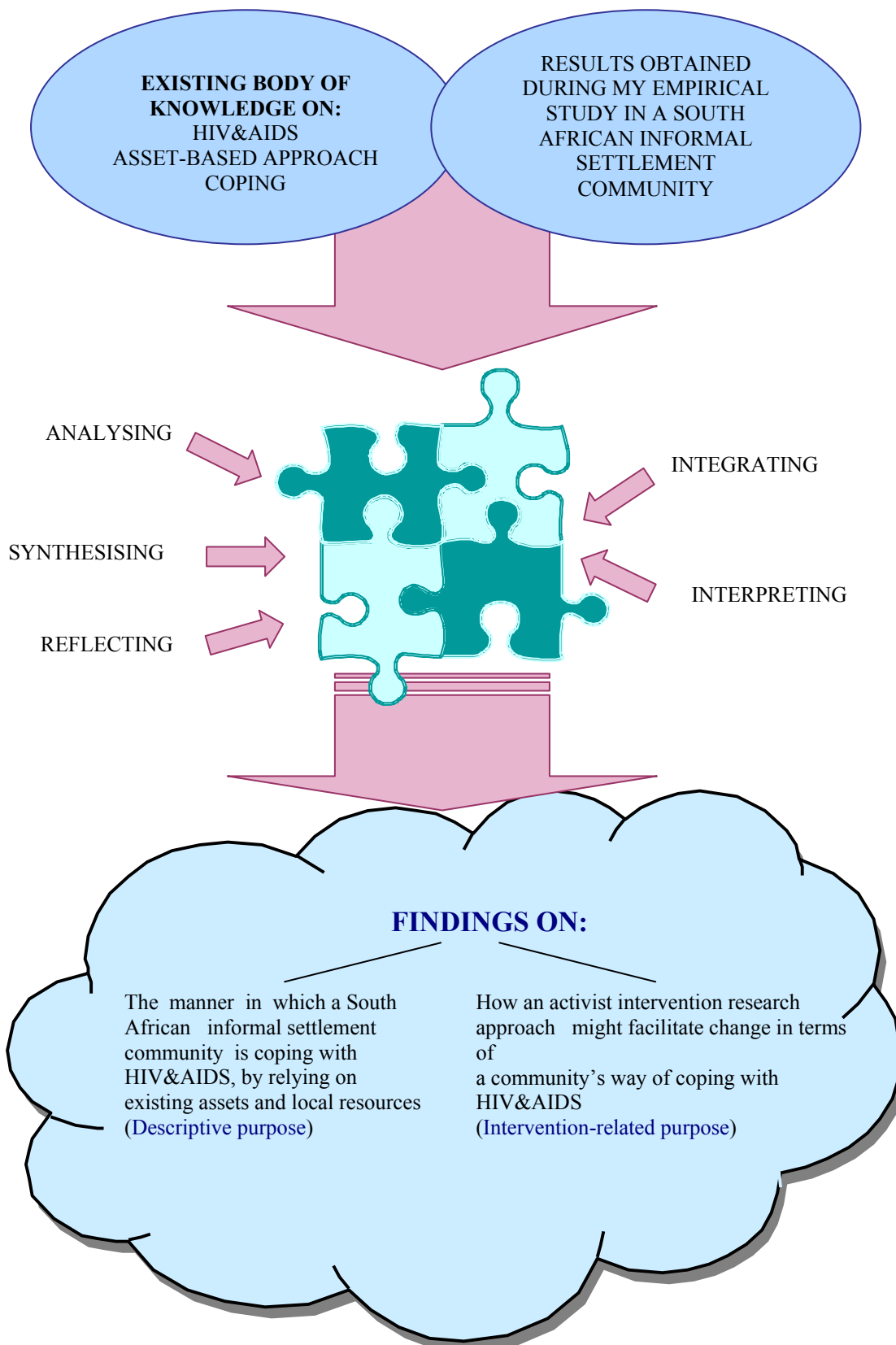


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# CHAPTER 5 AT A GLANCE



## **5.1 INTRODUCTION**

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In the preceding chapter I presented the results of my study, in terms of the themes and sub-themes that emerged during data analysis. In this chapter I integrate and interpret the results in order to present my findings. I structure my discussion in accordance with the structure I relied on in the previous chapter.

In addition to presenting a synthesis of my findings, I relate my findings to existing and relevant literature. I highlight correlations, as well as discrepancies between the findings of this study and those reflected in existing literature. In the next and final chapter of my thesis, I reflect on my research questions in terms of my findings, before I come to final conclusions.

## **5.2 FINDINGS OF THE STUDY – SITUATED IN EXISTING LITERATURE**

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I now present the findings of my study in terms of the structure I relied on in the preceding chapter. After discussing findings which relate to the challenges and stressors faced by the community where I conducted my study, I present the findings I obtained with regard to the assets and potential assets identified during my study. This is followed by a discussion of the community's way of coping with HIV&AIDS, after which I conclude by presenting findings with regard to the outcomes of my study that may be related to the selected methodological approach I employed.

### **5.2.1 CHALLENGES AND STRESSORS FACED BY THE COMMUNITY, WITHIN THE CONTEXT OF HIV&AIDS**

I henceforth discuss the challenges and stressors faced by the informal settlement community where I conducted my study. I refer to the experienced vulnerabilities related to HIV&AIDS, the challenge of supporting people living with HIV&AIDS and finally the challenges as experienced by community members.

### 5.2.1.1 Vulnerability related to HIV&AIDS

The participants in my study indicated vulnerability as a community challenge within the context of HIV&AIDS. Both individuals and the broader community experience vulnerability on various levels. On an individual level, vulnerability is experienced in terms of emotional (personal), physical and social aspects, thereby influencing the holistic functioning of the people involved. With regard to **personal vulnerability**, people infected with HIV or living with AIDS display feelings of shock, fear and anger, as well as a tendency not to disclose their status. This finding is supported by the work of authors like Tindyebwa *et al.* (2004), Van Dyk (2001) and Mkwelo (1997). I regard non-disclosure as a defence mechanism, initially employed by individuals infected with the HI virus during the phase of denying their status. This tendency of HIV infected people avoiding disclosure, which inevitably results in people living with HIV&AIDS preventing themselves (and their children) from accessing care and support by others, is highlighted in existing literature. For example, the Department of Social Development (2002), Ratsaka-Mothokoa (2001), as well as the International HIV/AIDS Alliance (2000) view stigma and discrimination as primary challenges with regard to people accessing care and support.

Brandt (2005) elaborates by emphasising that, in spite of the potential of disclosure allowing for social support and health benefits, the fear of rejection, social isolation, discrimination, violence and changes in relationships continue to be challenges faced by people infected with HIV and living with AIDS. This approach correlates with the emerged theme that the fear of disclosure ultimately remains a reality faced by communities infected with and affected by HIV&AIDS. Despite some of the community members being more willing to disclose their status towards the final parts of my study, the general view remained that disclosure might result in rejection and isolation. As a result, community members tend not to disclose their HIV positive status, thereby denying themselves care and support, thus again promoting a vicious circle – once again resulting in increased levels of vulnerability (also refer to Clacherty & Associates, 2002).

The results that I obtained with regard to community members avoiding disclosure for fear of being rejected, further corroborates the International HIV/AIDS Alliance's

(2000) view that the fear of disclosure is based on fear for discrimination of the individual, as well as the wider family. The Alliance propagates the important potential role that NGOs might play in promoting a non-discriminatory environment, thereby reducing stigma and discrimination, positively impacting on the well-being of people living with HIV&AIDS. In my study, participants also identified the potential role of NGOs in raising awareness of HIV&AIDS within the community, which might positively impact on decreasing stigmatisation of the pandemic.

**Physical vulnerability** and the need for physical care are closely related to emotional care and support. Tindyebwa *et al.* (2004) emphasise the fact that people infected with HIV and living with AIDS, who reside in communities with limited resources, still have limited access to basic HIV&AIDS and supportive care, even anti-retroviral treatment. The International HIV/AIDS Alliance (2000) adds to this discussion and regards it as unfortunate that people in communities characterised by poverty and limited service provision are often not able to access treatment. During my study, participants similarly indicated that community members (who do indeed decide to disclose their status) often do not have the financial means to obtain treatment and medical care. In some cases community members will even die of AIDS as they do not have money for transport to the nearest hospital, or to make a telephone call in order to obtain ambulance services. In addition, the lack of sufficient clinics and counselling services in the area contribute to the challenge as experienced by the community where I conducted my study. With regard to the provision of medical treatment, the fact that anti-retroviral treatment is supposed to be, but is not yet, sufficiently provided in each and every South African area, further intensifies the challenge of physical vulnerability.

The provision of anti-retroviral medication implies a *possible future impact* regarding the government grants that community members might apply for. According to the HIV&AIDS co-ordinator of the Department of Social Development for the Nelson Mandela Metropole, the provision of medication ought to extend the lives of people. As a result, less children might be orphaned in future, leading to a *decrease* in applications for *foster care grants* by relatives looking after orphaned children. On the other hand, applications for the *disability grant might increase* due to people living

longer and eventually reaching the advanced stage of illness where they qualify for the grant, instead of dying at an early stage of AIDS.

In addition to the lack of sufficient medical treatment, participants in my study related physical vulnerability to the inability of individuals and families to fulfil their basic needs, emphasising the interrelatedness between poverty and HIV&AIDS. Ratsaka-Mothokoa (2001) also found poverty to be a related challenge experienced by people living with HIV&AIDS. This author takes the impact of poverty one level higher, by ascribing some families' lack of coping to poverty, based on the fact that poverty results in a lack of food (nutrition) and people subsequently solely depending on external help in the form of, for example, food parcels provided by external agencies like NGOs. This finding of Ratsaka-Mothokoa (2001) does not support the results that I obtained, according to which impoverished and vulnerable families rely on resources within the close community in order to cope with the challenges they face, and not on external assistance or outside support.

Besides poverty and the lack of financial resources to meet basic needs and obtain medical treatment contributing to the physical vulnerability of community members, participants in my study identified government grants as a potential challenge, adding to the vulnerability of those living with HIV&AIDS. In correlation with the results that I obtained on community members often experiencing difficulty in accessing and obtaining government grants, a study by Clacherty and Associates (2002) for *Save the Children* found that participants in that study also experienced problems in accessing government grants that might support them to financially cope with the challenges brought by HIV&AIDS, for example, having to care for an orphaned relative or not being able to work and earn an income due to AIDS. One of the biggest challenges appears to be a lack of sufficient information with regard to application procedures, in order to access grants, as indicated by Clacherty and Associates (2002) and also indicated by the participants in my study.

Apart from the difficulty experienced when applying for, or accessing government grants, participants in my study held the perception that the disability grant is often misused, thereby adding to the vulnerability of the community in general. I relate the perceived misuse of the grant to poverty and to it being a potential means of making

ends meet, as indicated by the participants in my study. Marais (2005) supports this idea by emphasising the fact that the disability grant is often the sole income for a person qualifying for it, referring to a study by Nattrass in Khayelitsha in Cape Town, which revealed that the disability grant contributed 40-50% of the total income of households that received the grant. As such, I regard the disability grant as an important source of income of poverty-stricken people in South Africa.

Cloete (2003) supplements this line of thinking by reporting the tendency of young women in the Eastern Cape (where I also conducted my study) to have themselves tested in the hope of being HIV positive, in order to qualify for the South African disability grant. In this manner, the disability grant can be regarded as a way of combating poverty by people experiencing scarce possibilities of income generation opportunities. Yet on the other hand, the criteria for qualifying for the disability grant are quite strict and require an advanced stage of AIDS. As a result, people who set out to become infected with HIV in order to obtain the grant, will probably not be able to do so with immediate effect.

There are striking similarities between the themes that I identified with regard to stigma and disclosure (**social vulnerability**), and existing literature reporting on these HIV&AIDS-related challenges. In correlation with the results I obtained, Smart (2003b), for example, reports that HIV&AIDS-related stigma and discrimination are not limited to the people infected with the virus or those living with AIDS, but also influence their families. As a result, relatives affected by HIV&AIDS are often subjected to stigmatisation and discrimination on various levels, even within their immediate community. The International HIV/AIDS Alliance (2000) broadens the potential impact of stigmatisation and discrimination by reporting on NGOs paying regular home visits to people living with HIV&AIDS, in order to provide psychological and pastoral support, and prayer sessions with the people. The majority of these volunteers were found to identify themselves as working with *chronically ill people*, with very few mentioning HIV&AIDS, for fear of the possibility of being stigmatised and discriminated against.

The results of my study further relates to those of the Siyam'kela project (reported on by Masindi, 2003), where it was found that stigma impacts on three main levels

within the South African context, namely on disclosure, people living with HIV&AIDS not accessing essential services, and people's levels of innocence/guilt being judged. With regard to *disclosure*, stigma might result in rejection by partners (as also indicated by the participants in my study), problems surrounding the care of orphans and vulnerable children, and fear of disclosure at the workplace (not mentioned during my field work). In my study, the majority of community members tended to avoid disclosure to the wider community, and, in rare cases, even to family members – whom they wanted to spare sadness. As a result, people infected with HIV or living with AIDS, avoid discussing their status, thereby not availing themselves of care and support by others. In the case of individuals residing in the community where I conducted my study deciding to disclose their status, it appeared to be to a selected audience (namely social workers, family or friends) and mostly with the aim of accessing care and support – both financially and emotionally. In the minority of cases, community members disclosed their status based on their desire to live positively, be exemplary and educate other community members about HIV&AIDS. Yet, some of the community members were, as a result, isolated and rejected, even by their partners.

Concerning people infected with HIV or living with AIDS *being judged as immoral*, (Masindi, 2003), as well as Clacherty and Associates (2002) report the tendency of others to label people living with HIV&AIDS as displaying at-risk sexual behaviour. The results that I obtained during my study correlate with this finding, as I found that the community where I conducted my study related at-risk sexual behaviour to people living with HIV&AIDS, and tended to judge them. Consequently, people very seldom disclose their status to the church, as the church is regarded as an institution that discourages immoral behaviour and might be judgemental of a person being HIV infected.

Comparing the results that I obtained with regard to stigmatisation to the categorisation of stigma as suggested by the Siyam'kela Project (Siyam'kela Project, 2003; Clacherty & Associates, 2002; Strode *et al.*, 2001; Antle *et al.*, 2001) displays several similarities. On an external level, participants in my study indicated several of the categories identified during the Siyam'kela Project (2003) (refer to chapter two, section 2.2.3.1). Participants in my study identified reactions of avoidance based on



the *fear of being infected* (which I found might be related to the presence of myths concerning the transmission of HIV and/or ignorance concerning basic information on HIV&AIDS), *rejection* (by partners, relatives and the broader community) and *moral judgement* (by the community and churches). In addition, participants indicated *general discrimination and abuse* against people living with HIV&AIDS (for example by partners or the church), as well as *stigmatisation due to association* (where community members indicated their ability to identify people living with HIV&AIDS or dying of AIDS, based on aspects like weight loss, or where family members and children were stigmatised, based on their association with people living with HIV&AIDS). Participants in my study did not, however, explicitly indicate an *unwillingness to invest in people living with HIV&AIDS* or *discrimination against people living with HIV&AIDS, in terms of accessing services*, as external stigma-related factors. Concerning internal stigma, my findings further correlate with the categories proposed by the Siyam'kela Project (2003), as participants identified the *fear of disclosure* (related to the fear of being rejected, judged or discriminated against), *social withdrawal*, *negative self-perception* and *personal exclusion from certain services and opportunities*, as internal reactions related to stigma. I relate these reactions, as identified by the Siyam'kela Project (2003) and confirmed during my study, to coping strategies employed by people dealing with HIV&AIDS. On the one hand, those living with HIV&AIDS might cope with their illness by denying and not disclosing their status, withdrawing and socially isolating themselves from society and perceiving themselves in a negative manner, which might result in overcompensating behaviour. On the other hand, society might cope with people infected with HIV or who have AIDS by stigmatising and discriminating against them, judging, avoiding, rejecting or even abusing them.

In reaction to the need to urgently address the challenges of stigmatisation and discrimination, Kelly (2000a) reports on a study conducted in the Eastern Cape, KwaZulu-Natal and the Western Cape, revealing that young people (15-30 years of age) are becoming more informed on basic HIV&AIDS-related facts and tend to practice safe sex more often. Contradictory to Kelly's (2000a) finding, participants in my study hold the perception that community members infected with HIV or living with AIDS often display at-risk sexual behaviour. Of particular concern is the tendency of young girls to become involved in at-risk sexual behaviour, such as

multiple partners and sexual relationships without the use of contraceptives (also supported by the findings of Eaton, Flisher & Aarø, 2003). I partially ascribe the contradictions between this theme emerging during my study and the findings of Kelly (2000a), to the high level of poverty experienced by the community where I conducted my study, resulting in community members (including children) going to whichever lengths (even prostitution) to be able to survive and meet their basic needs. In this regard, Campbell (2000) emphasises the fact that safe sexual behaviour and prevention of HIV infection often take second place to addressing basic needs when faced with poverty, thereby explaining the tendency of young girls to provide sexual favours in return for money.

Kelly (2000a) further found that selected young people tend to display positive attitudes towards people living with HIV&AIDS, despite participants in rural areas (amongst others the Eastern Cape area included in the study) still displaying intolerance and negative attitudes. The results that I obtained, according to which community members still seem to stigmatise HIV&AIDS and discriminate against community members infected with HIV or who have AIDS, seems contradictory to Kelly's (2000a) finding that selected young people tend to be more tolerant with regard to people living with HIV&AIDS. This contradiction might be ascribed to the difference in age groups between the participants in my study and those in the study conducted by Kelly (2000a), with Kelly focusing on young people (15 to 30 years of age) and my study including different age levels. In addition, I conducted my study in a poverty-stricken community, which might display similarities with rural communities, thereby corresponding to Kelly's (2000a) finding that some people (in rural areas) still display negativity and intolerance. Another possibility might be that citizens of the Eastern Cape (as reported on by myself as well as by Kelly) might tend to maintain stigmatisation to a greater extent than other areas of the country. These potential explanations, however, are mere hypotheses that need to be researched further in order to establish accountable findings.

In relation to ***cultural vulnerability***, my study indicates the Xhosa culture as being a potential contributing factor concerning at-risk sexual behaviour (multiple partners, not practicing safe sex and a lack of sex education by parents), as well as the tendency not to disclose a HIV positive status within the culture. In the 2004 AIDS

review, Kometsi (2004) emphasises the dominant position that African men hold over women as a contributing factor to their perception of masculinity. Due to the patriarchal power men often possess in the home (characteristic of African cultures), women might tend not to insist on practicing safe sex or having only one sexual partner, thereby increasing their potential vulnerability, as also indicated in my study. The theme concerning women's tendency not to disclose their HIV positive status to their husbands in fear of being rejected can further be related to the way in which power positions are socialised in terms of gender, in conjunction with the stigma attached to HIV&AIDS (also refer to Barolsky, 2003).

#### **5.2.1.2 Supporting people living with HIV&AIDS**

Within the informal settlement community where I conducted my study, community members appeared willing to support other members of their community infected with HIV or living with AIDS, by means of material, as well as emotional and spiritual care and support. Participants indicated that they are able to identify community members living with HIV&AIDS, despite the hesitancy to disclose, which seems to be a reality in the community. However, participants displayed a lack of self-confidence and indicated the need to be informed on HIV&AIDS-related issues, for them to be able to support those infected with HIV or living with AIDS. Both educators and the community in general indicated such a need to be knowledgeable, in order to answer the questions of learners, colleagues and community members.

This need to be informed (as identified in my study) is supported by the findings of a study by Clacherty and Associates (2002), during which community members also indicated the need to be educated. Aspects that were identified as important to be informed on include the importance of community members supporting others living with HIV&AIDS instead of rejecting them, thereby addressing the challenge of stigmatisation; as well as HIV&AIDS-related facts on transmission. I propose that this need to obtain basic HIV&AIDS knowledge might be related to the extensive media coverage of HIV&AIDS-related issues, numerous HIV&AIDS campaigns and inclusion of HIV&AIDS programmes in various sectors of society over the last few decades – raising awareness amongst community members without necessarily providing detailed information. Secondly, the fact that community members often

face the reality of themselves, a family member or friend being infected with HIV or living with AIDS, might also result in the need to be informed.

In addition to the need to be informed, participants identified a general need for emotional support for both adults and children living with HIV&AIDS, as central to supporting others living with the disease. However, the participants further highlighted the occasional hesitancy of community members to become involved in caring for and supporting people living with HIV&AIDS, based on myths and misconceptions, especially relating to the transmission of the virus. This trend not to get involved agrees with the findings of a study by Clacherty and Associates (2002).

### **5.2.1.3 Challenges faced by the community**

As mentioned in section 5.2.1.1, poverty, unemployment and at-risk sexual behaviour were identified as general challenges experienced by the community where I conducted my study. According to the information provided by the ACVV (2004) (a faith-based organisation), 80% of the residents in the community have no income. The infrastructure of the community is underdeveloped and both informal housing (shacks) and more formal housing (occasionally a combination of the two) are present. The community is characterised by low educational levels and various social problems. Participants highlighted teenage pregnancies, alcoholism, domestic violence and child abuse, child neglect, crime, substance abuse, early school drop-out and difficulty in accessing resources in the community as such challenges. Not surprisingly, the results that I obtained on poverty and its associated social challenges within the context of HIV&AIDS is widely supported by existing literature, highlighting the interrelatedness between HIV&AIDS and such social challenges (refer to Oni *et al.*, 2002; Sogaula, Van Niekerk, Noble, Waddle, Green, Sigala, Samson, Sanders & Jackson, 2002; Kelly, 2000c as examples).

In my view, and based on my observations and data obtained during the time spent in the field, community members might get involved in at-risk sexual activities for two primary reasons. Firstly, at-risk sexual behaviour might be relied upon in an attempt to combat poverty (as discussed above), with children reportedly getting involved in activities like child prostitution in order to obtain money to make ends meet.

Secondly, at-risk sexual behaviour might be employed as a defence mechanism or a way of acting because of anger and fear, in an attempt to address emotional needs. Subbarao *et al.* (2001) summarise these two ideas, in reporting that orphaned children who are emotionally vulnerable and financially in desperate need often get involved in exploitative situations like prostitution, in order to survive.

Within the context of HIV&AIDS, participants identified the need to address stigmatisation (for example by educating the community), as well as the challenges of taking care of people with AIDS or orphaned children. These challenges are intensified by the lack of sufficient social services in the community, as well as the difficulty experienced by community members to access health and social services, which might in turn be attributed to poverty. In addition, it emerged that community members supporting others are in need of support themselves. Challenges related to carers being in need of care themselves are widely documented as part of the reality of HIV&AIDS, for example by Richter *et al.* (2004), Smart (2003b), Clacherty and Associates (2002) and the International HIV/AIDS Alliance (2000).

### **5.2.2 ASSETS AND POTENTIAL ASSETS IN THE COMMUNITY**

Numerous assets were identified in the informal settlement community where I conducted my study, which might be relied on when coping with HIV&AIDS. In addition, several potential assets that have not yet been utilised by the community and which might be employed during coping initiatives, came to the fore. In this regard, one of the participants (namely the HIV&AIDS co-ordinator of the Department of Social Development in the Nelson Mandela Metropole) highlighted the importance of assets (and potential assets) meeting the criteria of *accessibility* but also *acceptability*, as also emphasised by Eloff (2006b), as well as Bouwer (2005).

I found the assets identified in my study to comprise *individuals*, local *organisations and associations* (for example a community-based support group and community churches), as well as *institutions* (like schools, hospitals, clinics and the community care centre). As such, the emerged themes on assets conform to the basic categorisation of assets proposed by Ammermann and Parks (1998), as well as Kretzmann and McKnight (1993). In addition, the assets I noted also correlate with

the extended and refined categories proposed by Eloff (2006b), namely assets related to *individuals* (skills, knowledge, characteristics, experiences and values embedded in community members), *schools* (in terms of leadership and management, human assets, technical assets, assets related to structures and procedures, as well as assets related to the identity and strategy of the school), *classrooms* (such as resources, books in the school library and a positive classroom atmosphere), *families* (being supportive and providing assistance to relatives living with HIV&AIDS), *peer groups* (in the form of care and support), *citizen's associations* (such as churches, faith-based organisations and NGOs), *local institutions* (for example hospitals, clinics and the community care centre) and the *social system as a whole* (such as the media and political structures).

The assets that were identified during my study further adhere to Snow's (2001b) classification of assets, as participants identified assets related to *individual talents and skills of community members*; *associations and networks of relationships* (such as volunteer workers and church-based support groups), *institutions and professional entities* (NGOs and faith-based organisations); and *land, property and other physical assets* (referring to the community and the buildings situated in the community, for instance church buildings, school premises and shops). In addition, *economic assets* were identified in the form of a few shops situated in the community, as well as *agriculture* and *community-based experience, general skills and capacities*. However, and in contrast with Snow's (2001b) proposed classification of assets, within the community where I conducted my study, consumer spending power cannot be regarded as a significant economic asset, because of the high rate of poverty inherent in the community.

I henceforth present the assets that were identified during my study as being available to community members in coping with HIV&AIDS. I use the same structure I adhered to in presenting my results in chapter four.

#### **5.2.2.1 Assets relating to individuals**

In response to Kretzmann and McKnight's (1993) question whether or not everyone have capacities, I found the first possibility to be true. In my study, participants

identified assets related to individuals on a number of levels. For example, it emerged that community members who were living with AIDS at the time of my field work possess strengths such as the ability to establish support groups, and support one another spiritually by, for example, praying together, despite the general tendency to marginalise people with AIDS and label them as weak. Other community members were found to possess assets like being supportive and willing to assist others during challenging times. On a broader level, the negotiation skills of community members and key role-players were identified as assets, which might indirectly facilitate support of community members living with HIV&AIDS. The potential of educators to support and negotiate with community members (volunteers) was, for example, demonstrated by the three school-based projects that were initiated and sustained until (at least) my last field visit.

Besides identifying strengths and assets within individuals, participants highlighted the strengths of families and neighbours, referring to the potential support provided by relatives, neighbours, friends, volunteers and support groups. My observation that family and neighbour unity may be regarded as an important asset in communities coping with HIV&AIDS is supported by Fuller and Brockie (*s.a.*), who conducted a study on rural health within the context of the asset-based approach (asset-building). The authors found that health in rural communities are not merely related to physical well-being, but also includes aspects such as community culture and the tendency of community members to know and collaborate with their neighbours. My application of this finding in rural communities to the informal settlement community where I conducted my study, highlights the possibility of similarities between rural and urban informal settlement communities – both often characterised by poverty.

#### **5.2.2.2 Assets relating to institutions and organisations**

In my study, various institutions and organisations were identified as assets, namely a community care centre, schools, assets related to political organisations, NGOs, health-related assets and faith-based organisations. Participants placed strong emphasis on the role of schools and educators, in terms of care, support and assistance (for example in the form of food) provided to learners as well as the wider

community. Attaching such prominence to schools and educators conjoins with several other studies focusing on the role that schools and educators might play in assisting community members addressing the challenges they face (in my study coping with HIV&AIDS). I regard schools (being local institutions) as community-building assets and support Kretzmann and McKnight's (1993:173) view of the '*growing number of ways in which local schools are becoming the center of a web of relationships which can drive the community-building process*'. This approach proved to be applicable to my study, as the school where I conducted intervention sessions unlocked a variety of possibilities for relationships, once the school (educators) became accountable in terms of taking agency and leading the community. For instance, the school (educator-participants) co-ordinated the establishment of a community garden, information centre and support service in the community, thereby promoting the community's way of coping with HIV&AIDS and, by implication, community development. In addition, networks were established and relationships built with other organisations and institutions, not only within the community, but also on a wider level. Furthermore, the parents of learners were identified and mobilised as assets, which in some cases still needed to be utilised.

In rating the school where I conducted intervention as a valuable asset to the community (in terms of its facilities, educators, the principal, materials and equipment) I support Eloff (2006b), as well as the following comment by Kretzmann and McKnight (1993:210): '*What this means is that each local school should be seen not only as an "educational institution" but also as a rich collection of specific resources which can be used for strengthening the social and economic fabric of the entire community*'. Furthermore, the following comment also holds true to my study (Kretzmann & McKnight, 1993:210): '*... at the same time local schools that have fully integrated their resources within the community will become the best and most certain guarantee for that community's increased future strength and prosperity*'.

In support of the views formulated by Kretzmann and McKnight (1993), a study by Saidi *et al.* (2003) identified and successfully used schools as centres of community development. I directly relate this finding to my study, as the educator-participants initiated a vegetable garden, support service and information centre at the school – thereby implying the school to be a centre of community development, contributing to



the community's way of coping with HIV&AIDS. In this manner I regard the primary school where I conducted intervention as a *health promoting school*. During a study by Kelly *et al.* (2002) in a rural poverty-stricken community in the Eastern Cape Province, one of the activities included encouraging *health promoting schools*, where the Departments of Health, Social Development and Education, schools, educators, parents and learners were to be mobilised in an integrated attempt to addressing the challenge of coping with HIV&AIDS and related poverty. One of the activities that Kelly and his colleagues attempted was the establishment of vegetable gardens at schools, as was successfully conducted by the educator-participants in my study.

With regard to the establishment of support services, the manner in which educator-participants effectively initiated a school-(thereby community)-based support service during my study, corresponds to suggestions formulated at a workshop held in 2000 and focusing on orphans and vulnerable children (UNICEF, 2000b). During the workshop, delegates made recommendations as to the role of schools and education systems in support of orphaned and vulnerable children, within the context of HIV&AIDS. Suggestions were made in terms of the various roles of schools, such as identifying orphaned and vulnerable children, free education for needy children, as well as the provision of psychosocial support. In addition, delegates suggested that schools might become focal points in communities or even *one-stop orphaned and vulnerable children support centres*, where meetings could be held, support provided to caregivers and from where feeding schemes could be operated. Although the support service as initiated during my study did not directly focus on orphaned and vulnerable children, supporting community members in general might inevitable also positively impact on the manner in which the challenge of orphaned children are coped with by the community.

Besides schools being regarded as assets in the community's coping with HIV&AIDS, I found NGOs to be (potential) assets in the community where I conducted my study, with participants identifying ATICC as an important (potential) asset. In the same manner, Clacherty and Associates (2002) found NGOs to fulfil an important supportive role, as they might provide food, emotional support and advice on accessing grants. For example, one of the communities involved in the study by Clacherty and Associates (2002) provided a shelter for adolescents, offering physical

and emotional support. The authors do, however, emphasise that provision of such supportive services by NGOs is still rare within the South African context. This correlates with my observation that, despite participants' awareness of NGOs, they are often not yet utilised to their full potential and therefore remain potential assets that need to be mobilised. In this manner, I regard some NGOs as potential assets that might provide support in the form of training, material assistance or counselling services. As a result, I support Clacherty and Associates' (2002) opinion that the provision of services by NGOs cannot be generalised across South African communities, as different communities have different key role-players that might provide support and assistance.

In addition to the assets described in the previous paragraphs, it transpired that political meetings and organisations, clinics, hospitals, doctors, nurses, social workers and faith-based organisations seem to be important (potential) assets in the community where I conducted my study, despite such institutions and services being limited by nature. The fact that community members infected with HIV, or those who have AIDS, tend to deny their condition and avoid disclosure, may however add to the situation that doctors, clinics and hospitals sometimes remain only potential assets, not being mobilised. Despite the services being available to community members living with HIV&AIDS (such as treatment and counselling services), they often seem not to access them, possibly based on their own fears. Yet, political organisations, health-related institutions and faith-based organisations might fulfil an important supportive role and could take shared responsibility in a community's coping with HIV&AIDS, as also propagated by authors such as Birdsall and Kelly (2005), Amoateng *et al.* (2004), Tindyebwa *et al.* (2004), Kelly *et al.* (2002), Mugabe *et al.* (2002) and the International HIV/AIDS Alliance (2000).

### **5.2.2.3 Assets relating to government initiatives**

During my study, government grants emerged as an asset to certain community members (those who have already accessed such grants), albeit still a potential asset to others (those who were in the process of applying, or ignorant about the grants). Whatever the case may be, government grants seem to be an important source of financial assistance to community members coping with HIV&AIDS. In the

case of a person facing extreme poverty, the government grant often to a certain extent provide in meeting basic needs (in this regard also refer to the discussion included in section 5.2.1.1). In addition, the government might provide information, treatment, care and support to community members, for example in the form of workshops and social services. Providing such assistance and implementing government policies in support of communities living with HIV&AIDS, answers to the role that governments are supposed to fulfil in addressing the pandemic, as described by authors like Birdsall and Kelly (2005), Miamidian *et al.* (2004), Smart (2003a), Centre for Policy Studies (2001), UNICEF (2001) and Cook (1998).

#### **5.2.2.4 Systemic assets**

Several assets and potential assets emerged relating to financial support (for example by individual community members like friends, neighbours and educators, the South African government, NGOs or the national lottery on a macro-level), agriculture (open areas in the community) and available services in the community (such as electricity, running water, communication networks, public transport facilities, the fire station and the police station in the adjoining community), which might support community members in coping with challenges. In addition, I regard the school's library, internet facilities and on a macro-level the media (mainly in the form of television and radio) as important (potential) assets, which might provide community members with information on HIV&AIDS-related issues, thereby making them knowledgeable and more able to cope with the challenges implied by HIV&AIDS, such as a healthy lifestyle, nutrition and treatment options. In this regard, I wonder as to why only a few selected participants identified these resources, and, secondly, what the implication for accessing these assets thus might be. In a similar manner, Parker *et al.* (2000) highlight television and radio, as well as print media (such as newspapers and magazines) as important sources of communication with community members in widely spread communities.

However, it needs to be borne in mind that not every South African citizen has access to a television, and that printed media is mainly directed at literate people. Radio seems to be the most suitable way of communication, as it implies a wider reach than television and might be utilised in the form of, for example, talk shows,

advertisements, interviews, documentaries or music. In addition, outdoor media, such as billboards and mobile media like taxis and busses might be utilised to distribute information (Parker *et al.*, 2000) – potential assets that were not identified by participants during my study. In addition, I did not find folk media (such as songs, dances and riddles) to be regarded as potential ways (asset) of conveying information on HIV&AIDS, as indicated by Parker *et al.* (2000). Concerning the potential value of workshops in communicating with people in communities, the results I obtained relate to those of Parker *et al.* (2000), as participants identified workshops as potential source of information and support that could be provided and presented by NGOs, government institutions, health-related institutions or faith-based organisations.

Adding to the discussion on the media being an asset as described in the preceding paragraph, Kretzmann, McKnight and Puntenney (1999) report on the relationship between newspapers and neighbourhoods, specifically referring to the potential value of the media in assisting communities in coping with the challenges they face. As participants did not identify newspapers as an asset in my study, I regard local newspapers (and even media coverage on a wider scale such as billboards or advertisements on mobile busses or taxis – refer to Parker *et al.*, 2000) as a *potential* asset to the community where I conducted my study, which might provide community members with HIV&AIDS-related information. In addition, local newspapers might report on the three initiatives established by the educator-participants in the community. By reporting on the manner in which the educator-participants initiated the three projects and enhanced community development, other similar communities might gain and also apply related strategies in addressing the challenge of HIV&AIDS, or even other relevant social challenges they face. However, mobilising the media in this manner ought to be explored further.

### **5.2.3 COMMUNITY'S CURRENT WAY OF COPING WITH HIV&AIDS**

I now present my findings on the community's way of coping with HIV&AIDS. I refer to coping being community-based, coping of community members being infected with HIV or living with AIDS, coping strategies related to care and support in the

community where I conducted my study, and lastly the community's way of coping with children orphaned due to HIV&AIDS.

### **5.2.3.1 Community-based coping**

During my study, it emerged that the selected informal settlement community where I conducted my study is coping with HIV&AIDS by relying on themselves, their own abilities and the resources available in the immediate local community (thereby implementing the asset-based approach). This tendency of coping with the assets and resources that are locally available, contradicts the suggestions and perceptions of several authors. For example, Smart (2003b) criticises the tendency to presume that communities are able to cope with the HIV&AIDS challenge and voices the opinion that communities' coping mechanisms seem to have been used to their full potential and at a level that cannot be exploited further. In addition, Subbarao *et al.* (2001) are of the opinion that communities at ground level are not able to effectively cope with the challenge of taking care of the high numbers of orphaned and vulnerable children. Furthermore, Ratsaka-Mothokoa (2001) found the participants in her study to hold the opinion that many people living with HIV&AIDS are not coping, especially those who are unemployed and experiencing poverty and a lack of emotional and social support from others.

I ascribe contradictions between the themes that emerged during my study and the views and findings of the authors cited in the previous paragraph to the theoretical context from which I approached and conducted my study, namely the asset-based approach. Approaching a research field from the asset-based approach implies a focus on strengths and possibilities, as apposed to emphasising deficiencies, problems and challenges – often actualised by people not following a strength-based approach. Although I continually acknowledged the challenges and realities faced by the community where I conducted my study, I aimed to shift my focus away from these challenges towards that which is good and already working to the benefit of the community's coping with the pandemic. In addition, one of my primary assumptions with which I approached the community was that it is coping with the challenges brought by HIV&AIDS. This, however, is a personal stance, which needs to be explored further in order to obtain a clear understanding of possible reasons for the

contradictions mentioned between the results that I obtained and the findings of the authors cited in the preceding paragraph.

As such and by being guided by the asset-based approach during my intervention, despite some of the participants (community members) in my study experiencing the effects of the HIV&AIDS pandemic as very harsh, they were still able to identify possible resources they could rely on in coping with the challenge. They further acknowledged the fact that they are indeed coping by relying on the assets and resources in their immediate community, no matter how difficult and challenging they experienced this process of coping to be. They relied on themselves and their fellow community members to make the necessary plans and mobilise the relevant assets in order to, for example, support others living with HIV&AIDS or take children into their care when needed.

The tendency of community members to support vulnerable people (including children) within the context of HIV&AIDS might be related to countrywide initiatives that focus on supporting the capacity of families to protect and care for their children, which have been employed in our country over the last couple of years. In addition, South African citizens might be benefiting from responses focusing on social development, education and welfare, in an attempt to deal with the HIV&AIDS pandemic in an effective and integrated manner (Mugabe *et al.*, 2002; Gow & Desmond, 2002). Although it seems clear that such initiatives are not regularly employed in poverty-stricken communities (such as informal settlement communities) and the question is often raised as to whether or not the general public is indeed benefiting from such policy-orientated responses, the possibility of indirect influences of government policies and support remains. These communities can, for example, benefit from government grants, free schooling for children or being more informed or aware of HIV&AIDS-related issues. My study's indication of community members finding their own ways of addressing the challenges related to HIV&AIDS, is supported by the opinion of Gibson *et al.* (2002), according to whom communities spontaneously develop ways of dealing with trauma and life's difficulties. In support of the results that I obtained, these authors highlight the tendency of community members in need of support to rely on other community members (such as relatives or neighbours), in order to cope with the challenges associated with HIV&AIDS.

Karnpisit (2000) also describes the application of a holistic development approach, as part of the National Development plan of Thailand in addressing the HIV&AIDS pandemic. This approach requires a paradigm shift from a top-down approach to a bottom-up approach, emphasising the importance of community members at ground level being involved in planning and initiating their own development, as was done during my study. The approach ultimately aims at empowering community members, thereby enhancing agency and fostering self-reliance. This approach correlates with both PRA principles and the asset-based approach, as I integrated and applied it in my study. In line with the approach reported on by Karnpisit (2000), I supported a bottom-up approach and also aimed at community members taking agency for the challenges they face and coping with HIV&AIDS, by relying on available assets and resources based in the community (also refer to Eloff, 2006a; Kretzmann & McKnight, 1993).

During the course of my study, the importance of community (principle of *Ubuntu*) in coping with HIV&AIDS (or life challenges in general) was highlighted within the selected community (Xhosa culture). Such emphasis on the importance of collectivism within the Xhosa culture is supported by the following statement of Mbiti (in Van Dyk, 2001:124), describing the importance of the community within the African culture: *'When he suffers, he does not suffer alone but with the corporate group; when he rejoices, he rejoices not alone but with his kinsmen, his neighbour and his relatives whether dead or living. Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual'*. The emphasis that was placed on collectivism by the participants in my study is further substantiated by Walker (2002), who found that the psycho-social support of people infected with HIV or those living with AIDS ought to be provided within the community by community members themselves, as indeed seemed to be the case in the community where I conducted my study.

As such, culture and family emerged to be at the heart of coping with HIV&AIDS, as evident in the informal settlement community where I conducted my study. The potential importance of culture and family is supported by Amoateng *et al.* (2004), who emphasise that *'the maintenance of traditional family values and traditions has enabled many people to cope with the stresses of oppression and separation'*,

thereby implying cultural values or the culture of families, such as African families in South Africa. Based on the African culture and the high value placed on family as embedded in culture, community members take collective responsibility for coping with the challenges related to HIV&AIDS, such as caring for children orphaned due to the pandemic (Barolsky, 2003) – as found during my study.

In addition to family and culture, I my study indicated religiosity and, closely related to it, being positive about personal abilities and the future, to be central components in coping with HIV&AIDS. Participants' perception that hope, optimism and expectancy enable people to cope with the challenges they face reflects the basic principles of Positive Psychology. The theory of Positive Psychology propagates that emphasis be placed on intrinsic strengths, assets and positive intrapsychic domains during difficult times, thereby relying on positive aspects when coping with difficult situations (Ebersöhn & Eloff, 2006; Keyes & Haidt, 2003). With regard to religiosity, the participants in my study highlighted the tendency of community members to often rely on religion and faith in coping with the challenge of HIV&AIDS. This tendency is supported by Boeving (2006), who contemplates spirituality as a coping response. The author specifically refers to religious coping, which she regards as a potential way of coping with life stressors.

Despite my study indicating that informal settlement community members tend to rely on available social support systems when facing a challenge, and the fact that this trend is widely supported by existing literature (as indicated above), Amoateng *et al.* (2004) hold a contradicting opinion. According to Amoateng *et al.* (2004), African people in South Africa are assumed to have strong social networks, yet they in fact have less access to social networks than other population groups in South Africa. This seemingly contradictory view I obtained might be explained in terms of the possibility of urban communities (reported on by Amoateng and colleagues) not possessing strong bonds, where extended families might have been replaced by nuclear families. However, in the case of families not holding strong familial bonds, other support systems appear to take the place of extended family members, such as neighbours, community members or faith-based organisations that are, for example, regarded as potential sources of social and material support within the context of my study.



### **5.2.3.2 Ways of coping with being infected with HIV or living with AIDS**

Whitty (2003) relates coping strategies to defence mechanisms and is of the opinion that people employ both coping strategies and defence mechanisms when faced with challenges or stressful situations. The results that I obtained during my study corresponds with Whitty's (2003) opinion, as it emerged that community members infected with HIV regularly display initial reactions of denial and non-disclosure, thereby employing defence mechanisms, within the context of the informal settlement community where I conducted my study. Upon considering and accepting their status, they tend to employ specific strategies to address their illness, like seeking treatment and support, making the necessary lifestyle changes and obtaining information (thereby employing active coping strategies). This process of coping with their HIV positive status further relates to the *avoidance-approach* idea of coping with challenges, as formulated by Snyder and Pulvers (2001) (refer to section 2.3.1).

Brandt (2005) reports on a study by Olley, Gxamza, Seedat, Theron, Stein and Taljaard, exploring coping strategies among South Africans, with specific reference to coping with being infected with HIV or having AIDS. The findings of Olley and colleagues indicate differences in the coping strategies employed by recently infected men and women. Whilst men tend to become involved in substance use and other risk-related behaviour, women often rely on planning and religion in an attempt to cope with their illness. During my study religion and faith also emerged as important coping strategies, as well as the tendency of people infected with HIV or who are living with AIDS to abuse substances. I did not, however, distinguish between reactions (coping strategies) by the different genders. Hence I am not able to conclude whether or not the indications of my study support or contradict those reported on by Brandt (2005).

### **5.2.3.3 Coping in terms of care and support**

Participants in my study indicated that people infected by HIV and those living with AIDS might be supported in terms of material assistance, advice and emotional care and support. This perception on care and support to others living with HIV&AIDS is corroborated by the findings of Nnko *at el.* (2000) that support to people living with

HIV&AIDS include financial and material support, as well as regular visits to them. In addition, the World Relief HIV/AIDS Team (2003) also state that people living with HIV&AIDS need the comfort, love and care of their family. Central components of comfort that might be actualised by family members comforting a person living with HIV&AIDS include being together as a family at home, communicating with one another, touching people suffering from AIDS in a loving manner, assisting them when they experience pain and discomfort, praying and reading the Bible together, doing future planning and seeking the assistance and support of a church leader, such as a priest or pastor. These actions relate to several of the main components of coping, as identified by the participants in my study. It further corresponds with the potential value of support groups, as highlighted during my study.

The results that I obtained with regard to caring for and supporting others living with HIV&AIDS are further confirmed by the findings of Rehm and Franck (2000), who conducted a study on long-term goals and normalisation strategies of children and families affected by HIV&AIDS. The findings of their study indicate support by relatives, with specific reference to extended family members, as primary coping strategy with regard to HIV&AIDS. Secondly, these authors emphasise the potential role of spiritual and religious beliefs and practices. In support of this finding by Rehm and Franck (2000), Pargament *et al.* (2001) discuss the possibility of religious coping, with people relying on their religion as a primary resource to cope with difficult situations or challenges (also refer to Boeving [2006], reported on in section 5.2.3.1). In my study, personal religion, faith and prayer were identified as important coping strategies when supporting relatives or community members living with HIV&AIDS, thereby correlating with the idea of religious coping. However, with regard to the potential role of churches, participants revealed ambivalent feelings – being judged by the church based on an HIV positive status but being strengthened by means of services and prayers.

Correlating with the results of my study indicating that family members take primary responsibility of caring for and supporting relatives living with HIV&AIDS, Nnko *et al.* (2000) report on a study with care providers of people with AIDS. According to the study by Nnko and colleagues (2000), family members fulfil the main role with regard to caring for people with AIDS. Findings of another study (Bos & Leutscher in Nnko

*et al.*, 2000) further indicate that mothers, sisters, wives and daughters are the key role-players in the African culture, emphasising the importance of women in supporting people living with HIV&AIDS. This finding corresponds with my identification of (African) women as fulfilling an important supportive role and often form the core of support for coping efforts in the community where I conducted my study, based on the high level of inner strength they possess.

The socialised tendency of women to fulfil a caring role towards others in need of support, as highlighted during my study, is further substantiated by Amoateng *et al.* (2004), as well as Greenglas (2002), who report on the important link between social support and women's coping with challenges. During difficult times, women tend to rely on other women, who face similar challenges. Marais (2005) supports this finding in regarding the tendency to care and support for others as being embedded in the nature of women. In addition, Van Dyk (2001) acknowledges the inherent strength and autonomy of African women as important in overcoming challenges, as African women have in the past been mobilising and organising themselves in order to face challenges and meet the needs in their communities, by relying on available resources within the family, neighbourhood and other informal networks.

Ulin (in Van Dyk, 2001) adds to this line of argumentation by regarding African women's solidarity as their best source of strength for coping with the challenge of HIV&AIDS. The author mentions that this powerful asset is especially evident in women's groups. Although the indications of my study centre around the capacity of women *per se* and not on their roles within the context of groups, future research may further investigate the significance of the fact that the team of educator-participants consisted of women only (since the second visit onwards), as well as the potential impact this might have had on the outcomes obtained in initiating the various projects. Inner strength was especially noticeable within the support group that was established, supporting other community members by relying on their own perseverance. Despite educator-participants' indication that they were in need of emotional support themselves, they also relied on the strength within the group by supporting one another, whilst supporting others.

As in my study, Nnko *et al.* (2000) found that family members are sometimes supplemented by friends and neighbours – depending on the relationship between them and the person living with AIDS. Apart from relying on relatives, neighbours and community members in general, Greenglas (2002) reports on the potential role of colleagues, which might be linked to women's tendency to seek support from the possible resources comprising their social networks. The results of my study confirm this idea, as the participants in my study also indicated that both people infected with HIV or living with AIDS, as well as their relatives are supported by colleagues at work. By relying on family, friends, colleagues and other community members in coping with the challenge of HIV&AIDS, the informal settlement community where I conducted my study employed the *interdependent-self approach to coping*, as propagated by Johnson and Johnson (2002).

Within the context of my study, I relate community members' tendency to rely on the support of others to the idea of *coping by means of social support*. Dillon and Brassard (1999) conducted a study among adolescents coping with the AIDS-related death of their parents, during which a relation between coping and social support was indicated, with adolescents receiving social support from others, such as family members and friends, amongst other strategies, by talking with them. In addition to the support provided by family, friends and other community members, people infected with HIV and who are living with AIDS rely on social and health services for support (Amoateng *et al.*, 2004) – or, to a lesser extent, religious groups and community-based organisations (Nnko *et al.*, 2000). However, possibly due to the limited availability of such services in the community where I conducted my study, the results that I obtained do not fully support the findings of these authors. Yet, I regard social, health and religious services as important *potential* assets in the community where I conducted my study.

In addition, NGOs emerged as sources of potential support for community members infected with HIV or who are living with AIDS. This potential value of NGOs is substantiated by both Walker (2002) and the International HIV/AIDS Alliance (2000), who highlight the significant role that NGOs might fulfil in providing care and support to people living with HIV&AIDS by, for example, presenting workshops, providing material support, initiate care and support projects, and networking with other

stakeholders to provide care and psychosocial support. The various potential ways of supporting a community in coping with HIV&AIDS were also identified by the participants in my study.

#### **5.2.3.4 Caring for orphaned children**

In my study family members reportedly tend to take children orphaned due to HIV&AIDS into their care (supported by friends and neighbours). This trend is supported by some authors, yet contradicted by others. For example, Mugabe *et al.* (2002), Ratsaka-Mothokoa (2001), Anderson *et al.* (1999), as well as Geballe *et al.* (1995) found extended family members, friends and community members to be the main sources of support to children who are orphaned due to HIV&AIDS. In addition, the church is regarded as a potential support system. This latter finding is not fully supported by the results I obtained during my study, as some of the participants in my study experienced the church as being morally judgemental of people living with HIV&AIDS (refer to my discussion in section 5.2.1.1). However, some of the participants regarded the church as potential source of support (section 5.2.3.3).

On the other hand, based on the findings of a study by Clacherty and Associates (2002) conducted in rural and informal settlement communities in the East Rand, Bloemfontein and KwaZulu Natal, the authors question the generally agreed upon belief that orphaned children and children whose caregivers are living with HIV&AIDS, will be supported by local community members. According to the findings of the study by Clacherty and Associates (2002), the stigma attached to HIV&AIDS outweighs community members' willingness and sense of duty towards others who are infected with HIV or who are living with AIDS. However, in the various communities, a few adults could be identified as caring and willing to fulfil a protective role in children's lives. In addition, Smart (2001) argues that traditional models of surrogate child care have become less able to take care of children orphaned due to HIV&AIDS and that poverty-stricken communities in particular are in need of outside support. Based on the results of my study I do not support these ideas, as I found orphaned children regularly to be taken into informal care by extended family structures in the community where I conducted my study. A possible explanation for the contradicting findings might lie in the tendency of extended

families to be replaced by nuclear families, particularly in urban areas. As such, Smart's (2001) view might apply to communities characterised by nuclear families. It might also be possible that the community where I conducted my study had been accommodating orphans in the past, merely adapting to the increased numbers of orphans, by relying on the same way of coping that has been followed over the years, despite expectations that families will not be able to handle the increase in numbers of orphans.

The manner in which the selected informal settlement community appeared to be coping with children orphaned by HIV&AIDS correlates with the community-based approach proposed by Ramsden (2002). According to the community-based approach family members and neighbours ought to assist each other on various levels in taking care of orphaned children. They might further be supported by groups in the community (such as religious organisations, educators, social workers and support groups – as also identified in my study) and rely on resources in the wider community (like NGOs and government resources – also emphasised during my study). Results from my study support the following summary by Ngcobo (2001), who conducted a study on positive responses in coping with orphaned children and concludes that '*the community through extended families still holds the key to coping with the problem*'.

Yet, children orphaned due to HIV&AIDS are often taken in by elderly relatives (like grandparents) or already impoverished relatives (Ramsden, 2002; Townsend, 2001; Mkwelo, 1997). In this regard and in relation to the tendency of extended family members taking orphaned children into their care within the context of my study, I noted that such families experience additional financial challenges. These trends with regard to coping with children orphaned due to HIV&AIDS is supported by Cross (2001), who explored the manner in which rural people cope with orphaned children. Concerning the levels of poverty, Cross' (2001) findings indicate that participants' levels of poverty were increased after taken orphaned children into their households. In addition, the author found other relatives, and to a lesser extent neighbours, as the agents providing support (whether financial, material or emotional by nature) to the families who have taken children into their care. My interviews with people caring for orphaned children revealed similar tendencies.

The opinion of the HIV&AIDS co-ordinator of the Department of Social Development in the Nelson Mandela Metropole that an increase in anti-retroviral medication might result in less children being orphaned by HIV&AIDS in future, is supported by existing literature. Monasch and Boerma (2004) conducted a study in sub-Saharan Africa, reaching a similar conclusion, namely that anti-retroviral treatment might prevent a rapid increase in children orphaned by AIDS in the near future, in particular in cases where fertility is low. Meintjes *et al.* (2003) reached the same conclusion, based on their study in six sites across five provinces in South Africa. However, I speculate to what extent the provision of medical treatment might on the other hand result in an increase in at-risk sexual behaviour, thereby possibly increasing pregnancies and eventually the numbers of orphaned children in the community.

Within the context of my study I did not obtain any results relating to child-headed households, despite the possibility of this option being documented in existing literature. For example, Walker (2002) conducted a study on child-headed households in a farm worker community in Zimbabwe, concluding that any community can play a role in assisting children in child-headed households. Although community members might not be able to offer material resources to others, they are able to offer social and emotional support by, for example, paying home visits, loving and caring for others. Despite the fact that my study did not directly indicate child-headed households, I relate Walker's (2002) findings to my study, as I also noted that community members who are in financial need and not able to support others financially, do provide assistance in the form of food, advice and moral support. I further relate this way of support in different formats to the African culture, according to which people work collaboratively and support one another during times of difficulty.

In conclusion of this section, I relate the results that I obtained during my study with regard to the selected community's way of coping with orphaned children, to that of the Khmer HIV/AIDS NGO Alliance (2000), who conducted a study on children affected by HIV&AIDS, identifying the needs experienced by affected children in Cambodia, as well as possible resources to address their needs. These resources might be compared to the assets (resources) identified in my study (refer to section 5.2.2), as both studies concern ways of coping with the challenges posed by

HIV&AIDS. The Khmer HIV/AIDS NGO Alliance (2000) firstly identified *resources of children*, such as siblings who might offer support, care and advice, except in cases where they have to compete for resources. In my study, siblings were not identified as potential assets in supporting children coping with HIV&AIDS, possibly due to the fact that I did not obtain children's perceptions but merely focused on that of adults who might not think of children as being potential resources. Secondly, I regard *resources of families* as potential assets, as grandparents and other relatives might support a family when a parent is sick, take care of children orphaned due to HIV&AIDS, act as role models and provide education on life skills. In my study, the family was identified as primary source of care and support to those in need of emotional assistance. *Resources in the community* include neighbours, community leaders, community associations, educators and traditional healers as potential sources of emotional support, practical support (like assisting with household tasks), material support, treatment and taking care of children, as also found during my study. Next, *resources provided by people living with HIV&AIDS* can take on the form of support groups. Although support groups did not emerge as a primary coping strategy, the potential of such groups seemed significant. In addition, people living positively with HIV&AIDS appeared to serve as role-models to other community members and might possibly impact on attitudinal change in the community.

With regard to *resources provided by businesses*, none of the participants in my study indicated local businesses as potential resources that might provide financial and material support or work opportunities – thereby generating income, possibly due to the high level of poverty in the community. Concerning *resources provided by NGOs*, NGOs emerged as important potential assets as they might support the community in terms of counselling, workshops, and assistance in obtaining funding or combating social problems in the community. Towards the end of my field work, educator-participants mobilised this potential asset, by contacting a NGO to request funding for a community hall, which could serve as basis for income generation projects that community members might benefit from. Lastly, *government resources* might include HIV testing and counselling facilities, trained government health and social workers, national guidelines and strategies on HIV&AIDS, provincial hospitals, plans for home-based care programmes, and HIV&AIDS being part of the school curriculum (Khmer HIV/AIDS NGO Alliance, 2000). These aspects were indeed



identified as potential ways of supporting the community in coping with HIV&AIDS by the participants in my study.

#### **5.2.4 OUTCOMES OF INTERVENTION RESEARCH IN TERMS OF A COMMUNITY'S APPLICATION OF THE ASSET-BASED APPROACH IN COPING WITH HIV&AIDS**

UNICEF (2000b) propagates an approach to coping with HIV&AIDS during which individuals, family members and community members are involved and empowered to develop their own strategies and put them into action, in order to cope with the challenges related to HIV&AIDS, thereby implementing the asset-based approach. The first step, as identified by UNICEF (2000b) and which was also actualised in my study, requires that an awareness of the challenge needs to be raised, followed by community members initiating strategies. In my study, such awareness resulted in community members experiencing themselves as capable of coping with the challenges of HIV&AIDS, subsequently leading to participants initiating three school-based projects.

Such an approach during which community members identify possible ways of coping with a challenge often require facilitation by outside agencies, yet does not imply that outsiders formulate the strategies to be implemented, as emphasised by the Khmer HIV/AIDS NGO Alliance (2000). I found this to be the case during my study, as the community where I conducted my study was indeed able to implement community-based responses in coping with HIV&AIDS but needed facilitation to do so. Although participants initially indicated that they were not fully able to cope, they were aware of their abilities to do so towards the end of my study. I henceforth discuss the outcomes of my implementation of an activist intervention research approach, relating it to the application of the asset-based approach in supplementing the selected community's coping with HIV&AIDS. I discuss both the tendencies that remained constant, and the changes that occurred as my study progressed.

##### **5.2.4.1 Consistent coping tendencies**

Applying the asset-based approach, integrated with the application of PRA principles within the context of my study results in a few ideas on communities' coping with

HIV&AIDS. Firstly, it supports my initial assumption that informal settlement communities have been in the past, and are at present, able to cope with HIV&AIDS by relying upon themselves and the resources available to them within their local community. This idea remained constant throughout my study. Not only did individuals possess certain skills, capacities and assets that might contribute to the community's response to the challenge of HIV&AIDS, I also identified the community as entailing local associations and local institutions that contribute to the community's coping. Secondly, I found that in order to facilitate sustainable coping, potential assets that are not yet mobilised need to be accessed and utilised, and relations formed between the various role-players, as this could result in the community being empowered to effectively cope with the challenges implied by HIV&AIDS. Therefore, by employing the asset-based approach communities can take agency, thereby enhancing the possibility of sustainable coping (refer to Ebersöhn & Eloff, 2006; Snow, 2001b; Kretzmann & McKnight, 1993).

The reality and prevalence of stigmatisation and secrecy with regard to HIV&AIDS and its related issues remained constant during the entire course of my study, within the context of the broader community (refer to my discussion on stigmatisation-related findings in section 5.2.1.1). However, the educators who participated in my study displayed decreased levels of stigmatisation towards the end of the study. Closely related, selected parents of learners of the school appeared to be more willing to disclose their HIV positive status – but then only to selected educators at school – in order to obtain advice, guidance care and support. This can, however, not be accepted as the norm, as the majority of the community appeared to stigmatise and refrain from disclosure.

Participants displayed certain needs during my study, namely the need to be informed and continuously acquire new skills, as well as the need for money, in order to combat poverty (also refer to section 5.2.1.1). As such, the condition of poverty remained constant during my study, resulting in the participants having to rely on themselves and the resources in their immediate environment in coping with challenges, such as HIV&AIDS. Apart from relying on family members, friends and other community members as sources of support, religion, in terms of faith and

prayer, emerged as central constant components of coping, as experienced by the community where I conducted my study (refer to my discussion in 5.2.3.1).

#### **5.2.4.2 Changes in coping strategies**

I discuss the changes that occurred based on the intervention participatory research approach I employed in terms of the changes experienced by the participants, as well as the changes applying to the wider community where I conducted my study. I conclude the section with a final overview of results relating to the approach I selected.

##### **5.2.4.2.1 Changes experienced by the participants**

During my study participants became aware of their own capabilities and strengths, as well as the resources in the community – referring to individuals, associations and institutions. This result is supported by the findings of a study by Buysse *et al.* (1999), indicating that community members displayed an increased awareness regarding their community's needs and resources after completion of the study. Based on the fact that both Buysse *et al.*'s (1999) and my study followed intervention research approaches and involved discussions amongst community members, focusing on possibilities and resources in the community, I propose that facilitation and communication with and between community members might result in them becoming aware of what already exist but have not been utilised optimally yet.

In the same manner that my study's results highlight the value of asset-mapping, Moore's (1999) report on the Savannah communities project emphasises the potential value of mapping assets in a community. As a result of the mapping activities included in Moore's (1999) project, community members were able to recognise the strengths available in their community, as well as consider ways of utilising potential resources and strengths. One of the outcomes was the development of a programme that, amongst other things, focused on training and support. In a similar manner, the outcomes of my study also relate to community members (participants) recognising the assets and strengths in the community, the

sharing of information and supporting of those in need of support – within the context of coping with HIV&AIDS.

Based on their awareness of their own abilities, existing assets and local resources, educator-participants in my study became more motivated and enthusiastic to take action and assist other community members in coping with HIV&AIDS. Increased levels of motivation and feelings of empowerment subsequently resulted in them initiating the three school-based projects. Related to this finding, Kabiru *et al.* (2003), as well as Page-Adams and Sherraden (1997) report on the value of assets and being aware of assets. These authors indicate that assets positively impact on self-efficacy and life satisfaction, and therefore on the personal well-being of people. Within the context of community-based intervention focusing on adult literacy programmes, Archer and Cottingham (1996) also report an increase in self-realisation and self-esteem amongst participants. These authors relate such positive outcomes to the implementation of PRA, which supplements the asset-based approach. Participants' awareness of available assets (also within themselves) seemingly resulted in them feeling more competent regarding their own and the community's ability to cope with the challenge of HIV&AIDS is confirmed by the findings of the studies reported on in this paragraph.

Holmstrom (1996) further supports trends like these by emphasising the positive outcome of the presence of assets in people's lives, reporting on a survey conducted by the Moorhead Healthy Community Initiative (MHCI) in 1994, according to which children thrive when they have more assets available, as assets are regarded as means that enrich people's lives. Relating this principle to my study emphasises the importance of people being aware of the assets they possess and have access to. Facilitating community members (participants) to purposefully identify and mobilise available yet unused assets, had a positive impact on the community's level of functioning and way of addressing the challenge of HIV&AIDS within the context of my study. Secondly, in identifying and initiating the three school-based projects, educator-participants did not only take agency and experience feelings of pride, they also enabled other community members to believe in their own abilities and face challenges more positively. In accordance with one of the MHCI's criteria for measuring success, namely a change in attitude, the community members involved

in my study did indeed display a change in attitude – from feeling helpless and relying on outside experts, to believing in their own abilities and skills. As an outcome of becoming involved and initiating the three mentioned projects, the social capital of the community increased as my study progressed (as also found in a study by Kelly *et al.*, 2002).

I relate participants' increased awareness of existing assets and potential but not yet mobilised assets towards the end of my study, to two main factors. Firstly, approaching my study from the asset-based approach implied facilitating an awareness of assets amongst participants. Secondly, my decision to apply PRA principles supplemented the facilitation of an awareness of assets amongst participants. In this regard, Chambers (2003:125) – in his discussion of the advantages of PRA – refers to the response of a villager in Zimbabwe during a study: '*We did not know we had all this information,*' and later to that of a Sri Lanka villager after employing PRA during a Self-Help Support Programme, stating: '*We could do what we never thought we could do*'. The participants in my study acknowledged similar feelings of being capable and able to address challenges. My results are further supported by several of the proposed outcomes of PRA, which were obtained in my study, namely that participants learned from the process, gained confidence, owned the outcome of the process (thereby taking agency), obtained new knowledge, broadened their capabilities and discovered things about themselves (such as their strengths) (Chambers, 2004; Strand, Marullo, Cutforth, Stoecker & Donohue, 2003). These outcomes (as obtained during my study) further correspond with Kretzmann *et al.*'s (1997) distinction between tangible (the three projects) and intangible results (participants' change in attitude, feelings of empowerment, self-belief and hope for the future) of asset-based development initiatives.

Participants' high levels of motivation and involvement (participation) in my study resulted in positive outcomes, thereby correlating with the outcomes of a community prevention initiative which was launched in the Western Cape (South Africa) and reported on by the Department of Social Development (2002) in the following terms: '*Recognise that a lot can be accomplished with limited resources, as commitment and altruism are strong impulses that often produce incredible useful results. Such actions should be encouraged*'. Leach (2003b) emphasises the potential value that

participation and the active involvement of participants within the context of PRA hold for the facilitation of change. Besides the importance of participants' involvement, the author highlights the importance of becoming aware of and then utilising available resources in an attempt to build capacity and take agency of the process of community development. In my study, both these facets contributed to the participants taking agency and facilitating change in the community, thereby implementing the asset-based approach in coping with HIV&AIDS.

By being actively involved in the research process and becoming aware of their own abilities and strengths, participants were seemingly empowered as my study progressed. They were increasingly willing to mobilise their potential, by participating in decision-making, as well as developing and implementing action plans to initiate the three school-based projects, thereby facilitating change and becoming involved in community development. They displayed improved levels of confidence to address the challenges faced by the community. Participants also displayed the ability to establish community-based social networks and social support systems, in order for them not to have to rely on outside help and formal structures. Yet, they were able to effectively communicate their needs to selected identified outside agencies. They, for example, spontaneously approached an external agency for financial support towards the end of the study, based on their own feelings of confidence and belief in their abilities. This process of being empowered is widely documented in existing literature on both PRA and the asset-based approach (refer to Strand *et al.*, 2003; Mokwena, 1997).

In this regard, Eloff (2006a), points out that the focus of the asset-based approach on the resources and capacities inherent in individuals and their environments in itself also has an empowering and enabling effect on the outcome of the process. In support of Eloff's (2006a) view, Mahoney, Lafferty & Nutter (2003) report on a study on asset-building and the enhancement and advantages of an asset-based school environment, concluding that their manner of data collection is an asset-building activity in itself. In the same vein, I regard the methodological approach and data collection activities I chose (specifically the intervention activities) as asset-building activities, as it facilitated feelings of empowerment amongst participants. Not only did the educator-participants (and also some other participants) participate actively,

provided input and initiated projects; they also gained an understanding of the asset-based approach during the process of data collection and documentation. This theme on participation facilitating empowerment is supported by the findings of Kriek (2002), Lockett (2000), Feikama, Segalavich and Jeffries (1997), Dinnebeil, Hale and Rule (1999), as well as Webster-Stratton (1997).

The emphasis on the processes implied by the asset-based approach corroborates with the findings of Kretzmann *et al.* (1997), who report on the implementation of a capacity inventory as a method to enhance community development. These authors found that capacity inventories could, amongst other positive outcomes, result in people (community members) being *organised to address issues* (challenges) in the community. One of the outcomes of the second forth-flowing intervention of my study was the three projects initiated by the educator-participants. Firstly, the participants initiated a vegetable garden (involving community members) thereby addressing poverty and indirectly the community's way of coping with HIV&AIDS. In addition, the participants initiated an information centre and support group in the community, assisting community members to address the challenge of HIV&AIDS. As such, my (our) findings correlate with that of Kretzmann *et al.* (1997) concerning community members being able to address challenges. A second possible outcome identified by Kretzmann *et al.* (1997) relates to the *building of trust and social capital by means of connections and links*. In my study, the educator-participants displayed the potential to bring those living with HIV&AIDS into contact with others, in order to become part of a support group in the community, supporting one another in facing the challenge.

Kretzmann (1997) describes an empowered or strong community in terms of four basic criteria, which correlates with the results of my study, thereby indicating that the community was empowered by means of the educator-participants implementing the asset-based approach. According to Kretzmann (1997), an empowered community is a community in which the assets have been discovered, listed in the form of an inventory and made visible. In my study, participants compiled maps in order to identify available assets. Secondly, an empowered community is a community in which the assets have been put to use during strategic planning for the future. In my study, participants relied on potential and available assets to plan and

initiate the three school-based projects. Thirdly, assets need to be connected with one another in terms of new strong networks, consisting of mutual and beneficial relationships. In my study, participants established new networks and collaborated as a team (relying on a combination of assets) in order to support the community in coping with HIV&AIDS. Lastly, community members (and their assets) need to be involved in obtaining and managing resources outside the community, as was done by the participants during my study.

In my study, feelings of empowerment therefore resulted in community members taking responsibility. This finding correlates with the findings of Ebersöhn and Mbetse (2003:326), who relate capacity building being facilitated amongst community members, to individuals taking ownership and responsibility for the development of their career education process: *'Instead of the community playing victim to negatives, they chose to mobilise themselves as mutually supportive and caring change agents. Their approach to career education is not that of passively complaining and waiting for the government to save them. The control and power for their career education initiatives and solutions are internally situated.'* With regard to taking responsibility within the context of HIV&AIDS, I regard the Community-based Options for Protection and Empowerment (COPE) project described by Hunter (2002) as an example of an effective community mobilisation project. The outcomes of this project include that communities found their own solutions during the project, by taking responsibility to care for and support those infected with and affected by HIV&AIDS. Similar to my study, the COPE project facilitated community ownership, psychosocial support and community members being informed about HIV&AIDS. In addition, communities (participants) successfully mobilised resources within the community as well as on an external level (as was done in my study), in order to enhance food and income security. By identifying challenges and solutions themselves, their capacity to cope with orphaned and vulnerable children was developed, resulting in higher levels of social capital (Richter *et al.*, 2004; Strebel, 2004; Hunter, 2002). In my study, community members' (participants') identification of solutions positively impacted on the community's coping with HIV&AIDS.

The intervention research approach that I employed complies with one of the suggestions of Miamidian *et al.* (2004), namely community-level intervention, where



community mobilisation, community fundraising, income-generating initiatives, the promotion of linkages to developmental institutions and the provision of child care were suggested. As minimum requirements for such initiatives, Miamidian *et al.* (2004) suggest active involvement of community members in planning and management of initiatives, the use of local resources, and ownership by community members. Initiatives are suggested to be facilitated by outsiders or initiated by community members themselves. In conducting my study I adhered to these suggestions, thereby implying that community members might have been able to take agency of the process, as was found to indeed be the case.

I further relate the results obtained during my study to Lucas' (2004) description of yet another example of a successful community response to HIV&AIDS, namely the Salvation Army Change Programme in Zambia. The programme resulted in human capacity development, by building on local resources and strengths, facilitating community members to take action with regard to prevention, as well as caring for and supporting those infected and affected by the disease. It focuses on the strengths of individuals, families and communities, encouraging community members to recognise the ways that they are already responding to HIV&AIDS so that they can build on what is already there. As such, emphasis is placed on local community members' resourcefulness and innovative ideas of addressing the challenge, thereby on their way of coping (Lucas, 2004; Foster, 2001; Cook, 1998). This once again correlates with the asset-based approach, as employed during my study and enabling a selected community to better cope with HIV&AIDS.

As my study progressed, educator-participants clearly displayed the ability to rely on their own resourcefulness. They started supporting community members living with HIV&AIDS, by referring them to professional services and assisting them in applying for the disability grant by guiding them on the correct institutions to approach. In this manner, the results of my study correspond with those of Kretzmann, McKnight and Puntenney (1998) (in an adapted format), who report on the potential use and positive outcomes of employing a so-called *local capacity listing and referral service*, that might be utilised to refer community members to other suitable role-players who might assist or support them in overcoming challenges. In my study, this potential resource was used in an adapted format (simply by enquiring and then memorising),

as the participants did not rely on formal lists and information capturing systems to capture their information. However, the way this method was employed by the educator-participants, resulted in similar positive outcomes as that obtained when relying on formally captured lists. Yet, relating this method in its initial format to the participants might assist them even further in providing information to and supporting community members in coping with HIV&AIDS.

Concerning the possibility of extending positive changes to the wider community, selected individuals (primarily the educator-participants) were initially empowered during my study. However, as any community consists of individuals, the strengths and possible areas of improvement of the community represent that of its individual members. As such, the empowerment of the selected community members inevitably resulted in them going out into the community and in turn empowering other community members, by involving them in the initiatives that were planned and put into action. The empowerment of the broader community is supported by Mokwena (1997), who reports on various studies relating to the relationship between the empowerment of individuals and that of communities.

Moore (1999), as well as Puntteney and Moore (1998), report on a programme (the *Grants for Blocks* programme, initiated in 1993), which aimed at getting communities to initiate and implement community improvement projects by relying on local community members to address community challenges. The programme resulted in a variety of projects relating to aspects such as crime prevention, youth development, the presentation of workshops and improving the facilities and appearance of the community. In addition, it led (just as in my study) to an increase in resident empowerment, in the form of higher levels of involvement in initiatives focusing on the improvement of the community (neighbourhood), self-advocacy and taking the lead in the community. The following comment was made, referring to the *Grants for Blocks* programme: '*If you get a community together, you've got the power to do anything*' (Puntteney & Moore, 1998:1).

Despite the main difference of this programme involving financial assistance from an outside source, the main findings of the programme correspond with the empowerment of educator-participants in my study in turn resulting in other

community members becoming involved and actively taking part in coping with the challenges related to HIV&AIDS. As a result, the cohesion and relationships amongst community members most probably also improved, as found by Puntteney and Moore (1998) during the *Grants for Blocks* initiative. Both my study and the one reported on by Moore (1999), as well as Puntteney and Moore (1998), emphasise the positive outcome of community members being empowered to plan and implement self-help activities, in order to cope with challenges faced by the particular community. The following two examples of responses in the *Grants for Blocks* initiative directly correlate with responses that I obtained during my data collection, as reported on in chapter four: *'People have always had good ideas, they know how to solve their problems, but they need a little help. Grants for Blocks has helped us put our ideas into action'* (Puntteney & Moore, 1998:21), and: *'The beauty of Grants for Blocks is that it is a way to encourage resident involvement, and that involvement spills over into all sorts of other activities that are happening around development and improvement issues'* (Puntteney & Moore, 1998:43).

By supporting HIV&AIDS infected community members, the educator-participants (support group) enhanced the community's way of coping with HIV&AIDS. For example, by providing advice, physical support and paying home visits, individuals living with HIV&AIDS could be supported to better cope with the challenge of their illness. In addition, caregivers of orphaned children could be supported, in order to allow for such orphans to remain and be cared for within their community and tradition. Furthermore, other relatives, friends and community members provided help and assistance to those looking after orphaned children. These results relate to the Child Protection Society of Zimbabwe (1999), who suggests such initiatives as part of a support programme for orphaned and vulnerable children.

During the later stages of my study, the educator-participants acknowledged the significant role of their school in the community's coping with HIV&AIDS. In this regard Ford (1996) emphasises that community-based development depends on reliable and strong local institutions, being the school in my study. During discussions on the value of the school to the community, one participant labelled the school as a *'community school'*. As community schools refer to schools that are run by communities, where no school fees or uniforms are required and where teachers of

the close community are used, often on a voluntary basis and with limited training, the possibility exist that the particular participant did not clearly understand the concept. She might have referred to the '*school as a comprehensive community-based organisation*', which – per definition – implies that the school is the centre of activity and service for the community (Richter *et al.*, 2004; Kelly, 2000b; UNICEF, 2000b). On the other hand, the participant might have been of the opinion that the way in which the school was accepted in the community reflected something of the concept of *community schools*. Based on these uncertainties, I am not able to explain this result and will have to explore further in order to be able to do so. However, the importance of the school and the educators in assisting community members to cope with HIV&AIDS is not to be doubted.

#### **5.2.4.2.2 Changes in terms of community development**

During my study I found that the selected community was able to cope better with the challenges related to HIV&AIDS towards the end of my study, based on community members' implementation of the asset-based approach. This result is supported by Lubbe and Eloff (2004), who summarise the possible use of the asset-based approach in coping with challenges. Although these authors describe the asset-based approach within the context of Educational Psychology, the following view can be applied to my study: '*In partnership with parents, other caretakers and teachers, the assets of the family or community can be identified, then mobilized and expand in order to help them optimally cope in their daily lives (i.e. emotional health for life)*'.

As an outcome of the intervention research I conducted and facilitated in the community, community development was enhanced. In this manner, my study can be related to Snow (2001b)'s discussion on community development, according to whom positive changes in a community might be ascribed to the process of utilising assets in the community, being an indication that asset-based community development has occurred. In my study, the selected informal settlement community therefore underwent community development whilst implementing the asset-based approach. Visible changes that occurred and are indicative of the community development that took place include the establishment of the vegetable garden, support service and information centre, as well as community members becoming

more involved in community activities. In addition, the educator-participants identified several potential school/community-based projects (like a soup kitchen at school, initiating income generation projects and building a hall) that might be initiated in future, once again building the community.

Measuring the outcomes of my study in terms of the two criteria for successful community building as identified by Kretzmann *et al.* (1997) strengthens my conclusion that my study did indeed result in community development. Firstly, a belief in the capacities of local community members (and the educator-participants, who started viewing themselves as key role-players in solving [addressing] the problems faced by the community) was built and secondly, these capacities were mobilised in order to result in concrete outcomes, namely the vegetable garden, information centre and support service provided by the school. Results from my study correlate with that of Kretzmann *et al.* (1997), who report on six community groups implementing the asset-based approach (more specifically compiling a *capacity inventory*) and the positive outcomes of the processes in terms of community building, for example by identifying community members to be involved in addressing challenges, initiating community-based projects to address challenges and developing the capacities of community members in order to cope with challenging situations.

Based on the results obtained during my study, I regard the selected community (or rather school) involved in my study as an *AIDS responsive community*, a concept used by Kelly *et al.* (2002) in describing the rural community where they conducted their study. In my study, the challenge remains to extend on the activities initiated by the educator-participants and to apply it on a wider scale in the community than at the time of my study. The *launch day* planned and held by the rural community in Kelly *et al.*'s. (2002) study correlate with the *official celebration day* (which included the official opening of the school) planned and conducted by the school where I conducted my study in September 2005. This serves as an indication of the potential value of interventions in poverty-stricken and rural communities, where community members have to be made aware of their capabilities, in order to move them into action in facing the challenges associated with HIV&AIDS.

Kelly *et al.* (2002) conclude that the Eastern Cape rural community where they conducted their study might be used as a showpiece for similar and surrounding communities, as the project effectively connected AIDS responses and community development. In addition, the community complied with the national Department of Health's white paper which propagates community participation as part of health promotion and health service provision. The authors do, however, voice their concern regarding the sustainability of their intervention and remark that outside assistance might be needed in order to sustain the activities already started, in terms of aspects like advice networking. On the other hand, Moore (1999), as well as Punttenney and Moore (1998), are of the opinion that programmes such as the *Grants for Blocks* initiative holds the value of accomplishing sustained neighbourhood improvement, by achieving resident ownership (agency). By taking ownership, community members participate in the various areas of such initiatives and take on leading roles in the community. Applying these findings to my study result in my hypothesis that the initiatives facilitated in the community where I conducted my study will most likely be sustained, as the educator-participants (and subsequently also other community members) took agency of the various initiatives and its outcomes, and were (are) indeed involved in the various areas of the projects as members of the team but also fulfilling a leading role in the school and community. This idea is, however, a mere hypothesis that needs to be further explored.

#### ***5.2.4.2.3 Concluding findings related to the activist intervention research approach that I employed***

The activist intervention research approach I employed during my study correlates with the community-based intervention approach proposed by Trickett (2002). I firstly facilitated an assessment of the community in terms of challenges, assets and potential assets, as well as the various role-players in the community. Secondly, I paid much attention to building up a good collaborative research relationship between the community members (participants) and myself. I continually kept the context as well as the culture of the community members in mind. Lastly, my intervention research resulted in community development and an impact on the community's way of coping with HIV&AIDS.

The intervention research approach that I employed further correlates with the three areas of the COPE project, as described by Hunter (2002). I firstly conducted intervention sessions to raise awareness of HIV&AIDS and its impact on the selected community. Secondly, I facilitated community action towards taking agency in coping with HIV&AIDS. Thirdly, I (and my co-researchers) facilitated initiatives to be planned and implemented at community level, in order to better cope with the pandemic. The finding that educator-participants were mobilised to facilitate change in the community correlates with the following statement by Parker *et al.* (2000), discussing the value of participatory strategies in addressing HIV&AIDS: '*Individuals drawn into participatory communication activities often make marked changes to their own behaviour, and become catalysts for change at community level*'.

In conducting intervention, I adhered to the principles underlying interventions at community level, as formulated by Miamidian *et al.* (2004). Reflecting on the outcome of my study, I found that my intervention did indeed assist the selected community to do what it has been doing in a better way, that facilitation assisted in unlocking the capacities of the participants (community members) and that my intervention involved only a small core of community members, but in turn served to catalyse involvement on a broader community level. During my study, I further confirmed community ownership to be the basis of effective community action, and that community-based initiatives may commence with a collaborative effort of identifying areas of shared concern, but also of assets.

The specific steps I employed during community mobilisation are similar to those suggested by Richter *et al.* (2004), as well as Kretzmann and McKnight (1993), thereby qualifying the process as the *asset-based approach put into action*. After raising awareness of the impact of HIV/AIDS amongst participants, I facilitated a sense of ownership. In the process I included activities of mapping existing assets, capacities and resources in the community, identifying existing challenges, and planning how to manage these challenges by relying on internal resources. This implied the mobilisation of available but not yet utilised assets in the community. Throughout, I monitored the process and adjusted activities when needed. During intervention sessions I found Cook's (1998) principles for effective community development and Hunter's (2002) guidelines for mobilising a community, to be

valuable. Therefore, I spent prolonged time in the field, during which I continually focused on being culturally respectful, involving as many stakeholders as possible, constantly building relationships of trust, collaborating and communicating with the participants and building on existing strengths. I also encouraged participants to develop strategies and take action in coping with the challenges they identified, thereby facilitating empowerment and enhancing community ownership or agency.

In describing the process of effectively planning and conducting culturally appropriate community mobilisation, Cook (1998) mentions three basic steps as a possible strategy to follow in supporting families and communities. I applied these steps of assessment, analysis and action (so-called 'Triple A' approach) during my study. By employing this approach, I observed that facilitators can indeed assist community members in building on their own strengths, and developing strategies to address the challenges they face. During the assessment phase, I acted as facilitator and conducted interviews with stakeholders in the community, with regard to the community's way of coping with HIV&AIDS. During the analysis phase, I analysed the information that I collected and then requested feedback from the participants. After providing the participants with the collected information, they were facilitated to formulate plans to address the identified challenges. Finally, during the action phase the participants decided on plans and put them into action. The final step in the process entails a re-assessment of the intervention in order to determine whether or not it had been successful and plan on further steps to be taken.

The steps I followed also relate to most of the proposed strategies of The Child Protection Society of Zimbabwe (2001), as implemented during community-based orphan care programmes. The suggested process (which corresponds with the processes described in the previous paragraphs) firstly involves that awareness be raised about the challenge within the community. The second step relates to documenting the extent of the challenge by assessing the needs and keeping a register, finding out what community members can do (identifying resources and potential areas for growth or the development of resources), and monitoring the progress of the programme. These actions were conducted during the intervention sessions I facilitated with the educator-participants, as well as during individual interviews with members of the community. Thirdly, the community needs to be



mobilised into action by, for example, establishing partnerships with outside resources, networking with stakeholders and mobilising volunteers from the affected community to plan and take action. During my study, I focused mainly on the latter of these three steps, although the first two were also actualised. Next, the Zimbabwean programme focuses on making ends meet, helping to educate and train children, and improving legal systems to help children. Within the context of my study I included these final steps in an adapted format, as the participants were mobilised to assist community members in facing poverty and generating income (for example by means of the vegetable garden), educate colleagues, community members and children with regard to HIV&AIDS, and lastly assist community members in applying for government grants in cases qualifying for the grant.

In reporting on the Salvation Army Change Programme in Zambia, Lucas (2004) assesses the facilitation process as being successful, based – amongst other things – on the establishment of community gardens as a way of providing food and income, as well as an increase in community members responding actively to the HIV&AIDS challenge. Assessing my study solely in terms of these criteria implies that intervention and the participatory choices I employed during my study were effective. However, it is my view that various other aspects and outcomes need to be considered in determining the accountability of my study. Thus I cannot conclude that my study has been effective, merely based on these two isolated criteria.

### **5.3 CONCLUSION**

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Building on the results of my study that I presented in chapter four, I structured my discussion in terms of findings accordingly in this chapter. I continually related my results to existing literature, indicating similarities as well as contradictions. In the case of contradictions, I attempted to provide possible explanations.

In the next and final chapter of this thesis I summarise chapters one to five. I reach final conclusions by reflecting on my research questions in terms of cumulative findings resulting from this chapter. I conclude my study with recommendations for future research projects and practice.