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**Frustrated Potential, False Promise or Complicated Possibilities?  
Empowerment and participation amongst female health volunteers in  
South Africa**

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## **Abstract**

We present a longitudinal case study of lay women's participation in a Project seeking to facilitate home-based care of people dying of AIDS in a rural community in South Africa, drawing on four sets of interviews conducted with volunteers over a five-year period. We link participation in the Project to three dimensions of women's agency: their knowledge and skills, their confidence and their personal experiences of efficacy. We show that whilst the experience of participation enhanced each of these dimensions of volunteers' agency at various stages of the Project, the empowerment that did take place appeared to be limited to women's project-related roles, rather than generalising to other areas of their lives beyond the Project. The Project had limited impact on women's ability to negotiate condom use with husbands, to assert themselves in relation to male Project leaders, and to become more involved in wider community decision-making and leadership. We discuss three possible interpretations of our findings (i) that greater empowerment might have occurred had the Project run for a longer time period; (ii) that whilst such projects play a vital role in providing services, the more general 'empowerment via participation' agenda is a false promise in highly marginalised communities; or (iii) that whilst generalised positive impacts of such projects on volunteers are hard to track, such projects do open up glimpses of increased agency for many women. These might have positive but unpredictable results in ways that defy formulation in linear conceptualisations of social transformation and development, understood in terms of clearly observable and measurable inputs and outputs.

## **Introduction**

In this paper we provide a case-study of a project that sought to facilitate grassroots participation of female health volunteers providing home-based care for those dying of AIDS-related illnesses in a rural South African community. The aim of the Project was not only to provide essential healthcare services in a resource-poor community, but to use women's participation in this Project as a springboard for their wider social and economic development, through an 'empowerment via participation' approach (Campbell *et al.*, 2008a; Campbell *et al.*, 2007). According to this approach the experience of participation provides a starting point for the development of an empowering sense of agency – defined here as increased knowledge and skills, confidence and personal experiences of efficacy – in previously marginalised groups (Cornish, 2006; Gaventa and Cornwall, 2001). Such a sense of agency was seen as a first step towards women playing a greater role in wider community decision-making and leadership.

A commitment to the participation of socially excluded groups in health and development projects is a pillar of many health and social development policies and programmes (WHO, 1978; WHO, 2008a; Hickey and Mohan, 2004). It is also central to the achievement of the two Millennium Development Goals most directly related to our interests in this paper, namely Goal 3 (to promote gender equality and empower women) and Goal 6 (to combat HIV/AIDS) (UN, 2000). Within HIV/AIDS management there has been a particularly strong focus on the importance of community participation including a focus on the potentially empowering effects of participation for

marginalised groups (Beeker *et al.*, 1998). The direction of South African health and development policy reflects this trend (South African Government, 2007). Government policies and programmes emphasise the value of lay volunteer involvement in healthcare delivery, specifically HIV/AIDS (Schneider *et al.*, 2008).

There have been many discussions of the pro's and con's of participation in the development studies field (e.g. Hickey and Mohan, 2004; Cooke and Kothari, 2001), and discussions of women's empowerment and agency in the field of women's studies (e.g. Madhok, 2005; Parpart *et al.*, 2002). Much work remains to be done, however, in developing understandings of how best to think about participation and agency in the context of AIDS management in Africa. Different contexts and projects provide different opportunities for different forms of participation and for the development of agency in previously disempowered participants. As Madhok (2005) argues, agency is a socially embedded, constructed and enabled experience, and opportunities for agency need to be understood on a case-by-case basis from one social context to another.

Our case study focuses on lay women's participation in an AIDS-management programme in southern Africa against the background of the heavy emphasis being placed on 'task shifting' (training lay people to perform basic AIDS-related healthcare tasks previously performed by nurses) by international health and development agencies (WHO, 2008b). In this paper we examine the extent to which the 'empowerment via participation' strategy provides real

opportunities for women to increase their control over their lives, or the extent to which the strategy may be subverted to mobilise women into providing unpaid welfare services, arguably even reinforcing rather than challenging their social marginalisation.

The Entabeni Project – the topic of this paper - emerged to support an existing cadre of health volunteers to achieve two inter-related goals. The first was to support them in improving access to care and support for people living with HIV/AIDS (PLWHA). The second was to ensure that women’s participation in the Project would lead to an enhanced sense of agency. It was hoped that positive experiences of project participation and leadership would increase their confidence to assert their views and interests in relation to men in both interpersonal relationships and community settings in a heavily male-dominated environment, as well as enabling them to play a greater role in local community leadership.

The Project was a partnership between a university research group called HIVAN<sup>i</sup> and Entabeni health volunteers, and was funded by international donors. HIVAN served as ‘External Change Agent’ (ECA), helping local people set up the project, and facilitating the development of supportive ‘internal partnerships’ between health volunteers and key local actors and ‘external partnerships’ between health volunteers and external agencies. Over the three years it was hoped that health volunteers would gradually develop the skills and confidence to take control of the Project themselves, and that

this would have ‘spin-off’ effects on their role and status in the wider Entabeni community.

This paper reports on the authors’ five-year longitudinal case-study of this Project, to explore three questions:

1. In what ways did health volunteers’ participation in the Project enhance their agency over time?
2. What dimensions of women’s agency were enhanced through this participation?
3. What factors supported or hindered the development of these different dimensions of agency?

### **Entabeni Community and Project**

Entabeni is a rural community in KwaZulu-Natal, South Africa. Around 35 percent of pregnant women are HIV-positive and there are high levels of poverty and ill-health (Barron *et al.*, 2007). It bears a disproportionate burden of HIV/AIDS; with limited access to government healthcare and welfare services (Campbell *et al.*, 2008b) and increasing numbers of people returning from urban areas to be cared for and die (Clark *et al.*, 2007).

The community is governed by the traditional chief (the *Inkosi*) who delegates his day-to-day control to traditional councillors (*Indunas*). There is also a democratically elected Municipality whose jurisdiction overlaps with the *Inkosi*’s. In reality the municipality has limited authority in Entabeni and the

*Inkosi* has effective control of the community.<sup>ii</sup>

The Entabeni Project was a 5 year longitudinal Project, split into four phases (Table 1)

*Insert Table 1 about here*

Phase one of the Project (2003 – 2004) took the form of baseline research into community responses to HIV/AIDS in Entabeni (Campbell *et al.*, 2008b; Maimane *et al.*, 2004), culminating in 10 dissemination workshops with key community groups, during which the Project proposal was formulated, aiming to build capacity and support for the existing health volunteer group (Campbell *et al.*, 2008c; Campbell *et al.*, 2007).

Phase two (2005-2007) was the establishment of the Project. Participatory skills training in HIV/AIDS and home nursing skills was provided to the health volunteers. HIVAN also worked extensively with the health volunteer group to develop more democratic ways of working, including seeking to challenge its domination by male leaders.

During Phase two the Project also sought to develop strong internal and external partnerships. Internal partnerships were developed through participatory training with local community leaders (although poorly attended) as well as youth and church groupings, and through promoting the profile and status of the health volunteer group in Entabeni. Developing external

partnerships was the role of the HIVAN ECA. A Partnership Committee was formed between local community members and external agencies in the government and NGO sectors; however as discussed below, external agencies did not always deliver on their initial commitments nor establish lasting relationships with the community as hoped (Nair and Campbell, 2008).

Phase three was the gradual withdrawal of the HIVAN ECA from the Project (2007-2008). This phase included training for health volunteers in project management. In addition, HIVAN started paying small stipends to health volunteers to cover their expenses and to reward their efforts, given the Department of Health's prevarication around whether or not it would pay stipends to the local volunteers (Campbell *et al.*, 2008a). HIVAN-sponsored stipends ran from the start of 2007 through to mid-2008.

The fourth phase (to mid-2008) involved conducting interviews with health volunteers and Entabeni residents after HIVAN had withdrawn from active involvement in the Project, although HIVAN continued to provide stipends for volunteers until the end of 2008.

### **Theory/Framework**

Community psychologists argue people's poor health and their inability to protect their health is linked to limited agency resulting from social inequalities (Wallerstein, 1994). Participatory projects aim to expand people's agency so that they can start to take actions to protect their health and resist some of the negative effects of their limited agency (Gibbs *et al.*, 2008).

The framework for this study developed as a result of an iterative process of academic reading and data analysis, leading to our decision to conceptualise agency in terms of: knowledge and skills; confidence; and concrete experiences of agency.

Gaventa and Cornwall (2001) argue people's agency is structured by identities and practices that enable and constrain their possibilities for action. A key aspect of participatory projects is to expand people's agency is to encourage them to access and develop *knowledge and skills*, so that they can broaden "the boundaries and indeed the conceptualisation" of what they perceive as possible (Gaventa and Cornwall, 2001, p.72). This enhanced set of 'possible selves' and 'possible futures' serves to motivate people to resist some of the limitations of their existing social situations, and ideally to work towards less oppressive social relationships.

Gaventa and Cornwall (2001) also point out that the development of less restrictive visions of oneself and place in the world has to be backed up with action. Historically marginalised groups faced with seemingly unsolvable problems, such as poverty and HIV/AIDS, may have lost their confidence to act on new possibilities (Campbell *et al.*, 2005; Sliep and Meyer-Weitz, 2003). A second aim of participatory programmes then is to build people's *confidence* to respond or act in new ways.

Cornish (2006) however argues that simply having new possibilities of what is possible and the confidence to act is not enough. Rather for people to develop new forms of agency they need to actually experience firsthand, or see a peer, acting on these new possibilities. Participatory projects therefore need to make new possibilities real by providing *concrete experiences of agency*, if people are to start acting in new ways.

## **Methods**

Data were collected at the end of each phase of the Project. Table 2 sets out the number of people interviewed. HIVAN staff also kept fieldwork diaries throughout the Project.

*Insert Table 2 about here*

Interviews were all recorded in Zulu and later translated and transcribed into English. While topic guides varied over time, all sought to understand the experiences of the health volunteers, and the factors constraining and enabling their work.

Data were analysed by thematic content analysis (Attride-Stirling, 2001). Initial responses were categorised in terms of sub-themes raised by informants. These sub-themes were then grouped into according to their relevance to the three themes drawn from our theory/framework section: 1) Knowledge and skills, 2) Confidence, and 3) Concrete experiences of agency.

## Results

Results are presented in Tables 3, 4 and 5. Tables are simplified for purposes of presentation. Empty boxes mean the sub-category was not mentioned in that Phase. Results are discussed in detail below.

*Insert Tables 3, 4 & 5 about here*

### Knowledge and Skills

As seen in Table 3, four dimensions of knowledge and skills emerged as relevant to health volunteers' involvement in the Project. The first was their ability to *speak openly about HIV/AIDS in Entabeni*. Speaking and discussing HIV/AIDS openly is important in changing behaviours, challenging stigma and ensuring people internalise knowledge about HIV/AIDS into their everyday lives (Low-Beer and Stoneburner, 2004; Campbell, 2003). In Phase 1, volunteers emphasised their inability to speak openly about HIV/AIDS because Entabeni was a 'conservative' rural community, where sex was a taboo subject:

INTERVIEWER: Are young people here free to talk to their parents about sexuality?

HEALTH VOLUNTEER: To tell you the truth, I cannot talk to my children about that. When my child tells me what they have been taught at school, I just say it is correct but I can't repeat it or add on.

INTERVIEWER: Why can't you?

HEALTH VOLUNTEER: We are conservative people living in a rural area. I am just afraid to talk about that to my children because I don't know how I can answer my child if he/she wants to know what happens when people have sex. It would be embarrassing to have to explain that. (Phase 1)<sup>iii</sup>

However by Phase 2 and continuing throughout the Project, volunteers increasingly emphasised their ability to speak openly about HIV/AIDS and linked this to their involvement in participatory workshops the Project organised:

HEALTH VOLUNTEER: The training HIVAN organised made me confident to talk to other people about this deadly disease, especially school learners. I no longer hide anything from them. (Phase 2)

The second dimension emerging as relevant to this aspect of agency was *volunteers' access to public discussions in Entabeni*. Involvement in the production of knowledge is crucial if people are going to change what is deemed possible (Gaventa and Cornwall, 2001). In Phase 1 volunteers emphasised how their involvement in discussions was limited to 'female-only' spaces – church and gardening groups – amongst people similar to themselves.

By the Phase 2 interviews things had changed. Many spoke about how, after participating in the training run by the Project, they were asked to talk about

HIV/AIDS in public discussions in churches and schools; discussions previously unavailable to them. Health volunteers' increased involvement in public discussions about HIV/AIDS continued throughout the Project.

The final theme emerging around knowledge and skills was the *volunteers' perceptions of possibilities for themselves*. People's conceptions of what they can do are an important influence on their agency (Gaventa and Cornwall, 2001). Health volunteers in Phase 1 described the limited possibilities open to them, emphasising strong community expectations that women should stay at home, and that if women got jobs – including as health volunteers – they would be laughed at:

INTERVIEWER: Women are not employed here?

HEALTH VOLUNTEER: No they don't work. As health volunteers they laugh at us. They say we are short of something in our homes.

Following participatory workshops run by the Project during Phase 2, health volunteers described how workshops allowed them to imagine much broader conceptions of what was possible for them to achieve:

HEALTH VOLUNTEER: Already I have plans for my community. I always thought I should wait for someone to offer me money so I could do things. I didn't realise money was in my own hands. I have also learnt that I must also be responsible for the eradication of this disease that has killed so many people. (Phase 2)

Workshops opened up volunteers' sense of what was possible for them and they started to imagine alternative futures for themselves. However, these alternative futures did not continue into Phases 3 and 4 and were not mentioned again during interviews.

The Project built, through participatory workshops, health volunteers' ability to speak openly about HIV/AIDS and to become further involved in public discussions about HIV/AIDS. They also opened up alternative possibilities that were available to them as health volunteers that they had previously not considered.

### Confidence

Five themes emerged as relevant to *Confidence* (Table 4). A central theme was *volunteers' confidence in their work*. Building confidence in the work volunteers do is crucial if they are to expand such services outside their normal repertoires of behaviour. In Phase 1 most lacked confidence in their work, linking this to inadequate training (Maimane *et al.*, 2004).

Phase 2 interviews highlighted how this changed and volunteers were confident in their work. Volunteers linked this to the participatory workshops they were involved in during Phase 2:

INTERVIEWER: So how did you feel about having group discussions during the training, being with other people in a group?

HEALTH VOLUNTEER: I really enjoyed it. There were things that I didn't know, or things that I was shy to talk about, but because there were other people talking, I became confident to say whatever I wanted to say. I even enjoyed the criticism and the praise. It made me grow.

Health volunteers' confidence in their work further increased following the introduction of stipends in Phase 3. For volunteers stipends were recognition that the work they did was meaningful. However, they also knew that the stipends were liable to end (as they were funded by HIVAN), and were anxious about what this would mean:

HEALTH VOLUNTEER: If HIVAN leaves, who will give us a stipend? We won't be motivated and the whole Project will collapse. (Phase 3)

This continual concern continued into Phase 4 and undermined volunteers' confidence.

*Community support for health volunteers* is a crucial for successful health volunteer programmes and builds volunteers' confidence in their work (Bhattacharyya et al, 2001). During Phase 1 health volunteers emphasised they lacked support from Entabeni residents for their work, and recognition of their skills, undermining their confidence.

It was only in Phase 3 interviews that this changed and volunteers started reporting that they received community support:

HEALTH VOLUNTEER: I see a dramatic change from 2003 up to now.

Of late people in the community are confident to send for us if a person is very sick...I am now very confident. (Phase 3)

In explaining this change, the health volunteers suggested it was because they had received extensive training and that the health volunteer group had become formalised with name badges and uniforms (Campbell et al, 2008a). Positive references to community support for their work and their role continued throughout Phase 4.

Another theme linked to confidence was health volunteers' confidence in the future sustainability of the Project once HIVAN withdrew; referred to as *ownership of the Project by volunteers*. Ownership is crucial if projects are to be sustainable. Yet throughout the Project, health volunteers tended to express little ownership. Some increase in ownership was seen during Phase 2, but this dissipated in Phases 3 and 4. Explaining volunteers' lack of ownership, many linked identified how the Project was run by a small number of men who did not allow the female volunteers to take leadership positions (Campbell et al., 2008a). Others also added that uncertainty about stipends in the future also undermined their ownership of the Project as they were not invested in its future.

The final theme linked to confidence is *volunteers' access to health services and support*. In order to have confidence in the services they provided they

need support from the Department of Health and access to medicines and health facilities. During Phase 1 the limited access to health services and medication undermined health volunteers' confidence:

INTERVIEWER: Do you think the role you are playing in the community is sufficient, or is there something else you could be doing to care for the sick people?

HEALTH VOLUNTEER: We are aware our service is not sufficient. At times we find people are in pain. We cannot offer them a single painkiller because we are not allowed. The Government must provide us with medical kits with tablets that don't need any prescription. It is not enough to clean the house and cook food for a sick person and then leave them in pain. (Phase 1)

This limited support from the Department of Health, including only irregularly providing medical supplies, continued throughout the Project, despite efforts by HIVAN to build stronger relationships (Nair and Campbell, 2008).

The Project had some successes in building health volunteers' confidence, especially in the work they did and in community support for the health volunteers and this was linked to the training provided. Yet the Project failed to build volunteers' confidence in the future of the Project and did not manage to build structures with the Department of Health to provide long-term support to the volunteers, undermining their confidence.

### Concrete Experiences of Agency

Four themes emerged linked to concrete experiences of agency (Table 5). A key theme emerging was health volunteers' *participation in the health volunteer group* in providing spaces for volunteers to participate in decision-making. Participatory projects aim to build spaces allowing marginalised groups, who lack decision-making and leadership experience, the space to do this, translating into increased confidence and improved health outcomes (Cornish, 2006; Gibbs *et al.*, 2008). During Phase 1 it was apparent the health volunteer group did not provide such spaces as it was dominated by a small number of male leaders. And despite extensive efforts by HIVAN to develop more democratic ways of working, female health volunteers unable to play an active role in it throughout the Project:

INTERVIEWER: Are you now assertive enough to say 'no' if you don't approve of something the leader says?

HEALTH VOLUNTEER: I feel we need to adopt that attitude, but very unfortunately in the group, people have become very reserved because they don't know what will happen if they open their mouths. They don't want to anger our leader. (Phase 4)

A key aspect of agency is the ability of *volunteers to participate in community processes*; it is these decisions that shape people's lives and give people a sense of control. In Phase 1 volunteers explained how they were excluded from involvement in community processes and how *Indunas* hindered their work (Maimane *et al.*, 2004).

Following Phase 3 health volunteers increasingly said how they were involved in community processes related to HIV/AIDS. They highlighted how they were approached by local leaders to become involved in discussions around HIV/AIDS. Given the limited support and exclusion they initially experienced, this was a major change for volunteers. And this continued into Phase 4, where volunteers told us how *Indunas* had started to ask them to play a greater role in Entabeni's processes:

HEALTH VOLUNTEER: The *Indunas* have realised we are a link between them and the community. When they want the community to know something, they inform us because they know we visit every household in the community. (Phase 4)

Despite health volunteers' increased involvement with community processes and support from *Indunas*, they were still limited to arenas specifically linked to HIV/AIDS or else used to run basic errands, rather than being involved in substantive issues.

The role of *stipends in shaping health volunteers' agency* was another theme emerging from the data. Lack of economic assets is linked to women's social and political disempowerment; stipends provide one way women can control economic assets allowing them to start making decisions in their lives (Greig *et al.*, 2008). Stipends introduced in Phase 3 and 4, provided spaces for

health volunteers to start making decisions they were previously unable to, giving them an increased sense of authority in relationships:

HEALTH VOLUNTEER: I must say we do have problems since we are doing voluntary work. Though my husband doesn't really mind but he keeps asking when we are going to be paid a salary. He was very happy recently when I was back paid my stipend. I got R1000 and I put a deposit on a lounge suite without having told him. I just showed him the slip when I got home. He was happy and added R3000 because the total amount was R5000. Last month I put a deposit on a bedroom suite. (Round 4)

The ability to control money was an important experience of agency that health volunteers had because of their involvement in the Project, although there was concern around the stipend ending.

Women need *agency in the private sphere* if they want to take control of their health and well-being, especially around HIV/AIDS where limited agency stops women being able to ensure men use condoms when having sex with them (Greig *et al.*, 2008). In Phase 1, health volunteers described how they had limited agency in the private spheres. Many of their partners refused to use condoms with them, even though women suspected their husbands cheated on them. Volunteers explained this was because their husbands had paid *lobolla* (bride-price) for them:

INTERVIEWER: You say your husbands don't want to use condoms.

Why do you continue having unprotected sex with them?

HEALTH VOLUNTEER: We can be chased away from our homes.

They say they have a right to sex because they paid cattle [*lobolla*] for us. So they can demand anything from us and we have to oblige.

Throughout Phases 2 and 3 this did not change. However, by Phase 4 a number – although by no means all – the volunteers started to talk about how their agency had expanded in the private sphere linking this directly to their participation in the Project. One told how she could now talk to her husband about condoms, because he considered her a nurse:

HEALTH VOLUNTEER: I must say it used to be very difficult to talk to my husband because we were even afraid to mention the word, 'condom'. Now my husband regards me as a nurse and we can talk about them. (Phase 4)

Other volunteers said that they were now confident enough to tell their husbands to use condoms with their extra-marital partners. Such forthright discussions were a radical experience of agency for these volunteers. However several health volunteers continued to say they had limited agency in their private lives.

While the Project provided some experiences of agency for the health volunteers particularly around increased involvement in local public life and

increased agency in the private sphere, women expressed bitter disappointment that their stipend (which had been a major contributor to their enhanced sense of agency) was due to end shortly. Furthermore, their participation in the Project had failed to provide spaces for leadership and decision-making.

## **Discussion**

Our evidence suggests that the project did have some empowerment effects for the health volunteers. Volunteers increased their knowledge and skills around HIV/AIDS and increasingly participated in community-wide discussions around HIV/AIDS, and this was linked to their participation in the Project. There were also examples where involvement in the Project led to increased confidence and concrete experiences of agency by volunteer participants.

Yet most of these benefits were directly linked to their HIV/AIDS-related role, and did not generalise to improve women's confidence or power in their life worlds beyond their Project activities. After four years of Project participation, volunteers' efforts and new confidence remained narrowly focused on providing important healthcare services around HIV/AIDS, rather than expanding their agency to assert themselves in relation to husbands, male leaders and public life more generally. What are some of the reasons for the limited effectiveness of the Project's aim to increase health volunteers' sense of agency?

The data above indicate the persistence of male domination in the Project, despite its explicit goal of empowering women to run the Project on an equal footing to men. This limited the ability of volunteers to experience the Project as a space that was relatively free the oppressive gender relationships, or to develop leadership and decision-making skills (Campbell *et al.*, 2008a); skills which might have opened up spaces for their wider social and economic empowerment.

The data also emphasised that the Project did not gain the support and participation of key local leaders. While there were some successes in this regard, the support of local leadership was partial and ambiguous. Moreover the wider context of traditional authority areas, such as Entabeni, is one where the development of autonomous groups falling outside the control of traditional leaders is discouraged. Such groups are often regarded as a potential threat to the already tenuous authority of many traditional leaders – who work hard to ensure that alternative power bases do not develop (Campbell *et.*, 2008d; Campbell and Gibbs, 2008a).

The possible empowerment effects of participation for the health volunteers were also undermined by the Project's limited success in mobilising sustainable support networks amongst external agencies and organisations in the public and NGO sectors in the region. The Department of Health primary care clinic and outreach nurse did not deliver on their initial commitment to the project to provide proper regular supervision and material support for the volunteers (Nair and Campbell, 2008). Crucially the Department of Health also

failed to provide stipends for the health volunteers, despite promises that they would do so at various stages of the project (Campbell *et al.*, 2008a).

Limited external support also came from other government agencies, whose ability and willingness to engage with communities were hindered by bureaucracy, high workload and a lack of social development skills (Nair and Campbell, 2008). The lack of community support from public sector agencies is consistent with a wider tendency – in the South African public sphere – to devalue the importance of involving communities in responding to HIV/AIDS (despite the country's formal pro-community policy rhetoric), and to emphasise technical solutions for HIV/AIDS management (Campbell and Gibbs, 2008b).

### **Conclusion: Frustrated Potential, False Promise or Complicated Possibilities?**

There is no doubt that the volunteers provided vital support to many individuals, families and households over the life of the Entabeni Project. To what extent did this participation have the potential to lead to their wider empowerment in women's lives beyond the Project? We offer three possible answers to this question. The first possible answer is that the Entabeni Project's 'empowerment via participation' agenda could, in principle, have been realised if HIVAN's External Change Agent (ECA) been available (to support volunteers, facilitate project activities and continue to try and mobilise internal and external partners) for longer than the three year period of her involvement with the project. It could be argued that it was highly over-

optimistic to expect such significant changes in lives of women volunteers in such a marginalised community over such a short time period. Perhaps the potential of the Project was frustrated by its unrealistically short time-frame and by the problematically time-limited involvement of the HIVAN ECA.

The second possible answer to this question is that the 'empowerment via participation' agenda is nothing more than a false promise. Given the massive inequalities that frame life, health and social relations in Entabeni, many rooted in social processes well beyond the reach of small participatory projects, any 'radical' vision of empowerment through local community engagement is unrealistic. According to such a view, whilst projects such as this one can be used very successfully to mobilise women to provide cheap labour for healthcare in resource-poor communities with limited access to formal health services, it is unrealistic to expect them to open up genuine possibilities for radical change in women's lives.

The third possible conclusion ('complicated possibilities') is that the outcomes of development projects are messy and hard to track, that initiatives such as the one discussed above may take a long time to reap any benefits, and that benefits might not be in a form easily and immediately identifiable by an outside research team (Lewis and Mosse, 2006). Benefits may emerge in unpredictable ways much further down the line in the lives of this group of women, their families and their communities. Those holding this view would argue that social change is necessarily a complex and gradual process, and one that defies easy classification within the linear models of international

development projects, with clearly defined inputs leading to observable change measurable in terms of discrete and measurable outputs. Advocates of this position might argue that despite their reservations about their ability to sustain the Project without HIVAN support, their frustration with male leaders of the project and the community, and their bitter disappointment in the face of government indecision about stipends for uneducated rural volunteers, the majority of volunteers were enthusiastic and positive about particular aspects of their experiences of participation. They might further argue that even flawed and possibly unsustainable projects of this nature offer participants glimpses of empowerment, which contribute in a small way to the long-term process of building the capacity of women in remote rural communities to challenge men, to play a significant role in the leadership of local projects and to have their voices heard in community decision-making.

We are aware that our decision to end this case study with three possible interpretations does not point to clear and easy conclusions about the role of community participation in achieving the Millennium Development Goals. Reliance on health volunteers can increase access to healthcare and services and improve care for people living with HIV/AIDS, especially in remote areas, and in this sense is important in achieving the Millennium Development Goals. Yet as our case study shows community participation is unlikely to achieve wider 'empowerment' objectives quickly or easily, and therefore is unlikely to lead to such projects challenging the social and economic processes and structures underlying poor health and well-being in marginalised communities in a rapid or straightforward way. Whilst we have no doubt that effective

community participation is a necessary precondition for the positive social changes advocated by the Millennium Development Goals, our findings suggest that it is neither a quick nor easy solution.

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Table 1: T Entabeni Project Phases

Phase	Dates	Project Focus
1	2003-2004	Baseline research and project design
2	2005-2007	Establishing project, running workshops, building internal and external partnerships
3	2007-2008	Gradual withdrawal of HIVAN
4	2008	HIVAN exited, follow-up interviews 6 months on

Table 2: Interviews by Project phase

	Phase 1	Phase 2	Phase 3	Phase 4	Total
No. of people interviewed	26 (3 male, 23 female)	27 (all female)	17 (2 male, 15 female)	17 (all female)	87 (82 female, 5 male)

Table 3: Knowledge and skills

Sub-Category	Phase 1	Phase 2	Phase 3	Phase 4
Volunteers' ability to speak openly about HIV/AIDS in Entabeni	Volunteers' are unwilling to talk openly about HIV/AIDS	Training has built their ability to speak openly about HIV/AIDS	Training has built their ability to speak openly about HIV/AIDS	Training has built their ability to speak openly about HIV/AIDS
Volunteers access to public discussions in Entabeni	Volunteers only speak in 'female-only' spaces	Volunteers speak about HIV in schools and churches	Volunteers speak about HIV in schools and churches	Volunteers speak about HIV in schools and churches
Volunteers perceptions of possibilities for them	Possibilities are highly constrained	Participatory training allows them to imagine new possibilities		Narrow sense of possibility about what volunteers can achieve

Table 4: Confidence

Sub-Category	Phase 1	Phase 2	Phase 3	Phase 4
Volunteers' carers confidence in their work	Volunteers lack confidence in their work	Training boosts volunteers' confidence in their work	Stipends and training boost confidence of volunteers in their work	End of stipend undermines confidence of volunteers
Community support for volunteers	No community support or confidence in volunteers		Volunteers' training and uniform builds community confidence	Volunteers' training and uniform builds community confidence
Ownership of Project by volunteers	Limited ownership of the Project	Ownership and confidence in Project because of training	Limited ownership in Project by volunteers because of control by leaders	Limited ownership in Project by volunteers because of control by leaders

Volunteers' access to health services and support	Distance to hospital and lack of medication undermines confidence		Distance to hospital and lack of medication undermines confidence	Distance to hospital and lack of medication undermines confidence
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Table 5: Concrete Experiences of Agency

Sub-Category	Phase 1	Phase 2	Phase 3	Phase 4
Participation of volunteers' group	Female volunteers' play limited role because of male leader		Female volunteers' play limited role because of male leader	Female volunteers' play limited role because of male leader
Role of volunteers in community processes and politics	Volunteers are excluded from community politics		Volunteers are increasingly involved in community HIV/AIDS related activities	Local leaders increasingly involve volunteers in limited community processes
Stipend shapes volunteers' agency				Stipend builds volunteers' experiences of agency
Volunteers' agency in the private sphere	Male authority means husbands		Male authority means husbands refuse to use	Volunteers' status in Entabeni creates spaces to talk about condom use with

	refuse to use condoms		condoms	partners
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<sup>i</sup> HIVAN is the Centre for HIV/AIDS Networking at the University of KwaZulu-Natal and is where the researchers were based.

<sup>ii</sup> The provincial Department of Local Government and Traditional Affairs is the closest sphere of government to communities. They have district municipalities that are responsible for development planning in communities. These are further sub-divided into local municipalities, one of which services Entabeni.

<sup>iii</sup> All quotes are identified in the following way: PERSON: Quote. (Phase of Project interview comes from). Pseudonyms are used throughout.