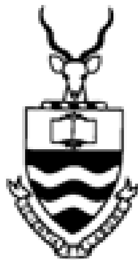
Social Interventions for HIV/AIDS
Intervention with Microfinance for AIDS and Gender Equity

IMAGE Study
Monograph No 2: Intervention

RADAR
RURAL AIDS & DEVELOPMENT
ACTION RESEARCH PROGRAMME



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Foreword

Limpopo Province in northern South Africa is home to over 4 million people. The majority face the same challenges as those in any developing country. 60% of households live below the poverty line and only one third of the population has access to employment.

The Small Enterprise Foundation (SEF) is a development NGO committed to the elimination of poverty through encouraging and nurturing self-employment. SEF is achieving this goal by providing micro-credit and savings services to rural, historically disadvantaged communities. It has challenged the industry by its specific focus on identifying the very poor and ensuring that it has a positive impact with this group.

Now SEF and RADAR have come together in a three-year pilot to deepen our understanding of the impact of microfinance on very poor individuals and communities. In particular, we are committed to learn more about the relationship between microfinance and HIV/AIDS.

The pilot aims to assess the ability of households and communities involved with microfinance programmes to cope with the effects of HIV/AIDS, as well as their ability to avoid the disease.

We are very excited about this opportunity to work towards improvements in two of the most important issues facing the region today.

Paul M. Pronyk

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IMAGE has brought together a diverse array of funders from the health and development fields – all of whose contribution has been critical. The South African National Department of Health, through Dr. H. Hausler, provided substantial support to all aspects of the project. The Anglo American/de Beers Chairman's Educational Trust, the Henry J. Kaiser Family Foundation, the Ford Foundation, and the Enterprise Development Innovation Fund of the UK Department for International Development have also graciously provide core support to programme activities. The International Alliance (Financial Women's Association of New York) provided further funds to support TCP. Finally, Orasure Technologies Incorporated provided Orasure collection devices and Omnimed and Organon Teknika provided Vironostika Uniform HIV 11+ O kits for use in the study.

List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
CBO	Community Based Organisation
DOH	Department of Health
GBV	Gender Based Violence
HIV	Human Immuno deficiency Virus
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
IPV	Intimate Partner Violence
LSHTM	London School of Hygiene and Tropical Medicine
MFI	Microfinance Initiative
MRC	Medical Research Council
NGO	Non-Governmental Organisation
OMT	Oral Mucosal Transudate
PLA	Participatory Learning and Action
PRA	Participatory Rural Appraisal
PWA	Person living with HIV/AIDS
PWR	Participatory Wealth Ranking
RADAR	Rural AIDS and Development Action Research Programme
NHLS	National Health Laboratory Service
SEF	Small Enterprise Foundation
SFL	Sisters for Life
STD	Sexually Transmitted Disease
TCP	Tšhomišano Credit Programme
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary Counselling and Testing for HIV

Chapter 1.0: Introduction

In 1999, in response to the escalating AIDS epidemic in South Africa, the National Department of Health established a new initiative to design, implement and evaluate strategies for addressing HIV/AIDS within three pilot sites across the country. All three sites were responsible for implementing a core package of HIV-related services and support, including the provision of voluntary counselling and testing services and the training of health care workers in the implementation of National HIV/AIDS clinical care guidelines. However, in addition to this basic package, the pilot sites were encouraged to test more innovative and multi-sectoral approaches to HIV control, and it is in this context that IMAGE (Intervention with Microfinance for AIDS and Gender Equity) has been developed.

The IMAGE study is based in Sekhukhuneland - a densely settled rural area of South Africa's Limpopo Province. Collaborative partners include a microfinance NGO (Small Enterprise Foundation), academic institutions from the South (University of the Witwatersrand) and North (London School of Hygiene and Tropical Medicine) and government (South African National Department of Health).

The **aim** of this initiative is to develop and evaluate an innovative approach to the prevention of HIV/AIDS – one which explicitly addresses key structural factors driving the epidemic, such as poverty, gender-based violence and broader gender inequalities. **By integrating and mainstreaming a program of gender awareness and HIV education into an existing microfinance initiative,** IMAGE attempts to operationalize a model for addressing the HIV epidemic which is relevant to settings where poverty and gender inequalities continue to pose a critical challenge to prevention efforts. This document describes the IMAGE intervention.

The **objectives** of this initiative are:

1. To expand access to an existing microfinance initiative to women from the poorest households within a group of villages in rural South Africa, as a means of facilitating improvements in household welfare and individual empowerment.
2. To develop a participatory approach to gender awareness and HIV education for loan recipients, and to mainstream this into existing microfinance program activities.

3. To investigate whether, in combination with social and economic benefits, the attitudes and skills gained through participation in this program can support patterns of decision making that reduce vulnerability to both gender-based violence and HIV.
4. To use a range of quantitative, qualitative and participatory methods to describe and document related processes and outcomes at multiple levels.
5. To implement and evaluate this intervention within the framework and policy environment of a South African National Department of Health HIV/AIDS Pilot Initiative.

Designed as a prospective, randomised community intervention trial, this study will evaluate and document the impact of IMAGE at individual, household, and community levels. A description of the study design is beyond the scope of this monograph, and is fully documented in the IMAGE Evaluation Monograph [1] (available www.wits.ac.za/radar)

This document describes the evolution of the IMAGE intervention.

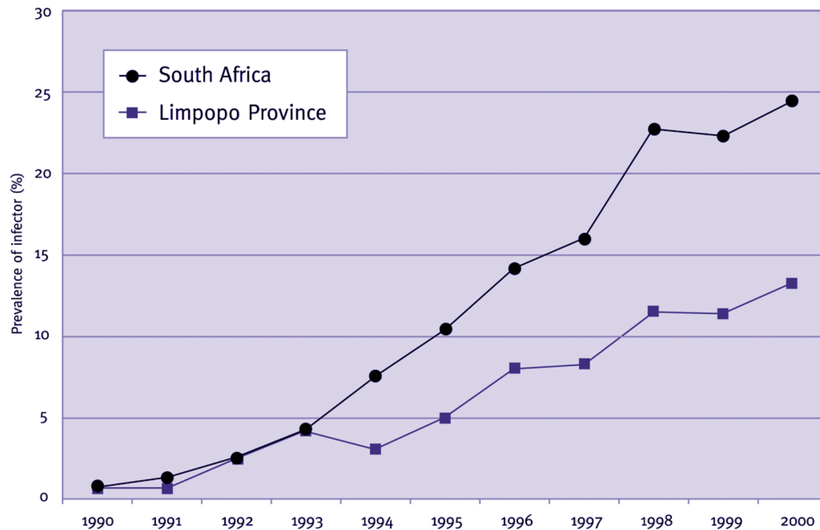
- It begins by setting the context of the AIDS epidemic in South Africa – in many ways a case study in the importance of structural factors in shaping an epidemic.
- It then turns to a description of microfinance, its potential strengths and limitations, and the rationale underlying its central role in IMAGE.
- Arguments for incorporating a program of Gender and HIV training into a microfinance initiative are then described.
- Finally, the monograph closes with a detailed description of how the IMAGE intervention attempts to operationalize this by developing and integrating a program of participatory learning and community mobilisation into an existing microfinance initiative.

Chapter 2.0: Background

2.1 HIV/AIDS in South Africa

South Africa is in the midst of one the fastest growing HIV epidemics in the world. Between 1992 and 2000, HIV prevalence among public antenatal clinic attenders has increased ten-fold, from 2.4% to 24.5% [2]. Mathematical modelling of current incidence/prevalence data suggest that a 15 year-old South African boy has a 70% chance of dying of AIDS in his lifetime [3]. In the year 2002, there are more people living with HIV in South Africa than in any other country in the world [3-5].

figure 1: *HIV Prevelance in South Africa and in the Limpopo Province 1990-2000*



Recent Medical Research Council (SA) projections highlight that while many communities are already beginning to witness increased morbidity and mortality as a result of HIV/AIDS, the worst it yet to come. In the year 2000, an estimated 40% of deaths in adults aged 15-49 were attributable to AIDS, making it the single highest cause of death in South Africa. The next decade anticipates 5-7 million cumulative AIDS deaths, and a decline in life expectancy at birth to below 40 years [6]. These devastating figures paint a picture now all too familiar to many countries in sub-Saharan Africa - one that raises serious questions about the effectiveness and impact of current intervention strategies.

2.2 Beyond Individual Risk

"It is now clear that HIV/AIDS is as much about society, as it is about a virus."
- Jonathan Mann [7]

To a great extent, the public health understanding of HIV/AIDS has been dominated by the notion of **individual risk** – a confluence of cognitive, attitudinal, and behavioural factors which operate at the level of individuals [8] [9] [10]. Early epidemiological models identified routes of transmission and patterns of spread, and these in turn generated interventions to control the transmission of HIV which focused on individual behaviour change. Explanations for the bias towards individual-level interventions have thus highlighted the predominance of behavioural psychology in influencing HIV prevention science. Most psychological theories applied to explain HIV risk behaviour (e.g. The Theory of Reasoned Action; the Stages of Behaviour Change Model; the AIDS Risk Reduction Model; the Common Sense Model of Illness and Danger; and the Health Belief Model) have centred on the level of the individual [10, 11].

Increasingly, however, there has been a shift from this individualistic approach to an awareness of how broader **contextual factors** converge to shape the complex environment in which individual behaviour takes place. There is increasing recognition that human behaviour does not take place in a vacuum, and that socio-cultural, economic, and political realities fundamentally shape individual risk by significantly limiting individuals' choices and options for risk reduction [11-14]. Over the past decade, researchers have documented some of the structural factors that facilitate HIV transmission and its concentration within particular geographic areas and populations [8,. 9, 15, 16] Most can be grouped into three interconnected categories: (1) **poverty** and economic underdevelopment; (2) **Mobility** - including migration, seasonal work, and the social disruption due to war and political instability; and (3) **gender inequalities**. In spite of the uniqueness of each local epidemic, the same general structures and processes interact to shape transmission in areas as diverse as Africa, Asia, and Latin America, as well as certain groups in Europe and North America [17].

South Africa is a compelling case study in how all three of these structural factors have fuelled a rapidly growing epidemic. Land expropriation and the forced introduction of a migrant labour system has eroded the fabric of rural communities, shaken the stability of household and community life, and

exacerbated gender inequalities. In addition, economic crisis has driven many women, either formally or informally, to exchange sex for resources as a means of survival [18]. It is the interplay of all of these factors which have highlighted the importance of addressing such broader realities.

2.3 Gender-based Violence and HIV/AIDS

"How can we win without singling out violence against women as a force driving the epidemic?" - Peter Piot [19]

Increasingly, researchers are calling attention to how unequal power in sexual relationships continues to shape the HIV epidemic [20, 21]. One important manifestation of this power imbalance, gender-based violence (GBV), has been found to both directly and indirectly impact on women's vulnerability to HIV infection [22-25]. HIV transmission may be the direct result of an unwanted or forced sexual act. In addition, refusing sex, inquiring about other partners, or raising the issue of condoms have all been described as "triggers" for partner violence - yet all are intimately connected to the behavioural cornerstones of HIV prevention [26-28].

Violence against women itself represents a significant public health issue, and has been linked to a range of short- and long-term health consequences [21, 25, 29]. In nearly fifty population-based surveys from around the world, between 10% and 50% of women report being hit or otherwise physically harmed by an intimate male partner at some point in their lives. Such physical violence is almost always accompanied by psychological abuse and, in one-third to over one-half of cases, by sexual abuse [25]. These global figures are also reflected in South Africa, where a recent population-based study in 3 provinces found that 19-28% of women reported physical violence by a current or ex-partner [30].

As with HIV/AIDS, early theoretical explanations of violence against women have focused primarily at the level of the individual, analysing characteristics relating to the perpetrator or victim [31, 32]. Increasingly however, researchers have recognized the importance of broader contextual factors in shaping the environment in which such abuse occurs. Gender inequalities, cultural norms, and poverty have all been raised as important underlying factors [25, 32, 33]. Yet in spite of the links between gender-based violence and vulnerability to HIV/AIDS, as well as convergence in their underlying structural factors, intervention and research on these two issues have been largely conceptualised and implemented in isolation [22, 23, 34, 35].

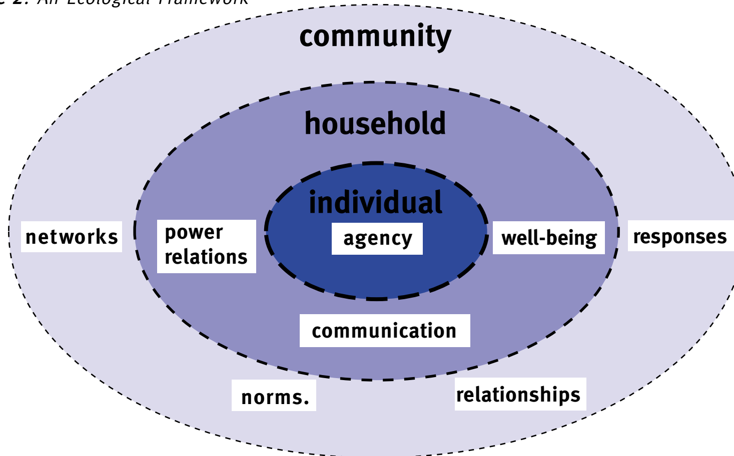
2.4 Broadening the Response

"The challenge is to come up with a macro-social view that adds to a workable response to the pandemic instead of one that overwhelms our capacity to act. "
- Esther Sumartojo [36]

Given the importance of the contextual factors described above, a major challenge in conceptualising effective responses to both HIV and gender-based violence lies in generating interventions which go beyond the concept of individual risk [7, 8, 11, 13, 14, 37]. Increasingly, researchers are turning to an **ecological framework** to understand and describe the interplay of personal, situational, and socio-cultural factors that combine to create patterns of vulnerability or risk [11, 25, 38]. Often represented as a series of concentric circles (see Fig. 2), such a framework locates the individual within a larger social system comprised of interrelated and dynamic parts. The innermost circle represents the biological and personal history that each **individual** brings to his or her behaviour in relationships. The second circle represents the immediate context in which behaviour occurs – frequently the intimate relationships within the **household**. The third circle represents the **community** – which includes the institutions and social structures in which relationships are embedded (peer groups, social networks) as well as the broader economic and social environment. The interface between these dimensions is fluid, and factors at one level may influence - and in turn be influenced by - those at other levels.

An ecological framework thus shifts the focus of analysis and intervention from concepts of individual risk to those of creating an **enabling environment.** In so doing, it can provide a useful tool for conceptualising interventions which take into account the broader contextual realities described above. However, increased calls for what has been termed an "expanded response" have not been matched by action, and the creation of such interventions has remained largely within the realm of theory [13, 17, 34, 39, 40].

***figure 2**: An Ecological Framework**



In relation to HIV, an ecological framework recognizes that behaviour change is complex and dynamic - and that a woman's ability to make decisions about her reproductive and sexual life is inextricably linked to her ability to make meaningful decisions in other areas of her life. For example, individual agency may in turn be influenced by factors such as power relations within the household, or broader social networks within the community. Similarly, in relation to gender-based violence, individual and household level factors may combine with broader social norms – such as those asserting a man's right to "discipline" his wife - to determine the likelihood of abuse.

** This framework is described in more detail in the IMAGE Evaluation Monograph [1]*

There are a number of challenging reasons why attempts to generate an expanded response to HIV/AIDS and GBV have been limited:

1. *Public health, with its traditional focus on epidemiology and disease control models has lacked the tools to conceptualise and mount social and economic interventions.*[40, 41] However, lack of public health experience in broadening the scope of HIV/AIDS interventions does not imply a lack of experiential basis emanating from other fields. For example, in relation to social development, many initiatives have sought to improve women's status by increasing their access to skills and training, economic resources, or legal and justice systems. These have fallen outside the purview of HIV or GBV interventions partly because such programs have

not been constructed with pre-declared objectives of reducing HIV transmission or the incidence of violence. Even though such initiatives have not been explicitly conceptualised in these terms, it is possible that they may actually do so [14, 42, 43]. However, in many cases, the lack of evaluation indicators designed to capture these outcomes makes such a determination difficult.

2. *Broadening the scope of HIV/AIDS interventions requires new collaborations across multiple sectors and disciplines.* For example, because the success of a poverty alleviation strategy such as microfinance depends critically on the experience of the implementing agency, health and family planning programmes would be poorly positioned to take on such an initiative alone. Yet bringing together a range of expertise extending beyond the health field can raise significant challenges for creating effective synergy. Potential difficulties range from logistical barriers such as compartmentalized institutional structures and disease-focused funding mechanisms, to less tangible factors relating to trust, ownership, and communication amongst diverse disciplines and approaches.

3. *Moving away from individual-focused interventions shifts the emphasis towards concepts of community participation, community mobilisation and empowerment.* The importance of community-led peer education and the participation of local stakeholders is emerging as a guiding principle for interventions which seek to engage the broader contextual factors relevant to vulnerable groups [44-46]. Yet, involving communities in the conceptualisation, implementation and/or evaluation of programmes can raise significant challenges, and there is little understanding about the process of community mobilisation or the techniques that best promote sustainable community participation [47-50].

4. *Complex interventions require complex evaluations.* Policy makers need evidence of the causal links between structural determinants and prevention outcomes - yet more upstream interventions demand innovation and complex experimental methods [11, 17, 36]. Moving from studies that measures individual risk factors to those which attempt to capture dynamic and relational features raises new challenges. For example, there have been very few rigorous quantitative models specifying the link between gender-based power relations and sexual and reproductive health outcomes. Yet this has likely been constrained by the lack of a commonly accepted definition of power and the absence of useful and practical

measures of power relations and gender inequalities [51-53]. Moreover, interventions which aim to move beyond concepts of individual-level risk may need to capture longitudinal changes across multiple levels of analysis, such as the individual, relationship, and community levels - yet the tools and approaches for measuring and analysing these levels of interaction are not yet well-developed [11, 45, 52]. In this light, researchers have begun to question the appropriateness of relying solely on the randomised controlled trial for assessing more complex interventions such as community intervention trials [14, 41, 45, 52, 54]. Finally, it is likely that interventions which attempt to address the underlying structures and social contexts influencing health behaviours will take time to manifest change in terms of population-level benefits to health. Yet there has been little systematic research investigating the impact of intervention timing or length on behaviour change outcomes - and decisions regarding program duration are typically driven by funding constraints, rather than by science [45].

5 *Attempting to address underlying structural factors can seem overwhelming.* As one paper recently put it: "How do we design and implement focused structural interventions that address the consequences of large scale factors such as poverty and gender inequality, and provide clients of the programme options which produce meaningful reductions in behavioural risk, without presuming that such small-scale programmes will end poverty or sexism?" [17]. Indeed, some would argue that addressing such issues falls beyond the remit and scope of public health – a view no doubt re-inforced by the fact that such interventions may challenge firmly rooted political, social, and economic interests [55]. Drawing attention to and challenging existing inequalities, whether manifest in intimate relationships or macroeconomic policies may generate perceived conflicts of interest, and therefore resistance, at multiple levels [50-52, 56].

As above sections have highlighted, the relentless progression of the HIV pandemic has focused attention on the limitations of control strategies which have been largely informed by the concept of individual risk. In this light, there have been growing calls to begin addressing the underlying structural factors, such as poverty, gender-based violence, and gender inequalities which are fundamentally driving the pandemic. However, given the considerable challenges to conceptualising, implementing and evaluating such broader interventions, it would appear that, at this point in time, our understanding of *what needs to be done* is substantially more evolved than our understanding of *how to do it* [14, 17, 34, 52].

Chapter 3.0: The IMAGE Intervention

It is in this context that the IMAGE study (Intervention with Microfinance for AIDS and Gender Equity) has been developed. It is an attempt to design and test a broader approach to both HIV/AIDS and gender-based violence – one which is informed by an ecological framework. By integrating and mainstreaming a program of Gender and HIV education into an existing microfinance initiative, IMAGE seeks to engage underlying structural factors, in order to create an enabling environment for behavioural change. The IMAGE intervention is thus comprised of two distinct but inter-related parts: (1) a microfinance program and (2) Gender and HIV training. These components, and their underlying rationale, are described in the sections that follow.

3.1 Microfinance

3.11 Why Microfinance?

Microfinance initiatives (MFI) are poverty reduction and empowerment strategies that expand access to credit and savings services among disadvantaged groups, particularly rural women. Since the mid-1980s, well-known programmes such as the Grameen Bank and BRAC (Bangladesh Rural Advancement Committee) have charted impressive gains in reaching poor rural women, and the past decade has witnessed a dramatic increase in funding for MFIs from large international donors [57]. Targeting ***women*** in these programmes has been increasingly promoted as a means for both increasing cost efficiency (due to higher female repayment rates) and more effective poverty alleviation (due to their prioritisation of expenditure on family welfare) [51].

Microfinance and Empowerment: The ability of MFIs to serve as "enabling strategies" among high-risk communities has been well described. The USAID sponsored "Assessing the Impact of Microenterprise Systems"(AIMS) project was commissioned from 1994-1997 to review the microfinance literature and make recommendations from the experience of 40 programmes in 24 countries from Asia, Africa and Latin America [58]. Significant documented outcomes include the ability of MFIs to achieve gains at the level of individuals and communities which go well beyond purely economic returns. In particular, several studies have demonstrated enhanced autonomy and resilience among women participants - where newly acquired economic and business skills translate to improvements in self esteem, larger social networks, and wider control over household decision-making. In this respect, studies that have examined the relationship between microfinance and empowerment have suggested improvements in women's confidence and co-operation, their ability to resolve conflicts, and their bargaining power in relations with family members [43].

Microfinance and Health: Using microfinance as a means of improving the status of women and reducing vulnerability to HIV infection has not yet been empirically tested. However, specific research on the health and social impacts of MFIs has shown improvements in the nutritional intake and educational status of children, and a greater likelihood of contraceptive use among participants as compared to control groups [59]. These impacts have even been shown to "diffuse" into non- households in the community, and to lead to more widespread improvements in specific community health indicators [43]. In addition, recent evaluations of the Grameen Bank and BRAC credit programmes have demonstrated an increase in contraceptive acceptance and use among poor families, suggesting that women who control money and participate in family decisions may have more control over reproductive health decisions [14, 43, 60-62]. Finally, these programmes have shown a potential to decrease the incidence of domestic violence, primarily by channelling resources through women, organising women into solidarity groups, and making women's lives more public [42].

Reaching a Captive Audience: MFIs may offer a strategic opportunity to target a "captive audience" of established, all-women peer groups, who meet regularly over an extended period of time. Recently, ICRW (International Centre for Research on Women) undertook a review of ten HIV prevention initiatives in eight countries, all of which incorporated a strong gender focus. A common feature of the interventions was the use of small groups which, in

effect, challenged the culture of silence surrounding the discussion of sexuality and gender in many cultures. Such group-based interventions were found to foster critical analysis, collaborative learning, communication skills, problem-solving and peer support. These, in turn, were seen as critical steps in changing social norms – and an important distinguishing feature in comparison to one-on-one educational interactions. The review further concluded that such group-based initiatives can result in increased knowledge, skills, and social support among women – all considered important components of power. Finally, the report stressed the importance of locating such interventions within the context of increased access to economic resources - highlighting the need to identify ways of linking group-based HIV prevention efforts to programmes that enhance women's economic and social status [46].

IMAGE begins from the premise that microfinance initiatives may provide just such a strategic entry point.

3.12 Small Enterprise Foundation

The implementing partner for this project, Small Enterprise Foundation (SEF), is a development microfinance NGO operating in South Africa's Limpopo Province. The program began operating in 1992, disbursing small loans for microenterprises owned by poor rural women. Based on the Grameen Bank model, SEF have adapted their own strategy to meet the unique social and cultural environment of rural South Africa. By utilising Participatory Wealth Ranking (PWR) methods, SEF identifies and recruits the most economically disadvantaged members within the target area, and it is the mandate of their Tšhomišano Credit Program to reach the poorest women within rural communities [63].

Loans are given to groups of five women for the purposes of developing income-generating projects. While projects are run by individual women, the members of a group act as guarantors of each other's loans. All five women must repay together to move up to the next loan cycle. Repayment rates are generally high (over 90%), and at the end of a loan repayment, a new loan cycle may begin. Loan sizes then increase in line with business value. In general, forty women (eight groups of five) comprise one loan centre, which meets fortnightly in order to repay loans, discuss business ideas and apply for new loans [64].

3.2 Gender and HIV Training

3.21 Why More than Microfinance?

The body of experience described above suggests that MFIs may provide a critical vehicle for generating a deeper, more contextual response to HIV/AIDS. At the same time, it is important to acknowledge that the links between microfinance and empowerment are complex, as reflected in recent debate and discourse within the field. Some researchers have raised questions about the extent to which increasing women's access to credit automatically translates into their increased control over its use [65]. Moreover, in what way - and in what circumstances - such economic empowerment then enhances women's well-being, and their wider status and autonomy is not well understood [51, 53, 66].

There is increasing recognition that empowering individuals requires strengthening access to resources and building individual agency to use those resources, make decisions, and take leadership [51, 52]. Some authors have suggested that adding a **training or educational component** to micro-finance programs, may play a key role in catalyzing their broader benefits. Although a greater understanding of how to enhance and operationalize this is needed, the following factors have been identified as potentially important:

- Complementary services: These would augment the more conventional business emphasis of MFIs by focusing explicit attention on gender issues, in addition to livelihood or well-being concerns. This might include gender training/awareness raising for clients which focused on increasing skills and networks for challenging gender inequalities [51].

- Using participatory processes: It has been pointed out that group formation per se is not necessarily empowering. Existing loan group structures could be used to encourage clients' participation in decision making, and to develop skills, confidence, and agency – rather than simply using groups as a mechanism for ensuring repayment of loans [51, 67].

- Addressing gender-based violence: It is interesting to note that credit programmes have shown a reduction in the incidence of violence against women in the absence of any focused interventions [42]. It has been suggested that such impacts might be strengthened by more explicitly engaging the issue - for example, though open discussions in group meetings, awareness-raising and collective action.

- Engaging with men: Channelling resources to women and challenging gender norms have the potential to exacerbate gender-related tensions in the household [65], and observers have noted that although MFIs generally interact directly with women, addressing issues of gender and empowerment necessitates engaging with men. Yet there is very little experience to guide the application of this principle [42, 51, 65].

- Engaging with communities: Acknowledging the broader social and political context in which MFIs are situated, raises the importance of using microfinance as an entry point for wider community mobilization. In some programmes, particularly in India, microfinance has formed the basis for organisation around issues such as dowry, domestic violence, and alcohol abuse, while in Bangladesh, programmes have mobilized members to vote for the first time in elections. In most programmes, however, there has been little attempt to link microfinance to wider social and political activity [51, 68].

- Addressing gender within institutional cultures: MFIs themselves cannot be separated from the broader cultural context in which they operate, and programme staff (both women and men) often need to be sensitized to their own underlying biases and assumptions regarding gender, race and class. In addition, the extent to which gender considerations have been integrated into institutional policies and practice are also important considerations [42, 51].

- Linking with other organisations: MFIs may not, by themselves, have the capacity or the time to take on many of the challenges outlined above. There is the danger of over-burdening existing systems. Moreover, an

emphasis on the development of financially self-sustaining credit programmes, may place significant constraints on the ability of MFIs to engage with these issues. In this light, inter-organisational collaboration between microfinance programs and other specialist agencies appears both strategic and necessary [51, 68].

3.22 Sisters for Life

Taking into account the above considerations, the **Gender and HIV training** component of IMAGE has been developed as an attempt to integrate a program of participatory learning and community mobilisation into an existing microfinance initiative. Called Sisters for Life (SFL), the program comprises 2 phases: **Phase One** is a structured series of 10 training sessions, and **Phase Two** is an open-ended program which allows the women themselves to develop and implement responses appropriate to their own communities (see below). The training program was developed by RADAR (Rural AIDS and Development Action Research Program), School of Public Health, University of the Witwatersrand.

Phase One of SFL: Structured Training Sessions

SEF centre meetings offer an ideal opportunity to introduce a program of training and skills development relating to Gender and HIV/AIDS. A curriculum based on participatory learning and action (PLA) principles has been developed and piloted specifically for this context, and covers a broad range of issues which have been identified as priorities by rural women. Topics include gender roles, gender inequality and cultural beliefs, the body, sexuality and relationships, and domestic violence, as well as the more conventional topics relating to HIV prevention (see Table 1). In particular, sessions are structured to give participants an opportunity to strengthen confidence and skills relating to communication, critical thinking, and leadership. Moreover, they are designed to complement SEF values and principles such as mutual respect, personal responsibility, and group solidarity. The curriculum comprises 10 one-hour sessions which are led by a team of facilitators during regular centre meetings. To build continuity between the fortnightly sessions, "homework" activities are assigned and used to reflect on how the sessions relate to ongoing experiences in the women's lives.

Phase Two of SFL: Community Mobilisation

Throughout Phase 1, participants are encouraged to identify both obstacles and opportunities for engaging with men and youth in their communities. In Phase 2, key women who have been identified in the previous phase as "natural leaders" are brought together for a further training on leadership and community mobilization. Taking these skills back to their respective centres, they are responsible for developing an Action Plan with their centres, with the aim of implementing what they regard as appropriate responses to priority issues. In this phase, the facilitators continue their relationship with the centres, this time using the one-hour sessions to provide support and guidance for the Action Plan.

Table 1: Sisters for Life - Phase 1 Training Curriculum

Session	Goals	Activities
1 Introductions	1. Help participants and facilitators to get to know one another and and program 2. Overview of program	• Introductions • Overall goals to feel comfortable • Expectations and concerns • Ground rules
2 Reflecting on Culture	1. Consider traditional wedding songs, names, and proverbs about women, and explore their content and meaning 2. Understand how gender roles and conditioning are reinforced from an early age	• Wedding songs, names and proverbs • Girls do's and don'ts
3 Gender Roles	1. Consider the differential work loads and responsibilities of women and men 2. Analyze how much of women's time is devoted to others and how much to themselves	• 24 Hours in a Woman's Day: map out hourly activities for a typical day
4 Women's Work	1. Explore the implications of women's heavy workloads on their health and well being 2. Understand the difference between "sex" and "gender" 3. Explore and challenge the notion of "culture" and how it reinforces gender roles and stereotypes	• Continued group discussions: 24 hours in a Woman's Day
5 Our Bodies, Our Selves	1. Become more comfortable speakingabout the body, sexuality, and women's feelings in relation to these. 2. Explore women's understandings of their bodies, particularly in relation to menstruation and sexual intercourse	• Group discussion: defining "womanhood" and what it means to be a woman • Body mapping: menstruation, sexual intercourse
6 Domestic Violence	1. Explore a range of experiences which constitute domestic violence 2. Explore attitudes, beliefs, and experiences of such violence 3. Understand how it is perpetuated, and link this to prior sessions on gender roles and culture	• Group discussion: forms of violence experienced or witnessed • Role play: Mother-in-law speaking to daughter-in-law who has been beaten by her husband

TABLE 1: SISTERS FOR LIFE - PHASE 1 TRAINING CURRICULUM (continued)

Session	Goals	Activities
7 Gender and HIV	1.Cover basic understanding of HIV/AIDS, including prevention, transmission, and myths 2.Explore reasons why women (especially young women) are at high risk 3.Link social context of women's risk to previous sessions on gender roles, culture, domestic violence	• Group discussion: HIV basic information • Trends and statistics: women and HIV • Who is at risk? Discussion of 2 stories
8 Knowledge is Power	1.Introduce VCT and where it is available 2.Prepare women for thinking about VCT, reasons for testing, and fears and concerns 3.Bring home the reality of HIV by speaking to a PWA	• VCT demonstration • Visualization exercise: finding out HIV status of yourself or someone you love • Disclosure session: PWA tells her story
9 Empowering Change	1.Explore why negotiating safer sex with a partner is difficult 2.Explore why speaking to youth about sex and HIV is difficult 3.Practice communication skills, and exchange strategies/personal experience	• Role play 1: Speaking to your partner about safer sex • Role play 2: Speaking to a young person about sex
10 Way Forward	1.Summarize and link all previous sessions 2.Explore obstacles and opportunities for greater involvement of youth and men 3.Link Phase 1 to upcoming leadership training and Phase 2	• Review of previous sessions and appreciation of progress • Group discussions: what can we change? What can't we • Next steps and closure

Chapter 4.0: Operationalising the IMAGE Intervention

As highlighted earlier, microfinance initiatives have the potential to increase women's access to and control over income, enhance well-being, and catalyze wider improvements in women's bargaining power, autonomy and status. In this respect, they may represent a critical opportunity to expand the scope of HIV prevention initiatives to encompass these broader social and economic dimensions. However, microfinance in itself is not a panacea. There is a need to better understand how such processes interact and unfold, and how to maximize their potential empowerment benefits. Creating effective partnerships to explicitly link these processes to broader health outcomes has yet to be explored.

The following section will describe the process of integrating the two components of the IMAGE intervention, bringing together the expertise of a microfinance NGO (SEF) and an HIV training and research program (RADAR). The following areas will be described:

- Program Integration
- Formative Research
- Facilitator Training
- Phase One
- Phase Two

4.1 Program Integration

A 2-day management training workshop on Gender, HIV/AIDS and Microfinance was held at the SEF offices, and this was followed by a separate one-week workshop for RADAR and SEF field staff (see below). These workshops provide an opportunity to raise awareness and knowledge around key issues, to allow program staff to become better acquainted, and to begin generating joint vision and joint ownership over IMAGE.

Thereafter, an ongoing series of joint management and field team meetings were established in order to co-ordinate and communicate operational issues relating to program integration and implementation as well as research.

Key themes addressed in Management Training

- An overview of the AIDS epidemic in South Africa
- The links between gender inequalities, poverty and HIV/AIDS
- Gender based violence and HIV/AIDS
- Basic understanding of HIV risk, transmission, and prevention
- Myths and misconceptions regarding HIV/AIDS
- Voluntary counselling and testing (VCT)
- Occupational risks and workplace policies
- The impact of AIDS on microfinance
- Opportunities for synergy between MFIs and HIV prevention

4.2 Formative Research

A series of consultative meetings between SEF and RADAR were then held in order to inform the conceptualisation of the training and to identify logistical constraints. In addition, SEF management and field staff were interviewed, existing centre meetings were visited, and focus groups and interviews were conducted with SEF clients in order to understand how best to integrate a program of training into ongoing microfinance activities. The following **recommendations** emerged:

- In between centre meetings, SEF clients are usually busy attending to their businesses, therefore training should only be held during centre meetings, in order to maximize attendance. Existing rules and incentives for encouraging attendance and punctuality at meetings should also apply to the training.

- In order that they not disrupt centre meetings, training sessions should be limited to one hour, and they should take place before the usual business proceedings – otherwise, clients may not stay on for the training.

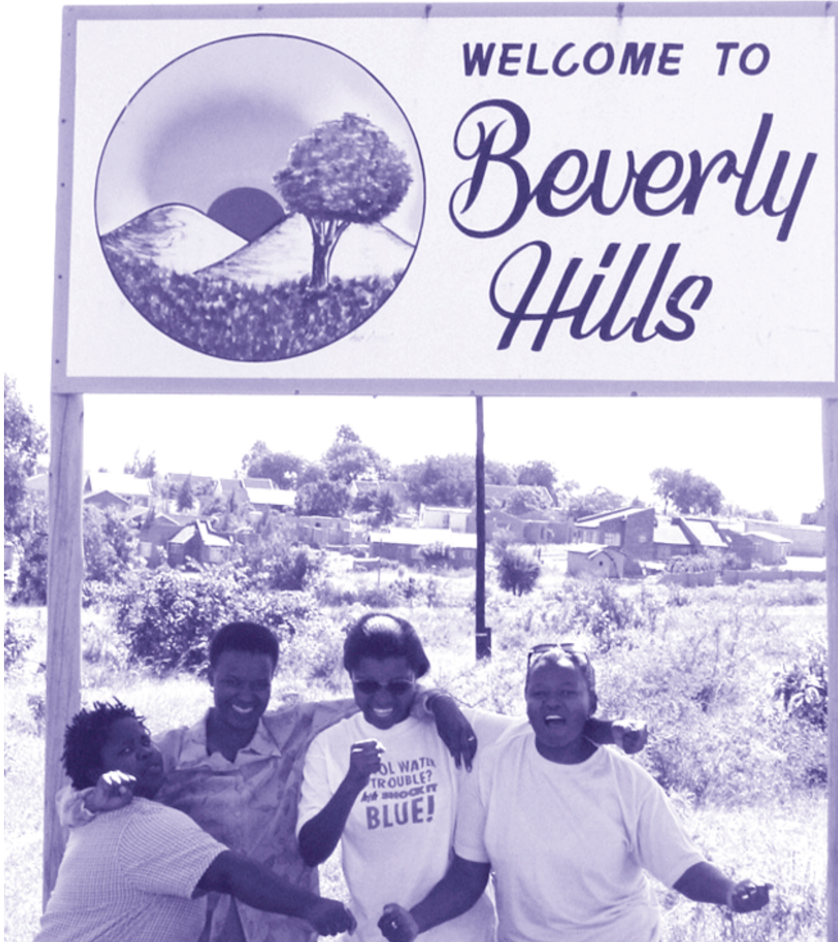
- Sessions should be highly participatory rather than didactic, and should not rely on literacy, as many of the clients may be illiterate.

- In designing group-work activities, sessions should capitalise on existing centre systems such as loan groups and centre leadership structures.

- The training should not be seen as an “add-on” but should be presented as an integrated package from the moment clients join SEF. The training facilitators should be seen as SEF field staff rather than outsiders, and should therefore dress as SEF staff, participate in centre protocols and formalities and stay on to attend the full centre meeting.

- Phase 2 should be used as an opportunity to generate broader engagement with men and youth in the communities. Involving men is a critical but challenging component of any intervention which aims to address issues relating to gender and HIV/AIDS. In relation to microfinance, SEF have found that establishing good communication and trust with male family members is important to the success of client enrolment and retention. The possibility of conducting similar peer-led workshops for men was raised, but deemed impractical for several reasons, including the reluctance of men to attend workshops associated with a women’s microfinance organisation, and the high levels of male labour migration in the region. However, Phase 2, with its emphasis on community mobilisation, was seen as an ideal opportunity to begin engaging with men, particularly those holding key leadership positions in the community.

4.3 Facilitator Training



Experience with participatory HIV training interventions suggests that their success depends critically on the skills and confidence of the facilitators [46, 69]. Certain elements must exist for group interventions to effectively engage participants in the kind of dialogue and discussion which can lead to changes in attitudes, perceptions, beliefs and behaviours. In this respect, the following 4 features have been identified as important components in the training of facilitators [46].

Such training needs to:

1. Provide facilitators with opportunities for experiential learning (i.e. participation in activities designed for the target audience). This helps facilitators develop skills such as how to engage participants in discussion, build consensus, and solve problems.
2. Provide direct feedback to participants regarding their development of skills as facilitators and educators.
3. Help facilitators become comfortable addressing gender/sexuality issues by exploring and discussing their own perceptions and attitudes.
4. Provide ongoing follow-up and consultation.

The facilitator training for IMAGE encompassed these principles and was structured in several stages.

Stage 1: Facilitators as participants
A one-week workshop was held in which facilitators, joining a larger group, took part in all ten SFL sessions as participants, rather than trainers. This provided an intense period of self-reflection and experiential learning and allowed facilitators to explore their own feelings and experiences in relation to the topics covered.

Stage 2: Directly observed training
A one-week workshop in which facilitators now studied the manual and ran through each session, with a local PWA support group acting as participants. Each session was directly supervised and then reviewed as a group. The review sessions focused on both facilitation skills and content of training.

Stage 3: Field Practice
Over the next two months, facilitators practiced the SFL curriculum during three workshops involving a local youth group, a church women's group, and a women's agricultural project. In addition to observation and feedback from supervisors, facilitators were also encouraged to critique themselves and one another.

Stage 4: On-going mentorship and support
As soon as the facilitators formally began the SFL intervention, a system of ongoing support was established. Over the next 6 months, and covering all 10 sessions, project staff were available on-site each week to provide immediate consultation where needed. In addition, a system of Review Meetings enabled facilitators to meet as a group after each day's training to

reflect on how the sessions had went, and to offer suggestions for improvement. These meetings were initially facilitated by project staff, who offered additional readings and activities to open up discussion on themes that were proving challenging to the team. Eventually the facilitation team began to lead these sessions themselves, inviting input from staff when needed.

4.4 Phase One

The Sisters for Life curriculum expanded upon RADAR's prior experience implementing training programs on gender, gender-based violence, and HIV/AIDS [70, 71]. Using the expertise of local PWAs and Gender consultants, a program of 10 interactive sessions was developed specifically for IMAGE. The training curriculum was piloted locally and changes incorporated into the manual. Based upon participatory learning and action (PLA) principles as well as Freire's approach to transformative adult education [72] these sessions covered a range of topics including gender roles, gender inequality, cultural beliefs, relationships and communication, and domestic violence. The training deliberately emphasised this broader exploration before turning to and linking with topics relating more directly to HIV/AIDS. Sessions were designed to maximize group participation, utilising songs, dances, games and role plays to generate broader questioning and discussion. In particular, sessions were structured to give participants an opportunity to strengthen confidence and skills relating to communication, critical thinking, and leadership. The following boxes hi-light key sessions from the FFL curriculum. (The manual itself is available at www.wits.ac.za/radar).

Session 2: Wedding songs

"*Bogadi ba dua ka pelo*" *(you must be tolerant, and bear whatever comes your way...)* Women at a centre meeting sing a traditional Sotho wedding song whose message is directed at the young bride. As a subsequent group discussion reveals, such "tolerance" also includes forbearance of a husband's infidelities, and silent acceptance of domestic violence as a part of marriage. The subtle gender conditioning that women encounter from an early age, and the implications for their vulnerability to HIV will be gradually explored over subsequent training sessions.

"*Mmatswale tiogela dipotwana*" *(Mother-in-law, leave the pots...)* Another wedding song exults at the mother-in-law's new status, and encourages her to leave all the household chores to the young bride. An ongoing theme in the training explores the role that women often play in oppressing other women. Later sessions encourage women to role play more supportive relationships between women, and to explore the issue of solidarity.

Session 3: 24 Hours in a Woman's Day

Women discuss the "double-burden" they carry as wage earners and housewives. This is often the first time they have been able to talk openly about the impacts (physical, emotional, spiritual) of carrying this burden alone. Mapping out what they do over a typical 24-hour period and comparing this to what men do, raises questions about gender roles and stereotypes. "Where does 'culture' come from?" and "can it change?" are questions which usually arise and are energetically debated.

Session 5: Our Bodies, Our Selves

Tracing the outline of a woman's body on newsprint and then drawing what happens during menstruation or sexual intercourse initially elicits embarrassed laughter or jokes. Women are encouraged to describe not only "factual" information, but also their feelings. What often emerges is a sense of ignorance and shame. Facilitators link this discussion to earlier sessions exploring the names (often derogatory) given to women and their bodies. The session ends with expressing acceptance and affirmation of womanhood.

Session 6: Domestic violence

Many women have either witnessed or directly experienced domestic violence, and facilitators must skilfully engage participants in a sensitive and supportive manner. This role play questions how a mother-in-law might either support or undermine her daughter-in-law, who has been beaten by her husband after inquiring about other girl-friends. A later session will make the link between domestic violence and this woman's vulnerability to HIV.

Session 8: Knowledge is Power

Many women are not aware that VCT services are now available at their own clinic. This session begins by explaining how the HIV test works, and explores advantages and disadvantages of getting tested. It closes with a PWA facilitator telling her personal story, and responding to questions from the group. For many women, this is the first time they have been able to speak to someone who is openly HIV-positive, and it brings home the reality of the epidemic in a powerful way.

Session 9: Empowering Change

Role plays are a way of bringing "real life" experiences to light, and an opportunity for practicing different responses and communi-cation strategies. Many of the women reveal themselves to be natural storytellers and uninhibited actors. In this role play, a woman is telling her husband about attending the SFL training, as a means of opening up a conversation about HIV more generally.

Phase 1 with a graduation ceremony. For many, this simple certificate marks the first time they have received affirmation in this way.

4.5 Phase Two

Previous sections summarised key lessons and experience emerging from the fields of both HIV/AIDS and microfinance. A notable convergence was the central importance placed on the economic and social empowerment of women. Within this goal, both fields highlighted the need to engage the broader community in mobilising for collective action and change. Yet, little is known about how to stimulate and sustain community participation, particularly in relation to HIV/AIDS interventions. There is some evidence that group-based initiatives can foster solidarity and action on HIV prevention in the wider community, however the process is neither straightforward nor easy [46]. Community mobilisation principles suggest that staying open-ended and responsive to arising needs and priorities is critical. However, as a recent review of community intervention trials acknowledged, there is an inherent tension between the need for ***standardisation*** (given the study design), and this need for ***flexibility*** in the intervention [45].

Phase 2 of Sisters for Life is an attempt to maintain this responsiveness to community needs, while staying within the parameters of a rigorous study design. Building on the opportunities and challenges identified in earlier SFL training sessions, this phase aims to expand the scope of the intervention to engage more explicitly with the broader community - particularly with men and with youth.

Selection of Natural Leaders

Woman in loan centres "vote" for natural leaders.

Phase Two begins by identifying "natural leaders" – women who have distinguished themselves in some capacity during the previous phase - and focuses on further developing their leadership skills through a subsequent training workshop. The selection of these leaders is left to the centres themselves, although the facilitators provide guidelines for consideration:

- Attendance and active participation during prior centre meetings and SFL sessions
- Interpersonal and problem-solving skills
- Age or prior leadership experience not a consideration

Each centre decides on its own selection process, but what is critical is that the chosen candidates are perceived as leaders by their peers, and are willing to develop their skills and assume further responsibilities upon their return.

Leadership Training

A woman holds a camera for the first time. Photography is used as a discussion starter and tool for community mobilization.

Natural leaders are then brought together for a one-week leadership training workshop. The goals of this workshop are to:

1. Build confidence and leadership skills
2. Review the content of the SFL training, this time approaching issues from a deeper and more personal level
3. Introduce principles and tools for community mobilization

Once again, facilitators use participatory methods such as role plays, dancing, drawing, and group work to delve further into key issues raised during the SFL training. In addition, women are encouraged to define what it means to be a leader, and to share their own experiences of leadership. Photographs depicting rural life are analyzed, and women use these to "tell stories" reflecting the realities of life in their communities. These photographs and stories then form a basis for introducing principles of community mobilization and for practicing approaches to problem identification, prioritization and consensus-building. Working in groups, participants then

practice developing village-level Action Plans to address problems which they have identified as priorities. Finally, participants are taught how to use disposable cameras to take photographs of life in their own villages. 2The workshop closes with natural leaders planning how they will introduce and integrate what they have learned back into their centres.

Development of Action Plans for Community Mobilisation

Taking these experiences and skills back to their respective centres, these leaders are now responsible for developing an Action Plan with their centres, with the aim of implementing what they regard as appropriate responses to priority issues. The way in which each centre chooses to do this is deliberately left open-ended, and the role of the facilitators is to provide support and guidance, rather than to drive the process.

Chapter 5.0: Conclusion

The IMAGE study represents a program of work that has developed against the backdrop of an escalating HIV epidemic in South Africa, and amidst a growing call for the development of interventions which begin to engage the broader economic and social factors driving the epidemic. Bringing together expertise from diverse partners, including a microfinance NGO, academic institutions, and national government, it is an attempt to generate a contextually-driven response to both gender-based violence and HIV/AIDS.

As described earlier, the IMAGE study is informed by an ecological framework, one which attempts to shift the focus of intervention and evaluation from concepts of individual risk to those of creating an enabling environment. In so doing, it embodies many of the opportunities and challenges inherent in implementing and evaluating such broader structural interventions. Creating effective partnerships for intersectoral collaboration, integrating participatory education into a microfinance program, stimulating processes for community mobilisation, and maintaining the balance between intervention flexibility and study design are just a few. It is hoped that by exploring and documenting emerging lessons, the IMAGE study will contribute to the development of innovative models and strategies for addressing the HIV epidemic in settings where poverty and gender inequalities continue to pose a critical challenge to prevention efforts.

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