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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 developed.

IMAGE 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 and North (the University of the Witwatersrand and the London School of Hygiene and Tropical Medicine) and national government (South African National Department of Health).

The goal 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. Designed as a prospective, randomised community intervention trial, this study will evaluate and document the impact of IMAGE at individual, household, and community levels.

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 of the importance of structural factors in shaping an epidemic. It then turns to a description of microfinance and the rationale underlying its central role in IMAGE. The process of developing and integrating the various components of the intervention is then outlined. Finally, the document closes with the IMAGE conceptual framework - one which deliberately shifts the focus of analysis from concepts of "individual risk" to those of creating an "enabling environment".

2.0 HIV/AIDS in South Africa

In 1990, South African national antenatal surveillance data documented an HIV prevalence of 0.7% among women attending public antenatal clinics. By 1993, these prevalence figures had already risen to 4%, signalling a dramatic shift in the burden of infection. Over the following years the epidemic began to spiral out of control, with the prevalence among pregnant women doubling every two years (see Figure 1). By 2000, South Africa had an antenatal prevalence rate of 24.5%, over 4 million infected individuals, and was now host to one of the fastest growing HIV epidemics in the world. In the year 2002, there are more people living with HIV in South Africa than in any other country in the world [1-3].

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 20% of all adult deaths 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 [4]. 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.

2.1 HIV/AIDS: Understanding Context

"It is now clear that HIV/AIDS is as much about society, as it is about a virus."
- Jonathan Mann [1]

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. 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. From the mid-1980s until the early 1990s, the risk reduction model became central to these efforts, as evidenced by the creation of a three-tiered approach within national AIDS programs supported through the Global Program on AIDS of the World Health Organisation. This approach involved information and education campaigns; programs to deliver services (such as HIV counselling and testing, treatment of STDs, and provision of safe blood and blood products); and promotion of non-discrimination regarding people with HIV/AIDS. [2] Explanations for the bias towards individual-level interventions have highlighted the predominance of behavioural psychology in influencing HIV prevention science. Virtually all of the psychological theories that have been applied to explain HIV risk behaviour, locate it at the level of the individual (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. [3]

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 is enacted. Such factors have been described using a broad range of terms – contextual, social, environmental, structural, and others - reflecting the diversity of disciplines which have begun to engage with the epidemic.[4] What such approaches have in common, however, is a growing 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. [2, 3, 5, 6]

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. [7-10] 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**. What is remarkable is that in spite of the uniqueness of each local epidemic, the same general structures and processes can be observed in Africa, Asia, Latin America, as well as certain groups and communities in North America [11].

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. Economic crisis has driven many women, either formally or informally, to exchange sex for resources as a means of survival [12]. In South Africa, as elsewhere, women's economic vulnerability and dependence on men has heightened their vulnerability to HIV by constraining their ability to negotiate condom use, discuss fidelity with their partners, or leave risky relationships. [13] Unequal power in sexual relationships continues to be a driving force behind the epidemic, and it is young women who are currently the group at highest risk of infection [14, 15]. In such a context, conventional health promotion messages such as "Abstain, Be faithful, Condomize" have had limited potential to play a meaningful role in prevention.

2.2 Gender-based Violence and HIV/AIDS

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

Worldwide, one of the most common forms of violence against women is abuse by their husbands or other intimate male partners. Often referred to as "domestic violence", "wife battering", or "intimate partner violence", it is generally part of a pattern of abusive behaviour and control, rather than an isolated act of physical aggression, and can take the form of physical assault, psychological abuse, and/or coercive sex. In nearly 50 population-based surveys from around the world, 10% to over 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 [16]. These global figures have also been 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 [17].

There is a growing body of research illustrating how different forms of violence against women may have both a direct and an indirect impact on women's susceptibility to HIV infection [16, 18, 19]. HIV transmission may be the direct result of an unwanted or forced sexual act such as rape. In addition, coercive sex, which includes young women and girls agreeing to sexual relationships with older men in exchange for material support, has been well described in Southern Africa. The power imbalances inherent in such relations have obvious implications for the ability of such women to protect themselves from HIV infection [20, 21].

Finally, the experience of domestic violence may profoundly impact upon a woman's expectations and agency within a relationship. Refusing sex, inquiring about other partners, or raising the issue of condoms (often interpreted as an admission or accusation of infidelity) have all been described as "triggers" for such violence, and yet all are intimately connected to the behavioural cornerstones of HIV prevention. [22-24]. Although recent years have witnessed growing acknowledgment of the intersections between gender-based violence and HIV/AIDS [25, 26], intervention and research on these two issues have been largely conceptualized and implemented in isolation [18].

2.3 Broadening the Response to HIV/AIDS

> "*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 [4]

In spite of global control efforts, there were nearly 35 million people living with HIV by 2000 [27]. Success stories are few. In the United States, rates show no evidence of decline, and between forty- to eighty-thousand individuals per year are being infected. In Sub-Saharan Africa, mortality rates are expected to double or triple, from a level already eight times that of developed nations [28]. Historical declines in infant mortality rates are being reversed [29]. To many in the public health community, it is unclear what impact - if any – has been made through global prevention efforts [1]. In many ways, the AIDS pandemic has posed serious challenges to the way we have come to think about the relationship between health and disease in populations. Despite seeing many important advances in our understanding of the basic science, the epidemiology of infection, and novel approaches for the care and treatment of people living with AIDS, there has been a relentless progression of the disease in country after country [1].

Major shortcomings in the prevailing approaches to HIV control have been articulated and these include both an over-emphasis on technical, health sector interventions, and health promotion efforts which have failed to acknowledge the broader contexts driving the epidemic [8] [7] [30]. Increasingly, there has been a call towards what has been termed an "expanded response" to the epidemic – one which recognizes the importance of addressing factors that contribute to both individual and societal vulnerability to HIV/AIDS. [1-3, 6, 8, 31] However, the growing recognition that the epidemic is fundamentally linked to broader realities has not been matched by action, and the creation of interventions to address HIV/AIDS within an expanded response framework has remained largely within the realm of theory. [6, 11, 25, 32, 33].

There are a number of challenging reasons why this may be the case:

1. *Public health, with its traditional focus on epidemiology and disease control models has lacked the tools to conceptualize and mount social and economic interventions.*[33, 34] 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 gender and 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/AIDS prevention due in part to the fact that such programs do not seek to reduce the spread of HIV or alleviate the impact of AIDS as established goals and objectives. Even though such initiatives have not been explicitly conceptualized in terms of addressing HIV risk reduction or sexual and reproductive health, it is possible that they may actually do so. [2, 35] However, in many cases, the lack of evaluation indicators designed to capture HIV-related 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 programs 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.[36-38] Yet, involving communities in the conceptualisation, implementation and/or evaluation of programs can raise significant challenges, and there is little understanding about the process of community mobilisation or the techniques that best promote sustainable community participation [39-42]

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 & complex experimental methods [3, 4, 11] Moving from studies that measure 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. [43-45]). 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 analyzing these levels of interaction are not yet well-developed. [3, 37, 44] In this light, the randomized controlled trial, traditionally regarded as the "gold standard" for scientific investigation, has recently faced questions regarding its appropriateness for assessing more complex interventions including community intervention trials. [2, 34, 37, 44, 46] 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 intervention length are typically driven by funding constraints, rather than by science. [37]

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 program options which produce meaningful reductions in behavioural risk, without presuming that such small-scale programs will end poverty or sexism?" [11]. Indeed, some would argue that addressing such issues falls beyond the remit and scope of public health – a view no doubt reinforced by the fact that such interventions may challenge firmly rooted political, social, and economic interests. [47] 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. [42-44, 48]

In the face of a pandemic that continues to spiral out of control in spite of more than two decades of global prevention efforts, there are signs that the public health community may be undergoing a period of critical self-reflection. In this light, there have been increasing calls to begin addressing the underlying structures and social contexts which the first two decades have shown are fundamentally driving the pandemic. However, what is also abundantly clear is 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*. [2, 11, 25, 44].

3.0 IMAGE: Overview and Rationale

It is in this context that IMAGE (Intervention with Microfinance for AIDS and Gender Equity) has been developed. It is an attempt to design and test a broader approach to the prevention of HIV/AIDS – one which engages 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. Designed as a prospective, randomised community intervention trial, this initiative aims to document and evaluate impacts at individual, household, and community levels. A full description of the evaluation and study design is beyond the scope of the this paper, and is therefore described in an accompanying monograph (IMAGE Evaluation Monograph 1)

The **objectives** of this initiative are:

1) To expand access to an existing microfinance initiative to approximately 450 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.

3.1 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 programs 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 [49]. Targeting women in these programs 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) [43].

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 programs in 24 countries from Asia, Africa and Latin America [50]. 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 demonstrated improvements in women's confidence and co-operation, their bargaining power in relations with family members, a better ability to resolve conflicts, and a freedom from family domination and violence [35].

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 [51]. 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 [35]. In addition, recent evaluations of the Grameen Bank and BRAC credit programs 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. [2, 35, 52-54] Finally, these programs have been shown to contribute to a decreased incidence of domestic violence, primarily by channelling resources through women, organising women into solidarity groups, and making women's lives more public. [55]

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 programs that enhance women's economic and social status*. [38]

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

3.2 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. [56] 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.[43, 45, 57] 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.[43, 44] And although a greater understanding of how to enhance and operationalize this through microfinance 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. [43]

- *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.[43, 58]

- *Addressing gender-based violence:* It is interesting to note that credit programs have shown a reduction in the incidence of violence against women in the absence of any focused interventions. [55] 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 [56], 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.[43, 55, 56]

- *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 programs, particularly in India, microfinance has formed the basis for organisation around issues such as dowry, domestic violence, and alcohol abuse, while in Bangladesh, programs have mobilized members to vote for the first time in elections. In most programs, however, there has been little attempt to link microfinance to wider social and political activity. [43, 59]

- *Addressing gender within institutional cultures:* MFIs themselves cannot be separated from the broader cultural context in which they operate, and program 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.[43, 55]

- *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 programs, 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.[43, 59]

The picture which emerges is that 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 impacts. Creating effective partnerships to explicitly link these processes to broader health outcomes has yet to be explored. It is in this context that IMAGE has arisen as a collaborative project involving a microfinance NGO (Small Enterprise Foundation), academic institutions from the South and North (the University of the Witwatersrand and the London School of Hygiene and Tropical Medicine) and national government (South African National Department of Health).

4.0 IMAGE: Program Description

4.1 The Small Enterprise Foundation (SEF) and Tshomisano Credit Program (TCP)

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 of the target area, and it is the mandate of their Tshomisano Credit Program (TCP) to target the poorest women within rural communities. [60]

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, 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. [61]

4.2 The Rural AIDS and Development Action Research Program (RADAR) and Sisters for Life (SFL)

RADAR is part of the University of the Witwatersrand School of Public Health and like SEF, is based in Limpopo Province, South Africa. In addition to the IMAGE study, RADAR is involved in a broad portfolio of HIV-related research and programs, including expanding HIV counselling and testing, strengthening TB/HIV clinical services and PWA support groups, and the introduction of

PMTCT (prevention of mother-to-child transmission) services. RADAR is one of three National Department of Health TB/HIV pilot sites in South Africa.

The program has always had a strong gender focus, and prior research and training on gender-based violence and health [62, 63] has informed the development of the Gender and HIV training component of IMAGE. Called Sisters for Life (SFL), the program comprises 2 phases: Phase 1 is a structured series of 10 training sessions, and Phase 2 is an open-ended program which allows the women themselves to develop and implement responses appropriate to their own communities. These are described in more detail below.

Phase 1: TCP 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 for 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 Appendix A). 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 TCP 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 4 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 2: 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 4 facilitators continue their relationship with the centres, this time using the one-hour sessions to provide support and guidance for the Action Plan.

The following sections will describe the development of the Sisters for Life training curriculum, and its integration with the Tshomisano Credit Program to form IMAGE.

4.3 Developing Sisters for LIfe

4.31 Sensitisation and Training for Program Staff

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. Key themes that were addressed included the following:

- 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

These workshops provided 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.

4.32 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 four facilitators should be seen as SEF field staff rather than outsiders, and should therefore dress as SEF staff, participate in centre formalities (e.g. opening prayers and pledge) and stay on to attend the full centre meeting.

In addition, several **challenges** were identified:

- *Reaching younger women:* Because younger women are at particularly high risk of HIV infection, it would seem desirable to target the intervention at this age group. However, in spite of a minimum cut-off age of 20-years for joining the program, the majority of SEF clients tended to be middle-aged women in their 30's-50's. Often such older women were seen by staff to be more "reliable" clients, because they were perceived to be more responsible, and less likely to leave the area due to marriage or other opportunities. SEF was therefore reluctant to actively "target" younger clients, for fear of jeopardising the viability of the program. A compromise was reached in that SEF fieldworkers would be encouraged to not discriminate against younger clients, although an age quota would not be set.

- *Roll-out of training:* Because the pace of client recruitment and enrolment could not be predicted with certainty, the training program would have to be flexible enough to accommodate this. Because the intervention aimed to target 450 clients, a two-tiered roll-out of training was developed in order to allow time for centre membership to grow (see section 4.35).

- *Involving men:* The intention to involve men, and in particular, male partners of clients, was seen as an important aspect of the intervention – however it was not immediately apparent how best to do this. In approaching potential clients, SEF field staff had found that establishing good communication and trust with male family members was important to the

success of client enrolment and retention - beyond this, however, involvement of men was not part of SEF's mandate. The feasibility of a program of peer-led workshops for men was raised in discussions with SEF clients. However, women generally felt that the men would not come to such workshops for three main reasons:

1. Because SEF was seen as a women's program, they would not feel comfortable attending.

2. Because SEF was associated with money and loans, they would not attend simply for training.

3. Because many men were migrant workers, and were away from the area for much of the year, many would not be able to attend such meetings.

However, it was suggested that engaging with men who held key leadership positions in the community might be an effective entry point for increasing male involvement in issues such as HIV/AIDS. Taking these perspectives into account, it was decided that Session 9 of the Sisters for Life training should be devoted to giving clients the opportunity to identify obstacles and challenges for engaging with men. Session 10, the final session, could then be used to brainstorm ideas for generating greater male involvement – ideas that would then be further developed and implemented during Phase 2 of the intervention.

4.33 The Training Curriculum

The Sisters for Life curriculum expanded upon RADAR's prior experience implementing training programs on gender, gender-based violence, and HIV/AIDS. Using the expertise of local PWAs and Gender consultants, an initial program of 8 interactive sessions was developed specifically for IMAGE. Based upon participatory learning and action (PLA) principles as well as Freire's approach to transformative adult education [64] 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. (See Appendix A for a summary of the SFL curriculum. The manual itself is available at www.wits.ac.za/radar)

This first draft of the curriculum was piloted with a pre-existing SEF centre of 30 women which was not part of the IMAGE study. All 8 sessions were completed at fortnightly centre meetings, which provided an opportunity to field-test both the content and delivery of the training. Following the last session, an evaluation was conducted, involving both the participants and the trainers. Based on this pilot, several changes were made:

- Individual sessions were modified where necessary to conform to the 1-hour time limit
- Session 2 was divided into two separate session to allow more time for discussion on gender roles and culture
- An additional session focusing on the body and sexuality was created to make room for women's many questions and concerns regarding these issues.
- "Homework" assignments were created to build continuity between the fortnightly sessions and to encourage reflection on how the sessions might relate to ongoing experiences in the women's lives.

The second draft of Sisters for Life - now comprising 10 one-hour sessions - was then edited and compiled into the Training Manual.

4.34 Training of Facilitators

Four women were recruited and trained as facilitators for SFL. Two had no prior experience with group training, but originated from local villages where the intervention was to take place. The others were not from the immediate communities, but had more extensive experience relating to gender training and HIV/AIDS. It was hoped that this combination would bring together a developing skills base with a grounded understanding of the local culture and dynamics.

Experience with participatory HIV training interventions suggests that their success depends critically on the skills and confidence of the facilitators.[38, 65]. 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 [38]. 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 4 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. During this stage the curriculum was further refined using inputs from participants and facilitators, and the third and final draft of the SFL manual was now complete.

Stage 4: Ongoing 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.

4.35 Implementation and Roll-out

As described earlier, launching the SFL training required awaiting a critical mass of clients who had been recruited to participate in the microfinance program. The goal was to eventually reach a target group of 450 women. In order to accommodate this, a **two-tiered** roll-out of SFL was designed (see Fig. 1). Phase 1 (the 10 training sessions) would begin when half of the anticipated target group (roughly 225 women) had been recruited and enrolled into TCP. Following completion of Phase 1 (approximately 6 months later), this tier would continue on to the open-ended Phase 2. By this time, the remaining 225 women, having joined TCP, would now commence their own Phase 1 of training. Following a 6-month period of training, they too, would continue on to Phase 2.

Figure 1: A 2-tiered roll-out for SFL

Tier 1	Phase 1	Phase 2	
Tier 2		Phase 1	Phase 2

4.36 Phase 2

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.[38] 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. [37] 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 (see Evaluation monograph).

Building on the opportunities and challenges identified in earlier SFL training sessions, Phase 2 aims to expand the scope of the intervention to engage more explicitly with the broader community - particularly with men and with youth. It 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 to be a consideration

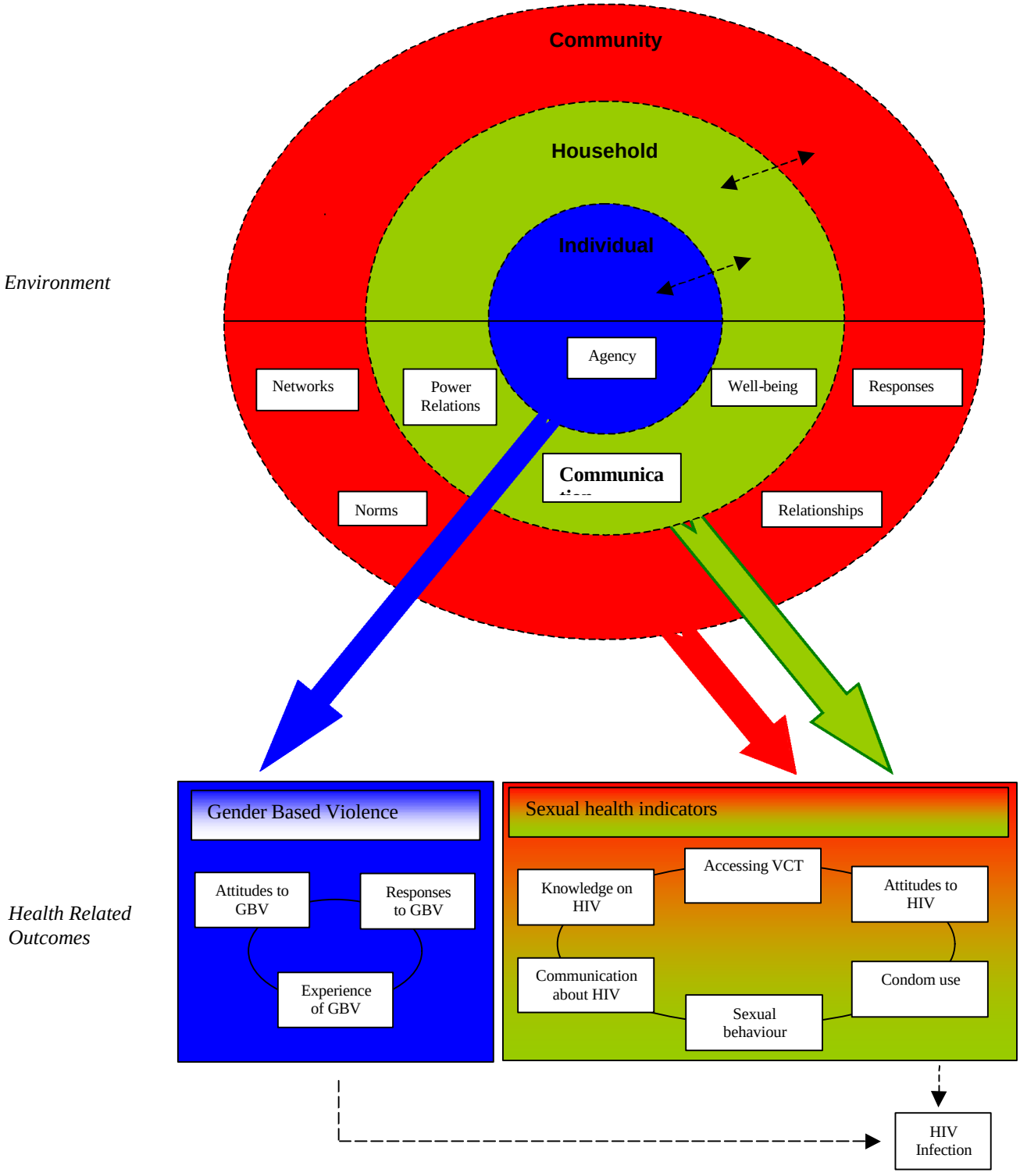
Taking these skills back to their respective centres, these leaders are now responsible for developing an Action Plan with their centres, with the aim of implementing what they regard as appropriate responses to priority issues. The way in which each centre chooses to do this is deliberately left open-ended,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

5.0 A Conceptual Framework

Increasingly, in regards to both HIV/AIDS and gender-based violence, researchers are turning to an "ecological framework" to understand and describe the interplay of personal, situational, and sociocultural factors that combine to create patterns of vulnerability or risk. [3, 16, 66] Often represented as a series of concentric circles, such a framework locates the individual within a larger social system comprised of many interrelated and dynamic parts. An ecological framework thus shifts the focus of intervention or analysis from concepts of "individual risk" to those of an "enabling environment".

The IMAGE conceptual framework seeks to underscore the importance of this **enabling environment** in shaping vulnerability to both gender-based violence and HIV. The concentric circles in the framework reflect the notion of dynamic, inter-related systems at the individual, household and community level that together constitute an environment. The use of dotted-lines to indicate boundaries explicitly emphasises their permeability, while dotted two-way arrows are used to imply a constant process of communication and exchange of knowledge, attitudes, and other 'resources' between different levels.

Figure 2: Conceptual framework for the IMAGE study



Individual level: *Agency* reflects the capacity for free and independent decision making. Agency is realized through actual autonomy in decision making, determined in part by levels of self-esteem, self-confidence, and a perceived control over one's environment. An individual's ability to make choices in relation to their reproductive health and sexual well-being is thus inextricably linked to their ability to negotiate decisions on a variety of other levels. For the purposes of this framework, agency defines a property attributable to individuals. However, relationships of social, economic and political importance at the levels of households and communities provide the context, opportunities and constraints for its development.

Household level : At the household level three factors are emphasised that influence - and are influenced by - individual agency. *Household well-being* reflects the absolute and relative availability of resources, the ability of the household to meet basic needs and in turn, the standard of living enjoyed by household members. *Power dynamics* in relation to control over resources and household decision-making may operate both between sexes and between generations. In addition the levels and types of *communication* between household members, and of household members with the community, contribute to the household environment.

Community level: A number of community level factors are emphasised in the framework that may influence and be influenced by the processes occurring at adjacent levels. *Social norms* represent an evolving common understanding of pertinent social issues, such as gender, sexuality or the HIV epidemic. While individuals may constantly challenge norms in their cognitive processes, there often remain underlying beliefs and attitudes that shape communities and their responses. *Social networks* including membership in community groups and institutions, provide the opportunity for exchange of resources (material, informational, or emotional) within communities. The networks that exist, the strength of their association and the focus of their activities, are important in defining a community environment. Further, *relationships* that exist between groups and individuals in a community dictate levels of social cohesion and social capital, outlining the extent of connectedness and solidarity in relation to levels of trust, reciprocity, mutual aid and resource flows. Finally, *social responses* are an indicator of collective action taken by community groups in relation to pervasive social or political circumstances. These responses contribute to, and are themselves the product of, the environment in which they occur.

Health related outcomes

The IMAGE framework hypothesises that the environment, as defined above, is important in shaping health related outcomes, specifically those relating to gender based violence, sexual health and HIV infection.

Gender Based Violence : Outcomes of interest in the IMAGE study include the range and extent of gender based violence, the perceptions and attitudes of those in the community, and the responses to its occurrence.

Sexual Health Indicators: A broad range of indicators will be followed in relation to sexual health. Sexual behaviour models suggest that there are important linkages between knowledge, attitudes, and behaviour relating to HIV. Moreover, communication with peers and household members regarding sex, sexuality, and HIV risk may be related to the process of sexual socialisation. Accessing VCT may be an important decision in strengthening sexual health and providing access to information. Finally, sexual behaviour and use of condoms are factors which more directly influence HIV risk.
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HIV infection : IMAGE aims to strengthen HIV prevention through an impact on the outcomes and environmental factors outlined above. The use of dotted lines linking GBV and sexual health to HIV indicate that these relationships are complex and non-linear.

The evaluation strategy for IMAGE is also based on this conceptual framework, and uses a range of quantitative, qualitative and participatory approaches. It is fully described in the IMAGE Evaluation Monograph 1. The questionnaires used in the study are available at www.wits.ac.za/radar.

6.0 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. In many respects, the project is already engaging many of the opportunities and challenges described earlier – from creating effective intersectoral collaboration and community mobilisation, to maintaining a balance between intervention flexibility and the standardisation of study design. It is hoped that by exploring and documenting emerging lessons, the IMAGE study will contribute to the development of innovative models for addressing the HIV epidemic in settings where poverty and gender inequalities continue to pose a critical challenge to prevention efforts.

Box 1: Wedding songs (Session 2)

"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.

Box 2: 24 Hours in a Woman's Day (Session 3)

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.

Box 3: Our Bodies, Our Selves (Session 5)

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.

Box 4: Domestic violence (Session 6)

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 girlfriends. A later session will make the link between domestic violence and this woman's vulnerability to HIV.

Box 5: Knowledge is Power (Session 8)

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.

Box 6: Empowering Change (Session 9)

Role plays are a way of bringing "real life" experiences to light, and an opportunity for practicing different responses and communication 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.

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Appendix A: Overview of Sisters for Life - Phase 1 Training Curriculum

	Session	Goals	Activities
1	Introductions	1) Help participants and facilitators to get to know one another and to feel comfortable 2) Overview of program	▪ Introductions ▪ Overall goals and program ▪ 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 speaking about 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
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 change? ▪ Next steps and closure