

POSITIVE TRANSFORMATIONS:

Case Studies of Good Practice in HIV Interventions



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To strengthen our own programmes SAfAIDS firmly believes in documenting its own interesting experiences. We hope these case studies will however be useful in other programmes.

SAfAIDS would like to thank our national and community partners for the ongoing commitment and dedication to HIV prevention, care treatment and support.

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INTRODUCTION

Established in 1994, SAfAIDS is a regional non-profit organisation with its Regional office based in Pretoria, South Africa, with country offices in Mozambique, Zambia and Zimbabwe. In partnership with national partners, SAfAIDS currently implements programmes in Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. SAfAIDS' core activities include providing accurate and cutting edge HIV and AIDS information through a variety of innovative channels to Intermediary Organisations (IOs), to enable them to reach communities with strategic information in order to catalyse positive behaviour change that results in reducing people's vulnerability and risk to HIV.

This document presents two case studies selected from some of SAfAIDS' innovative work as a regional southern African organisation. In both case studies, it is evident that there is added value when a regional organisation works through strategic partnerships with governments and other key players in a country to implement innovative programmes; initially as pilots and then expanding and replicating them in other countries. Very often, Governments and non governmental organisations (NGOs) are so involved in fire-fighting in their own countries, it compromises the time and the opportunity to learn from other countries. Regional organisations that have a *helicopter view* of the region, are better placed to package the necessary information, learning and experiences and to facilitate their cross-sharing across countries.

With access to regional resources and technical experiences, SAfAIDS has had the opportunity to support local organisations to adapt innovative models that have been found to work in several countries. Over the years, SAfAIDS has observed that it is very difficult and sometimes impossible, to convince a government or a poorly resourced local NGO to implement new models, due to lack of technical skills and financial resources required. Regional organisations have a key role in facilitating effective adaptation and the replication and cross-learning. Regional organisations can invest their own resources to implement new models and interventions that Governments can then adopt, once impact at local level becomes evident. The roles of regional and local organisations are therefore mutually reinforcing for reciprocal benefit, and will contribute to the reduction of HIV in the region.

CASE STUDY 1:

Cascading Model for Scaling Up Access to Targeted HIV and TB Prevention, Care and Treatment Information for Behaviour Change in Lesotho, Zambia and Swaziland

A SAfAIDS Model of Strategic Partnership between Government, NGOs, Networks of People Living with HIV and a Regional Partner

1. Introduction

SAfAIDS' goal is to ensure that evidence-based HIV information is used as a catalytic tool for influencing behaviour change among the targeted populations. In the last three years, SAfAIDS has been refining its cascading methodology, as a tool for scaling up access to information and for capacity building of NGOs and Community-Based Organisations (CBOs) to reach communities with targeted HIV information.

The Cascade Model (see Figure 1.) goes beyond simply producing HIV and TB information, by providing capacity building activities such as training of trainer's workshops and skills building sessions to service providers, to catalyse effective uptake of the produced materials at national and community level.

The Cascade Model has **10 key steps** that must be followed to ensure its success:

1. Identify the **area for capacity development** as defined by partner and country/regional information needs.
2. Develop capacity development **tools and materials** (training manuals, toolkits and handbooks).
3. **Mobilise** the relevant Government department responsible for the area of focus, share the model and capacity development materials and sign a **Memorandum of Understanding (MOU)**.
4. Obtain **Government endorsement** of materials for use in their country.
5. **Translate** materials with the support and leadership of the material adaptation team for that country.
6. Select **in-country, scale-out partners**, based on the SAfAIDS set criteria and in-country consultations. The SAfAIDS Partner Selection Criteria considers whether the potential partner has:
 - The potential for multiplier effect
 - Strong linkages with grassroots communities
 - Credibility among its beneficiaries and stakeholders
 - A commitment to a serious formal collaborative partnership with SAfAIDS.

7. Organise a partner **consultative meeting** to share the project process and materials with selected partners. Sign MOUs with partners.
8. Conduct the first **national training** of trainers.
9. Support **subsequent trainings** by partners with materials and technical support - the cascading approach.
10. Establish a **monitoring and evaluation** system (develop a database for tracking the people trained and beneficiaries reached at community level). Conduct impact assessments of the programme with partners and beneficiaries to assess knowledge, behaviour and changing practices.

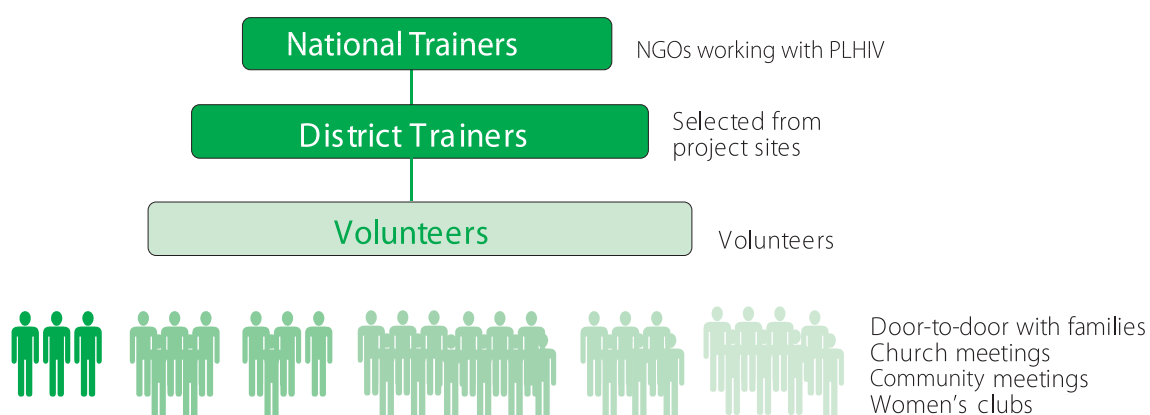


Figure 1. SAfAIDS' Cascading Model

The benefits of this approach include :

- Larger pool of trainers developed within a short period of time
- Standardised training, ensuring uniformity of skills and knowledge sharing
- Multiplier effect begins to take effect
- Cost effective in the long run
- Sustainability ensured as skills and knowledge remain within communities
- Critical mass of trained and capacitated people at community level
- Large pool of beneficiaries reached without necessarily printing more materials.

2. Project Inception and Description

In 2004, SAfAIDS launched the Cascading Model for scaling up access to information in Zambia. This was part of the programme to **complement Government efforts to scale up uptake of antiretroviral therapy (ART) through enhanced community preparedness and advocacy**. The programme was in line with the Government's response to a global call by the WHO and UNAIDS to reach 3 million people with antiretroviral therapy (ART) by 2005.

One of the key strategies outlined in the Country Strategic Plan was to build the capacity of 13,000 non-health workers in treatment literacy to enhance access to voluntary counselling and testing (VCT) and ART for 130,000 people by 2008.

In spite of Government efforts to reach this target, uptake of both services remained very low, due to stigma and discrimination, lack of adequate knowledge among communities regarding the benefits of ART, and low adherence to ART due to lack of information about side-effects. SAfAIDS' project was therefore designed to address these challenges.

2.1 Key project components

The project combined the following five interventions/strategies that built on each other to achieve the desired results:

- Production of HIV and TB **materials which were translated** into local languages and endorsed by the Government
- Cascading approach to **build the capacity** of partners and community volunteers in disseminating HIV and TB information
- Policy Dialogues to **influence policy by enabling civil society, people living with HIV (PLHIV) and communities to engage** in dialogue at national and community level to address policy barriers to accessing treatment
- **Use of community radio** to complement the work of community-based volunteers (CBVs) by disseminating the same information and mobilising people to seek counselling, testing and treatment
- Creation of **documentation and information sharing platforms**.

2.2 Strategic partnership (SAfAIDS, Government of Zambia, Network of PLHIV and Civil Society)

The project was deliberately designed to work through strategic partnerships. SAfAIDS signed MOUs for partnerships with the Ministry of Health, the Zambian Network of People Living with HIV and three large national NGOs working in at least 16 Districts with the highest HIV prevalence in Zambia. The role of SAfAIDS in the project was to build the capacity of the selected partners in community preparedness for ART, using the Cascade Model as well as to; provide targeted information kits and offer overall technical support to partners.

The Government's mandate was to oversee the roll-out of the project through the Government structures and create an enabling environment through the provision of effective policies and frameworks that ensured that the demand for services was met. In turn, NGOs were responsible for project implementation, which included training of trainers, and follow up and support to volunteers during door-to-door visits to educate the community. The Zambia Network of People Living with HIV (ZNP+) was expected to play a watchdog/monitoring and advocacy role to hold Government accountable for the delivery of quality and universal HIV treatment services for people living with HIV. In addition, ZNP+ would be involved in the training of its own members to influence scale up within its constituencies.

2.3 Applying the Cascade Model

The project worked in 16 districts through the ZNP+, the Catholic Diocese Home Based Care Programme and the Salvation Army. The partners selected had a large pool of volunteers providing home-based care to PLHIV at community level. SAfAIDS aimed to reach communities with information on HIV, including VCT and treatment in the most efficient and cost effective manner.

The Cascade Model was successful in reaching large numbers of people with information, in the shortest time possible, and in a sustainable way. Using the materials and toolkits developed by SAfAIDS in partnership with Government and the National AIDS Council (NAC), SAfAIDS trained the first group of national trainers who returned to the districts and trained CBVs. After training, the volunteers were equipped with toolkits from SAfAIDS, which they used to educate the community using a door-to-door approach. The door-to-door approach was not new for volunteers as they were already using it in the course of their home-based care work. In the Cascading Model, each volunteer aimed to visit households twice a week, to provide education on HIV prevention, testing and treatment. In the process, they referred people to local Health Centres.

Due to the success of the project, Health Centres now refer clients to CBVs for adherence support. On average, each CBV reaches at least 10-20 people per month.

3. Why this Programme is a Good Practice?

3.1 Effectiveness and Impact

3.1.1 Partnerships

As was observed later in the project, the strategic partnership between Government, NGOs and PLHIV was the cornerstone of the success of the project. By working closely with all the key players, the project ensured that it was responding to Government priorities and needs, reducing the risk of duplicating efforts and wasting resources, strengthening the relationship between the Government, civil society and PLHIV through improved transparency and increasing ownership of the project and its outcomes by Government. The national/regional partnership provided opportunities for sharing information and resources with each partner contributing in a way that added value to the whole process. While SAfAIDS provided the information and technical resources, the local partners had the much needed linkages with the communities, including volunteers. The network of PLHIV ensured the meaningful participation and capacity strengthening of PLHIV.

This combination of relations in a highly co-ordinated and deliberate manner led to the huge success and impact achieved by the project. According to the Governments: *“partnering with a regional organisation enhanced the quality of information disseminated and brought opportunities for us to learn from what other countries in the region were doing to scale up access to treatment. Treatment was a very new area for us, particularly around the challenge of mobilising communities in order to increase access.”*

3.1.2. Impact of the Cascading Model in reaching out to communities

Table I below describes SAfAIDS' Cascading Model with its scale-out partners and its ability to reach out to large numbers of people on the ground.

Table I: SAfAIDS Cascading Model

Country	Number of National Trainers	Number of Community Based Volunteers trained at district level	Number of people reached at community level through door-to-door visits
Zambia	420	5,582	130,000
Lesotho	15	225	3,000
Swaziland	18	420	8,400
Total	453	6,227	141,400

* Figures as of 30th of June 2009

3.1.3. Impact of Cascade Model in changing behaviour and practices

- **Increasing access to VCT and ART through increased knowledge**

In Zambia, the project's achievements are documented in an impact assessment done in 2008. It was observed that in all the districts in which the project was implemented, the number of people accessing VCT and ART had increased significantly by 2008 due to the following reasons;

- **Good understanding of ART,**
- **The process of accessing treatment and importance of adherence,**
- **Reduction in stigma and discrimination,**
- **Increased openness in accessing treatment**
- **Reduction in stigma and discrimination**

Similar impact of the SAfAIDS work has also been reported at community level in Lesotho. A recent internal evaluation of the programme, which utilised information from Focus Group Discussions (FGD's) and interviews with members of partner organisations and beneficiaries revealed that SAfAIDS' approach to treatment literacy through the Cascade Model has been effective. By training community volunteers who conduct door-to-door visits with HIV information, SAfAIDS and its partners **have been able to break barriers around language, culture, stigma and discrimination.**

*"Through the programme, people's attitudes are changing; people come for testing and are willing to speak out". - Female, Phelisaneng Bhopelong
Member, Leribe, Lesotho*

A Municipal Counsellor in Leribe District, highlighted that the reduction in stigma and discrimination was a success of the programme in her area. Phelisaneng Bhopelo (partner supported by SAfAIDS) volunteers who conduct door-to-door visits and attend community gatherings to talk about HIV find that community members are more open about HIV and willing to seek testing and treatment.

One client in Zambia explained,

"Previously you would have to look over your shoulder, if you were entering a clinic, but now we have queues everywhere and no one cares if you are there for treatment."

- **Referrals to and from health centres**

CBVs are playing the critical role of referring people to clinics for testing and to access ART. CBVs often accompany patients to make sure they go to the clinic, a role which is appreciated by the clinics. Most clients interviewed mentioned the CBV as their main source of reliable information on HIV. One clinic officer in Zambia stated that:

"The cadre/volunteer trained in the project is not only going door-to-door educating clients, but is also referring clients to us. We are now overwhelmed by the number of people wanting to be tested so they can access treatment. In return the Health Centre is now referring clients to CBVs back home for on-going support and follow ups."

- **Client follow up and adherence support**

The Government clinics reported that now they work closely with CBVs to provide not only adherence support, but to follow up clients on treatment who live in remote areas, to avoid defaulting and treatment failure. The Government structures are too resource-constrained to provide this kind of support and therefore, they rely on reports by CBVs and referrals of clients. Clients who had been reached by the CBV had many testimonials to share about how they have benefitted from the CBV's work.

- **Positive prevention**

Positive prevention education has become an important part of the information disseminated by the CBV. The toolkit from SAfAIDS contains both male and female condoms. The clients mentioned that when the CBV visits them they talk a lot about positive living and how to prevent further infection by using condoms. They also demonstrate how to use condoms effectively. The CBV also refers clients to support groups, so they can get encouragement from others who are living with HIV.

"For SWAALES, I knew SAfAIDS was the organisation to work with - because of their facilitation skills, empowering programmes, materials and technical support...it was a pleasure to work with SAfAIDS." - **Dr. Rathabaneng, founding member of the Society for Women and AIDs in Africa Lesotho Chapter (SWAALES), currently with Baylor's Children's Clinic.**

“Since the visit from the LENEPWA trainer who taught me about HIV treatment and adherence, I have become a treatment buddy to three people. It has helped me because it reinforced what we are told at the clinic.”
- HIV positive female beneficiary, the Lesotho National Network of People Living with HIV and AIDS (LENEPWA)

3.1.4 Impact of combining strategies for mutual reinforcement

- **Influencing policy and strengthening partnerships through dialogue**

Policy Dialogues were held both at national and community level by all partners in the project. This process brings together policy makers from Government, Civil Society and PLHIV to debate selected policy issues affecting the delivery of HIV related services. The dialogue provides policy makers with opportunities to listen to the needs of the affected and to respond to and find solutions together, which each party must commit to addressing.

In the national dialogues, SAfAIDS assumed the role of convenor and facilitator. Because of its position as a regional organisation, SAfAIDS was viewed by all partners as neutral and as playing an arbitration role. As a result, the meetings attracted policy makers from the highest level within the Ministry of Health who, after a while, commented on the usefulness of the meetings in strengthening partnerships and collaboration between all the major players.



A story from a client living with HIV in Zambia

At the end of 2006, I started being ill. I was on and off with many diseases. In February 2007 I became bedridden for six months. A CBV from Mpongwe called Brenda Mulenga visited me after being sent by my sister. When she came I did not want to talk to her as I was convinced that I was bewitched. I had tried everything and nothing seemed to work.

When Brenda came to visit she came with her little bag (referring to the SAfAIDS toolkit on treatment literacy). She put in an audio cassette from the kit and asked me to listen. The tape talked about HIV testing and treatment. Afterwards the CBV talked to me again and encouraged me to go for testing. On a Monday, Brenda, the same CBV, accompanied me for testing. The test showed that I was positive and my CD4 was 150. I was put on treatment there and there.

Today I am healthy and happy thanks to Brenda; otherwise I would have died a long time ago. I am not the only one that has benefitted in this village.

Figure 2: Community volunteers trained in treatment literacy by SAfAIDS in Zambia

The structure and moderation of the meetings facilitated dialogue in a respectful but productive manner that yielded positive results. Some of the pertinent issues addressed in the dialogues were on the hidden costs of ARVs, the need to increase ART clinics and to expand access to treatment for children. As a result of these dialogues, there was a dramatic increase in the number of ART centres from 2006 to 2008. Zambia increased access for children and the cost of ARVs has significantly reduced. Overall, the dialogues have improved the relationship between the Government and PLHIV and civil society, as well as the advocacy capacity of PLHIV.

- **Community Radio Programmes increase access to information and services**

Through the project, the capacity of community radios to disseminate HIV information was strengthened. At least seven community radio stations with a listenership of between 2,500 and 2.5 million were supported to package and disseminate HIV information. The impact of these programmes was reported by Chikuni Health Centre in Zambia, which reported an increase from 400 people on ART at the beginning of 2007 to 1,400 by the end of the same year. The CBVs complemented the radio programme and vice versa, by visiting the hard-to-reach populations that are often not reached by the Health Centre. Table 2 (below) is from a survey conducted on people they listened to the radio program before and after.

Table 2: Change in Attitude towards VCT and ART

Attitude	Before				After			
	Towards VCT		Towards ART		Towards VCT		Towards ART	
	Count	%	Count	%	Count	%	Count	%
Positive	10	5.9	7	4.1	165	97.1	152	89.4
Negative	160	94.1	163	95.9	5	2.9	18	10.6
Total	170	100.0	170	100.0	170	100.0	170	100.0

Material production and dissemination adds value to Country programmes



Figure 3: Trained community volunteers from Phelisaneng Bhopelong displaying the SAfAIDS treatment literacy toolkit (Lesotho)

One of the strategies SAfAIDS used to support communities was used to produce HIV treatment literacy toolkits and materials. The materials were developed in conjunction with the Ministries of Health in Zambia, Lesotho and Swaziland, who authenticated and endorsed the quality of information contained in those materials and ensured that they conformed to what was pertaining in the country. The materials were developed with different community target groups in mind. These included materials for community trainers and an advocacy campaign guide, which was developed for treatment access advocates. It contains information on how to engage in advocacy. SAfAIDS HIV treatment literacy toolkit for communities, included several leaflets, booklets, an audio tape and two condoms (a female and male condom) for demonstration. This was developed for CBVs who were carrying door-to-door out activities at community level.

The impact of the HIV training materials produced in the programme was evident during the Focus Group Discussions with Government, NGO partners, CBVs and clients in Zambia. The training materials had been used extensively to train over 6,000 CBVs who now have the competence to mobilise and educate the community on ART. The treatment literacy toolkit was the most appreciated and well known material in the community. This may be due to the visibility of the bag that volunteers walk around with - but it was also appreciated because it contains lots of easy to read leaflets and other useful materials that PLHIV found very helpful, such as suggestions on how a person can keep track of taking their HIV medication. The fact that the materials and the audio tape were in local languages for the three countries contributed to them becoming a useful communication tool available to the CBVs and communities and ensured that even those with low literacy levels had access to the information.

While most National AIDS Councils/ Programmes have a mandate to produce materials, they do not always have the capacity or the resources to do so. SAfAIDS' expertise in producing quality and relevant materials in a timely manner was appreciated by both the Government and local partners. The strategic position of SAfAIDS globally and in the region ensured that the information packaged is accurate and up to date, which helps local organisations to update their own programming. According to one clinic officer in Zambia,

“SAfAIDS is the first organisation to provide materials in local languages that explain HIV in detail, including VCT and ART for our catchment area.”

Feedback from community volunteers and beneficiaries in Lesotho also emphasised that SAfAIDS training and follow-up materials gave the volunteers confidence to discuss treatment information, but also seems to have given beneficiaries confidence in the volunteers as a source of quality HIV information. This is because the information was perceived to be 'confirming' or 'reinforcing' information being provided by the government (through the Ministry of Health) and other health professionals.

“When you go through the books and read to patients - there is better trust. What information we get from the materials matches with the clinics' information. This is an important finding, as partner organisations have reported high level of suspicion, denial and disbelief about HIV within Basotho communities. With SAfAIDS materials, SWAALES has also used the information on treatment literacy to engage traditional leaders and healers in HIV prevention and treatment literacy.” - **SWAALES Member, Pitseng**

“The information from SAfAIDS influenced the local herbalists in Leribe district and Berea, regarding the information they tend to be secretive about, because ART providers generally counsel against existing herbs. ART was well received and as a result most clients in their area improved condition.” - SWAALES Presentation; Partners Feedback Meeting (Feb 26-28, 2009)

3.2 Sustainability

The project was designed to be self sustainable at country level right from the point of conceptualisation. A number of key processes undertaken during project implementation demonstrate this objective, including; country ownership and commitment was built into the project through the careful architecture of partnerships between SAfAIDS as a regional organisation, and the in-country key players of Government, PLHIV and civil society in each of the three countries. The MOUs signed clearly articulated the key roles for each partner, signifying the high level of commitment to the project and how much governments viewed the project as adding value to their existing programmes. The programme activities had a natural synergy with already existing government plans and efforts, playing a complementary rather than a competitive role. An important fact is that while the project requires large resources at the beginning, in the longer term, the costs go down by 50% or more, once the level of implementation really takes off. The CBVs that are the backbone of the model are not paid, which significantly brings down implementation costs. All these processes had already established a positive stage for the continuity of the project in one form or another.

Because of the high impact of the Cascade Model, some of the partners involved in the project in Lesotho, Swaziland and Zambia, have continued the activities initiated by the project with funding from other sources. In Zambia the Government has sourced funding to support SAfAIDS to expand the project to the remaining districts. A key observation is that where a partner has failed to secure other funding sources the work by the volunteers has continued, as they already have the skills and toolkits they need, as well as recognition of their skills within their communities. There is also clear evidence that the model can be used in a variety of thematic areas and settings with very little modification required. The cascading methodology has proved that it is low cost, can yield high outputs and is sustainable, which makes it worth replicating in other countries in the region.

4. Risks

Currently the major risk for SAfAIDS and all its programmes in the region is the effect of the global recession and the potential shift in priorities for many donors and countries.

Sadly, the need for information to assist individuals and communities to make informed decisions remains critical if we are to achieve the Millennium Development Goal (MDG) 6, which aims to halve all new infections by 2015. Failure to fill this information gap will almost certainly reverse any gains made to date; new infections will emerge while those already infected may die from ignorance associated with lack of adequate and strategic information.

To date, SAfAIDS is the sole organisation in the region whose primary focus is HIV information production, repackaging and dissemination. In the last few years, SAfAIDS succeeded in its goal to scale up information dissemination in the region by using multiple innovative approaches, including the Cascading Model to reach out to communities. Scaling down will have serious negative impact on countries and CBOs that rely primarily on SAfAIDS for information to build their own capacities to respond to the epidemic

While the activities may continue through local partners, in the absence of SAfAIDS support, the materials will soon become outdated and the volunteers will lack access to new information and updated skills. In many countries there are no clear mechanisms for updating volunteers and local NGOs with new information and skills, and countries in the region and beyond, rely on SAfAIDS' technical skills and materials to adapt to their own situations. The communication of strategic information needs to continue to scale up.

SAfAIDS has responded to this by building the capacity of national organisations and governments to develop their own materials. However, the process has not yet yielded positive results for a number of reasons; there is a very high staff turn-over within governments, and as resources dwindle and needs grow, very few governments in the region will put resources on information production and dissemination even if the need exists.

5. Challenges

- ***Volunteer Management***

SAfAIDS chose its partners because of their comparative advantage in using volunteers. This was important as the project was intended to capacity build and support strategic partners with knowledge around treatment. There was no intention on the part of SAfAIDS to create its own structures at community level. While this was communicated to partners, it seems not to have been understood to the same extent that SAfAIDS understood it. As a result, the volunteers at community level had a lot of expectations for 'double benefit'.

6. Conclusion

In general, the project has had positive impact at community level. Not only did it manage to increase people's knowledge on HIV treatment, it also created space for community members to engage in policy discussions with Government and local leaders. The project not only contributed to the national ART scale up plan of the Ministries of Health, as well as contributed to the implementation of the National AIDS Strategic Framework and to achieving universal Millennium Development Goal Number Six which focuses on health and HIV and AIDS.

The approaches used by SAfAIDS constitute good practices for increasing community engagement in enhancing treatment literacy and the capacity of communities to support people on treatment. The engagement of communities through cascade model was innovative. It built the skills of people at community level and ensured that those skills were put to good use to reach more people. The strategy of combining information development and dissemination, community engagement through training and support and partnership building between Government and civil society actors was very strategic and useful in complementing the national efforts of ART scale up.

CASE STUDY 2:

Changing The River's Flow Programme - Transformative approach to addressing gender inequality and promoting behaviour change in Seke district of Zimbabwe

A partnership project between SAfAIDS and Seke Rural

1. Introduction

Seke is a peri-urban community situated about 50km to the south-east of Harare. The district has a population of 1.5 million people. The people of Seke are generally poor, with most making a livelihood from growing vegetables and selling them in Harare. The area has been hard hit by HIV firstly because of its proximity to Harare and secondly it is affected by the same issues fuelling the epidemic in the whole country. Seke Rural had been running home-based care programmes in Seke for many years and had over 800 community-based volunteers already working in the community. Due to the success of its home-based care programme, Seke is well-known and respected by the community and government.

1.1 Project Start Up and Description

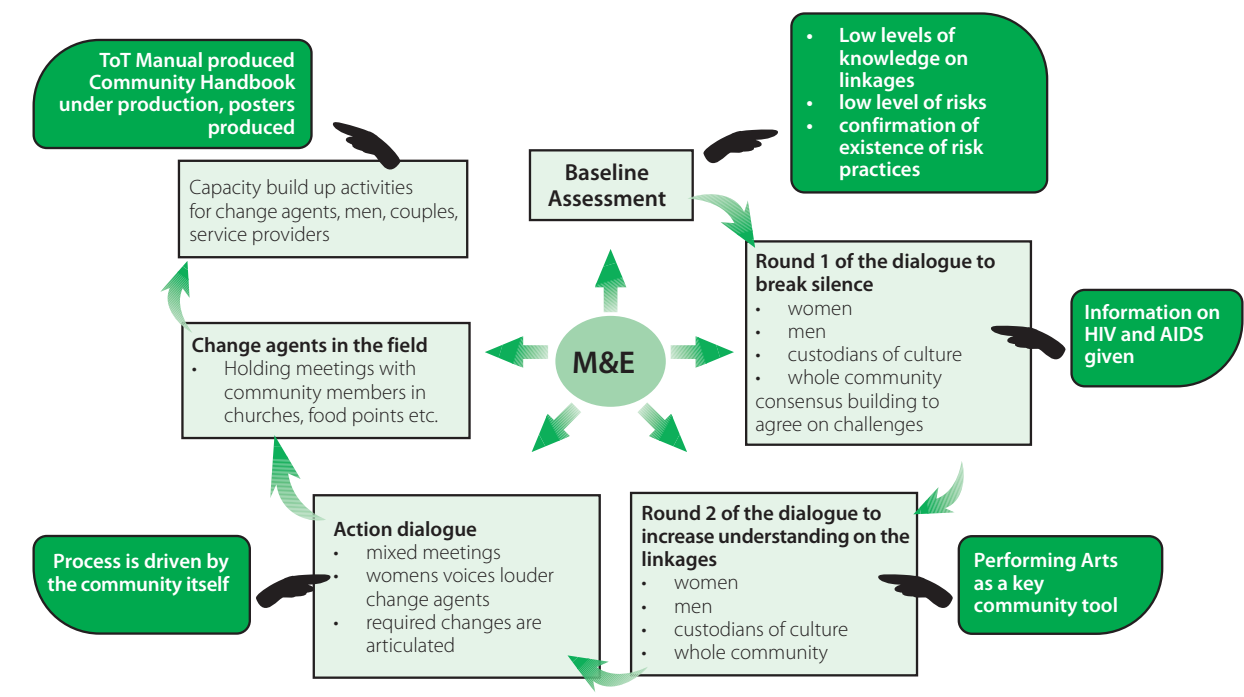
In 2006, SAfAIDS partnered with Seke Rural Home-Based Care Community Hospice (popularly referred to as 'Seke Rural') to launch a two-year pilot project that would work differently with communities by focusing on gender transformation as a way to fight HIV and promote behaviour change. The interventions support and build community capacity to reflect and critically think about those practices that fuel gender inequality and HIV, and how the community itself would bring about the required positive behaviour changes within the context of culture and tradition.

The project intervention targeted eight (out of 21) wards in Seke district. The methodology consisted of three rounds of culture dialogues. Each round took four weeks and included dialogues with women (week one), men (week two), custodians of culture (week three) and the whole community (week four), in that order. At the end of the rounds of dialogues, a community gala officiated by the Minister of health was organised and attended by more than 2,000 people. Mobile testing and other HIV-related services were provided by different NGOs from that community. More than 50 people were tested with support from the whole community.

At the last dialogue, held a year from project inception, the Chief, in his closing remarks, concluded, by sharing with the community his own opinion of some of the practices in the community.

He emphasised the need to do things differently "now that we are informed." To ululation and screams of joy from all the women present, he pointed out that any woman who is forced to have sex must seek recourse from the community court presided over by the chief and his aides, most of whom had been part of the dialogues. He spoke openly about HIV and the need to be faithful to one partner, stating that even though he has the power to marry many wives, he will stay with one wife. He repeated the call from his people for the project to provide testing services and to expand the project beyond the eight wards. He indeed provided the leadership and role modelling that the community needed.

Figure 4: SAfAIDS Model of Culture Dialogue Series



2. Why Is This Project a Good Practice?

According to SADC, an organisation is a best or good practice when it has been successful in at least seven areas. In our evaluation using the set criteria, this project scored above 80%, implying that it is indeed a best practice. But a good practice is probably best described through the voices of the beneficiaries; the project had tried new interventions and succeeded.

“This project has been helpful. In Seke, men and women have grown to like this project. We have seen its results”- Female project beneficiary, Seke

“As women, this project has helped in our households as we can now discuss sexual issues with our husbands. Our husbands are now more accepting of condoms in the household” - Female project beneficiary, Seke

2.1 Effectiveness and Impact

To measure effectiveness, the project objectives were compared with the project outcomes. The CTRF aimed to mitigate the impact of HIV and change behaviours through addressing gender relations and women's rights. There was unanimous agreement from all informants, including Government, that the CTRF had significantly improved the well-being of women in the target communities and had led to increased safer sexual practices. This effectiveness was largely indicated by numerous testimonies and by the observation that the participants were enthusiastic about the project's success. In the mixed male and female focus group discussion, some of the women did indeed speak up, even though two headmen were present, indicating success, since in the past, this would not have been possible.

The following list outlines the key successes of the CTRF series.

- ***Changing harmful cultural practices***

Several informants cautioned that cultural change was a slow process and that whilst progress was being made, it was not universal. Nonetheless, there were stories of positive change:

“We do not want to hurt anyone. We know we cannot cure HIV. We cannot cheat about this, as it is obvious. Now, instead of suggesting an afflicted man sleep with a virgin, we tell him he must go to the clinic to get ARVs.”

- Traditional healer, Seke

As regards the most contentious practice of appeasing spirits by offering a young girl, it is becoming common for a traditional healer to suggest that money or cattle, rather than a girl child, be given to appease an avenging spirit. Not everyone agrees with this position but it is encouraging to see that the community agreed to at least test the idea. Similarly, there is growing disapproval of practices such as wife inheritance - marrying a dead husband's brother; 'small houses' and polygamy. Where these practices are still being followed, the parties now determine their HIV status beforehand. If either tests positive, they cannot go through with the ceremony. It has been observed that there now seems to be more respect than contempt for women who refuse to be inherited, as was the case previously.

Gender-based violence is being discouraged and the chief has encouraged women to report cases of abuse. The change agents are also playing an important role in counselling couples to have better relationships and creating awareness about the existence of the Domestic Violence Act. Political leaders, such as the local woman MP Tracy Mutiniri, have spoken very strongly to the community about domestic violence. Greater communication also seemed to have benefited women whose husbands have multiple sexual partners (perhaps they have a 'small house' or other wives) as they reported that they can now talk about condom use, where they were unable to do so before.

Paralegal advisors are also providing the Seke community with an understanding of the differences between customary and civil law and allowing them to insist on women's rights of inheritance upon the death of the spouse, as well as on the importance of writing a will. Work has also increased on disseminating the Domestic Violence Act that protects women against gender violence.

- ***Increased acceptance of and demand for condom use***

It was claimed that men have generally become less reluctant to wear condoms. The greatest challenge was in persuading men to use condoms in the marital home to protect the wife, but even here, there were claims that improvements had been seen. The project implementers were also distributors of condoms and they reported an increased demand for the female condom, indicating greater autonomy of women over their bodies. They also reported an increased demand for the male condom.

- ***Enhanced communication around sexuality***

Women are now being given greater freedom to participate in discussions about sex, in the home with their husbands and in the communities, even in front of headmen. The chipangamazano community advisors (also called change agents) many of whom are women, reported that the headmen often gave them a platform at community meetings to talk about the dangers of certain cultural practices. A woman recounted the following story that shows not only a general community acceptance of the need for men to use condoms in marriage, but also the ability of a woman to discuss issues of sexuality with a male in authority, in this case, the headman. Such a discussion would previously have been unimaginable.

“I was married to a man who everyone knew had many other partners. When he went away to work for a time, I knew he would not be faithful. So, when he returned home I told him he must use a condom, but he refused. I went to the headman and told him my problem. The headman agreed with me and spoke to my husband, asking him to use a condom. My husband refused, and in the end I had to divorce him and the headman agreed. My husband has since died, so if I had stayed with him, I would also be dead.”

- Woman from Seke

A nurse with Seke Rural, who had lived and worked in the area for 30 years, described how she had recently sat in on a workshop discussing the use of condoms, as part of the support group service offered, and was amazed at how freely the women talked about sex. One implementer noted, *“Just the dialogue in itself is a success”* because it was a move towards openness in communication.

Finally, one of the success stories held up by the community was that of the marriage of a couple who were both open and outspoken about their HIV positive status. The fact that they felt secure and confident enough to share their status and had even married, indicated that the stigma against those who are HIV positive was being broken down, as are the barriers to communication between the sexes. In the past, spouses had preferred to keep their HIV status secret, even from each other (Mamimine et al, 2007). The husband in this example also stressed that he considered his

wife his partner and that they came to joint decisions in their household. His wife explained how the project had helped them communicate better so that they could now offer each other greater psychological support.

- **Access to information about HIV**

A beneficiary - an unmarried female youth in Seke - explained how the Changing the River's Flow series had provided women and men with the same education on HIV and said this had given her confidence to insist on safer sexual practices with her partner.

“Before, I did not want to say yes, but I had to, because I did not have knowledge. Now I know I have rights, I know what is safe and I can say no if I want.”

- Unmarried female youth, Seke

2.2 Relevance

The relevance of the Changing the River's Flow cannot be questioned. Its overall goal of reducing HIV through addressing key drivers of the epidemic is in line with the Zimbabwe National Behaviour Change Strategy. Not only was a comprehensive baseline survey carried out, but the positive reception of the project by the community and their call for it to be scaled up indicate that it was extremely relevant. This project was timely; it came at a time when the community was tired of the usual HIV and AIDS workshops of yesteryear and was yearning for something fresh. The fact that the project used culture as an entry point instead of churning out the usual messages made the dialogues more exciting and relevant to the community.

2.3 Cost-effectiveness

The whole Changing the River's Flow was cost effective in a number of ways; the project made use of already available resources in the two partner organisations, SAfAIDS and Seke Rural. The national/regional partnership between SAfAIDS and Seke Rural provided opportunities for skills transfer, sharing and learning. SAfAIDS, as a regional organisation, brought in learning and experiences from the region to influence new thinking and innovation at the local level, while the local organisation mobilised local resources in the form of meeting venues, linkages to community leaders and local labour to cook at meetings.

In addition, the local organisation provided the volunteers that are serving as volunteer community change agents, which has not only increased the sustainability of the project but also reduced costs, as these advisors are disseminating HIV information without salaries or transport costs. Their activities have been integrated into community activities.

2.4 Sustainability

The design and model used in the project was well thought through to achieve sustainability. First and foremost, the project is driven by a local organisation with buy-in at the highest community leadership level, with technical support and resources from a regional organisation at very low cost; secondly the community change agents are community members, not remunerated and are doing the work in line with their own day-to-day activities as home-based carers. Thirdly the issues being addressed, such as HIV, are priority problems for the community that they have been grappling to resolve for years. Community ownership is very high in this programme, as demonstrated in the change agent's comments that the chief accords them time to speak at key community events. Lastly the capacity building given to the change agents and their linkages with Seke Rural Home-based Care will ensure that they provide quality work under the guidance and support of Mrs Ngwerume, the Director of Seke Rural, and her team. For these reasons, the project will continue, even in the absence of funding support by outsiders, including SAfAIDS.

Financial Sustainability

At the time of documentation, the funding cycle for this project was drawing to an end, but the project activities in the community are gaining momentum. The cost of starting and running such a project is very low because of the limited resources required to implement. Further, there has been a general call from the community for the project to be scaled up and for further funding to be secured in order to carry out the project in other Seke wards. As a result of several fundraising efforts that included documenting the project and sharing the finding, at international platforms, SAfAIDS hopes to secure funding to scale up the project in Zimbabwe and beyond. This is a demonstration of the value added by partnerships between a local small organisation (Seke Rural) and a larger regional organisation like SAfAIDS. In the process, Seke Rural has strengthened its own exposure and capacity to attract funding independently of SAfAIDS, a situation that will make them sustainable beyond the relationship with SAfAIDS.

Organisational Sustainability

SAfAIDS and Seke Rural have been in existence for 15 years and 6 years respectively and have become solid organisations with a good reputation in Seke, Zimbabwe and the region. The staff that initiated the project in 2006 are both still with the two organisations. Over the years, Seke has gained enough capacity to support this and other projects being implemented by the organisation. SAfAIDS has since handed over the project to Seke Rural and moved on to support other countries. The high ownership and support for the project within Seke Rural and the community is an assurance of its likely sustainability beyond the project lifespan.

3. Challenges

Changing cultures is long term and success is not always guaranteed

At project inception, it was very difficult to convince donors to support the project because in the development world people would like to see impact within a short space of time. In other programmes like feeding orphans, it is easy to see the children fed and to note their improvement in health. With culture, we are entering a grey area where there are no guarantees. Literature shows that a number of interventions to try to change culture in the past have found it difficult, slow and frustrating, with very limited positive results to show in the end. Changing culture does not necessarily fit into the usual log frames and objective language that programmers are familiar with. The lesson from this project is that piloting is a good way to start, because it offers opportunities to learn and if necessary, adapt, as the project expands. In this project SAfAIDS and Seke Rural learned to develop smart objectives and log frames so that the proposals that followed were much clearer on issues of impact.

Resistance by the community leadership to culture change was an initial concern. In the first meetings, the headmen made comments such as, "You know children of today! Women are not teaching the children!" and some of the men strongly expressed that "These are our cultures and we cannot change them". However within months of project roll-out the cultural leadership gradually became allies in mobilising the communities for the workshops. It seems likely that this was due to increased awareness of the linkages between culture, gender and HIV, and partly because the implementers clearly stated that their purpose was not to criticise cultural practices or to impose alternatives, but to simply explore what was good or bad about culture and then allow the communities to find their own solutions. The already existing good reputation of Seke Rural helped to build the trust that was required for the community to believe the project implementers, who included strangers from SAfAIDS.

Another frequently mentioned challenge was how slowly culture change comes about. Several of the informants commented that although advances had been made, there was still much to be done. One *chipangamazano* mentioned that whilst the community now largely frowned upon polygamy and 'small houses', some men had simply become more secretive in their activities with multiple partners.

"Changes in cultural practices are slow - I can't say it's a radical change."
- Female volunteer, 'chipangamazano', Seke

Economic Challenges in Zimbabwe at the time

The project was implemented at a time when the political and economic situation in Zimbabwe was deteriorating rapidly. Many of the communities could not afford food or bus fares to come to the meetings. To address this challenge, the project provided transport and food to the people who attended the dialogues. Despite the hard times, the community still contributed mealie-meal and labour to cook the meals. In a way, this partnership strengthened the community ownership of the programme from the very beginning going forward.

4. Lessons Learnt

The richness of the project and successes gained have also brought to the fore critical learning points, which will add value to future planning of similar projects targeting communities using the dialogue series approach.

Some key lessons learnt:

“Communities, with the right knowledge, skills and approach, have the capacity to solve their own problems. After all these are their practices and traditions. Who are we as outsiders with our limited understanding and appreciation to try to get involved beyond the role of catalysts? Instead we must use these opportunities to learn, so that our future materials are based more on evidence and less on assumptions.”

- Comment from Lois Chingandu the Executive Director of SFAIDS

- It is important to engage with the community leadership, including chiefs, traditional healers and headmen. Without this initial and continued support, it seems unlikely that the project would have succeeded.
- Combining local and regional partners provides numerous opportunities to share resources and piggy back on existing programmes.
- Working with partners who have a good reputation and who are able to conduct their activities transparently is key to the success of an intervention. The success of this project was due in part to the fact that both SFAIDS and Seke Rural were able to maintain their reputations as efficient, effective organisations, exhibiting integrity in their practice.

5. Way Forward

Seke Rural hopes to continue the Culture Dialogue Series project and offer it to the other wards in Seke. At the moment, only eight out of the 21 wards have benefitted. There is great demand for the services offered by this project and several headmen revealed in the Focus Group Discussions and in interviews that it was important for the other wards to be offered this service. The benefits of the project were not in doubt, hence its popularity. A member of the Seke Rural management expressed his determination to "try to solve problems with the community together - putting the community in front - conducting workshops behind."

For SAfAIDS, the way forward lies in scaling up the project to the national and regional level. SAfAIDS plans to use the training manual on Gender, Culture and HIV and AIDS and other materials, now called the 'Changing the River's Flow series' to support this effort.

6. Conclusion

The success of this project is remarkable, given that it started as a simple, though innovative, idea. Not only has it witnessed change and improved lifestyles and practices among community members, especially women, but it has done so at national and regional level. Thus this project looks set to change the culture of HIV interventions in Africa, as it is well positioned to revolutionise the mainstreaming of culture and gender issues into all HIV project activities and vice versa.



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