A CONVERSATION ABOUT CONVERSATIONS: DIALOGUE BASED METHODOLOGY AND HIV/AIDS IN SUB-SAHARAN AFRICA

by

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A thesis submitted in conformity with the requirements for the degree of Masters of Arts
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Ontario Institute for Studies in Education of the
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Abstract

The world’s understanding of HIV/AIDS is grounded in biomedicine and shaped by cognitive psychology. Both biomedicine and cognitive psychology bonded with historically top-down development mechanisms to create “prevention” strategies that obscured from vision the root causes of the pandemic. Within this hierarchy, biomedicine and the cognitive psychological conception of human beings silenced indigenous voices and experiences of communities fighting HIV/AIDS. This is most certainly true in the case of Sub-Saharan Africa. This research explores the emergence of the Community Capacity Enhancement – Community Conversations prevention approach that places community dialogue, and the voices of communities, at the forefront of the battle to end HIV/AIDS and deconstruct and challenge the forms of structural violence that hold prevalence rates in their place. Within these spaces, oral traditions, indigenous knowledge, and resistance illustrate new and complex pictures of the viruses’ socio-economic impact and provide new foundations for community generated movements to curb the virus.
In this work I write about ÒintentionÓ as a visible and sometimes sub altern global intention that enables and maintains poverty with its acceptance of it. An ÒintentionÓ that as I write, both actively and passively maintains the sorts of inequality that gives birth to some of our grossest atrocities.

This truth reminds me of the macro and microcosmic power of intention and its ability to quietly, and steadily shape life; to lead the lives of millions into oppression and bondage, while also opening the way for freedom and equality and, in the end, happiness for others. The same is true for ÒintentionsÓinfluence on the life of one as it is for many. The same is true for my own life.

This work is the result of an interwoven tapestry of intentions that collectively contribute to my ability to write this and have the experiences I needed to have in order to do so. The intention of my great-grandmother, a woman that walked thousands of miles in her lifetime intending to contribute to the lives of her grandchildren with the little money she saved travelling by foot. Grandfathers and grandmothers that intended the best for their children and so remained forever vigilant and present. Parents, my parents that always impressed upon me that blackness need not be a barrier and that despite what society suggested I was indeed limitless. This tapestry of intention is what brings me to this moment and so in fact this moment belongs to us all.

I thank my ancestors, those that fought and resisted domination and the inhumanity of the cane fields. Thank you. I thank my great-grandparents and grandparents for their sacrifice and the goodness they sowed into my parents. Thank you. I thank my father for his pride and for the stories that connected me to who I am. Thank You. I thank my mother for her grace and lessons in strength and love. Thank You. I thank my sister for teaching me about honesty and keeping her brother real. Thank You. And above all I thank God for binding us in his all embracing intention and for forever pushing me towards what I
believe is His divine purpose. Our moment would not be possible without Him. Thank

This work passed through many hands to reach this point. It passed through the hands of loved ones that read, smiled, and filled me with the courage to write on despite my questions and fears. It passed through the hands of new friends and advisors that added their wisdom and knowledge; and finally it passed through the hands of academic guides. I must thank my supervisor Professor Daniel Schugurensky for his patients and for walking with me through till the end despite a move to Arizona. I thank Professor Njoki Wane, who appreciated me and my ideas and welcomed me into an institutional space that embraced Africanness, my blackness. I must thank Thebisa Chaava, my CCE mother and mentor, an outstanding person that has supported me greatly from our first meeting. Thebisa, this is a movement and I am at its service.

I thank my family, Anwar, Jamal, Jelani, Lydy for never forgetting that I had a thesis and urging me on. I thank my spiritual brother, sister, and new nephew Devi, Mandeep, and Khumalo especially, for walking me through this, urging me forward, cooking, locking me in rooms until I wrote, and reminding me that just as spirit can turn water to wine so can it make a family of strangers.

This belongs to all of us.
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Forward

I write this with the memory of a notable meeting in which a colleague remarked “If the cure for AIDS was a clean glass of water, people throughout Africa would still die.” This statement remains seared into my heart as a brand that perpetually reminds me of the precarious relationship between health and abject poverty.

I offer this work as an African.

I am an African, not in the conventional sense. There is no stretch of land from which I can say I come. No language to which I can set the rhythm of my heart. I know the cracked concrete stretches of the North better than those of the South. Yet I am still an African, albeit split from the soil upon which my ancestors stood, the soil under which they remain buried. I mine my people’s hearts and minds for lessons from the past and present, for our future. I honor our wisdom, placing it in the pantheon of all other great knowledge.

Because I belong nowhere; I belong everywhere. The rhythm of my heart is set to the beat of bare feet on the Kgalagadi, as much as it is to the steel drum, and to the pound of a step troop on stage. I belong to all and, out of respect, claim none. I could say that I am comprised of African scholars from across the diaspora; that indeed would be a truism. But I speak of rhythm, drum, and stage because these facets of society and culture are as important as the thoughts of Lumumba, Malcolm, Nyerere, and CLR James. My intention to locate myself in the rhythm, the drum, and the stage is intentional. After all, what I write of is a reinvigorated form of civic life that belongs not to the university halls but to the sand and ground that was there before the brick. I speak of the blood and marrow in the bone. I speak of conversations, dialogue and the power of voice. I speak of the brilliance in the natural and innate as opposed to the complexity of the learned. I speak about space that is simultaneously traditional and revolutionary. I speak of spaces that could potentially make room for the spectrum of brilliance humanity around the world naturally produces, avoiding our current pitfalls that narrowly define brilliance and in
I am speaking of conversations, dialogue and the power of voice.

I am aware of the criticism lodged at ‘identity politics’ but I write this because what I write has ground. Neither the personal experience in the international development or international health sector is sufficient ground. The imperative to fight HIV/AIDS through word is bound by the other half of a dual imperative; the personal half, the half that identifies as an African and speaks as an African. The dual imperative urges me to respectfully speak of the brilliance and ingenuity of men and women engaged in developing interventions that pair brilliance and creativity by responding to the pandemic through multiple dimensions simultaneously.

And as this work will argue that sustainable social change begins with heart, this piece, this work, this thesis begins with mine.
Chapter 1

Introduction

“Of all forms of inequality, injustice in health is the most shocking and the most inhumane.”

Martin Luther King Jr

The Truth about AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a communicable disease. One transferred through blood, sexual intercourse, and from a mother to her fetus. It is a grouping of seventy conditions that are the result of a complete and painful collapse of the human immune system. The retrovirus is not a forgiving one. AIDS dismantles our natural ability to fight infection and fosters the invasion of other viruses through the erosion of the immune system. In the end, the human body is left untreated, helpless, and open to slow decay. In Uganda it has been called ‘slim disease’ for the ravaged and lifeless skeletons the disease left behind. As time passes the virus has become one of the single most devastating pandemics of this century. While disabling and dismantling the bodies of men, women, and children, the virus has simultaneously devastated communities, countries and societies by challenging the fabric of human existence and co-existence.

The pandemic traveled along the seams of societal fabric, carving distinctions in and around the most impoverished communities, revealing patterns that clearly link poverty to prevalence. HIV/AIDS surged into the bodies and lives of peoples through contaminated needle stems in urban spaces and places, and found itself transmitted through consensual, coercive, and non-consensual sex in the rural and urban landscapes. AIDS is a deeply revealing disease that strips away the facade of untreated inequalities and unaddressed injustice throughout the world. Its devastation has traveled the globe, most clearly, along the fault lines of economic, political, and social inequality, severely impacting the health and livelihoods of peoples and geographies that have long histories
Socio-economic vulnerability to HIV/AIDS is a balance that maintains the prominence of Harmful Tradition Practices in varying parts of Sub-Saharan Africa, as it also inhabits the concrete urban stretches that house the politically and economically marginalized African American and Latino communities of America, as it also inhabits the aboriginal and first nations reservations throughout Canada.

As an equally biological, social, political, and economic phenomenon, HIV/AIDS has not remained locked within the lives of the marginalized, nor did it necessarily begin with communities that have a historical familiarity with a debilitating life of less. The entry of HIV/AIDS into communities is varied, and it has been argued by many that HIV/AIDS entered marginalized communities through their relationship with more affluent centers. HIV/AIDS is not exclusive. If there is anything the pandemic has shown us, it is our forgotten interconnectedness.

The backdrop for my critical examination of the pandemic and prevention strategy is Sub-Saharan Africa. Sub-Saharan Africa remains the region most affected by HIV/AIDS worldwide. According to the UNAIDS/WHO: AIDS epidemic update 2009 Sub-Saharan Africa accounts for approximately 67% of all people living with HIV and for nearly 72% of AIDS related deaths in 2008. (UNAIDS, 2009, pg 1)

The intention of this thesis is firstly to specifically recognize the relationship between HIV/AIDS prevalence and historical and present day forms of oppression. The defining characteristic of communities with heightened prevalence rates is a distinct balancing of troubling ‘vulnerability’ with one side related to poverty and social exclusion and the other related to the inspiring resilience, brilliance and ingenuity of the people that form that community. But, fundamentally, this thesis hinges on the recognition that the most severe and widely embraced Harmful Traditional Practice is the acceptance and subsequent maintenance of local, national, and global inequality.
The thesis is a recognition that complete equality or equity is unattainable, but transformation begins with truth, and the definitive truth expressed in this thesis is the express relationship between poverty, health, and power. The basis for using the terms oppression and marginalization in this thesis is to openly recognize the corollary between poverty, marginalization, oppression and ultimately ‘intentions.’ It is the recognition that the persistence of these realities is the result of specific, global and local ‘intentions’ that actively or passively maintain the reality. The ‘imperative’ for using these terms consistently is to permanently remove from the table discussions that the lives of those in our global community that live in such circumstances, are accidental realities of remorseful global histories whose relevance to the present circumstance have somehow passed. It is to recognize that the regretful haunts of our shared history will continue to animate and shape the present as long as we actively refuse to dismantle the social, political, and economic remnants of these histories. Whether we are willing to embrace this perspective or not, a fundamental truth acknowledged by few and ignored by many is that the passive acceptance of oppression is as equally damaging to our collective humanity as the active propagation of it. The use of ‘structural violence’ throughout this thesis is a prism through which HIV/AIDS is viewed and is expressly related to this frame of thinking.

Because AIDS is a deeply revealing disease that has stripped away the façade of untreated inequalities, and unaddressed injustices in that it has most severely affected peoples and geographies that have a long history of imposed deprivation and marginalization. This is most certainly true in Sub-Saharan Africa. Through periods of colonialism, neo-colonialism, and now globalization, the political and socio-economic landscape of Sub-Saharan Africa has vacillated between the great hope offered by new and independent leadership and the struggle that accompanies the international powers’ persistent desire to impose designs of disempowerment through neoliberal policies, practices, and impositions. These designs of disempowerment have co-existed with an apparent stroke of benevolence that has been marked by the international community’s increasing involvement in the fights against AIDS in Sub-Saharan Africa through aid and HIV/AIDS intervention programming.
This is a conversation about conversations. This thesis is a conversation about a form of HIV/AIDS prevention that can potentially challenge both the structural violence associated with pandemic and the narrow traditional forms of prevention. This conversation attempts to answer the following questions:

What are the possibilities and limits of biomedical approaches for HIV/AIDS prevention?

What are the possibilities and limits of community conversations for HIV/AIDS prevention?

This thesis will explore the Community Capacity Enhancement (CCE) program as a framework that can potentially challenge not just the pandemic, but forms of HIV/AIDS prevention that marginalize communities’ capacity and consciousness. The emphasis will be on exploring dialogue as a transformative social change method that breaks with the norm.

Chapter Summary

Our conversation is divided into six chapters. Chapter 2: Theoretical Foundations of the Study sets out to reframe HIV/AIDS through the concept of ‘structural violence’. This section’s intent is to illustrate the multiple forms of determinants that shape HIV/AIDS prevalence in given localities, arguing that the transmission of the virus is about more than sex, needles, and transfusion. Recognition of the pandemic’s oppressive roots provide a platform from which the thesis, and this section in particular, critically examines the traditional approaches to HIV/AIDS prevention and institutions that promote such approaches. This will happen through a critical discourse that deconstructs the popularized prevention approach that defines ‘individual behavior change’ as the definitive and proven mode of preventing the spread of HIV/AIDS (Basu, 2003, pg 1). This thesis posits that the focus on individual behavior change models of prevention is
A discussion of designed disempowerment will place forms of structural violence within the context of historical and global principles and philosophies that have served to shape the international community’s perceptions and practice in relation to HIV/AIDS in Sub-Saharan Africa. The notion of designed disempowerment removes the sense of casual relationship between past and present and places the pandemic in the context of global mechanisms and trends that possess intention and purpose. It acknowledges that if HIV/AIDS has been promulgated through the previously named forces and the structures of violence they erect, then a complete shift in international thinking would need to occur in order to ensure that the structure of international prevention efforts do not inherit the lattice work of structures of violence. I argue that individual behavior change has been positioned and stands at the center of designed disempowerment schemes. It stands as programming with destructive assumptions, philosophical impositions, and critically flawed logic.

Hegemonic benevolence will serve as the framework through which this thesis critiques the international community’s approach to HIV/AIDS funding and programming. The term hegemonic benevolence refers to a form of international cooperation that stands in tandem with various forms of structural violence as a superstructure that promotes designs of disempowerment. Throughout this critique I will argue that bilateral agreements like President Bush’s Emergency Plan for AIDS Relief (PEPFAR) is an example of a mechanism whose principles and approaches to HIV/AIDS prevention stands as an accessory to the structural violence inflicted upon the poor and ill of health in Sub-Saharan Africa.

To engage in a critical discourse without observing potential spaces for change is a sort of crass form of critique. Through a discourse on the convergence of these two concepts—designed disempowerment and hegemonic benevolence—and their impact on HIV/AIDS prevention, this analysis stands as a platform for offering recommendations. **Chapter 3:**
Liberation and Emancipatory Pedagogy borrows a vision of change from the discipline of liberation and emancipatory pedagogy that suggests to serve the vulnerable, those most affected by structural violence, those patronized by hegemonic benevolence, requires deep and radical change from our global systems of exchange all the way down to our interpersonal exchanges (Famer, 2005, pg 140).

Because the core of this thesis is about three equally outstanding phenomena, the HIV/AIDS pandemic and the rise and evolution of community conversations, and community dialogue as a social change methodology Chapter 4: A Conversation about Conversations focuses expressly on a methodological exploration of the Community Capacity Enhancement approach to HIV/AIDS prevention. Central to this discussion is a multifaceted discourse on dialogue, examining knowledge, resistance, empowerment, social capital, and democracy as interlinked discourses that speak to the transformative potential in dialogue.
Chapter 2:

Theoretical foundations of the study

The headlong stream is termed violent
But the riverbed hemming it in is
Termed violent by no one.

The storm that bends the birch trees
Is held to be violent
But how about the storm
That bends the backs of the road workers?

— Bertrold Brecht “On Violence”

HIV/AIDS and ‘Structural Violence’

The concentration of HIV/AIDS in Sub-Saharan Africa (SSA) is deeply embedded in the complex local, national, and global structures that perpetuate systems of inequality, poverty, and resultant vulnerability to the virus and disease. These structures are the composite of an intricate formation of lattice work in which each lattice reflects the mutually reinforcing political, economic, and cultural systems that prohibit the equitable distribution of resources across and between populations. Factors such as poverty, economic exploitation, racism, and gender inequities and oppression intertwine to synergistically exert structural violence on marginalized populations (Parker et al, 2000, pg 23). Turray writes:

Structural violence has been defined as social personal violence arising from unjust, repressive and oppressive national and international political and social structures. According to this view a system that generates repression abject poverty, malnutrition, and starvation for some members of a society while other members enjoy opulence and unbridled power inflicts covert violence with the ability to destroy life as much as overt violence, except that its does it in a more subtle way. (Turray, 2000, 251)
Naming these systems of inequality and marginalization as ‘structural violence’ challenges the notions that the factors listed above are ‘natural’ elements of human society or the unfortunate byproducts of a history with little relevance to present day. Naming these systems, intentionally examining the lattice work of structural violence, acknowledges that there is indeed intentionality that underlies their persistent reproduction of chronic inequality. While a great deal of the HIV/AIDS discourse depicts an unfortunate convergence of chance factors, through the prism of structural violence we see a contextual rendering distinctly different to the traditional story told.

During the colonial period, numerous communities throughout Sub-Saharan Africa struggled against distinct forms of social, political, and economic oppression. While post-independence offered a moniker of hope, the post-independence trade relations between developed and developing countries greatly contributed to the erosion of official and fully realized African independence. A running theme throughout both of these eras was indeed ‘development’. While in the colonial era ‘development’ was overtly framed as means for emerging industrial states to capitalize on the socio-economic and political bondage of African colonies, the theme of ‘development’ significantly shifted during post-independence to a rhetoric reflecting ‘Assistance’ or ‘Official Development Assistance’. (Moyo, 2009, pg 12)

One of the more important signifiers of the post-independence rhetorical shift was undergirded by an emphasis on free markets. The rhetoric of the time linked the espoused belief that the means for nations to realize their full potential lay in the emergence of free market systems. This period saw the rise of Structural Adjustment Policies or (SAPs), a series of policies and practices that were sold as stimulus to nations that endeavored to enter this new era. With the advent of neoliberal thinking, the theme ‘development’ in the post-independence era was refocused by the emerging emphasis on the centrality of free-market systems to the development paradigm. Many argued that the SAP initiative, propagated by the International Monetary Fund (IMF) and the World Bank (WB), while rhetorically preaching eventual economic and political freedom for emerging nations,
that was distinctly neo-colonial, and a clear indicator that the historically unequal relationships between nations and identities had yet to change. The policy prescriptions of this era seemed intent on integrating Sub-Saharan African nations into the bottom of the world’s economic system. According to Gitu Sen:

“Africa’s problem [was] not marginalization from the global system. Africa’s problem [was] that it has been integrated far too well into the global system right going back to slavery. .. but it’s been integrated at the bottom of a very unequal system: And the people that are paying are the common ordinary people.” (Sen, 2008)

Structural Adjustment Policies, clearly rooted in a neoliberal discourse, reflected the pillars of the Washington Consensus: Fiscal austerity, privatization and market liberalization. In exchange for funds that accompanied SAPs Sub-Saharan African economies embraced the free market solutions to development (Moyo, 2009, pg 21).

By the end of the 1980s the emerging market countries’ debt was close to US $1 trillion, accompanying their debt were massive service costs which compounded the crisis. According to Dambisa Moyo, the costs associated with debt re-servicing became so substantial that, in time, they surpassed official development assistance in most Sub-Saharan African nations. During this period most if not all Sub-Saharan nation states saw a sharp increase in poverty that rose in tandem with the unfurling effects of the countries’ prescribed divestments in critical social sectors like health and education. According to Labonte et al, the ultimate outcome of the Washington Pillars was “reduced subsidies for basic items of consumption; removal of barriers to imports and foreign direct investment, reduction in state expenditures, particularly on social programs such as health, education, water, sanitation and housing; and rapid privatization of state owned enterprise.” (Labonte, 2005, pg 208)

The convergence of rising poverty and the divestment in the social sectors of countries ultimately resulted in the creation of severe community health vulnerabilities.
The manner in which the vertical violence of SAPs potentially exacerbated the experience of horizontal violence at the community level is particularly relevant in conceptualizing HIV/AIDS through the prism of structural violence. Basu writes:

”HIV transmission is a background of neo-liberalism a context where rapid movement of capital is privileged over long term investment and the ability of persons to secure their own livelihoods. Increase in forced migration are strongly correlated with some the most significant increases in HIV transmission across Southern Africa, East Asia, East Europe and Latin America (although few members of the public health community have addressed this fact) and such migration most often occurs when rural agricultural sectors are destroyed after the liberalization of markets and the subsequent drop in primary commodity prices, which leads (mostly male laborers) to find work in urban centers and leave their families behind.Ø (Basu, 2003, pg 13)

In the gold mining region of Summertown South Africa, approximately 70,000 male migrant workers leave their homes and travel for miles to work in mines for unseemly pay and extremely dangerous circumstances. Migrant work and the mining of gold is a means to earn a wage and means to support their families. Within the all male setting, a strong and rooted commercial sex work industry has expanded greatly. Women migrate to escape poverty, erecting shanty settlements and selling sex and alcohol to men in order to survive (Campbell, 2003, pg 12). HIV rates among the mineworkers were estimated at 22%, ultimately meaning that prevalence rates for women may in fact be higher. HIV/AIDS prevention projects funded by international donors identified peer-education, condom distribution and treatment and care as a priority. One of the critical flaws of these interventions is that they ignore the forces that converged to shape the sexual behavior of the Summertown community. While the public health initiatives were certainly initiatives worth funding, they are funded at the behest of larger and more telling indicators related to prevalence. Rarely are the roots of poverty and migration addressed. The miners, in the
environment, are ultimately placed in a high-risk
and great concern are women whom, in order to
escape poverty with almost no options, venture away from their homes and are prompted
to place their own bodies in the market place as commodities within the larger economic
system.

Through Basu’s analysis and the depiction of Summertown we see a micro lattice work
manifested in the relationship between poverty, mobility, and gender equity supported by
a macro lattice work of national and global inequality.

Research conducted by Women and Law in Southern Africa (WLSA) on the relationship
between the fishing trade and sexual violence in Malawi draws direct correlations
between the prevalence of sexual violence against women and structural violence. (Banda
et al, 2005, pg 65) The report Sexual Violence and women’s vulnerability to HIV
transmission in Malawi: a rights issue explores sex as a commodity of trade in Nkhota-
kota district located on the shores of Lake Malawi. The research broadens the
understanding of who may constitute a perpetrator of sexual violence by including states
and institutions. By WLSA’s definition of sexual perpetrator, any actor that may be
indirectly complicit in the creation and/or protection of social, legal, or political
economic systems that enable, and even encourage, the prevalence of sexual violence in
society WLSA research clearly illustrates that sexual violence cannot be viewed
separate from any other form of violence. As the report asserts, the macro lattice work of
structural violence generates a form of economic abuse that is founded upon the
connection between poverty and women’s subordinate status experienced at the micro
lattice work level of the structure. The report further asserts that:

Ñ. it is important to integrate an analysis of women’s poverty (lack of
access to and control of resources) as a form of structural violence that
operates as a conduit for the gendered transmission of AIDS(Banda et al,
2005, pg 66)
This depiction of structural violence reveals a structure, made of mutually reinforcing lattice work beginning at the broader based micro level, and working its way up into a narrow point at the macro level. The depiction illustrates the interconnectedness of policy ranging outside the realm of health intervention, relationships seemingly distinct and disconnected from the pulse of Sub-Saharan African communities, yet distinctly connected by way of force and influence. Within this structure, the neo-liberal policies prescribed in the halls of Washington D.C. by the few, grossly impact the many men and women who struggle to scratch out a living in rural South Africa.

Through the prism of structural violence we see that, in short, vertical violence begets horizontal violence.

The lattice work of the structure further reveals the interconnectedness of peoples, communities, and decision making bodies, and illuminates that fighting HIV/AIDS will require the engagement of stakeholders at various critical points in the lattice work. While marginalized communities are indeed the most vulnerable, the vulnerability that structure propagates for is a dismantling process involves individuals, communities, governments, and multilateral bodies to reengage in new and innovative ways which reflect a deep understanding of this structure.

Viewing HIV/AIDS through the frame of structural violence reminds us to revisit the interconnectedness of our efforts and strike new relationships that pose stark contrasts to elements that perpetuate the pandemic. We may find that it is not the number and level of stakeholders that is of sole importance, but the relationships between these stakeholders that poses the greatest threat, and more importantly, the greatest opportunity.

Furthermore, a revision of such relationships in most cases will reveal an unfortunate commonality in the voicelessness of those at the base of the lattice work in numerous societies. It reminds us that any interpretation of HIV/AIDS prevalence that does not take into account the correlation between structural violence and voicelessness obscures the
Any intervention that privileges the voices of ‘experts’ potentially rededicates the voices of peoples and communities most infected and affected to the margins.

Narrow interpretations of HIV/AIDS place onus squarely on the backs of the communities with little opportunity for communities to speak back and out about how they view their local, national, and global context as it relates to HIV/AIDS prevalence. Reframing HIV/AIDS within the context of structural violence prompts all of us to ask the question: why there exists a seemingly myopic emphasis on sex, self-empowerment, and individual behavior change. If, as we have seen, there are much larger machinations that shape the choices and actions of individuals, then how does this reflect on the history of HIV/AIDS’ programmatic and policy intervention up until this point?

Paul Farmer’s comments highlight the disconnect between the intentionality of such structures to exert violence on sections of the population, and a widespread belief that individual action (or inaction) is responsible for deprivation and vulnerability to HIV/AIDS:

"Structural violence is violence exerted systematically—that is, indirectly by everyone who belongs to a certain social order: hence the discomfort these ideas provoke in a moral economy still geared to pinning praise or blame on individual actors." (Farmer, 2004, pg 307)

Farmer’s comment not only validates the importance of reframing global HIV/AIDS efforts around the concept of structural violence, it also leads us into a necessary exploration of the international community’s response to HIV/AIDS and the historical focus on programs and policies that revolve around individual behavior change initiatives.
By expanding the focus of HIV/AIDS prevalence from simple sexual behavior to include an exploration of structural violence, we see the vulnerability of communities is a complex set of facets. While many throughout the international community recognized that HIV/AIDS prevalence could not be solely attributed to sexual behavior, the international community’s historical emphasis on individual behavior change remained dogmatic during the most devastating period of the pandemic and has only seen noticeable shifts in the past decade. With a slow but steady paradigm shift emphasizing ‘participation’ as a guiding principle, HIV/AIDS intervention has promoted greater recognition of the complex range of determinants of sexual behavior.

According to Catherine Campbell this "move towards more community-oriented intervention techniques has not been matched with the development of understandings of the community and social changes that are often necessary preconditions for health-enhancing behavior change" (Campbell, 2003, pg 9). This impasse implies that while there is hope in the slow and steady shift in HIV/AIDS intervention approaches, HIV/AIDS intervention has not yet reached its ‘dipping point’. Vestiges of the past still inhabit modalities of prominent intervention paradigms throughout SSA. Condoms, Abstinence, and Faithfulness still dominate community-based discussions, functionally castrating the consciousness of those engaged in changing their contexts and conquering their vulnerabilities. By unpacking the proverbial question, ‘why the emphases on individual behavior change?’ we can place the origins of HIV/AIDS intervention in focus and begin to question closely how intervention can constructively untie itself from the very same structures that hold prevalence rates in place.

In order to understand why a great deal of internationally driven HIV/AIDS prevention traditionally focused on individual behavior change, it is important to unpack the perspectives and beliefs that have shaped the international community’s view of the pandemic in Sub-Saharan Africa. Arguably, the very same perspectives and beliefs that have historically shaped the international community’s encounters with Sub-Saharan
While the international community has channeled a great deal of financial and technical support to the fight, it is quite evident that the shape and nature of HIV/AIDS prevention was formed by the same forces that historically bolstered the structural violence that encouraged the spread of the virus. Two forces—amongst others— have served to influence the shape of international prevention racism and racialism, and neoliberal thought and practice. It is through the examination of these forces as constants in the west’s encounter with Sub-Saharan Africa that reveals perceptions and principles that serve to shape the broader conceptions of HIV/AIDS prevention.

**Racist and Racialist Mythology**

The shared history of Sub-Saharan Africa and the West is one heavily influenced by racial imbalance based on dominant racist ideologies and the predominant economic desires that preceded them (Rodney, 1972). Colonization marked the point at which Sub-Saharan Africa became cast as the other and the subsequent understanding of the region flowed from this context. The presence of the western world in Sub-Saharan Africa was entirely developed for the greater part from this standpoint and ultimately influenced the future formation of relations between the two geographies. While I recognize the experiences of colonial rule and confrontation across the continent are not monolithic and varied, it is safe to say that, in most regions, relations between western powers and African peoples were predominantly hegemonic and oppressive.

It is a foregone conclusion that the international slave trade, colonial rule, and the subsequent subjugation of African peoples and resources throughout the continent served to develop foundational lattice work for the forms of structural violence we see today. This foundation has influenced a great deal of the continent’s encounters with the rest of world, has continued to reproduce relationships of imbalance and enforce forms of powerlessness and subjugation albeit in more subtle formations. The explosion of HIV/AIDS across SSA has created a new platform for encounters between the west and
Sub-Saharan Africa. These new encounters have in no way escaped the influence of marked previous encounters. This is most obvious in the realm of globally driven HIV/AIDS prevention strategies with specific reference to individual behavior change approaches. As Farmer recounts:

For example, when we were faced with sexual practice or AIDS outcomes that were manifestly linked to poverty and inequality, we wrote about exotic reflections of cultural difference... The conflation of structural violence and cultural difference has marred much commentary on AIDS, especially when that commentary focuses on the chief victims of the disease: the poor. A related trend is the exaggeration of the agency of those most likely to become infected. Often such exaggeration is tantamount to blaming the victim. Explorations of AIDS have involved intense scrutiny of local factors and local actors, including the ‘natives’ conceptions and stated motives. (Farmer, 1990, pg 8-9)

Of the utmost importance is Farmer’s acknowledgement of the manner in which historically racist and racialist conceptions have greatly influenced the international community’s conception of the pandemic and, in turn, the technical responses the international community has developed. It becomes critical to clearly identify how historical conceptions of African society have resurfaced in the discourses of HIV/AIDS.

According to Gaussett, the 19th century and early 20th century marked a period in which the west developed its distorted fascination with various African sexualities. Missionaries - disconnected ‘anthropologists’ - engaged in rudimentary and shallow studies of local traditions ultimately branding them as primitive and immoral. (Gaussett, 2001) By the 1950s these accounts were rare but, in Gaussett’s view, have seen resurgence with advent of the HIV/AIDS pandemic. This resurgence is most apparent in studies that have specifically identified race as a predictor of sexual behavior. Theorists Rushton and Bogaert suggested that sexual and reproductive strategies varied according to race. They believed that these differences influenced susceptibility to AIDS. From a racialist
Bogaert invoked archaic categories of racial classification and proposed that each group possessed different levels of sexual restraint. Needless to say, the Negroid was deemed to have the least restraint. (Rushton et al, 1989)

Other theorists of this period created generally constructed conceptions of African cultural systems of sexuality and reproduction and defined them in relation to Western cultural systems in order to explain differentiations in the pandemic. Caldwell characterized African systems through weak marriage bond, a lack of importance placed on chastity, the accepted sexual freedom of young men and women, and the seemingly high emphasis placed on human fertility (Caldwell, 1989, pg 188). Interestingly enough from a clearly guised racialist standpoint, Caldwell cautioned against broad judgments and loaded terms while ignoring the vast constellation of African societies and civilizations and their massive cultural dichotomies that exist even within a country. This sort of analysis further consolidates the conception that the difference in AIDS prevalence rates is related to the difference between African and European culture and sexuality (Hunt, 1996).

The formulation of African peoples, societies, and places as Other has ultimately created an environment in which all things seemingly different are suspect and therefore implicated in the spread of HIV/AIDS. As it has been made clear, often these differences are conceived through a racially and culturally unjust lens. In this context Culture is often co-opted as a barrier to the creation of individual behavior change programming and unrestrained sexuality becomes the focus. As Katz put forth this focus is antithetical to what we know about global sexual behavior:

What seems to emerge from the literature with consistency is that multiple, mostly serial, casual and unprotected sex is common in Africa, Europe, the USA and parts of Asia, with most men everywhere having more partners than most women. Differences in sexual behavior between regions, countries and cultures appear to be small, although of
course, in every population group, there are people whose vulnerability is high. (Katz, 2002, pg 130)

It is clear that Paul Farmer’s words hold truth, throughout the pandemic’s history in Sub-cultural difference is often conflated with structural violence. Racialist and racist mythologies and conceptions of African culture and sexuality have served as overt participants in historical encounters between Sub-Saharan Africa and the West; AIDS, as the new platform for encounter unfortunately did not fully escape this paradigm. As racialism and racism has formed the lattice work for historical forms of structural violence, racialism and racism have most certainly served as the lattice work in the structure of globally driven HIV/AIDS prevention that chose an obsessive focus on individual behavior change approaches.

Eileen Stillwaggon engages in an expansive discussion that illustrates the ways in which Caldwell’s early studies on fertility and sexuality in various parts of Sub-Saharan Africa served to influence contemporary institutional policy documents. John Caldwell and Pat Caldwell of the Australian National University wrote articles widely cited in Africa AIDS social science and policy literature. In the 1980s, the Caldwell’s published articles that attempted to illustrate the way “African” religious values impeded the aims of population control programs. Caldwell and Caldwell while cautioning against value judgments, offer that “The African system tends to increase the number of sexual partners and is vulnerable to attack by coital related disorders” (Caldwell, 1989, pg 187). The words of Caldwell and Caldwell stood as influential works that informed the development of western based AIDS knowledge in the context of Sub-Saharan Africa. In 1989 Quiggin used Caldwell articles to illustrate the social context of AIDS in Sub-Saharan Africa (Quiggin, 1989, pg...). Ultimately the Caldwell’s “African” fertility discourse influenced one of the most influential policy documents of the 1990s, the World Bank “Confronting AIDS: Public Priorities in a Global Epidemic” 1997. Despite recognition that many sources discounted the relevance of behavioral explanations for prevalence rates, the document’s overall plan was greatly focused on the behavioral
As argued, a great contributor to focus on individual behavior change was a historical 'othering' and skewed perceptions of culture and sexuality. Sanjay posits that individual behavior based approaches to programming often are not helpful and in fact do not impact long term determinants, as long term determinants lie beyond the grasp of the individual, community, and even beyond the grasp of the nation (Basu, 2003, pg 10).

**Neoliberal Policies and Practices**

It is argued by many (eg. Basu, Campbell, Gupta, Katz, Moyo, O'Manique) that neoliberal policies and practices stand at the head of Sub-Saharan Africa's struggle with poverty. As argued earlier the spread of HIV and the increase in prevalence rate of AIDS accompanied growing socio-economic decline, growing debt burden, and structural adjustment programs, which were to later on become Poverty Reduction Strategy papers. The major proponents of the neoliberal policies in Sub-Saharan Africa-- the major proponents being the International Monetary Fund (IMF) and the World Bank-- identified positive growth in many countries that continued to struggle with rapidly declining rural living standards. The rationale of the IMF and the World Bank? Greater activity in the national capital markets and greater, albeit unequal, integration into international markets, was still an indication of positive growth and progress. This was the fertile garden for the planting of a potential pandemic. As social welfare systems were dismantled in favor of the market system, AIDS took root and devastated populations. Neo-liberalism ultimately became an additional support to the structures of violence.

As with racism and racialism, Sub-Saharan Africa's confrontation with neo-liberalism was not relegated to a history of economic subjugation and oppression. Neoliberal principles were present when the international community returned support in efforts to stem the tide of the AIDS pandemic. Of great concern to this discussion is the influence that neoliberal policies and practices had on HIV/AIDS prevention.
Within the context of neoliberal thought, HIV/AIDS preventions were designed. Paired with the evolving institutionalization of AIDS expertise and a development discourse that to a greater extent fell in line with neoliberal principles, the conceptual frameworks that emerged were dominated by particular professions and spoke little to the deeper and more complicated realities contributing to the increase in prevalence rates (O'Manique, 2004, pg 18). Prevention once again was distilled down to the biomedical construction of AIDS and its focus on the individual behavioral dimensions of the disease. Furthermore, programs that focused on the individual were assessed not just through the lens of biomedicine but also the reductionist zero-sum approach of cost-effectiveness. Prevention efforts that were aimed at saving lives and improving health were weighed against other "more pressing" interests in the world of aid. These practices fell in line with the foundational principles of SAPs that helped to create the forms of structural violence that fed the spread of HIV. In both cases, the fundamental human right of health was weighed in relation to other more pressing initiatives. As Kelley points out:

Rather than a ‘meeting of minds’ health policy is being shaped foremost by broader context of certain value systems, beliefs, aspirations, and so on that seek to maintain a particular world order. Debates over how health should be defined are being reframed, from a concern with how to ensure health as a basic human right available to all and collectively provided, to health as a product whose attainment and consumption by individuals should be regulated by the marketplace. This shift is further reflected in the normative criteria and resultant analytical tools (eg. Burden of disease, cost-effective analysis), which are applied to translate certain values into decisions over, among other things, the allocation of limited health resources. (Lee, 2002, pg...)

As neoliberal policies stand in tandem with degradation of local social safety nets, these policies and practices have also had great influence on the conceptualization of HIV/AIDS. Where systems of economic inequality clearly contribute to prevalence rates,
the sexual behavior of people rather than the structures of poverty and marginalization. Within a framework of neoliberal thought the violence of market mechanisms and consolidated capital are ignored. To design HIV/AIDS programming in this context is to design disempowerment. Designed disempowerment robs individuals of their agency as potential actors and activists for their own health. The popular individual behavior change approach in many cases constructed a one-way dialogue with the community and both inadvertently and advertsently pronounced that prevalence rates were the fault of the people alone.

**Designed Disempowerment: Whose knowledge? Whose voice?**

Conceptualized within the tight nit and traditionally privileged circle of bio-medicine, conceptions of HIV/AIDS prevention have focused intensely on individual behavioral analysis. Expanded within the *hallowed* halls of public health think tanks, the management of HIV/AIDS was conceptualized through the management of people’s behavior (O’Manique, 2004, pg 17). Bio-medicine and public health are sciences that may potentially be objective but without critical reflection the structure inherits philosophies and principles from the forces that form its context. While Racism and Racialism, and Neoliberal thought and practice have served influential forces in the formation of bio-medical based HIV/AIDS prevention programming, bio-medicine and its bedfellow cognitive psychologies as *Western Knowledge* systems also served to marginalize the role of communities. O’Manique writes: *The understanding of AIDS in Africa lies in a complex mix of bio-medicine, behaviorism, a wider moral and political agenda, and the development, security, and human rights discourses of the past decades.* (O’Manique, 2004, pg 17)

O’Manique’s words are even more telling. HIV/AIDS within Sub-Saharan Africa has initially researched and conceptualized within environments far removed from the lived experiences of those infected and affected by the virus. Western *Medical Science* and more specifically, the field of bio-medicine dominated the response to HIV/AIDS shaping policy, practice, and research focus. Bio-medical enquiry, and its bedfellow cognitive psychology, launched individual behavior change intervention to the forefront
The placement of individual behavior change intervention at the forefront of HIV/AIDS prevention internationally has a great deal to do with the power of professional institutions, and medically based expertise as western forms of knowledge production. Very few disciplines rival medical science in their ability to assemble a body of knowledge established through text, journal articles, and clinical studies (O'Manique, 2004, pg 17). The power of the professional institution as sites for knowledge production is an important component in this discussion. Set against the potential contributions of community based knowledge and experience, Western based medical science has an overpowering presence in the lives of people infected and affected by HIV/AIDS. It became the lens through which the pandemic is viewed. Billboards, t-shirts, and banners with the letters ABC (Abstinence. Be Faithful. Condomise), stood as an overt simplification of a much more complex issue. While bio-medicine offered a great deal to the understanding of HIV/AIDS as biologically based virus, what is of great concern to our discussion was the power laden relationship between local knowledge and knowledge systems and the knowledge systems of western medical science.

In 1944 Gunnar Myrdal suggested that cultural influences "pose the question we ask; influence the facts we seek; and determine the interpretation we give the facts" (Myrdal, 1944, pg 92), and by the beginning of the HIV/AIDS pandemic in the 1980s some began to acknowledge science as a "socially embedded" activity. Linda Tuhiwai discussion of education systems and knowledge is useful here:

"Knowledge systems however were informed by a much more comprehensive system of knowledge which linked universities, scholarly societies and imperial views of culture. Hierarchies of knowledge and theories which had rapidly developed to account for the discoveries of the new world were legitimated at the centre underpinning all of what is taught.. is the belief in the concept of science as the all-embracing method for gaining and understanding the world." (Smith, 2006, pg 65)
Western medical science has stood dominant to all forms of research, and experience. The historical power imbalance of knowledge systems was erected in the colonial period and continues to thrive within institutions that have not yet moved to make radical breaks with the past. Sub-Saharan Africa continues to be the “laboratory” for many forms of western science (Smith, 2006, pg 65). When the pandemic began, responses were greatly influenced by international development institutions and their local institutional counterparts. The World Bank, UNAIDS, and WHO all provided technical assistance in the development of National HIV/AIDS programs and strategic frameworks. As stated earlier, many of these institutions already stood as dominant figures in Sub-Saharan Africa’s post-independence period deconstructing social welfare systems through SAPs and poverty reduction initiatives grounded in neoliberal philosophy (Katz, 2002, pg 128). The creation of knowledge in relation to AIDS prevention was generated at the center of these institutions only to be marginally amended with the input of local governments and civil society.

The outcome has been individual behavior change education approaches that function as designed disempowerment, ultimately blaming the victims and obscuring the root determinants of AIDS prevalence in Sub-Saharan Africa. Through a programmatic discourse that conveys very strong messages of personal responsibility, self-esteem, and choice without attention to structural violence and its manifestations in people’s lives, this approach reinforces powerlessness and disempowers.

As professional institutions and their housed experts developed global partnerships, the ideological underpinnings of these partnerships remained tethered to the social and historical context from which they came. A history of hegemonic knowledge systems and their grounding in racialist thinking ultimately created responses that, in their narrow view, stood in tandem with very same structure of violence that influenced the explosion of AIDS in Sub-Saharan Africa. Within this phenomenon, the voices, beliefs, and knowledge of communities based in various regions of the continent were subjugated by the “expertise” of western medical science and the institutions and experts that
Individual behavior change and the power of its proponents developed HIV/AIDS prevention initiatives that viewed community members as objects of change. The paradigm from which these initiatives sprang indicated a generalized “African” sexuality as culturally unique factor greatly contributing to prevalence rates.

The designed disempowerment schemes found their greatest prominence through multilateral and bilateral partnerships. While many global partnerships aimed at stemming the spread of HIV/AIDS and have been positive support to the fight, some partnerships have been distorted by dogma reflective of the designed disempowerment scheme. These partnerships reflect what we may term hegemonic benevolence.

Hegemonic Benevolence and PEPFAR

In the final chapter of The Invisible People, Greg Berhman writes about the beginnings of President Bush’s Emergency Plan for AIDS (PEPFAR). PEPFAR was deemed to be a sharp turn of policy in that, up until January 28, 2003, America had for the most part abdicated itself from full participation in the international fight to stem the pandemic (Behrman, 2005, pg 306). Due in large part to the quiet work of Secretary General Colin Powell, the pandemic and its impact on Sub-Saharan Africa was placed squarely as new international policy priority for the United States Government. In his address, President George W. Bush, Jr pledged $15 billion over 5 years to address AIDS in Africa and the Caribbean. While many applauded the effort and its symbolic shift in American foreign policy as it related to the pandemic, others were skeptical. Berhman recounts:

Focused on only fourteen countries in Africa and the Caribbean, lacking a sufficiently aggressive diplomatic plan of attack, assuming a bilateral approach, and conceptualized as a humanitarian work of mercy it was not a comprehensive global strategy (Behrman, 2005, pg 315)
While PEPFAR dedicated rather sizeable amounts of funds to anti-AIDS efforts, the conceptual framework of the funds are of the greatest concern to this discussion. Although there has always been welcomed room for bilateral partnerships in the fight against AIDS, PEPFAR chose bilateralism at a crucial time in the pandemic. The Global Fund to Fight AIDS Tuberculosis and Malaria promised to be one of the most effective and comprehensive strategies for generating financial and political support, and also promised to be one of the more articulate and grounded forms of funds disbursal. The infusion of American funds would have served as leverage to encourage other international partners to financially and politically enlist in the global effort. Even more important, as a bilateral partnership the United States government ensured that it had full control over the philosophy and practice of the partnership. In time what became painfully apparent was that this seemingly benevolent stroke of what was deemed "compassionate conservatism" was accompanied by clearly conservative dogma.

PEPFAR was marked by standards that allocated 20% of funds to HIV/AIDS prevention specifically. It was within this 20% allocation that the hegemonic nature of partnership was revealed. Touting Abstinence Be Faithful and Condomise (ABC) approaches as the definitive AIDS prevention strategy, PEPFAR confined the work of many in Sub-Saharan Africa to work within this framework. Many organizations grounded in creation of holistic programs were forced to restrict their activities to suit the tenements of PEPFAR. Within the 20% demarcation, 33% were slated to be directed towards abstinence until-marriage funds (IOM, 2007). Furthermore, based on the Mexico City Policy enacted in the Reagan era and revived in the Bush era, PEPFAR funds restricted work with commercial sex workers. Many rallied against these stipulations as prevention policy ruled by religious dogma and political conservatism, but within the larger discourse of this paper the foundations of the program philosophy are multifold.

The Abstinence Be Faithful Condomise (ABC) strategies fall firmly within the context of designed disempowerment schemes. It is important to recognize that the ABC approach in many ways inherited the same perceptions and principles of designed disempowerment
and are, in turn, blind to the larger societal and global determinants of health that impact HIV/AIDS. As the U.S. Institute of Medicine in their evaluation of PEPFAR to date suggest:

\[ \text{An effective sustained response requires programs to attack social factors that sustain the epidemic, in particular the low social status of women and girls. The legislation that established PEPFAR specifically called for US initiatives to support programs that address the conditions that make women particularly vulnerable to HIV/AIDS including improving women's access to paid work and economic resources, and advancement of women's legal rights.} \text{(IOM, 2007)} \]

Within the already myopic focus on individual behavior change, the layering of heavy right-wing political thought has served to not only disempower women and communities on a whole. The restrictions of the program have also served to bind the work of lively civil societies engaged in HIV/AIDS intervention. The Institute of Medicine evaluation report went on further to suggest:

\[ \text{The abstinence-until-marriage budget allocation in the Leadership Act hampers these efforts and thus PEPFAR's ability to meet the target. Despite the efforts of the Office of the U.S. Global AIDS coordinator to administer the allocation judiciously, it has greatly limited the ability of Country Teams to develop and implement comprehensive prevention programs that are well integrated with other.} \text{(IOM, 2007)} \]

The PEPFAR framework was damaging to the strong and articulate response to HIV/AIDS in various parts of Sub-Saharan Africa. Even further, the impact that the policies had on grassroots efforts is potentially devastating. It has been widely shared and proven that in many cases young women specifically contract the virus within marriage making the abstinence-until-marriage portion of prevention programming potentially dangerous rhetoric (Human Rights Watch, 2005). By restricting work with women caught
addressing the economic factors that force tough decisions to further stigmatize victims. If we revisit the story of Summertown South Africa, explored in our discussion on structural violence, we are forced to imagine a prevention program that does not see the young women forced to flee impoverishment through sexual trade as worthy of the support and change these funds might offer. The migrant workers of Summertown would be offered a great deal of support through various programming that acknowledges their presence in the pandemic but only so far as whom they choose to bed and how. Young South African women are, in essence left to suffer in poverty and eventually die.

Individual behavior change education and its place in HIV/AIDS prevention has often stood in unison with various forms of structural violence, disempowering the powerless further and obscuring the larger issues, the global issues, the issues that the global community is not comfortable addressing. PEPFAR serves as an example of how the designed disempowerment scheme of individual behavior change assumes its prominence and was in turn established as the dominant model for HIV/AIDS prevention. While the bilateral strategy has offered a great deal of funds in support of Sub-Saharan Africa’s fights against HIV/AIDS, this form of benevolence has served a particular hegemony that is a reflection of the international communities’ historical encounters with Sub-Saharan Africa.

True transformation will only be possible if HIV/AIDS intervention evolves, moves beyond the confines of the traditional prevention paradigms, and makes clear and distinct breaks with the ideologies that fed the pandemic.
Chapter 3

Liberation and Emancipatory Pedagogy

"To tell the truth, the proof of success lies in the whole social structure being changed from the bottom up."

Frantz Fanon. Wretched of the Earth

HIV/AIDS Prevention and Emancipatory Pedagogy

Traveling through the confinements and constrictions of HIV/AIDS prevention provides both a reminder of what has been lost and what is still possible. Fundamentally a conversation about HIV/AIDS prevention is ultimately about people and communities, those lost to the pandemic, those struggling with pandemic, and those yet to experience its devastation. When we speak of peoples, communities and HIV/AIDS, we are not merely speaking about the loss of bodies and the possibility that lies in the physical strength of those still standing, we are also speaking about the intangibles. We are speaking about lost creativity, intellect, compassion, and empathy; equally we are speaking about the abundance of creativity, intellect, compassion, and empathy that continues to thrive and the possibility this holds. We are speaking about consciousness, we are speaking about a resource that, as global society, we struggle to tap. Thus what we offer as an alternative, how we conceptualize change must honor what has been overlooked; the abundant and thriving consciousness of peoples, families, and communities throughout SSA. The infinitesimal source for change lies both active and dormant in the consciousness of those most infected and affected by the pandemic. Our conversation must now shift to examine ways to challenge the confines and constrictions of the traditional approaches from an infinitesimal source that has been historically relegated to the margins. We will do so first by way of pedagogical critique.
While “liberation” or “emancipation” may be considered terms too strong for a critical discussion, it is an important point of transition in our conversation. For the purposes of this discussion, liberation and emancipation will be used interchangeably based on the notion that they both speak to the same ends. In his critique of developmentalism, liberation theologian Gustavo Gutierrez writes:

Development—approached from an economic and modernizing point of view—has been frequently promoted by international organizations closely linked to groups and governments which control the world economy. The changes encouraged were to be achieved within the formal structure of the existing institutions without challenging them. Great care was exercised, therefore, not to attack the interests of large international economic powers nor those of their natural allies, the ruling domestic interest groups. Furthermore the so-called changes were often nothing more than new and underhanded ways of increasing the power of strong economic groups—developmentalism thus came to be synonymous with timid measures, rarely ineffective in the long run and counterproductive to achieving a real transformation. (Gutierrez, 1973, pg 17)

The term Liberation, according to Gutierrez is distinct in meaning and overtly challenges the frequently used term developmentalism proposing a sort of radical change unfamiliar to developmentalism. The theologian argues that only development framed by liberation will seek to attack the root causes of problems—the deepest among them being the economic, social, political, and cultural dependence of some countries upon others— an expression of the domination of some classes over others (Gutierrez, 1973, pg 17).

Encapsulated in Gutierrez assertions are a distinct challenge; The challenge being not to just modify traditional HIV/AIDS prevention, but rather, to radically reconceptualize prevention through the prism of an emancipatory framework. The challenge calls us to move beyond the confines of development from the traditional towards the radical. Ultimately this moves us to embrace the notion that the end to AIDS is encapsulated not
nurtural violence, but equally, in the deconstruction of maintain the status quo. At the XVII International AIDS Conference in Mexico, Lancet held a symposium to launch a series of articles focused primarily on HIV prevention. Presented during the symposium was the article ‘The History and challenge of HIV prevention’ (Merson MD et al, 2008, pg 475-488). The article offered this:

‘Overall HIV/AIDS prevention has overly focused on individual’s behavior. Prevention needs to embrace the political, economic, and social determinants of risk too. We now require an urgent and revitalized global movement for HIV prevention that supports a combination of behavioral, structural, and biomedical approaches and is based on scientifically derived evidence and the wisdom and ownership of communities.’ (Merson MD et al, 2008, pg 475-488)

The Lancet article identifies two key points: 1) the need for an integrated approach, and 2) the need for HIV/AIDS prevention efforts to be rooted in community wisdom and ownership which is critical for our discussion.

An emancipatory prevention methodology by necessity is distinct in both form and content from that of a developmental one. More importantly, prevention methodology framed by emancipation would be rooted in the collective, creative consciousness, and efforts of people living with, working with, and coping with the pandemic in their daily lives.

As depicted earlier in our discussions Designed Disempowerment schemes are fundamentally antithetical to a prevention methodology framed by emancipatory principles, ideologies, and practices. Probably the greatest disjuncture between Designed Disempowerment and emancipatory methodologies are the ideologies that form these frameworks. In the case of Designed Disempowerment, the confluence of oppressive
ideological underpinnings, racialism, racism, and neo-liberalism have worked identities, knowledge, and voice of peoples and communities throughout Southern Africa.

An analysis of the relationship between health, culture and AIDS, Crawford illustrates that the pathologized not only as diseased but also as dangerously sexual Gay men, Native Americans, Africans and African Americans, Jews, the working classes, the poor and women have all been periodically characterized as hyper-sexual and deviant (Crawford, 1994). The implications of this both racist and racialist frame are dire for those conceptualized within it. Evidence of this is present in the words of Amina Mama who, in a critical discourse on Gender, Power and African Context, draws a direct parallel between the word identity and the words integrity and security. In her article, Mama situates identity and struggles on the basis of identity at the center of struggles for the equal distribution of resources. According to Mama, struggles based on identity are in fact struggles for material redistribution; underpinning both is a call for freedom and power. Mama writes:

I would like to suggest that much of what we are grouping under the dubious rubric of identity politics is actually about popular struggles for material redistribution and justice, and the related desire for existential integrity and security. (Mama, 2001)

With both Crawford's and Mama's words in mind we must recognize that the ideologies underpinning designed disempowerment schemes marginalize the capacity of communities throughout Sub-Saharan Africa by othering. In this way, both inadvertently and advertently, communities are told that in part their identities and their differences are responsible for their endemic illness. As a result the purveyors of Designed Disempowerment schemes consolidate their position as teacher and establish peoples and communities throughout SSA as students to be taught. From the perspective of an emancipatory framework identity, the culture, and knowledge of peoples are at the center of all efforts to mobilize for sustainable change and
Transformation. Freire’s work on ‘Cultural Synthesis’ clearly illustrates how an emancipatory framework would in fact challenge Designed Disempowerment. He writes:

“In cultural invasion, the actors draw the thematic content of their action from their own values and ideology; their starting point is their own world, from which they enter the world of those they invade. In cultural synthesis, the actors who come from ‘another world’ to the world of the people do so not as invaders. They do not come to teach or to transmit or to give anything, but rather to learn, with the people, about the peoples’ world. In cultural invasion the actors (who need not even go personally to the invaded culture; increasingly, their action is carried out by technological instruments) superimpose themselves on the people who are assigned the role of spectators, of objects. In cultural synthesis, the actors become integrated with the people, who are co-authors of the action that both perform upon the world.” (Freire, 1974, pg 182)

As Freire writes, the identities of peoples and communities are central to action and educators must come not only as teachers, but also as leaners. While it is true that there may be elements identified as cultural (i.e. ‘Widow Cleansing’ that increase transmission rates) these elements exist amongst a constellation of health enhancing cultural elements. Freire continues on to argue that ‘cultural invasion’ traumatizes the creative enthusiasm of communities that have been invaded. Through Freire’s words and thought an emancipatory prevention framework would view knowledge of the formerly ‘alienated’ culture as a transformative moment that results in a culture being freed from alienation fortifying Mama’s identity in the ‘integrity’ and ‘security’ sense which could subsequently lead in part to liberation. The words of Freire are further echoed by Airhihenbuwa, who suggests ‘cultural empowerment’ as HIV/AIDS prevention strategy:

We have proposed ‘cultural empowerment’ as a way of reinscribing the positive strengths in cultures as a collective process at the beginning of health promotion intervention. Cultural empowerment takes into account
how micro (individual, family, and community/grassroots) and macro (national and international power and politics) levels. Thus the decision making of individuals and families must be situated within its proper political, historical, and cultural context. (Airhihenbuwa, 2007, pg 183)

In tandem with the racist and racialist ideologies of designed disempowerment are neoliberal policies that further served to obscure the broader context of structural violence within which the pandemic took root. Arguably, HIV/AIDS prevention has continued to reflect Gutierrez’s developmentalism because of neoliberal ideologies. Within the context of Summertown shared earlier the structural violence was responsible for the destruction of local production, community self sufficiency, and the subsequent migration of labor. At the end of this chain lay broken families, and migrant workers and commercial sex workers either infected or affected by AIDS. Within the context neoliberal ideologies that do little to address the root issues of AIDS utilize individual behavior change strategies and IEC (Information.Education.Communications). The neoliberal underpinnings of IBC and IEC are evident in the initiatives refusal to engage larger structural issues. According to Katz this is part the desire to obscure the link between HIV/AIDS and the aim to maintain and further concentrate wealth and power through a monopolistic, totalitarian, corporate-led, and increasingly violent, form of capitalism. (Katz, 2003, pg 23) Katz continues on to assert:

The neoliberal approach addresses symptoms, in the short term, through magic medical bullets interventions through health services. It focuses on individuals and blames them for their irresponsible behavior. The social justice/ Human Rights approach addresses root causes in the long term- miserable living conditions through meeting basic needs for health food, water, shelter, a means of survival, employment, physical security and basic health services. It focuses on structural poverty and violence and blames the system- social and economic determinants of health. (Katz, 2003, pg 22)
As seen in Katz’s accounts, the ideological underpinnings of HIV/AIDS intervention continue to reflect the dominant discourse on AIDS. This dominant discourse is reflected by both a fundamental refusal and incapacity of global actors to challenge their role in the maintenance of structural violence. As seen in the case of PEPFAR, the prevention strategy was not only shaped by the conservative ideology propagated by the government in power, it also reflected a fundamental, unquestioned world view; neo-liberalism. Many of the global actors involved in HIV/AIDS programming, whether it be bilateral institutions like USAID and CIDA, or multilateral agencies like the United Nations, continue to operate within the context of global political and economic machinery whose modus operandi for ordering the world is neoliberal policy and practice. In his critical discourse Basu writes:

“AIDS, then is a symptom as much as it is disease. In the context of the new South African Customs Union (SACU) trade agreement with the United States, it will be a most severe symptom. THE SACU deal promotes the rapid liberalization and the movement of capital over the securing of stable investment and employment, privileging companies who wish to setup base temporarily and shift capital at will. If similar deals in East Asia and The Caribbean are of any indication, both TB and HIV will increase markedly in this context as forced migration and poverty render monogamous marriage a nonsensical idea and commit both women and men in poverty to constant movement to find new sources of income wherever they can. (Basu, 2003 ,pg 3)

The neoliberal ideological underpinnings of prevention call peoples and communities throughout SSA to act upon themselves as opposed to becoming active conscious interveners in the world Freire argues the fundamental aim of liberation is to first recognize that peoples have always been within these structures, and then to engage in dialogical inquiry that begins to name and subsequently deconstruct these structures.
According to Freire, the aim of the "oppressor" is to obscure from vision such structures and communities' comprehension of the world they live in. The intent of liberation emancipation, on the other hand, is not to integrate people, rather the aim is to change the structure. In the case of HIV/AIDS prevention, it would call for peoples and communities to engage in addressing the root causes of AIDS while also addressing the immediate. An emancipatory framework reflects a space in which the collective consciousness of communities is not only confined and turned inward, but simultaneously engaged in looking outward to the world, with the recognition that the sexual choices of community members play out against the backdrop of the rapid liberalization of markets, international trade policies, and national economic growth strategies grounded in neoliberal ideology.

Beyond the ideological underpinnings of designed disempowerment are the actual prevention approaches utilized within communities. Because of the confluence of ideologies that make up designed disempowerment, individual behavior change not only became the primary mode of prevention, but it also mirrored a form of education and change prescription not so unfamiliar to emancipatory pedagogy.

**Individual Behaviour Change as ‘Banking Education’**

Potentially one of the most confining realities of the individual behavior change modality is its ability to relegate the minds of those whom receive the prescribed information to the margins. Mirroring the relationship of doctor/patient, community issues are diagnosed and with limited participation from the community a prescription is made and, in turn, paid into by multilateral and bilateral institutions. As discussed earlier, the traditional diagnosis placed a narrow spotlight on the sexual behavior of people and communities ostensibly obscuring structural inequalities that feed HIV/AIDS prevalence rates. The unfortunate truth is that HIV/AIDS interventions focused on individual behavior change to greater extent reflect what liberation theorist and practitioner Paulo Freire termed banking education.
The banking concept of education in conjunction with the banking social action apparatus, within which the oppressed receive the euphemistic title of ‘welfare recipients’. They are treated as individual cases, as marginal men who deviate from the general configuration of a ‘good, organized, and just’ society. The oppressed are regarded as the pathology of the healthy society, which must therefore adjust these ‘incompetent and lazy’ folk to its own patterns by changing their mentality. (Freire, 1974, pg 60-61)

One of the primary concerns of liberatory framework is to fully recognize and honor the innate power and wisdom of communities. The rootedness of traditional interventions in racist, racialist, and neoliberal ideologies have constructed intervention and mobilization efforts that treat people and communities as automatons to be ‘shaped’ and ‘changed’ from the top down.

The ‘deposits’ of information aimed at influencing the sexual habits of peoples and communities in actuality limits the ability for peoples and communities to actively engage in transforming the structural determinants of the virus. According to Freire, the acceptance of this form of knowledge counteracts the generation of critical consciousness necessary for true transformation.

Individual Behavior Change mirrors ‘banking education’ by framing knowledge as something to be imparted by ‘experts’ as oppose to an elemental force, whether dormant or latent, already inherent to peoples and communities. Catherine Campbell identifies information provision as a commonly utilized HIV/AIDS intervention strategy. Information provision initiatives are framed by a rationale that sees unhealthy behavioral choices as a byproduct of ignorance. With adequate knowledge ‘information provision initiatives presume’ individuals will make rational choices that favor their short term and long term health (Campbell, 2003, pg 41). A great deal of early HIV/AIDS prevention and present prevention is framed by this rationale. While it remains true that knowledge is indeed a key component in the cognitive process of individuals, there is an
The unfortunate power paradigm that undergirds this approach. The transmission of knowledge to communities is not a passive act but assumes the passivity of individuals and collective community consciousness. The underlying power paradigm is one that views people and communities as objects to be filled by the dominant knowledge system. Within this paradigm an outside expert transmits information to what is assumed to be a passive target audience. Freire writes:

“\[\text{Freire, 1974, pg 66}\]”

Freire continues on to describes what he deems to be \textit{authentic liberation}:

\[\text{Freire, 1974, pg 66}\]

This idea is echoed in the findings of Catherine Campbell whose research in the Summertown region asserts the need to move away from prevention efforts framed solely by bio-medicine and behavior change to interventions that focus on \textit{structural interventions} and \textit{enabling approaches} (Campbell, 2003 pg 23). Rather than encouraging people to change behavior through education programs, Campbell suggests that communities be engaged in collectively identifying what is needed in order to create an enabling environment for health enhancing behaviors. Such an approach could in fact create a learning space that emphasizes what Freire terms problem-posing education.
the dogged emphasis on individual behavior change, HIV/AIDS prevention has increasingly been framed by participatory rhetoric. While this rhetorical shift may seem more in line with an emancipatory framework, the term participation and participatory approaches need be critically examined. While the rhetoric of this shift is punctuated by terms like power, empowerment, community involvement, ownership and even more poignant participation this shift may not fully reflect the sort of emancipatory spirit and frame necessary for deep and long term change.

**Community Participation and Empowerment**

Many professional international institutions now seek to develop policy and interventions that impact the social and community context (Campbell, 2003, pg 11). As a result, community participation and community mobilization have become common intervention practice in prevention efforts. Often terms including empowerment, social inclusion, and even in some cases emancipation, are concepts and potential outcomes closely associated with participation. While these approaches indicate a shift in thinking, they may still remain confined by the frameworks professional institutions create.

Participation as defined by professional institutions provides an opportunity to examine the philosophical underpinnings of participatory interventions. The World Bank Participation Source Book was developed through the Banks learning group on participatory development. The definition the Bank subscribes to is as follows:

> Participatory development is a process through which stakeholders influence and share control over development initiatives and over the decisions and resources that affect themselves. (World Bank, 1996)

In comparison, the United Nations Research institute for Social Development defines participatory development as a capacity for influencing decision making processes at all levels of societal organization. The UN Definition continues on to evoke terms such as
empowerment, social capital, capacity building, and social movements. These two professional institutions in their construction of community members as either ‘objects’ or ‘agents’ of social change. Through the creation of frameworks for participation, institutions and experts become the gate keepers. The sheer ability to create definitions for participation at the level of the professional institution is an action that expresses a complete and absolute power over the social change process. In the realm of participatory approaches, communities find themselves placed along a gradation between object and agent. In many cases the professional institution dictates where the community falls as ‘partners’ in the development processes. While erecting these poles of ‘object’ and ‘agent’ may seem simplistic, it stands as an important consideration in light of the fact that many participatory initiatives speak of empowerment.

The historical power, privilege, and social context from which international institutions like the World Bank, USAID, and even the UN originate requires us to problematize ‘participation’ as social change approach, to ensure mechanisms for change do not become frameworks for bondage that stand quietly in line with histories of oppression. In the realm of AIDS prevention ‘participatory approaches’ may be particularly problematic because communities are ‘empowered’ to participate and mobilize within already established hegemonic systems.

In the case of USAID, a powerful partner in the global AIDS effort, the complexities of power and participation are very apparent. Family Health International stood as one of the primary beneficiaries of USAID HIV/AIDS intervention funding and operates in numerous countries throughout Sub-Saharan Africa. The AVERT model, developed by Family Health International (FHI), is a behavior change model that is quite reflective of traditional prevention approaches. As Stillwaggon puts forth:

‘None of the transmission models used by major organizations in the AIDS field takes into account ecologic factors or in any way reflects the population health of the regions under study. They assume very few factors in HIV
The AVERT model has extremely narrow population variables: occupation, type of partner, gender, partner gender, and HIV prevalence. Even more concerning are intervention variables: the average number of sex partners, average number of sex acts, prevalence of STDs, and condom use. These variables are considered to affect transmission. Programs with these population and intervention variables are considered to be targeted interventions that are cost-effective. An intervention such as this would consider condom promotion amongst commercial sex workers as viable and highly targeted intervention. Organizations like FHI place community participation and community mobilization at the center of their programming. Participation in this case is defined as communities participating in the final stages of intervention. The program is already planned packaged and researched before it reaches the grassroots.

In an account of the Summertown Project based in a mining community just outside of Johannesburg South Africa, Campbell identifies the limitations of participation as defined by professional institutions. Although community participation is deemed to be an important part of the project, participation on the project level was confined to peer education. Community participants served as conveyors of knowledge and mobilizers of a project designed and developed far outside of the context of Summertown:

In retrospect, having an outsider write the proposal was less than ideal for a number of reasons. The first was that it meant that local stakeholders had a limited sense of ownership of the original ideas of the Project. Although there was some consultation between the external consultant and some Summertown stakeholders in the development of the proposal, this appears to have been fairly superficial...the projects internationally based funding agency commissioned a London-based consultancy company to develop the project proposal. (Campbell, 2003, pg 39)
Such accounts stand as clear examples that participatory approaches in the realm of HIV/AIDS prevention still remain within the control of the professional institutions that define these approaches. Within this approach, community members remain objects of change as distant ponds to be played on the landscape of AIDS prevention. Grassroots movements remain locked within the confines of dominant knowledge systems that negate the experience and knowledge of communities, functionally robbing communities of their power while speaking of empowerment and mobilization. As Michael Woof states:

“The poor (are allowed to) participate in development, but only in so far as they do not attempt to change the rules of the game. (It is like) riding a top-down vehicle of development whose wheels are greased with a vocabulary of the bottom-up discourse.” (Woost, 1997, pg 249)

**Up from the roots: HIV/AIDS prevention and grassroots driven social change**

“It is time South Africans acknowledge that what can be done technically to prevent and treat HIV/Aids is being done. We won't solve the crisis by simply improving the techniques, be it ABC campaigns, counseling, testing or treatment. They are tools that depend on the hand that guides them. Little more can be achieved without a change in society's consciousness of how to live with HIV/Aids.” (Qulo et al, 2007)

How do we define empowerment and emancipation? If we are in agreement that HIV/AIDS was born of multiple levels of structural violence rooted in oppressive power dynamics then surely the root of empowerment and emancipation, being power and freedom respectively, are part and parcel of change. Prevention of AIDS based on social change must be a process that stands for grassroots power and freedom. According to Paulo Freire:
A truly liberating pedagogy can remain distant from the oppressed by treating them as unfortunates and by presenting for their emulation models from the oppressors. The oppressed must be their own example in the struggle for their redemption. The pedagogy of the oppressed, animated by authentic, humanist (not humanitarian) generosity, presents itself as pedagogy of man. Pedagogy which begins with egoistic interests of the oppressors (an egoism cloaked in the false generosity of paternalism) and makes of the oppressed the objects of its humanitarianism, itself maintains and embodies oppression. It is an instrument of dehumanization. That is why the pedagogy of the oppressed cannot be developed or practiced by the oppressors. It would be a contradiction in terms if the oppressors not only defended but actually implemented a liberating education. (Freire, 1970, pg 39)

As we have recognized, professional institutions and their current practices are shaped by their social and economic context. Typically prevention approaches stand in tandem with structures of violence. Within this context, Freire’s analysis is fitting; the grassroots must possess a voice that is powerful and not confined by the pedagogy of the hegemonically benevolent AIDS assistance. This is not to negate the importance of bio-medicine as a knowledge system, rather to negate its place as a hegemonic force over more localized interpretations of prevention. If we conceive of AIDS as oppression, and conventional prevention as standing in tandem with that oppression, then prevention models based on grassroots empowerment and freedom, health and healing must stand in resistance to the conventional models in both form and content.

AIDS prevention must be a process born of indigenous knowledge and its kin endogenous knowledge. For communities to have power and freedom and a voice that is central to prevention efforts, people must shift from objects of change to agent of change. One might ask, why is this important? Surely western medical science offers a great deal in the fight against a biologically based disease?
medical science has and continues to offer a great deal but not as a standalone overpowering knowledge framework. As the HIV virus writes itself into the biological makeup of women, children, and men, it also weaves itself into the fabric of society, communities, and interpersonal life. Prevention efforts typically seek to transform the most intimate and intricate interpersonal and social relations in an attempt to create health-enabling societies. The recognition of AIDS as an illness propagated by macro and micro level structures of violence makes it clear that prevention will ultimately lie in the realm of grassroots social change. This means that social change that confronts structural violence is an intimate community based struggle that cannot be fully conceived by those who live on the outside. Only community members will fully understand and comprehend the web of susceptibility inherent in their experiences.

Ironically within the cannon of professional AIDS prevention many acknowledged the failures and limitations of conventional prevention policy and programming. Participation as an approach clearly acknowledges the limitation and weakness of conventional practice. Furthermore, within the cannon terms like empowerment, social inclusion, and social capital, the approaches serve as theoretical spaces to argue for a radical shift of power. While arguing within these concepts is problematic in that it may seem to reflect a reliance on the power and privilege of institutional cannon these concepts reveal the very real limitations of hegemonic humanitarianism. These concepts and the subsequent shift towards participation and mobilization clearly illustrate that change cannot be legislated and that the power that change requires is within the human experience of relationship and dialogue. They illustrate the inherent power of community, and show that the social change required to stem the tide of the pandemic will continually require institutions to surrender power to people and communities, the grassroots.

Throughout Sub-Saharan Africa communities responded to the immediate need of people infected and affected by HIV/AIDS. In many countries a vast array of formal and informal prevention and treatment and support systems sprung forth from the initiatives of various community members. Community-Based organizations and locally based Non-governmental organizations stood in resolute indignation against the devastating
staff these organizations are often residents of the work. There are numerous community members that may be politically engaged in HIV/AIDS as full-time activists or as people either affected or infected by the pandemic. Consequently, it is those on the ground, working in NGO's and CBO's, those living in communities as concerned community members that live with the impact of conventional prevention practice. With the creation of numerous opportunities for funding, the gaze of many communities immediately turns vertical, first to governments and then to donors. Prevention and treatment is expensive and, in many communities, resources for living are limited. Many of the initiatives that have since taken shape have been forced to conform to conventional behavior change prevention frameworks and the stipulations of international donors. People at the grassroots are those most restricted by the stricture of projects funded within the narrow confines of the behavior change model. Consequently, it is the grassroots that may pose the greatest challenge to popular prevention practice. It is the infinitesimal source the consciousness of communities, where true and lasting change begins and ends.

Through the creation of community based, community driven prevention efforts that function beyond the confines of behavior change people at the grassroots can create prevention practice that reveal the limitations of conventional practice through their form and content. Initiatives like Rights-Based Approaches, citizen led development programs that speak of holistic community based community driven intervention, have all been generated at the level of local civil society within community. Many of these initiatives are generated from long term, lived, and grounded experience in the respective communities. Organizations like the United Nations Development Program have only recently absorbed these concepts. While this gives pause for concern, once again, it is testament to the power of community based knowledge and experience.

A shift of power of this nature may in fact seem radical, but in light of our discussion is it not necessary? I offer that a community engaged in the development of local prevention practice, engaged in a transformative process, supported as central powers in their own change process, is a truer reflection of power and freedom than what has been
in this place communities stand as the true and rightful agents of social change. While it may seem implausible to some I am reminded of the word of Gustavo Gutierrez:

"Misery and injustice go too deep to be responsive to palliatives. Hence we speak of social revolution, not reform; of liberation, not development; of socialism, not modernization of the prevailing system. Realists call these statements romantic and utopian. And they should, for the reality of these statements is of a kind quite unfamiliar to them." (Gutierrez, 1984, pg 44)

**Umuntu Ngumuntu Nbabantu**

Our global experience with broad based social movements transformed the minds and hearts of communities while challenging the larger structures that inflict violence suggest that we are of a grander design than traditional HIV/AIDS intervention suggests. Locked within the consciousness of every individual is a potential revolution. David Cooper identifies this phenomenon as the dual imperative of any successful transformative movement. Cooper (1968) illustrates the dual imperative as need for community generated social change to attempt to transform both there 'inner reality' and 'outer reality'. As Cooper frames it, the fundamental failure of many revolutions is that there has been the disassociation of liberation on the mass social level, i.e. liberation of whole classes in economic and political terms, and liberation on the level of the individual and the concrete groups in which he is directly engaged. Cooper's perspective offers important recognition to the role of and the need for a transformative binary that intertwines the personal and political revolution in the societal change process. This perspective speaks directly to the core of an emancipatory HIV/AIDS framework that envisions the change processes as a work from the inside out rather than the outside in.
The emancipatory writings of Freire have shown us that unlocking revolution within peoples and communities is where, as a society, the evolution of our humanity lies. Challenging the structural oppression that propagates abnormally high prevalence rates on the back of life crushing poverty indices is a movement to both reframe and regain our collective humanity. The writings of Freire have shown us that this sort of revolution is achieved through dialogue that restores our humanity through both a fundamental transformation of our relationships with one another and the broader society.

Central to this belief is the recognition that true social change is achieved through the living negotiation of relationships. Imperative to the development of critical consciousness and subsequent social change is the exploration of relationships to others and all things as Kwame writes:

"A person comes to know who she is in the contexts of relationships with others, not as an isolated, lonely star in a social galaxy." (Gyeke, 1996 pg 43)

*Umuntu Ngumuntu Ngabantu* translated means *a human is a human through other human beings*. It is a concept central to the Ubuntu philosophy. The concept that societal change and transformation can emerge out of a dialogical process is one that predates the writings of Freire. Throughout South Africa the Ubuntu philosophy has for centuries shaped the deliberative processes, interrelationships and transformative framework of peoples and communities. The Ubuntu concept, based on a notion of compassion with an emphasis on reconciliation, served and still serves as both a rule of conduct and social ethic (Louw, 2001, pg 16). The 1997 South African Government White Paper officially recognizes Ubuntu as:

"The principle of caring for each other’s well being and a spirit of mutual support. Each individuals humanity is ideally expressed through his or hers relationship with others in theirs in turn through a recognition of the individuals humanity. Ubuntu means that people are people through other people. It also acknowledges the rights and responsibilities..."
The Ubuntu philosophy and accompanying principles envision transformation and change, not as something to be taught but rather as something to be synthesized through the medium of relationship. Like Freirean pedagogy, the Ubuntu philosophy is animated by a deep and profound belief in dialogue reflected in the emphasis on ‘agreement’ and ‘consensus’ (Louw, 2001, pg 19). Consensus and agreement are Ubuntu principles that emphasize the important of engaging in rigorous critical dialogue aimed at not only building understanding but also aimed at enabling the creation of an communal environment that invites and is conducive to the proposed change. The Ubuntu philosophy recognizes the power of conversation and, as a result, the inherent power of the participants.

As stated in the beginning, this thesis is indeed a conversation about conversations. We turn to dialogue and conversation as communal space that challenge structural violence, the silencing of communities, and the marginalization of community consciousness. This is a work that explores the power of these ‘conversational spaces’ and their relation to the HIV/AIDS pandemic. Our conversation is about a reinvigorated form of civic life that cannot locate its origins in university halls, the offices of global think tanks, or the technical strategies of multilateral agencies. This reinvigorated form of civic life belongs but to the sand and ground that was there before the brick. This is about the blood and marrow in the bone. This is about contemporary HIV/AIDS prevention strategy that ideologically and structurally challenges Designed Disempowerment and Hegemonic Benevolence. This is about the spirit and philosophy of Ubuntu, made flesh through the Community Capacity Enhancement- Community Conversations approach to HIV/AIDS prevention. At the heart of CCE-CC is the recognition of the power of voice and communities, and that in fact ‘the answers lie within.’
Chapter 4

A Conversation about Conversations

“.. Truth (is) being involved in eternal conversation about things that matter, conducted with passion and disciplineâ€ truth is not in the conclusions so as in the process of conversation itselfâ€ if you want to be in truth you must be in conversation.”

Parker Palmer

Community Capacity Enhancement (CCE) and Community Conversations

HIV/AIDS within Sub-Saharan Africa was initially researched and conceptualized within environments far removed from the lived experience of those infected and affected by the virus. Western ‘medical science’ and more specifically, the field of bio-medicine dominated the response to HIV/AIDS by ultimately shaping policy, practice, and research focus. Bio-medical inquiry and its bedfellow, cognitive psychology, advanced individual behavior change intervention to the forefront of the fight as a status quo/best practice. The placement of individual behavior change at the international forefront of HIV/AIDS prevention is directly correlates with the power of professional institutions, and western forms of knowledge production through medically based expertise. Very few disciplines rival medical science in their ability to assemble a body of knowledge established through text, journal articles, and clinical studies (Smith, 1999, pg 18). The place of the professional institutions, primarily western, and the expertise that accompany these institutions have relegated the voice of communities to the margins (Chilisa, 2005, 669). The individual behavior change approach mirroring the Freirean concept of banking education -- constructs a one-way discourse with the community and assigns fault of prevalence rates to the people alone(Katz, 2002, 130). At its foundation, HIV/AIDS intervention, is therefore dialogical and community driven requiring a break in convention.

â€œCommunity Conversations,â€ the central component in the United Nations program designed to encourage and cultivate grassroots leadership called the Community Capacity
The Community Conversations (CC) methodology was initially developed by Zambian native Thebisa Chaava and Senegalese native Daouda Diouf in 1990\(^1\) during their respective positions in the Salvation Army (Zambia) and Enda Tiers Monde/Sante (Senegal) (Chaava et al, 2005 pg 1). The leaders united to develop forms of intervention that would give way to the communal African context of closely nit community, kinship networks, and collective decision-making. Initially created and developed within the community context, the CC methodology inspired great change in their respective localities and offered a distinctly different approach to HIV/AIDS prevention. As Chaava and Diouf put fourth:

“Communities immediately began to recognize for themselves the values and actions that would have to change. Such awareness came about through community conversations. This series of facilitated dialogues stands in contrast to conventional approaches in which people are grouped together for awareness raising lectures, often accompanied by the distribution of pamphlets or posters. Such approaches often leave communities with bleak, prescriptive messages that deny them the benefits of dialogue on how the community could be affected. Communities are often times overwhelmed and feel a sense of hopelessness following such events. ”(Chaava et al, 2005 pg 2)

In 2004, the UNDP launched the community conversations throughout Sub-Saharan Africa as a part of the newly developed CCEP program after visible success at the grassroots level in both Zambia and Senegal.

Our conversation about Community Conversation’s potential begin with a focus on what Community Conversation’s may mean to Sub-Saharan Africa, with emphasis on accounts from Botswana, Ethiopia, and South Africa. While the following conversation will be conceptual in nature, accounts from varying Sub-Saharan countries will form the backdrop against which we explore Community Conversation as a potentially...
Community Capacity Enhancement Methodology In Focus:

The purpose of dialogue as it is defined in the context of CCE is a process in which facilitation shifts power relations, strengthens ownership and responsibility for change, and mobilize local capacity and resources. Local responses often remain relegated to the confines of prevention initiatives that preach and teach behavior change, with little reflection of the local context in their methodology or content. Community level responses from the perspective of CCE must always be grounded in the social, political, and economic dynamics and concerns of the community itself. Conversations create a space of trust from which local responses can be drawn. Through conversations peoples and communities learn to actively listen to competing and aligned concerns, generate mutual respect ultimately strengthening social capital, and devise local responses that reflect a change process stimulated from within. On conversation Paul Born writes:

"Conversation is not just what is said; it is also what happens between people. Conversation is not always about an event or a time; it is part of a much larger process of change. It leads to more conversations and is a part of a journey to understand. Community conversations are a deliberate form or listening to the people in a community in an effort to learn to agree, to become committed and engaged, and to create a place in which discovering the obvious is possible." (Born, 2008, pg 20)

Born's words touch upon two important points related to the transformative potential of CCE. First, the role conversation as a methodology plays in generating commitment and engagement and second the way the internally generated commitment and engagement leads to a discovery of the obvious. Within the context of community based dialogue, Paul Born recognizes that the obvious, as it relates to HIV/AIDS prevalence, can only be truly discovered by the community itself. Born's obvious is not simply the surface causalities, but the deeper causalities; the causalities that can only be known and
understood through intimate knowledge of the communal context. The CCE approach is enabling themselves to identify and engage the underlying causes of HIV/AIDS be they power relations, gender issues, [or] stigma and discrimination. While most community methodologies rightly focus on awareness-raising and discussion; CCE focuses heavily on creating an interactive dialogue on the epidemics deeper causes.Ô(Chaava, 2005, pg 3)

The Community Capacity Enhancement methodology facilitates conversations that enable communities to apprehend the ŒobviousÔ. It employs tools and processes that encourage communities through an exploration of concerns, possibilities and opportunities for addressing the complex challenges associated with HIV/AIDS while identifying opportunities for change. Facilitation and the tools, and processes CCE embodies, serve as key composites in the CCE methodology.

Facilitation and Change

CCE guiding principles explicitly define the role of the facilitation and the facilitator. The guiding principle calls for Facilitation rather than the intervention of ‘experts.’ Using this principle, the facilitator aims to build trust with and amongst community in order to create a space for mutual learning. Within the context of conversation, the facilitator is, like the community participants, both ÔteacherÕand ÔstudentÕequally engaged in learning. Facilitators are trained according to this principle and, as a result, develop skills that encourage a form of collaborative inquiry. The initial distinction between facilitator and participant is the facilitatorÔs responsibility to ÔpropelÔ the conversation forward while supporting a space that can become emotional, tense, and at times volatile:

ÔThe facilitatorÔs role is to guide communities in identifying the social cultural dynamics that related to the HIV/AIDS epidemic and to empower communities to take action. Facilitators should not impose their own views. They must build a relationship of trust, understanding and respect with communities that may view development interventions with suspicion. Facilitators guide and support groups and individuals who are
By way of the CCE framework, trained facilitators from inside and outside of the community propel conversations to a deeper place ultimately unpacking the ‘surface causalities’ in order to reveal the ‘deep causalities.’ The facilitators have a number of key aims. First, to build relationships of trust and respect, and understand community values by identifying and exploring community concerns through strategic questioning. Strategic questions are those that cannot be answered with a simple yes or no. These questions require deep thought on the both the part of the facilitator and the community. The facilitator intentionally avoids imposing their views of the world by engaging in a very particular form of question asking. Here, for instance, are two examples of strategic questions:

*How do we reduce stigma and discrimination.?*

*How do we strengthen and expand community responses, building on the capacity within individuals, families and wider groups?*

The facilitator avoids at all costs providing prescriptions through direct assertions or leading questions. The facilitator focuses to guide communities in identifying and understanding the socio cultural dynamics of HIV/AIDS in there given locality.

The relationship between the facilitator as a ‘thought catalyst’ reflects in form and function the Freirean concept of ‘cultural synthesis.’ Opposed to offering a prescription, the facilitator attempts to initiate the collective creation of a dialogical space that encourages emergence. As a facilitator you must blend in, and meet a lot of people and decide who will be walking beside you, not matter whether it's an ordinary person or someone influential. You have to support the locals but not take the lead. The community
The Community Change Process

The CCE process change model guides the facilitator's purpose and overall role in the community based prevention process. According to Gueye, Diouf, Chaava, and Tiomkin:

“This methodological framework outlines the steps in Community Conversation and links the change process to facilitation skills and tools. It recognizes that change and transformation are often complex and require a supportive facilitation process. A facilitator requires an understanding of how change occurs and how to support the change process using a framework of skills and tools.” (Chaava, 2005, pg 7)

The CCE methodology is a framework made up of 6 distinct stages: a) relationship building b) concern identification c) concern exploration d) decision making e) action and f) reflection and review.

One of the more distinctive elements of the CCE process is the emphasis on Relationship Building as the initial step in the social change process. The methodology inherently makes little assumptions about the presence and strength of local social capital. While the question of Dialogue and Social Capital will be taken on later in this work, it is important to recognize a particular strength garnered through the presence of this critical step in the prevention process.

The emphasis on relationship building inherently recognizes the influence of societal context, community norms, values and practices on the consciousness of individuals. It also intentionally recognizes Relationship and relational linkages as a critical determinant in the spread of HIV/AIDS. The presence of relationship building in itself challenges the traditional approach to HIV/AIDS intervention. Relationship building
and change at the community level is comprised of various negotiations at the level of "Relationship" and "Relational Linkages." It also recognizes that the negotiations of 'relationship' and 'relational linkages' require a special and privileged space in the change process; a space that intentionally supports and nurtures their transformation. Catherine Campbell writes:

"In the face of a phenomenon so intricately linked into the fabric of a society and as personally and professionally threatening as the HIV epidemic, it may be that only programs which penetrate the soul of a community, organization or nations will be effective." (Campbell, 2003, pg 34)

The critical shortcoming in many HIV/AIDS prevention efforts is the sole emphasis on the community's cognitive realm. This emphasis is at the expense of what Campbell refers to as the 'soul' of the community; the 'soul' of the community being arguably akin to Freire's reference to the consciousness of a community, including the cognitive, the mind, the emotional, the heart, and the relationships, or culture of the community. At the forefront of the prevention efforts, there is recognition of the necessity for a dedicated space for relationships. Community members and facilitators are encouraged to bring their "whole selves" into the change process, and in turn be wholly transformed.

Throughout South Africa relationship building in the context of CCE has been shaped by key trust building moments that offer community members the opportunity to both reflect on and share personal stories. A relationship building exercise "Counting your losses" is an exercise which gives the community an opportunity to reflect individually on how HIV has affected individual's family units and entire communities. (Nelson Mandela Foundation, 2008, pg 12) The exercise begins with the facilitator asking those in attendance, themselves included, to remember the family and friends they have lost to HIV/AIDS. Participants are then asked to take small stones brought by the facilitators, or from outside the venue. These stones will represent the lives they have lost. Participants are then encouraged to file past a cloth laid in the middle of the room and place these...
rocks on the cloth. Often a hymn may be sung as form of ceremony while the rocks are placed. Facilitators attempt to encourage a quiet atmosphere that promotes reflection. Afterwards, participants are encouraged to share their feelings. According the Nelson Mandela Foundation report on CCE in South Africa:

“This experience is the beginning of a healing journey for some of the community members; it provides a platform for sharing pain and experiences. It can be highly emotional, but the idea is that it is a safe and supportive place to express those emotions. Sometimes this is where people disclose their HIV status for the first time, or talk about their regret and remorse, having infected other people with HIV or neglected sick people in need of support.” (Nelson Mandela Foundation, 2008, pg 12)

In contexts where stigma and discrimination lay a heavy and often suffocating blanket over very real pain and loss associated with HIV/AIDS. ‘Counting your Losses’ surfaces the lived struggle and pain of community members through collectively sharing the pain associated with loss. Surfacing feelings and memories aim to generate a space of openness and trust which ultimately encourages participants in the open reflection on their own relationships and relational linkages. The Nelson Mandela Foundation reports on experiences shared by participants in a ‘counting the losses’ moment held in Soshanguve, South Africa:

“A feeling of sadness comes over me. I didn’t do anything for three people I’ve lost. For the first time I am forced to acknowledge that these people suffered so painfully. As I speak now, last week I was burying my uncle and I did not help him enough.” (Nelson Mandela Foundation, 2008, pg 23)

And,
Sometimes when I think about my life I feel miserable, I feel sad and I feel terrible. I cannot believe my past behavior. The way I used to have a different girl every day. When I think about how many people I have infected, I feel ashamed. I would like to apologize to all of them. Right now I'm standing in front of my community saying that I am HIV positive. I'm trying to break the stigma. Let us rectify the mistakes we've made. This is the first time I have talked about my status in public and I want to thank God for giving me the courage. A chance to make a change. (Nelson Mandela Foundation, 2008, pg 24)

It can be argued that these quotes reflect Campbell's community soul.

The next steps, Concern Identification and Concern Exploration aim at unearthing general issues that disturb the community. These concerns are to be considered distinct from needs. In later stages community members extract their needs from the common identified concerns.

Through story, the Concern Identification portion of the process attempts to unearth the underlying factors that contribute to communities HIV/AIDS prevalence. The underlying causes may not just be identifiable in visible needs (Chaava, 2005, pg 28). The facilitator's use of strategic questions and the encouragement of active listening supports the proliferation of the concerns. Stories are central to the concern identification process because it is a way of understanding social life - its dynamics and influences and impact on people. The Mandela Foundation reports:

Stories and proverbs are the ways that people were traditionally helped to understand their own actions and their impact on others. They can create a depth of understanding more quickly than by other means. (Nelson Mandela Foundation, 2008, pg 14)
The ‘Concern Identification’ process often segments community members into groups such as older men, older women, or youth. Often, the division of the community members depends on the community’s traditional, cultural, and social dynamics. The facilitator places particular emphasis on ensuring that concerns are not prioritized during this stage.

Following the identification of concerns is the ‘Concern Exploration’ stage. It is within this stage that the concerns identified are further verified and validated. The concern exploration process focuses on examining the magnitude of the concerns and their underlying factors. The aim of exploration is bi-fold in its own right. It aims to reveal the interconnectedness of concerns and other factors, while also unraveling the multiple manifestations of the same issue at the individual, collective, and organizational levels.

Gueye, Diouf, Chaava, and Tiomkin writes:

‘HIV transmission and rape may be related to housing of female worker in the community as well as poor law enforcement regarding rape. Exploring issues leads to linkages. It identifies who else may be affected and creates possibilities for partnerships in addressing the situation. This scenario may call for the involvement of the local police, employers or health service providers.’(Chaava, 2005, pg 4)

Of particular note are the examples of concerns identified by marginalized communities throughout South Africa. While some concerns were informational and educational, most of them were structural or relationship based. In Mhuluzi, Thaba Nchu, Giyani, Galeshwe, KwaMakhuta identified poverty and its impact on primarily youth as a contributing factor. A number of the communities identified poverty as a primary contributor to intergenerational sex for sustenance, clearly expressing the link between structural forms of violence and interpersonal relationships.
The Decision-Making and Commitment to Action phase takes the identified concerns and engages the community in the collective creation of a common vision. This common vision is comprised of key decisions and commitments that are necessary to address the challenges identified in the concern exploration phase. It should be noted that there are no limits to the decisions made in the context of conversation. In tandem with the decision-making and action commitments are the identification of the resources needed to support the action points. The facilitator checks community decisions and community plans against a human rights framework with a value for equity, equality, no-discrimination, human dignity, non-violence, participation, inclusion, accountability and responsibility. Of particular interest are the implications of the decisions and commitments on both the individuals and communities. The facilitator also supports the community in exploring how the actions will impact power relations with the intent to collectively ensure that the potential actions do not generate conflict or further entrench inequitable power relations. As a follow up, action committees are assembled to promote the community's transition to the action phase.

During the Action phase communities implement the decisions and actions prioritized by the community. The action plans devised by communities often require support from various levels of society and critical access to resources and services. Typically both the facilitators and action committees support the community's connection with the relevant stakeholders and resources while also supporting the overall change process. Most of the action committee's initial plans include meetings with local stakeholders, like Local AIDS Council's municipal governments, health services and civil society organizations involved in HIV/AIDS intervention.

The final stage of the change process is the 'Reflection and Review' stage. This stage provides a moment for communities to reflect on their progress. Facilitators support communities in asking critical questions about the change process related to shifts in values, attitudes, environment, and overall context. This final process aims to provide a platform for further planning and action.
The CCE methodology provides us with a critical opportunity to break from traditional HIV/AIDS prevention strategies. In line with our earlier conversation, on the form and function of an Emancipatory HIV/AIDS prevention approach, we find that CCE's theoretical orientation reflects emancipatory principles and practice. The role of the facilitator and the CCE change methodology framed by the rubric 'the answers lie within' holds a potential that can only truly be acknowledged by unpacking the approaches grounding in dialogue; the essential transformative element.

Therefore our focus turns to the possibilities that dialogue holds for the communities besieged by AIDS and its contextual violence. The central question is how we can understand the power of dialogue, not only as a methodology for social change, but as methodology for empowerment within the struggle for health and equality.

As a methodological practice we can view the power of dialogue through five distinct but interlocking discourses: Dialogue, Knowledge and Learning; Dialogue as Resistance; Dialogue as Empowerment; Dialogue and Social Capital; Dialogue and Democracy.

**Dialogue, Knowledge and Learning**

Every community has a story. A community’s story is an interwoven composite of numerous stories that detail the past, present, each shaped by power, perspective, and history. No one story, is the story, of a community. As we touched upon earlier, the traditional HIV/AIDS approaches, marginalized the minds of communities and in ostensibly silencing a vast constellation of stories. Silencing community stories confines community knowledge and wisdom. This confinement can be attributed to the way in which Designed Disempowerment schemes view the learner. The view of the learner ultimately shaped the learning paradigm that informed traditional HIV/AIDS prevention initiatives. This learning paradigm placed a heavy emphasis on Information Education and Communication initiatives (IEC). According to Airhihenbuwa IEC’s initiatives learning emphasized visual learning. Airhihenbuwa critique is that individual behavior
The ability to engage in the production of individual and collective mental imagery in learning is superior to visual or physical abilities. Instead of focusing on encouraging the production of mental vision that engages individuals by affirming their own space and voices, institutions of higher learning (which for the most part provide training instead of education) as well as development agencies have institutionalized the production of standardized learning based on physical vision. (Airhihenbuwa, 2007, pg 153)

The relegation is subtle but distinct. Rather than supporting communities in a process of meaning making that intertwines various forms of knowing and intentionally integrates different forms of knowledge, the emphasis on visual learning projected globally defined knowledge through IEC HIV/AIDS prevention training.

Dialogue, on the other hand, engages communities in meaning making and challenges this narrow view of the learner through a conversational learning methodology. Baker, Jensen, and Kolb couch conversational learning within the experiential learning tradition. These thinkers give value to conversational learning’s implicit recognition of the participant’s knowledge. Their proposed dialectical stance views conversational learning as a process that attempts to achieve understanding through the interplay of opposites and contradictions (Kolb et al, 2007, pg 7). The author’s perspectives are greatly informed by the traditional view of dialectics:

Traditionally dialectics have been viewed as a linguistic process that leads to a generation of new ideas and concepts by one’s awareness of a tension and paradox between two or more opposites. It involves stating a point of view and questioning it from different points of view, eventually seeking consensual agreement which in turn is ultimately from still other
perspectives. As the opening quote by Parker Palmer suggests, truth lies in the journey, not in a destination or in a final word.\( ^{63} \)

(Kolb et al, 2007, pg 2)

The CCE process is a dialectical, process rooted in conversational learning. Through story, conversations create room for varying narrations of the community's context. Story becomes the vehicle through which communities identify, explore, and unpack determinants for HIV/AIDS. The process facilitates the sharing of various forms of knowledge and knowing, holding their tensions in sway with an aim to create a common vision for change. This, according to David Bohm, is the ultimate aim of dialogue - to develop a "tacit ground"(Bohm, 1996, pg 20). The "tacit ground" Bohm refers to can be considered a common understanding that is able to hold, in clear view, the varying perspectives that have contributed to it. The concept of "tacit ground" is cemented in the belief that sustainable change must occur on both the conscious and subconscious level. The idea is that knowledge creation at the conscious level evolves from a collective subconscious shift indicative of deep sustainable change. The subconscious, both individual and collective, is not easily apprehended by intervention efforts that employ visual aids framed by visual learning methodologies that attempt to preach and teach.

The "tacit ground" serves as a platform for action because it is an expression of deep personal and social change. Encapsulated in the notion of "tacit ground" is the sentiment that in order to activate change, we ourselves must be changed. Baker, Jensen, and Kolb acknowledge "through learning together the human community is created and recreated."\( ^{63} \)

The conversational learning approach, because of its rootedness in community voice, can create a "tacit ground" a common understanding that reflects forms of emancipatory knowing. The dialectical dimension of conversational learning promotes a critical awareness of our subjective perceptions of knowledge and the constraints of social knowledge. Emancipatory knowledge is gained through a process of critically questioning ourselves and the social systems we live within. This knowledge becomes
transform the interpersonal and societal realm. If a form of knowledge confined by traditional prevention approaches, if this knowledge is transformative in its ability release community consciousness from the strictures of designed disempowerment, then dialogue can itself may be construe as an act of resistance.

Dialogue as Resistance

Set against the potential contributions of community based knowledge and experience, Western based medical science has an overpowering presence in the lives of people infected and affected by HIV/AIDS. This is most certainly the case in Botswana where numerous billboards, t-shirts and banners with the letters ABC (Abstinence. Be faithful. Condomise) stand as an over simplification of a much more complex issue. While bio-medicine as a knowledge system has offered a great deal to the understanding of HIV/AIDS, what is of great concern is the power laden relationship between indigenous knowledge systems and the knowledge systems of the west.

In 1944, Gunnar Myrdal suggested that cultural influences "pose the questions we ask; influence the facts we seek; and determine the interpretation we give the facts" (Mydral, 1944, pg 92), and by the beginning of the HIV/AIDS pandemic in the 1980s science was recognized by a minority as a "socially embedded" activity (Stillwaggon, 2006, pg 133). The role of professional institutions, including the expertise and the knowledge they have produced in the global effort, is embedded in historically hegemonic positions of western knowledge systems. Linda Tuhiwai Smith's discussion of knowledge production in the context of education systems is also useful to HIV/AIDS:

Knowledge systems however were informed by a much more comprehensive system of knowledge which linked universities, scholarly societies and imperial views of culture. Hierarchies of knowledge and theories which had rapidly developed to account for the discoveries of the new world were legitimated at the
what is taught is the belief in the concept of method for gaining and understanding of the world.\textsuperscript{(Smith, 1999, pg 65)}

Western medical science has stood dominant to all forms of indigenous belief, knowledge, research, and experience in histories of oppression. The historical power imbalance of knowledge systems was erected in the colonial period and continues to thrive within institutions that have not yet moved to make radical breaks with the past. Southern Africa continues to be the \textit{laboratory for Western science}.\textsuperscript{(Smith, 1999, pg 65)}. According to Chilisa, \textquote{western knowledge entrenched in its inherent research methodologies marginalizes knowledge on HIV/AIDS from the perspective of most Batswana (Chilisa, 2005, pg 20). In many cases, any knowledge that falls outside of the accepted knowledge is deemed false and ignored. As a result, many Batswana do not participate in furthering the national agenda to eradicate the transmission of HIV/AIDS by 2016 (NACA, 2007, pg 2). Encouraged to embrace Western knowledge systems, the Government of Botswana creates a fundamental disconnect with those that fight HIV/AIDS on the ground attempts to connect and mobilize communities.

Dialogue provides a space that radically challenges the Western knowledge paradigms. The dialogical methodology harnesses long-standing oral traditions. Botswana, like many South African communities, evolved out of highly complex oral traditions that shaped knowledge and served to transmit and shape social dynamics within the community. Dei writes:

\textquote{Elders utilized the medium of (oral tradition) storytelling to bring families together to share historic and cultural information and to transmit the values of social responsibility and community services to youth\textsuperscript{\textendash}traditional education reflected the cultural knowledge and individual understanding\textsuperscript{\textendash}dialogue consensus and co-operation, and egalitarian interactions were encouraged among members of the community.}\textsuperscript{(Dei, 1995, pg 147)}
In her writings, Chilisa specifically connects the failure of HIV/AIDS programs to their grounding in colonial practice and thought. Within this context, any approach that would further subjugate indigenous knowledge finds little success in the Botswana context. Interventions must validate African resistance to neo-colonial techniques such as A.B.C (Abstinence. Faithful. Condomise) and find messages that emanate from within the African voice (Reece et al, 2005, pg 19). The connection between dialogue as a methodology and oral tradition creates space in Conversations where communities may bring their indigenous selves to fore. As a result, community members may be more inclined to contribute to the process; making the relationship between facilitator and participant key. In the context of community conversations where the facilitator is present, the teachers may be simultaneously a member of a group and yet standing apart from it using concrete experience and knowledge of the many but relying on dialogue to construct new knowledge (Kaufman, 2000, pg 438). This is what bell hooks would call coming to voice; the point at which subjugated peoples begin to speak to power (Hooks, 2003, pg 234).

The knowledge that dialogue generates forms a basis for resistance in communities that have been inundated by HIV interventions rooted in Western knowledge traditions. Initially ignored or valued, in so far as consent or marginal consultation, the voices of community members find space to create understandings that value traditions and beliefs. The creation of new formations of indigenous knowledge through dialogue may be viewed as resistance against what Ngugi Wa Thiango calls the “culture bomb”:

“The biggest weapon wielded and actually daily unleashed by imperialism against that collective defiance is the cultural bomb. The effect of a cultural bomb is to annihilate a people’s belief in their names, in their languages, in their environments, in their heritage of struggle, in their unity, in their capacities and ultimately in themselves. It makes them
Dialogue becomes a means of creating knowledge about the communal experience of HIV/AIDS while it is written on, and before it is written over, by western knowledge systems. Dialogue in this form is can be an act of liberation.

**Dialogue and Empowerment**

But that is if we use the concept in the context of a need to decentre hegemonic power and control over the development process by the experts and allow local peoples to define their aspirations and needs within a framework for social justice and respect for fundamental freedoms and rights. In this context, empowerment means local peoples have the voice to articulate locally defined legitimate concerns. It also means local peoples having autonomy over their own resources and dictating their own path to meeting basic livelihoods and group survival. After all, no one can empower anyone. (Dei, 1995, pg 148)

In the words of Dei we see that dialogical methodology can indeed be a process that is empowering. Not because I prescribe it to be so but because of the space it occupies within a framework of power. As Sandra Jovchelovitch suggests, power is not just a phenomena to be explained through intrinsic negativity but a space for possible action where community members strive for social change. (Jovchelovitch, 1996, pg 19). Whenever communities and community members enter this space on their own volition they in fact enact their own power. Dialogue as it relates to HIV/AIDS is an exercise in power so far as it exists within challenges structures of violence, resists western intervention paradigms, and expertise in the name of self-determination and liberation.
The simple act of moving from recipients of knowledge to creators of knowledge is powerful in relation to personal movement and social change. Freire suggests that true social change cannot be achieved through depositing ideas into the mind of others:

*Because dialogue is an encounter among men (people) who name the world, it must not be a situation where some men (people) name on behalf of others. It is an act of creation; it does not serve as a crafty instrument for the domination of one man by another. The domination implicit in dialogue is that of the world by the dialoguers; it is conquest of the world for the liberation of men (people).* (Freire, 2007, pg 77)

Within the structure of violence, dialogue created through the participation of multiple voices at the grassroots may articulate the sprawling complexities of HIV/AIDS and its determinants. Through such a methodology various experiences of illness are illustrated through story and sharing. Some stories identify issues that were not previously connected to HIV/AIDS. In a review of the outcomes of Community Conversations training of trainers in 2004, there were a number of HIV/AIDS related issues that may have, within traditional intervention practice, been considered unrelated:

a) Disintegration of Setswana values  
b) Lack of youth interest in Kgotla (*Traditional governance system*) meetings  
c) Migration of youth to the cities  
d) Shebeens (bars) scattered around the village  
(UNDP, 2004, pg 60)

Within individual behavior change interventions, issues such of these may have been lost. Through the process of *naming the world* for themselves, communities in conversations create their own power and in turn become empowered. On a large scale a number of the discussions outcomes point to larger structural issues. The migration of youth to cities is a global issue. Rural flight has resulted in numerous young people throughout Southern Africa migrating to urban centers in search of jobs. Employment is often scarce in urban
are at greater risk of contracting the virus. The rural patterns it encourages relate to neoliberal policies that strangle rural areas in the interest of urban expansion. The disintegration of Setswana values relates to our earlier discussion of resistance and the domination of indigenous knowledge systems. Such examples provide strong evidence of the importance of community voices in their role as leaders in HIV/AIDS prevention.

Beyond the realm of interpersonal relationships and sexual behavior the experience of communities speak to HIV/AIDS and the responsibility of the world. If as Freire suggests, naming is a means of liberation, then the naming that occurs within dialogue is the first step to dismantle the lattice work keeping structural violence present in the lives of people in Botswana and throughout Southern Africa.

Dialogue and Social Capital

Within the context of Community Conversations, an integral component of the methodology is relationship building — relationship building not only for the reinforcement of healthy behavior but also for overall social change. Sexual behavior has always existed within the context of relationships. Relationships shaped by environment, power relations, and a myriad of social and economic factors. According to Reece and Ntseane:

"The fact that behavioral change is slow suggests that closer attention needs to be paid to underlying social and cultural contexts for behavior and beliefs between and by men and women." (Reece, 2005, pg 7)

While behavioral interventions streamlined gender discourse into frameworks, they remain limited by their approach. Gender, like sex, is a relational component of interpersonal and societal relationships. Power imbalance cannot be simply taught away. As Adeokum puts forth the process of negotiation between men and women is often not sex but power. (Adeokum, 1994, pg 33) Most important is Adeokum’s use of the words negotiation and power. An important part of dialogue is its ability creates a vital space
relationships are tested and challenged through the voicing of competing perspectives and experience. Dialogue is the space where differences meets for the purpose of reconciliation.

From the perspective of intergroup dialogue theory, dialogue as a methodology is intended to achieve such reconciliation. Nagda states:

“We can conceive of a learning community about and across differences that captures motivations to co-learn fosters intentions to bridge intergroup differences and leads to reflection and reappraisal of the groups research specifically on intergroup dialogue shows that [participants] break down ignorance and stereotypes, think more about their social group membership and build skills for communication and working across difference.” (Nagda et al, pg 5)

Intergroup dialogue engages communities members and learners in a learning community collectively bound by a desire to see social change. The negotiation of relationships and the power-laden differences or relational linkages that shape them can only be fully understood by the community themselves. Within conversation, across difference, participants critically examine and negotiate power relations challenging the way they manifest in daily interaction.

Specifically for adults, this learning model is an important consideration in the context of HIV/AIDS intervention. For the adult learner, the capacity to reason requires a less didactic relationship between teacher and learner. The dialogical process that draws on the learner knowledge base is of greater preference. According to Reece and Ntseane, adult learning is typically context specific and accepts contradictions (Reece, 2005, pg 8). This argument is based on the idea that adult life is infinitely complex. As a result, adults are capable of creating multiple solutions and reflecting critically on their actions and belief systems. Intergroup dialogue offers community members engaged in conversation the opportunity to generate solutions and meet challenges based on locally shared
rather than recipients in waiting, community members, own social change through the reconciliation of differences.

Communities are the site for the negotiation of social and sexual lives and identities. Forming the local context relationships play a key role in ‘enabling or restraining’ people from taking control over their health (Campbell, 2003, pg 3). The negotiation of relationships for the purposes of health, enlists a community’s social capital in the fight against AIDS.

Bourdieu places emphasis on the role various capitals play in the reproduction of unequal power relations (Bourdieu, 1986, pg 251). He argues that unequal social relations are maintained through a range of social processes that generate social inequalities through political, cultural, economic and social capital. From this perspective, social capital can conversely be harnessed for the purposes of mutually beneficial social networks. Through intergroup dialogue and the subsequent negotiation of relationships, social processes that maintain inequality can be transformed and enlisted in a positive process of social change that creates equality. Enacted social capital results in greater connectedness and mutual responsibility of the community to mobilize against HIV/AIDS.

Within the Botswana context, social capital and intergroup dialogue is of great relevance. Bagele Chilisa states:

Most African communities, with particular reference to Bantu people of Southern Africa for instance, view human existence in relation to the existence of others. Among views of ‘being’ for instance is the conception that ‘nthu, nthu ne banwe’ (a person is because of others) or ‘I am because we are.’ This is in direct contrast to Western views that emphasize individualism: ‘I think therefore I am.’ Most African worldviews emphasize belongingness (Chilisa, 2001, pg 19)
Chi \textit{Lisa} suggests a radical break with western bio-medicine and cognitive psychology and the placement of Setswana traditional beliefs and knowledge as the foundation for intervention practice in its stead (Chilisa, 2005, pg 20). According to Chilisa within the \textit{Kgotla}—the traditional governance system based on dialogue and consensus—an open space system of communication is encouraged through the saying \textit{mmua lebe oa bo a bua la gagwe} or ‘every voice must be heard’. Through this communication process conclusions are reached through consensus. Within this context, intergroup dialogue and its influence on social capital should be considered a manifestation of Ubuntu, the social technology that has a longstanding presence in the socio-cultural fabric of Botswana and the rest of Sub-Saharan Africa. This is an important consideration when we consider the limitations of individual behavior change and the context from which it originates.

Chilisa’s critique provides an important perspective on HIV/AIDS and the origins of intervention knowledge and practice. While dialogue expands the perspective of intervention and enlists communities in interpersonal negotiations that transform social dynamics, it also creates a platform for the creation of civic spaces that may potentially expand communities’ influence on their governing bodies and policies.

**Dialogue and Citizenship**

As stated earlier, vertical violence begets horizontal violence. While conversations challenge and transform the horizontal realm, community voices cannot truly transform local livelihoods and create health-enabling environments if they cannot vertically scale and dismantle the structures that feed and fortify prevalence rates. Moreover, the vertical forms of violence, often outside of the immediate per view of communities, act as a quiet animator perpetuating local inequality and voicelessness. With this in mind, we may ask ‘how can they support the transformation of structures that reflect decisions so far removed from lives of communities.’ Our answer is that Community Conversations as a methodology have an implicit emphasis on ensuring community level transformation whose influence ranges beyond the local and horizontal. The CCE methodology itself
Community Conversations provide an opportunity for local authorities to listen to and understand a community's concerns and decisions in order to integrate them into national planning and implementation processes. In this way, they help bridge the gap between local governments and their constituents and contribute to democratization and good governance (Chaava et al., 2004, pg 9).

This emphasis is in part related to the approach's genesis. In Chikankata, Zambia, Community Conversations began with the engagement of traditional governance structures; it began with traditional leaders that could no longer ignore the impact of HIV/AIDS on their respective communities. The recognition was met by the concern and subsequent action of community members no longer willing to accept premature death and suffering as commonplace. The conversations that emerged embodied two key contextual elements of interest, responsive and engaged leaders, and concerned and engaged community members. Essential in this context was the engagement and commitment of governing bodies that were ready and able to meet the active citizenship of community members touched, sensitized, and socially radicalized by conversation.

Community conversations intentionally attempt to generate active citizenship. It encourages community members to both shape their own local context while also influencing their democratic institutions. Conversations can potentially encourage a deeper expression of democracy. According to Mindell, dialogical spaces have the ability to generate a particular form of 'deep citizenship' that encourages what Arnold Mindell refers to as a 'Deep Democracy'. Mindell writes:

"There are two reasons why democracy doesn't work well. In the first place democracy mainly addresses social issues, not inner personal ones. Democracy which in principle strives to empower all the parts cannot..."
A deeper democracy recognizes only as a blueprint for external structures. To make democracy an inner experience we need to engage in some form of inner work or inner dialogue to create a deeper democracy. Second problem with democracy is that it is based on the concept of citizen power—more specifically the power of the majority—instead of awareness of each citizen. (Mindell, 2002, pg 113)

The form of democracy Mindell speaks of exemplifies the twinning of the citizen’s self-realization with an ever deepening understanding of their context. It is a democracy shaped by active citizens whom have embraced the dual imperative of social change referred to by Cooper and Freire. Within such a context, active citizenship is not just measured by the citizen’s ability to openly advocate and collectively mobilize; the active citizen becomes a conscious aware citizen. The active citizen is one whose decisions and actions within a collective are the result of a deep consciousness and knowledge of the systems that influence their lives. More critically, the citizen is conscious of their own place within system and their place within their locality; the active citizen is deeply aware of their own self. This layered citizenship experience is possible within the context of a social change approach shaped by emancipatory principles and practice.

Dialogue in the context of a “deep democracy” can dramatically contribute to changes in communities’ relationship with decision-making bodies and the subsequent decisions that affect the prevalence of HIV/AIDS. Active citizens in this context view themselves as change agents rather than beneficiaries, consumers, or clients invited to participate in Designed Disempowerment. More importantly, communities engaged in this sort of deep and active citizenship possess the potential to figuratively and physically deconstruct the structural lattice-work that marginalizes their capacities and traumatizes their health. The process of deconstructing structural violence of HIV/AIDS from the local, to the national, to the global generates a critical citizenship consciousness that connects local belonging to national citizenship and ultimately to global citizenship.
Community Conversations emphasis on promoting action out of dialogue creates a space for Mindell’s deep democracy. As communities and community members come to full voice through valuing their knowledge and generating emancipatory knowledge; through resisting global narratives of HIV/AIDS and creating their own; through addressing the fissures amongst themselves, deconstructing and equalizing local forms of inequality and challenging oppression, they both advertently and inadvertently begin to construct a ‘deep democracy’ from the bottom up, the inside out.
CHAPTER 5

Conclusion

“As we are the creator of our thoughts we are the creator of our lives”

Wayne Dyer

Throughout this discussion there are many questions I have asked. Despite the promise of dialogue, more often than not, the shaping of the “conversation” and the context within which it happens often dictates the outcome. This work is a conversation about conversations. This thesis explores the potential of dialogue and the unquestionable power of voice.

By no means am I mystified by the potential limitations of Community Conversations they are conceived within the context of the UNDP. If the shape and nature of UNDP stands in tandem with structural violence by way of salary rewards, flawed “participatory” practice, or simply the influence on the supports the methodology receives, then this in fact places the process in great jeopardy.

I have indeed asked myself numerous questions, but the fact remains. This was a conversation about conversations. This was a thesis about the potential in dialogue and the unquestionable power of voice, and this thesis is framed by two central questions around which this discussion has revolved.

*What are the possibilities and limits of biomedical approaches to HIV/AIDS prevention?*

*What are the possibilities and limits of community conversations for HIV/AIDS prevention?*
Exploring both of these questions has not intentionally ignored the immense amount of dedication and work of various activists, community leaders, and institutions engaged in prevention efforts. In honor of the many men and women on the ground that work within these mechanisms, spirited with genuine intention and committed to see true social change, I have problematized the structures that potentially dement their dedication and contribution.

In addressing the first research question: *What are the possibilities and limits of biomedical approaches to HIV/AIDS prevention?* I have given both credence and skepticism to bio-medicine and international cooperation in the fight against AIDS. After all, one cannot ignore bio-medicine’s advancement in the alleviation of the biological manifestations or to the understanding of prevention, care, and treatment of the disease. One cannot ignore the great input of the international community (although it may fall short at times) where prevention, treatment, care and support are concerned. Still, our conversation attempts to call these elements into balance. We explore how the strength of community voice can actually be the space from which this call comes.

Our conversation exposes the evolution of the AIDS pandemic within the context of structural violence. Sadly this violence tips power dynamics towards oppression and marginalizes communities throughout Sub-Saharan Africa. Poverty and oppression exacerbated by neoliberal policy and international practices are complicit in this reality. Ultimately we recognize that any intervention attempting to stem the pandemic must philosophically and functionally stand in radical opposition to these structures, making narrow biomedical approaches to prevention incongruent with the greater reality.

The second question central to this thesis initiates the exploration of an approach that may in fact be far more congruent with the greater reality. The question being: *What are the possibilities and limits of community conversations for HIV/AIDS prevention?* With a focus on the negotiation of relationships and indigenous knowledge systems, Community
Conversations signal a dramatic change in the way HIV/AIDS intervention is done. This pronounced break from the IBC tradition of minimal participation of the people infected and affected by AIDS and the over reliance on western knowledge systems. Instead, we recognize that dialogue through Community Conversations enables communities to identify issues rooted in global imbalances. The CCE methodology positions community members as the most powerful source for change at both the micro and macro level.

The power of dialogue is that it has the potential to inspire and create whole new approaches to prevention.

Through the sharing of indigenous knowledge and the coupling with local experience, dialogical methods hold the potential to inspire HIV/AIDS intervention programming that is truly holistic in scope. As dialogue champions voice, and voice generates knowledge, we may see an even more enlivened and emboldened Sub-Saharan grassroots that is self-empowered and free to fight AIDS on their own terms. The evolution of our thinking on how to end HIV/AIDS is directly linked to evolution as human beings. Ultimately we will reduce our prevalence rates by transforming humanity. Part and parcel to your humanity is our dignity - dignity that is more often than naught compromised by the contexts within which we live. If indeed our dignity is compromised by oppression, economic, political etc then our humanity is in turn jeopardized by initiatives that purport to offer change while standing in tandem with the sorts of oppression we experience. As communities are enlisted in initiatives like these their identity and overall humanity is further compromised.

The process that we enlist to sustainably end the pandemic, must build relationships that serve to reflect our highest expression of humanity in both the method and the means by strengthening and in some cases restoring the compromised humanity and dignity of communities most affected by the pandemic. The facilitated processes should value our voice, our gifts/assets and our culture, while simultaneously creating room to challenge
This work cements that true sustainable change cannot be mechanized. There is a realm within transformative movements that is ephemeral, spiritual, and not easily apprehended by the hard or social sciences. This recognition should ostensibly prompt us to face a horizon that recognizes the multifaceted brilliance of communities is in the midst of dialogue and mobilization. It prompts us to honor the unexplainable in social movements. It prompts us to turn our focus to mining the unknown for learning and lessons, minimizing traditional health based approaches to HIV/AIDS.

Our discussion has also been couched in a larger perspective by acknowledging that HIV/AIDS is not just an issue for the impoverished. While AIDS has spread quickly amongst the marginalized, it is also present in the lives of the affluent and the middle class. From a structural violence frame we must shift to recognize that AIDS and poverty is our issue not theirs. The holistic mobilization effort to end AIDS requires that we acknowledge our society’s vulnerabilities as our own. Poverty and the related issues cannot remain a concern relegated to those who struggle within its confines and the few that struggle to transform it. We are all infected and affected by AIDS therefore we are equally implicated in its proliferation.

Our sad, but very real example of interconnectedness of humanity is the public health response to AIDS in Sub-Saharan Africa. The evolution of these efforts occurred in the context of an exorbitant debt crisis and the structural adjustment era that saw numerous African states withdraw from the social spheres of their nations. In the midst of this retraction, health and education systems crumbled, privatization surged and African economies opened to the global market. AIDS stole from nations the most productive men and women even more so than the constellation of long standing infectious disease. The human cost was evident in the reversals of child survival and overall life expectancy. While heaping immense pressure on the already inadequate health infrastructure of
The evolution of Community Capacity Enhancement evolved in the context of the rapidly expanding pandemic. It was a response not to the overall pandemic; it was a natural response from community members tired of burying aunts, uncles, mothers, sisters. Because CCE’s origins rose from lived experience within communities, Community Conversations reflects an intuitive understanding of liberation and emancipation. Inherent in its methodology is the recognition of community voice and knowledge as a valued resource. As much Ubuntu as it is HIV/AIDS prevention, the spirit of Community Capacity Enhancement is fortified by an emboldened Sub-Saharan African grassroots, whom have responded with home based care, localized counseling and testing, and other services that act as critical supports in the fight against AIDS.

So let’s not be mistaken. The promise Community Conversations holds is not its methodology, nor the support it receives from multilateral agencies like the UNDP. The promise of dialogue and conversation is not its unique prevention approach. The promise conversation holds is its ability to magnify the contents of local communities throughout Sub-Saharan Africa and propel forth the rich knowledge and consciousness of community members. Community Conversations embody emotion and spirit, making room for the evolution of transformative change defined by love. It creates a space for all of the traditionally ignored facets of communities -- assets knowledge, skills, love, and action — and draws them into a sharp point aimed at the heart of the pandemic and the structures that maintain it.

May this approach, this time, make its mark.
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This distinction between "Relationships" and "Relational Linkages" can be defined as such. Relationships are the interpersonal connections between individuals expressed in day-to-day verbal and non-verbal interactions. Relational Linkages refers to the way in which interpersonal relationships are shaped by gender, race, ethnicity, ultimately the power dynamic present in all relationships be they person to person or institutional.