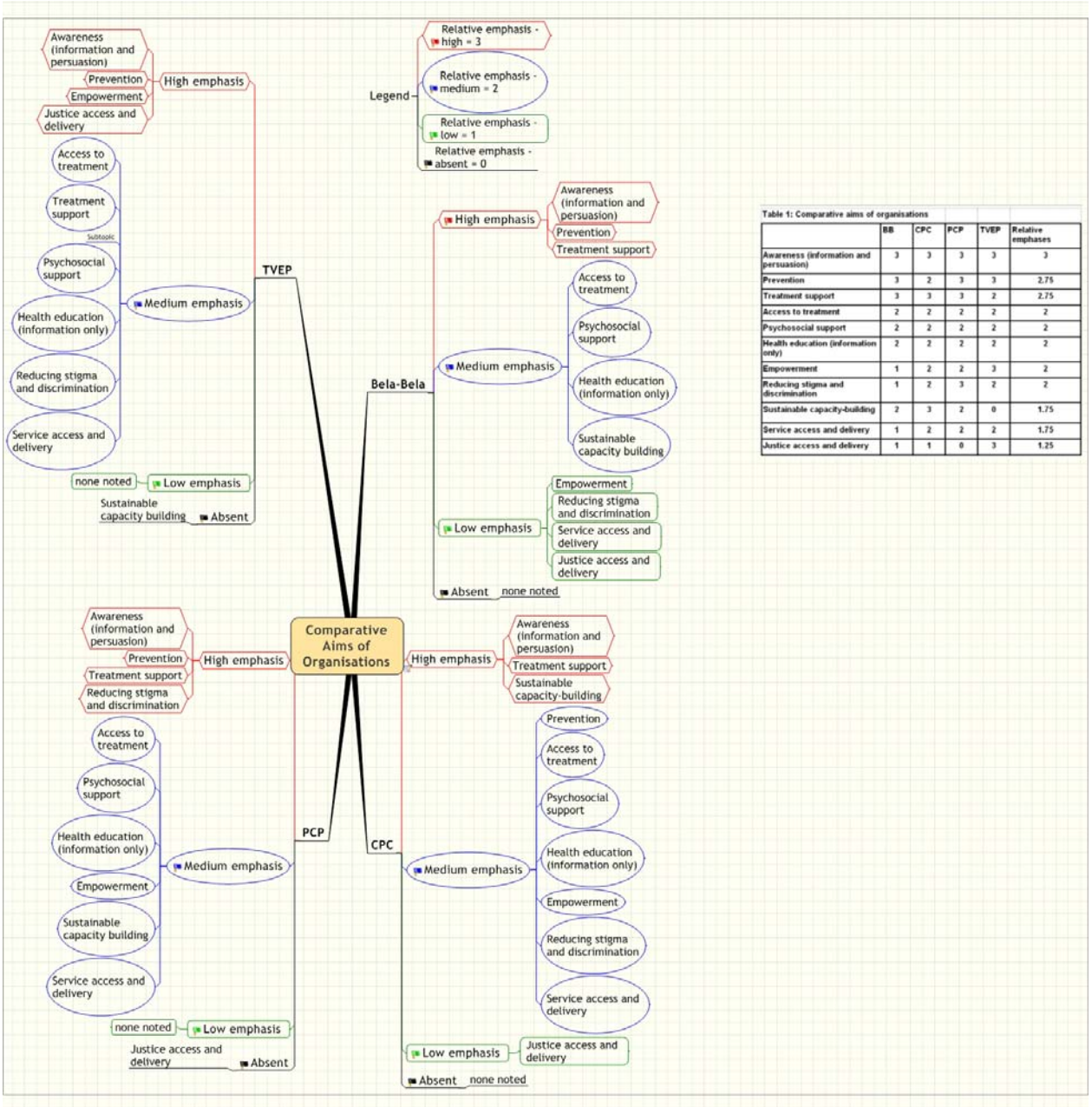

Table 1: Comparative aims of organisations

	BB	CPC	PCP	TVEP	Relative emphases
Awareness (information and persuasion)	3	3	3	3	3
Prevention	3	2	3	3	2.75
Treatment support	3	3	3	2	2.75
Access to treatment	2	2	2	2	2
Psychosocial support	2	2	2	2	2
Health education (information only)	2	2	2	2	2
Empowerment	1	2	2	3	2
Reducing stigma and discrimination	1	2	3	2	2
Sustainable capacity-building	2	3	2	0	1.75
Service access and delivery	1	2	2	2	1.75
Justice access and delivery	1	1	0	3	1.25

Figure 2: Intervention recipients

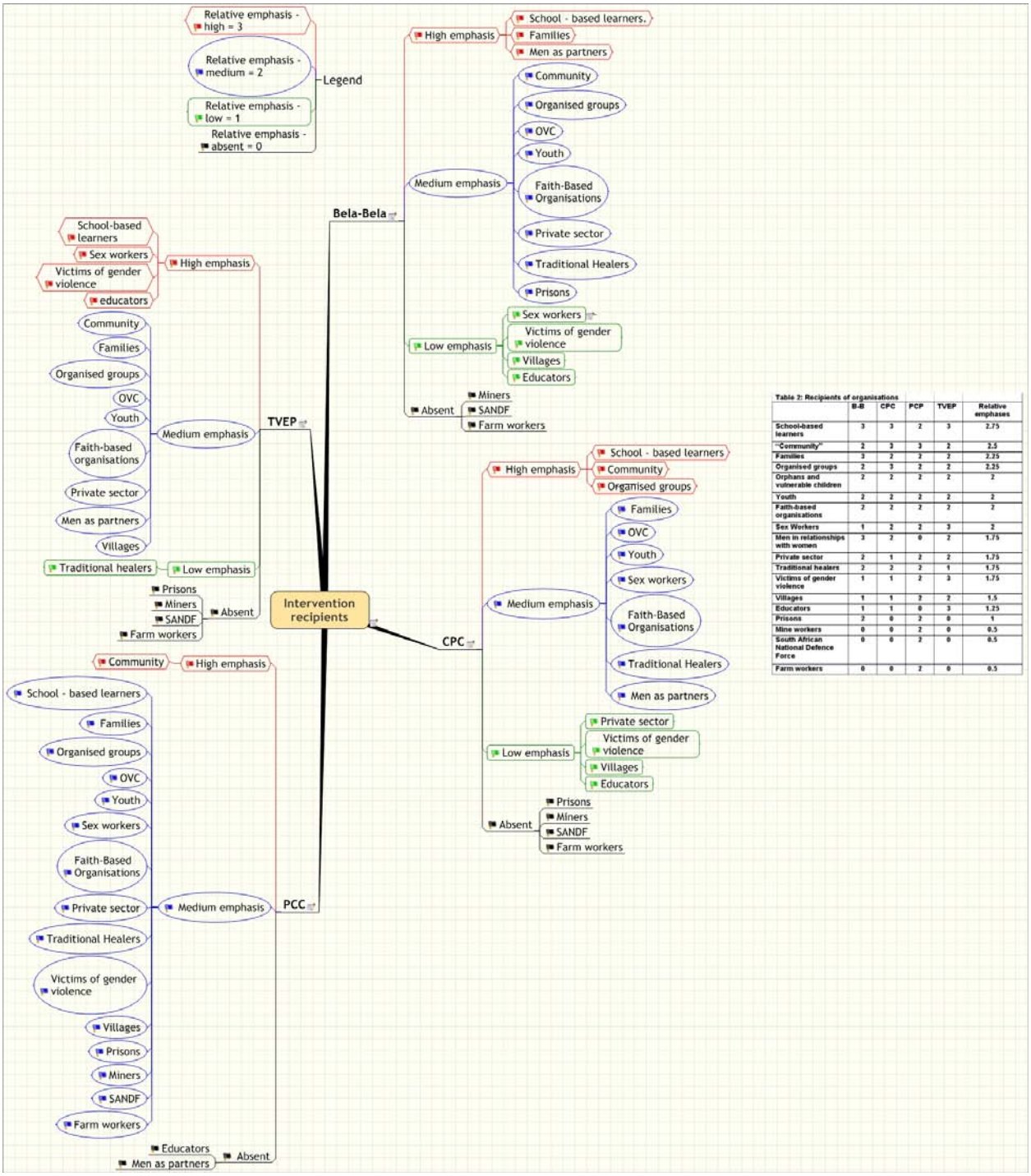

Table 7: Recipients of organisations

	B-B	CPC	PCP	TVEP	Relative emphases
School-based learners	3	3	2	3	2.75
"Community"	2	3	3	2	2.5
Families	3	2	2	2	2.25
Organised groups	2	3	2	2	2.25
Orphans and vulnerable children	2	2	2	2	2
Youth	2	2	2	2	2
Faith-based organisations	2	2	2	2	2
Sex Workers	1	2	2	3	2
Men in relationships with women	3	2	0	2	1.75
Private sector	2	1	2	2	1.75
Traditional healers	2	2	2	1	1.75
Victims of gender violence	1	1	2	3	1.75
Villages	1	1	2	2	1.5
Educators	1	1	0	3	1.25
Prisons	2	0	2	0	1
Mine workers	0	0	2	0	0.5
South African National Defence Force	0	0	2	0	0.5
Farm workers	0	0	2	0	0.5

Figure 3: Emerging Lessons

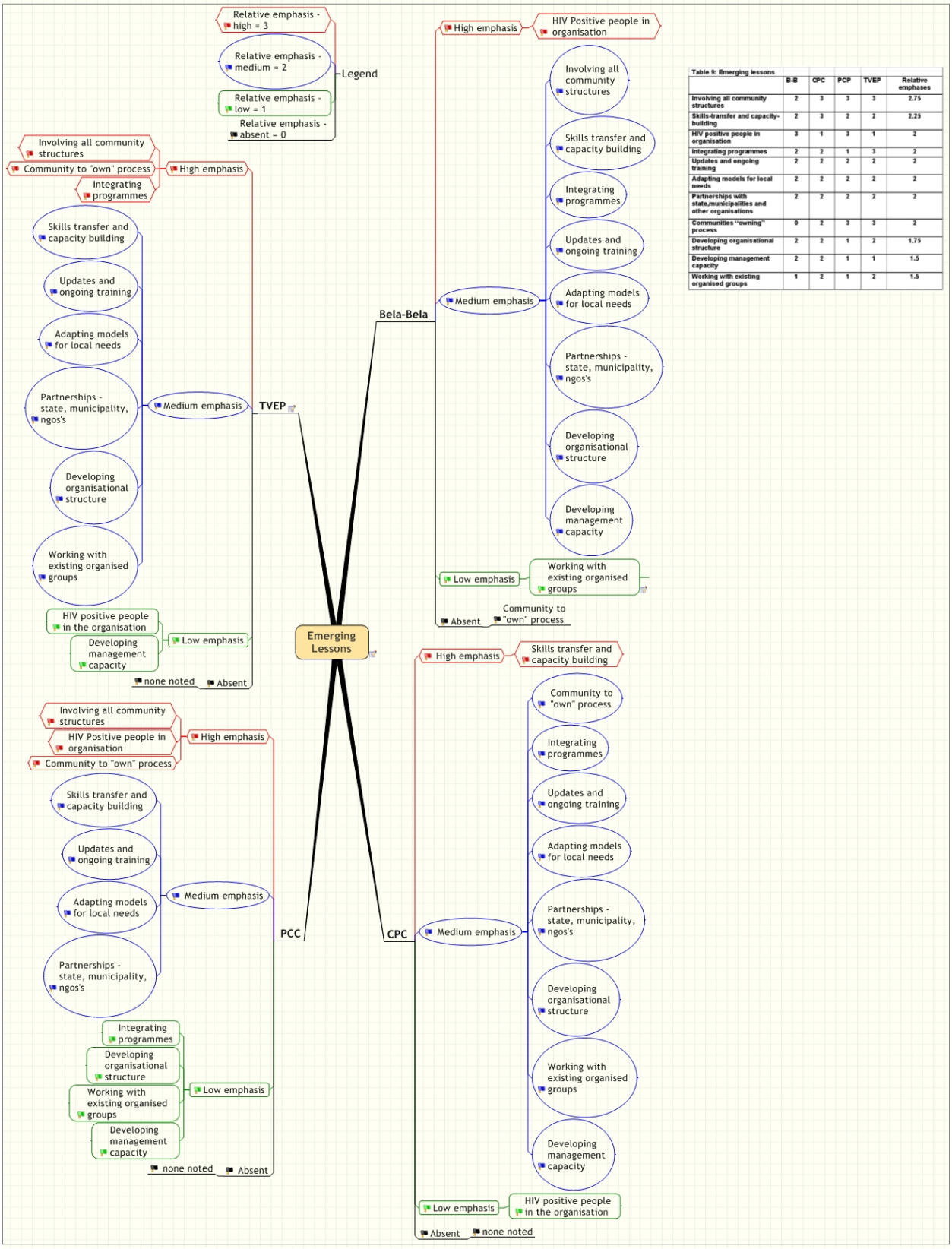

Table 9: Emerging lessons

	B-B	CPC	PCP	TVEP	Relative emphases
Involving all community structures	2	3	3	3	2.75
Skills-transfer and capacity-building	2	3	2	2	2.25
HIV positive people in organisation	3	1	3	1	2
Integrating programmes	2	2	1	3	2
Updates and ongoing training	2	2	2	2	2
Adapting models for local needs	2	2	2	2	2
Partnerships with state,municipalities and other organisations	2	2	2	2	2
Communities "owning" process	0	2	3	3	2
Developing organisational structure	2	2	1	2	1.75
Developing management capacity	2	2	1	1	1.5
Working with existing organised groups	1	2	1	2	1.5

Figure 4: Local Risk Factors and Community Challenges

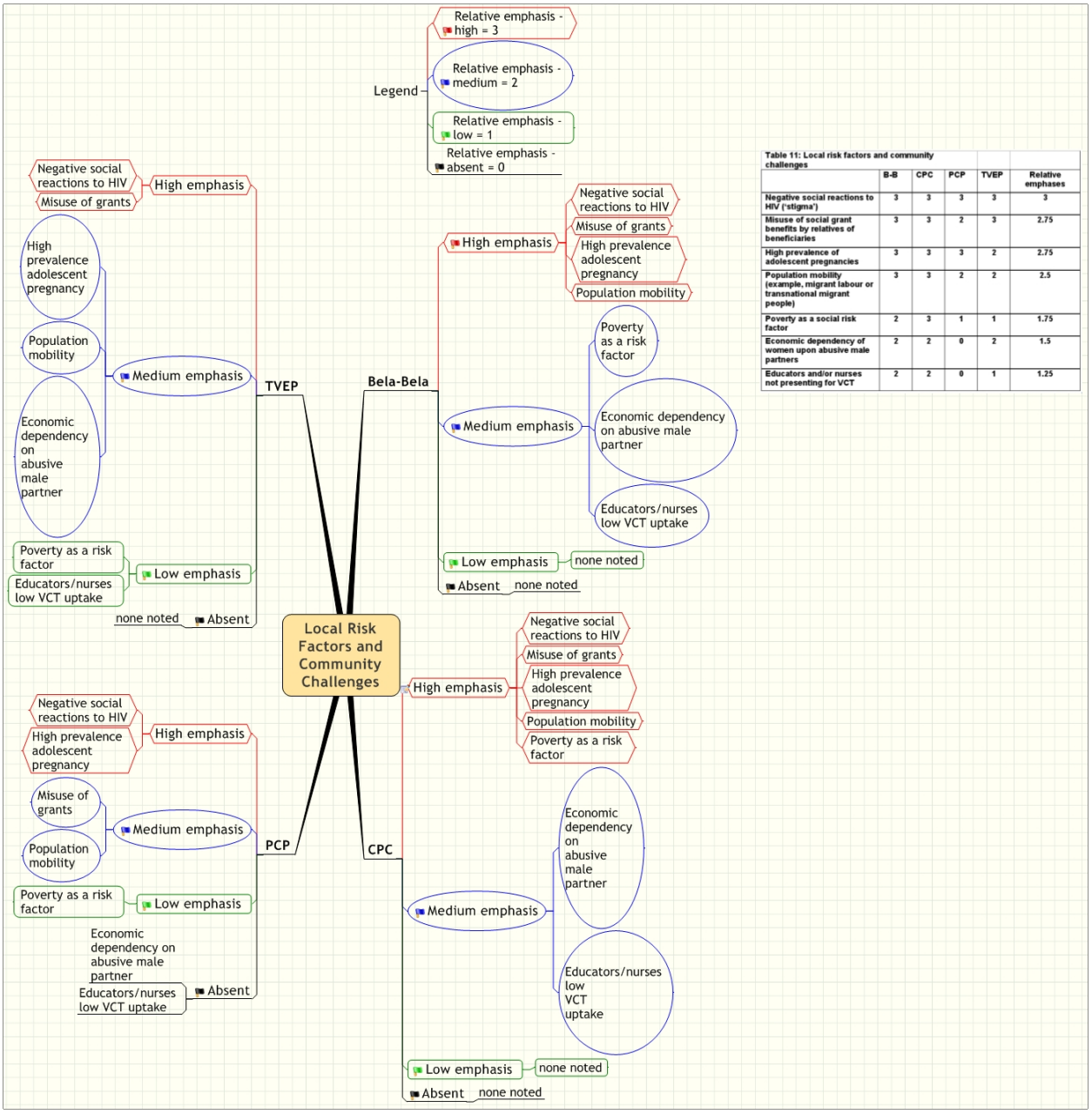

Table 11: Local risk factors and community challenges

	B-B	CPC	PCP	TVEP	Relative emphases
Negative social reactions to HIV ('stigma')	3	3	3	3	3
Misuse of social grant benefits by relatives of beneficiaries	3	3	2	3	2.75
High prevalence of adolescent pregnancies	3	3	3	2	2.75
Population mobility (example, migrant labour or transnational migrant people)	3	3	2	2	2.5
Poverty as a social risk factor	2	3	1	1	1.75
Economic dependency of women upon abusive male partners	2	2	0	2	1.5
Educators and/or nurses not presenting for VCT	2	2	0	1	1.25