the HIV/AIDS Learnership Programme

Adult Education and Poverty Reduction

A Draft Report about the Impact of an Adult Education and Training Programme on Poverty Reduction

Designed and piloted by IIZ/DVV South Africa
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HIV/AIDS is one of the fastest growing diseases around the world, and more so in Sub-Saharan Africa. (Department of Social Services and Poverty Alleviation, 2002) It is estimated that by 2005, six million South Africans will be infected by the disease and that 2.5 million people will already have died of the disease. “In those countries most heavily affected, the costs of providing care to people with AIDS threatens to overwhelm their health systems”. (Panos, 1996) This is leading most governments and organisations to explore more cost-effective ways of providing care to people with AIDS. One of the most widely promoted strategies is to provide care for people at home rather than in hospitals since hospital in-patient care is the most expensive way of providing care to people with AIDS.

In South Africa as is the case in many developing countries one cannot ignore the connection between poverty and HIV/AIDS. Poverty does not cause HIV/AIDS, but in many cases it worsens it. There are many ways in which that poverty can place people at a greater risk of acquiring the virus and can worsen it for those already infected.

- Unemployment and poverty often force women to take on jobs as sex workers.
- Migration of men to cities because of lack of jobs in rural areas often lead to multiple sex partners therefore increasing the risk of both HIV and sexually transmitted diseases (STDs).
- A person who is HIV positive and poor often finds it difficult to access health services or medication necessary to keep him/her healthier for a longer period of time.
- An HIV positive person that is poor might not be able to afford the necessary foods and vitamins to stay healthy. This may weaken the person and increase the person’s chance of getting sick with AIDS.

In South Africa, both civil society and government have implemented a variety of programmes to deal with the demands and challenges brought about by the pandemic. However, research has shown that many of these programmes
often have a narrow focus and either deal with a specific aspect of the HIV/AIDS issue, i.e. prevention, education and awareness, counseling, home-based care, etc. or a combination of these aspects.

In view of the importance of adult learning to relate to this difficult situation having to cope with huge impacts on the communities IIZ/DVV had submitted a proposal in 2002 to the funding ministry in the framework of a newly created budget line on poverty reduction. The objective of this proposal was to show the role that volunteers could have in responding to the challenges in both rural areas and in South African townships. The proposed pilot programme intended to reach out to a sample of volunteers who would be trained in a holistic way to deal with all aspects of the crisis in their respective communities. The pilot was composed of groups of volunteers selected and identified by a range of NGOs in the Western Cape province, Kwa-Zulu Natal, Limpopo Province and the Eastern Cape. Later on the sample of beneficiaries was extended to include trainers or facilitators recruited via member organisations of the Adult Learning Network (ALN). This extension was made possible because of a matching grant from the Cross Cutting Fund of the German Agency for Technical Cooperation (GTZ). In the following report we often distinguish between the volunteers or learners from the initially proposed Pilot and the Extension group.

Initially the programme was run and managed by staff recruited by IIZ/DVV. However, ownership of the programme was vested with the involved stakeholders and should in the process be deployed to a dedicated working group under the auspices of the ALN. One of the major innovative aspects of the programme was to structure the training in line with requirements of the National Qualifications Framework. This means that trainees in the programme would in the end obtain a level one qualification. With such a qualification at hand employability for the beneficiaries of the programme could be increased and further rollout of the training could be facilitated within the framework of an accredited skills programmes. Accredited skills programme are the building blocks for a learnership. A learnership is a programme that contracts the provider, the learner and the prospective employers (health services, local government and NGOs), who would be in need of skilled and competent intermediary agents in the field of HIV/AIDS. 60% of a learnership is workplace orientated. Learnership training is financed by the Department of Labour. The
funding usually comes from the SETAs (Sector Education and Training Authorities). All SETAs have been asked by the Department of Labour to use some of their funding to the overarching issues of HIV/AIDS training. The proposal had identified this resource opportunity as a way to secure in the long run the sustainability of the programme. Poverty alleviation would be effected on the one hand directly for the beneficiaries of the training, as it leads to a qualification for them and thus increases their employability. On the other hand indirect effects are expected from the impact that their skills and their application would have on all members of those communities where volunteers or other multipliers would apply their knowledge and become agents of change and of coping strategies.

In line with these and the underlying assumptions, the Pilot programme was named the HIV/AIDS Learnership.

What the HIV/AIDS Learnership programme strives to achieve is to address the pandemic by using a holistic and developmental approach. It is a response to the need\(^1\) for a single comprehensive health care programme built around HIV/AIDS for voluntary caregivers in South African communities. The purpose was to equip thousands of voluntary carers in the communities with a wide range of knowledge and skills thereby enabling them to have a noticeable impact on their own environment.

This has lead to the development of 2 skills programmes (SP). SP 1 is more theory-based and covers factual information about HIV/AIDS (prevention, transmission, etc.) and general health and development and environmental issues. SP 2 is more focused on practical components of home-based care. Both programmes consist of a theoretical and a practical part. The theoretical part is covered in 30 days of tuition and the practical part in 30 days fieldwork where the learner’s acquired knowledge is implemented in their communities. This practical caring component in particular will be further expanded and developed in line with the Ancillary Health Care Certificate qualification (a Level 1 qualification, accredited and registered by the Health and Welfare SETA).

By eventually providing a qualification, this programme gives formal recognition for the work of these committed volunteers, not only by improving

\(^1\) See research conducted by Vaughn John in May 2002 in Annexure 1.
their current status but also by potentially increasing their employability.
Sustainability will be maintained through the accreditation of the programme with the Health and Welfare SETA that is currently in progress.

Two rollouts have taken place in 2003 (Pilot and Extension) that have resulted in the training of approximately 240 volunteers and 34 trainers in 7 provinces. The process and results of this implementation will be discussed below.

2. ACHIEVEMENT OF GOALS

The programme goals and the extent, to which those goals have been realized, will be discussed below.

2.1. Overarching goal

The overarching goal of the programme is: “The spreading of HIV/AIDS in South Africa is slowed down and the socio-economical impacts of the pandemic are reduced”

Even though no programme can claim to single-handedly have slowed down the spreading of HIV/AIDS and reducing the socio-economic impacts of the pandemic, programmes such as the Learnership programme can certainly claim to have made a major contribution.

2.2. Project goal

The project goal of the programme is: “Voluntary social caregivers in affected rural and semi-urban communities are trained in HIV/AIDS prevention and social care and receive a qualification”

The project goal has been met with great success. In total 240 voluntary social caregivers were trained in HIV/AIDS prevention and social care. These volunteers have been providing services to people infected and affected by HIV/AIDS in 8 provinces. These volunteers are based in urban, rural and peri-
urban areas and have been providing very valuable and necessary services to communities in desperate need of this support. Learners will only receive certification once the skills programmes have been accredited. Find details under heading “Seta will register course with SAQA”.

### 2.3. Specific goals

“An educational plan for HIV/AIDS social workers has been developed”

This goal has been met with great success. The curriculum developers, ABE services and Action Direct developed the curriculum framework as well as the learner and facilitator’s manuals.

The present course follows a modular design comprising 2 core skills programmes (SP).

The entire course stretches over a total of 60 days. See Annexure 1, for a more detailed overview.

Each of these SP’s consists of a 15-day theoretical component (with a suggested 6 hours of training per day and a 15-day practical component herein referred to as the fieldwork. For the fieldwork, learners are applying their new knowledge and skills with selected clients in their communities. The programme prescribes a minimum of 2 visits per day.

The SP’s offer the learners the knowledge and skills to provide development-focused health care in the communities, including health promotion, developmental services and preventive health care within varying contexts, sectors and organisations and in order to meet the basic HIV/AIDS education, advisor and home based care needs of their target communities.

Without losing focus and depth of the issues addressed, the language and content of the material is kept simple and neutral, in order to accommodate a broad spectrum of differing contexts and to also allow accessibility for community-based caregivers with limited formal schooling.

Fundamental numeracy, literacy and communication skills are also integral to the programme.

The programme is based on a learner-centred participatory approach. Course work involves a variety of activities that encourages creativity,
teamwork and playful understanding, but also requires learners to do their individual “self-study” outside the classroom.

As mentioned in the introduction, SP1 is more theory based, whereas SP2 focuses on practical home-based care aspects.

Elective specialisations are currently being developed as part of alignment with the Ancillary Health Care qualification. They should provide an opportunity to focus on specialised knowledge and skills required for HIV/AIDS work within a specific sector or context, such as counselling, labour law etc.

“SETA is willing to register course with SAQA”.

This goal has been met. The services of a consultant that has extensive experience in the accreditation of courses and interacting with various SETA’s was brought on board to fast-track the accreditation process. The contribution of the consultant, who has extensive knowledge on the accreditation of courses and learnerships, played a very crucial role in getting the Health and Welfare SETA interested in the HIV/AIDS Learner ship.

Three meetings facilitated by the consultant were held with the Health and Welfare SETA to get the buy in for the programme. They expressed their support for our programme and indicated their willingness to work very closely with the organisation.

As a result of these meetings, two options about accreditation arose that required debate. The one option was to apply for a new learnership whilst the second option was to align the existing material to an existing certificate course in preparation for a learnership.

According to the information obtained from the Health and Welfare SETA officials, an application for a new learnership could take up to five years and this process would require an extensive consultation and lobbying process. The second option, to align the material to an existing learnership, would mean that the process could only take up to one year for accreditation to be approved. This process could be fast tracked based on the compliance of service organisations (i.e. the Adult Learning Network) with criteria for the accreditation process.
The outcome of the discussions with partner organisations and other service provider’s lead to the decision to align existing materials to the Ancillary Health Care (AHC) qualification.

There was general consensus that to provide formal recognition through a qualification for the sterling work done by volunteers in the communities infected and affected by HIV/AIDS could not be delayed. Another motivating factor was that the employability of the volunteers could be increased because the Department of Health in South Africa has identified the AHC Certificate course as a priority and have made funds available to roll out this course. A further reason for choosing this option was the issue of sustainability of the programme. The funds made available by the South African government would allow to alleviate some of the overwhelming demand on the already limited health services caused by the pandemic.

The enthusiasm of the Health and Welfare SETA has motivated the project staff to put the necessary systems in place to ensure provisional accreditation by mid-2004. Restructuring the relationship between ALN, ALN-AIDS and IIZ/DVV also needs to take place for the accreditation process.

“Abstracting the outcomes of developed materials into unit standards”.

This goal has been partially met. As mentioned above, the present two skills programme are currently being aligned with the existing unit standards of the Ancillary Health Care Certificate course. The motivation for the alignment of the materials to an existing Learnership versus the application for a new Learnership is discussed in detail above. A group of writers has been commissioned to write entire new sections, for example, Basic Life Support and/or First Aid Procedures in Emergencies, Life Orientation, Natural Sciences, etc. As stated above, this will result in the development of a new skills programme.

Where possible, the existing material will be aligned to the unit standards of the AHC Certificate course.

“Programme is rolled out in another 3 provinces for approximately 300 volunteers/learners”.

The programme has been implemented in two stages. The first group, the Pilot group, started the training of skills programme 1 in March/2003. The
following table depicts the provinces, organisations and number of learners and facilitators involved:

Table 1: Partners with numbers of facilitators and learners in the PILOT GROUP

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>ORGANISATION</th>
<th>Number of facilitators</th>
<th>Number of learners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>Masifunde</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Kwazulu Natal</td>
<td>CDOP</td>
<td>5</td>
<td>51</td>
</tr>
<tr>
<td>Limpopo Province</td>
<td>Choice</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Western Cape, Montagu</td>
<td>Breede River Development Council</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Western Cape, Worcester</td>
<td>Breede River Development Council</td>
<td>4</td>
<td>35</td>
</tr>
</tbody>
</table>

Due to the financial support received from the GTZ Cross Cutting Fund, the training of volunteers was then extended to a further 84 learners, herein referred to as the Extension group. The programme was extended through the services provided by the 7 partners from the various Adult Learning Network (ALN) offices in the following provinces: Eastern Cape, Free State, Gauteng, KwaZulu Natal, Limpopo Province, North West Province and the Western Cape.

Initially 8 provinces (of nine) were supposed to participate. The partners from the Northern Cape however had to be excluded from the training because of their absence at the Training of Trainers Programme. It was impossible to identify, select and train suitable facilitators at a later date, as it would greatly have hampered the finalisation of the programme. This province was therefore excluded from the programme altogether.

In each of these provinces 2 facilitators were trained who in turn trained 12 learners (in each province). The table below depicts the total number of facilitators and learners that participated in the programme so far. The selected number of learners was based on funding available and also taking into account the Rand/Dollar exchange rate at the time.
Table 2: Totals of facilitators and learners for both PILOT and EXTENSION GROUP

<table>
<thead>
<tr>
<th></th>
<th>Total number of facilitators</th>
<th>Total number of learners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot group</td>
<td>20</td>
<td>156</td>
</tr>
<tr>
<td>Extension group</td>
<td>14</td>
<td>84</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>34</strong></td>
<td><strong>240</strong></td>
</tr>
</tbody>
</table>

For the first sample our data gathering methods as well as the organisation and coordination was still less matured. The Extension group benefited largely from the lessons learned in the first implementation phase. The information collected from the second sample is therefore more elaborate and extensive. The patterns and the kind of information however are very similar and the results are discussed below under the heading Evaluation of HIV/AIDS Programme.

“About 12 qualified trainers have been identified and have been prepared intensively for their role as implementers”

In reference to Table 2 above, it is clear that more than 12 facilitators were trained in the Pilot Group. Several problems arose that lead to the training of more facilitators for this group. In the initial discussions with some of the partner organisations a list of criteria for facilitators were drawn up. The criteria included the following:

- Facilitators should be experienced trainers with a minimum of at least 3 years prior experience.
- Facilitators should be fluent in English.
- Facilitators should be able to read and analyse material in English and train in the mother tongue of the learners.
- Facilitators, where possible should come from the targeted communities.
- Facilitators training in the field of HIV/AIDS should be considered first.
- Facilitators should be familiar with the participatory/interactive teaching approach.
Facilitators should have experience in training learners with low literacy levels.

Partners who initiated the programme and who were part of the discussions that lead to the list of selection criteria were left with the responsibility to select four facilitators for the Training of Trainers (TOT) Programme.

The Pilot group had a 3-day orientation of SP 1 in November 2002. Because the materials for SP 2 were completed in early July 2003, the Pilot group was only orientated in the materials of SP 2 in late July 2003, together with the Extension group.

The orientation of the two SP programmes was conducted over 10 days. On the last day was reserved for the administering of instruments with learners, administration (financial accounting, budgets, etc.), monitoring and evaluation of the programme were discussed. Debi Tromp from Action Direct, one of the curriculum developers, conducted the orientation of the facilitators. The projected cost of orientating all the facilitators with the materials for both SPs was huge. The number of days was therefore kept to a minimum. The actual training preparation process will be discussed in detail in the evaluation section.

A total of 34 facilitators attended the second orientation. 20 facilitators were from the Pilot group and 14 were from the Extension group.

One of the ‘facilitators’ from Limpopo Province resigned from the programme and cited heavy workload in her organisation as the reason for her resignation.

The service provider, Choice Comprehensive Health Care sent an individual to the TOT who they were in the process of grooming as a facilitator. This individual had no prior experience in training.

In the Western Cape four out of the five ‘facilitators’ that attended the TOT were committed volunteers and had no prior facilitation experience. One of the facilitators resigned from the programme, as she was unhappy with the prominent role played by one of her learners that was a retired nurse and community counselor in her area.

In the Eastern Cape one of the three ‘facilitators’ who were sent to the TOT were completely unsuitable. The one person, a post-graduate student in
HIV/AIDS who required some mentoring, left the programme because she resigned from the service provider Masifunde.

In total 59% of the ‘facilitators’ who attended the TOT were not fully equipped to train the volunteers and 42% of this group required serious mentoring.

The overall ‘drop out’ rate of the ‘facilitators’ from the Pilot group who attended was 47%. The reasons ranged from no experience to lack of experience, heavy workload and lack of commitment to non-performance.

From the 8 ‘facilitators’ that dropped out, 5 were from the Western Cape. Four of them were removed from the programme by IIZ/DVV because they were committed volunteers in their communities, but had no prior facilitation experience and one of them resigned as mentioned above.

In the Extension group the drop out was significantly lower (14%). Based on the experiences in the Pilot group, partner organisations from the Extension group were asked to select their facilitators and submit the Curriculum Vitae’s of these facilitators before attending the TOT. The retention rate of facilitators was therefore higher because partner organisations and the staff at IIZ/DVV jointly selected the facilitators.

All of the facilitators who attended the TOT from this group were facilitators with prior experience. They are all ABET (Adult Basic Education and Training) facilitators. One of the two facilitators that dropped out had an opportunity to study full time. The other facilitator had a large group of his ABET learners that had to sit for the Matric examination and therefore did not participate in SP 2.

8 of the facilitators from the Pilot group had prior training experience in the field of HIV/AIDS. Most of the facilitators in the Extension group had many years of experience in adult education, but none of them had trained in the field of HIV/AIDS.

“A network of providers has been structured”.

This goal was also met with some success. In 7 provinces, relationships with service providers were established. All the service providers in the Pilot group had experience in the field of HIV/AIDS whereas the service providers in the Extension group did not, but they had strong linkages with
HIV/AIDS organisations and many of the volunteers were already involved with caring for people living with AIDS.

Because of the additional 84 volunteers in the programme resulting from the Extension into 3 more provinces there was an increase in the workload of the IIZ/DVV staff. More time was spent on coordination of the programme and the providing support for the facilitators. Less time was therefore available to grow an extensive network of service providers.

In the Western Cape and KwaZulu Natal several other service providers have been identified for future rollouts.

A database has been established listing all the organisations involved in the field of HIV/AIDS. These organisations have also been subdivided into the various provinces. In 2004, before the next rollout takes place, training organisations will be invited to an orientation workshop. Discussion groups, workshops and report back sessions will follow the initial introductory workshop.

“PR concepts through road-shows, LCF, GTZ mainstream projects”

The programme was showcased at the Learning Cape Festival (LCF). The programme was promoted at all the events of the LCF in the various areas in the Western Cape. A time slot was assigned for a presentation of our project to inform participants at the Adult Learners Week (ALW) about the programme. Professor Rybicki shared the platform with IIZ/DVV. He gave a public lecture on myths surrounding HIV/AIDS. It was also showcased at the Adult Learners Week in Bloemfontein in the Free State.

“Commercial publisher produces learner and facilitator manual in English

The publishing of learner and facilitator manuals will be dealt with once the programme has been aligned with the AHC Certificate course and the accreditation with the Health and Welfare SETA has been granted.

“Translation into 3 national languages”

This has also been put on hold until the completion of the new materials and once accreditation has been granted.
The evaluation of the programme included the following:

1. Context
2. Global aim of the evaluation
3. Specific aims
4. Content of the evaluation
5. Expected outcomes
6. Methods

### 3.1. Context

The programme of the AIDS Learnership Network intends to contribute to the reduction of negative socio-economical impacts of the HIV/AIDS pandemic in South Africa. Research about the content and implementation of existing HIV/AIDS programmes in this country has confirmed the need for a single comprehensive learning programme centrally focused around HIV/AIDS.

Such a programme designed for community-based carers, was developed by ABE Services and Debi Tromp on behalf of the AIDS Learnership Network, and is currently being piloted in various provinces in South Africa. The accreditation of this skills programme shall allow other providers as well as local governmental structure to buy into this programme, thereby expanding the scope of the training. An accredited qualification shall furthermore contribute to the employability of the learners and allow them to operate as an integral part of the health care system.

### 3.2. Global aim of the evaluation

To assess the success of the pilot implementation of the programme in terms of learning and teaching materials, training implementation and
fieldwork, as part of a pilot testing of the programme and as a basis for further development and reviewing of the programme.

3.3. Specific aims

- Development of qualitative evaluation tools for the implementation of the training materials.
- Development of a monitoring system for the fieldwork component of the programme.
- Client satisfaction analysis.
- Development of interview guidelines and plan for site visits.
- Analysis of results of evaluation and monitoring.

3.4. Content of the evaluation

- Qualitative evaluation of the learning material used by the community-based carers.
- Qualitative evaluation of the teaching material used by the facilitators.
- Evaluation of the implementation plan, including timeframes, selection criteria of learners as well as facilitators.
- Evaluation of further need of training of facilitators.

3.5. Expected outcomes

- Information about the appropriateness of the language used, topics covered, lack of information or unclear information in the learning and teaching manuals.
- Clarity on how to improve the implementation of the programme in relation to the time frames, tasks covered by different parties involved, organization etc.
- Information on the impact of the programme on the service recipients.
3.6. Method

- Development of evaluation and monitoring tools.
- Implementation of evaluation questionnaires for learners after the skills programme.
- Implementation of visit reports to monitor fieldwork activities.
- Randomly selected interviews with the clients (patients in the community) during site visits.
- Group discussions with the learners during site visits.
- Group discussions with the facilitators during site visits.
- Interviews with selected sample of clients of the learners during site visits.
- Analysis of reports compiled by facilitators about their training.
- Analysis of reports compiled by facilitators about their own training orientation to this programme.
- Compiling of final report.

4. FINAL REPORT

To determine the overall success of the programme and to improve the programme, the following were assessed:

- The evaluation of the training of volunteers
- Teaching materials;
- The overall learning experience;
- The quality of the facilitators;
- The community or patient satisfaction; and
- The fieldwork

To continuously improve the programme and to ensure that the aims and objectives of the programme were realised qualitative methods were used.
The training of volunteers was evaluated based on feedback from the questionnaires, group discussions, feedback from the reports compiled by the facilitators and discussions held with the facilitators.

One evaluation form per volunteer was administered on the last day of each SP. Facilitators and/or staff from IIZ/DVV explained the purpose and importance of the questionnaires to the volunteers. They also elaborated on the value of each volunteer completing a questionnaire against the need to improve the programme for future volunteers. Volunteers were requested to give honest and detailed input. The questionnaire was administered in English, but volunteers were explained each question in great detail to ensure that they understood each question correctly in English, and where applicable, in their mother tongue. Volunteers who had difficulty in completing the questionnaire in English were encouraged to complete it in their mother tongue.

The questionnaire (see Annexure 2) consisted of 33 open questions about 3 main areas of the training:

- The training itself (including expectations, groups size, time available);
- The manuals used and topics covered; and
- The performance of the facilitator

On average, the questionnaires took volunteers between 30 to 45 minutes to complete based on their respective competency in English and their level of education.

Target group analysis (statistics about age, gender, language, education, experience) was based on the information required by the learners on the questionnaires.

The questions for the group discussions (see Annexure 3) covered the same areas as did the questionnaire but allowed for more elaborate detail (i.e. experience and problems with the fieldwork thus far).

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2 For the pilot stage (with a relatively small number of learners) open questions were used to gain more insight from the feedback. For further roll out the questionnaire will be shortened and more closed questions used.
Group discussions lasted between 1-1/2 hours on average, depending on the group size and varying time available for different site visits. All group discussions were conducted in English. At each group discussion, translation services where available for those who required them. This obviously lengthened the time for group discussions, but added great value to the input and feedback provided by the volunteers.

After every SP, facilitators were required to submit detailed feedback in the form of a report on both the positive and negative experiences with the four manuals. They were also expected to report on the difficulties experienced by the volunteers with the two learners manuals. The report also required facilitators to report on the activities that had worked well for the volunteers and what had not. And lastly, they were expected to provide input on how the manuals could be improved. The feedback received so far from the facilitators was not as elaborate as required. Facilitators were therefore asked to rework their reports for a newly set deadline. Analysis of this feedback therefore had to be postponed until early 2004.

For the interpretation of the results the questions were clustered as shown in the figure below:
Question 33 (for additional suggestions feedback etc.) was often used as extra space for suggestions of additional materials. This information was then added to the content questions. General comments were handled separately.

The following questions are in fact closed questions. In the table they are therefore listed as such with the number of yes and no responses respectively; 4, 6-10, 14-19, 22-25, 29-31.

Questions 1-3, 11, 12, 13 were also often answered as closed questions and therefore treated in the same manner. Additional commentary to those questions is listed in a separate table where applicable.

The answers of the learners were then also clustered into emerging categories. For example if learners used different descriptions to indicate “gain of knowledge”, these would be grouped together into one category.

### Target Group Analysis

The target group analysis only relates to those learners that completed the programme and not the total number of learners that participated in the programme. The target group analysis include the following:

- The drop out rate;
- The gender of the learners;
- The ages of the learners;
- The mother tongue of the learners;
- The educational level of the learners; and
- The learner’s prior experience in community work.

### Drop out rate

The number of learners that participated in the Extension group was 85. Unfortunately, one of the learners passed away before the programme was completed.

The number of participants that were targeted for the Pilot group was 200 learners that are 50 learners per province in 4 provinces (KZN, Limpopo,
Western Cape and Eastern Cape). In Limpopo province, due to capacity problems the service provider indicated prior to the commencement of the programme that they would only be able to train 25 learners. The Pilot group therefore started out with 175 learners and ended with 140 learners. The drop out rate for the Pilot group was 20%.

In the Eastern Cape the drop out rate was 30% and in the Western Cape it was 42%. The reasons for the high drop out rate in the Western Cape were because the learners got part-time work.

In the two areas in the Western Cape where the learners were trained, there are many opportunities for seasonal work between the period November and February. In October some of these learners attended another training programme in preparation for their employment in November.

In the Eastern Cape, one of the largest arts festivals in South Africa, namely the Grahamstown Festival took place in the middle of the programme. This huge festival also provides several casual employment opportunities for people in Grahamstown. Several of the learners therefore worked for about two weeks of the training. The majority of them did not return to the programme. There were no dropouts in Limpopo and Kwa-Zulu Natal.

Given the exceptionally high unemployment rate in South Africa, this drop out rate does not suggest a lack of commitment from the side of the learners but rather the urgent need for sustainable poverty alleviating measures.

Programmes such as the HIV AIDS Learnership, in the long run also strives to create employment opportunities for people that are providing voluntary services for communities infected and affected by HIV/AIDS. The services provided in this programme and so many other programmes should be largely the responsibility of the South African government.

Obtaining formal recognition for the enormous tasks performed by voluntary workers and by our learners provides learners with a greater chance of gaining meaningful employment.

Six of the learners from Kwa-Zulu Natal have had not yet submitted all their information, therefore the analysis of the data of the Extension group is based on input received from 78 learners, that is 92% of the total learners that participated in the programme.
Gender

The majority of the learners in both the Pilot and Extension group were female. In the Pilot group 86% of the learners were female as opposed to the Extension group that had 82%.

The number of male learners per group varied from one to three learners. The number of male learners that participated in the programme was very similar in both groups (14% in the Pilot group and 18% in the Extension group).

In Limpopo province all selected participants were female. In the villages where the Pilot programme was implemented, the community was responsible for identifying potential learners for the programme.

The dominance of women in programmes such as these are the same in South Africa and in other countries in sub-Saharan Africa where there is a high HIV infection rate. Because programmes like these also involve caring for people, men often shy away from it, mainly because women are seen as the carers in society. Women are also more likely to do voluntary and community work whereas males often less likely to engage in work that does not provide any monetary compensation. They are more prone to look for opportunities that relate to paid employment instead.

Age

The average age of learners was 29.5. The mean age in the various provinces varied between 23 and 38. Research has shown that young women in particular are more affected (and infected) by the pandemic, which could be a major reason why they are more involved in programmes like this one.

Mother tongue

The mother tongue of the learners that participated in the Pilot group were:
The mother tongue of the learners that participated in the Extension group were the following:

- Xhosa
- Zulu
- Sotho
- Afrikaans
- Tswana
- Tsonga
- Sotho (North and South)

The mother tongue of the learners from the Pilot group constituted only 4 of the 11 official languages in South Africa whilst the mother tongue of the Extension group constituted 6 of the 11 official languages.

As indicated above, the facilitators and learners manuals were produced in English only. The training was provided in the mother tongue of the learners.

The programme was therefore taught in 6 official languages even though the materials were produced in English only. This was decided before the commencement of the programme to ensure that the learner received tuition in the language that they are confident in and because they would benefit the most from the learning experience if it was offered in their mother tongue.

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**Educational level**

The educational level of the majority of the learners in both the Pilot and the Extension group was significantly higher than the entry requirement of Grade 9 for the programme.

In both groups, the educational levels of the learners were higher than Grade 6.

In the Pilot group 39.5% of the learners have a Matric Certificate and 31% in the Extension group.
In the Pilot group 14.5% of the learners have Grade 10 and 10% in the Extension group.

Some of the learners that also participated in the programme had post-matric qualifications. The Extension group had the highest number of learners with post-matric qualification (18%) whilst the Pilot group had 5%.

These qualifications ranged from Teachers Diploma’s to Diploma’s in Secretarial and Computer Skills.

One of the reasons for the high educational level in the programme relates to the high level of unemployment in South Africa, where any opportunity for additional training is highly welcomed.

### Prior experience in community work

In both the Pilot and Extension group more than 50% of the learners had prior experience in community work. In the Pilot group, 83 learners (59%) had prior experience and in the Extension group it was 45 learners (58%).

In the initial questionnaire very few learners indicated what type of community work they were involved in. In the follow-up discussion groups, learners revealed that the majority of the learners that were involved in community work contributed voluntary work as caregiver in TB and/or HIV/AIDS treatment and care programmes. Some of the learners also reported involvement in community campaigns as prior experience in community work. These campaigns ranged from anti-crime to election campaigns. Election campaigns do not relate to political party election campaigns, but to the campaigns of the Independent Electoral Commission campaigns in South Africa and other NGOs who are involved in encouraging citizens in South Africa to vote. These volunteers also assisted people with the registration of identity documents.

### Results from the training of learners

The feedback from learners is based on the information received after the completion of SP 1 and SP 2 in both the Pilot and Extension group. The
programme was assessed based on the input from both the questionnaires and the group discussions.

### Results from the questionnaires

The information received however, was not analysed according to the various provinces because of the similarities in the data received. It is important to note that the data for the Extension group was not as detailed as the Pilot group.

Statistics for the Extension group are based on SP1 questionnaires because there is still data outstanding from some provinces for SP2. In the Pilot group only the learners that have completed both SP1 and 2 have been considered, which in the case of the Western Cape reduced the number of participants quite considerably. The patterns and kinds of responses available are however very homogenous and can be looked at as one.

### Feedback from Skills Programmes

The feedback from the SPs have been clustered under the following categories:

- Expectations of the course;
- Mother tongue;
- Time allocation, group size and participation of peers;
- Outcomes; and
- Facilitator

### Expectations of the course

More than 80% of the learners in both groups who completed SP 1 indicated that their expectations were met whereas 9.6% of the learners indicated that the course had not met their expectations. A few indicated that the course exceeded their expectations. However, after the completion of SP 2, only about 70% said that their expectations were met, 10% said they were
not. It is possible that the learners, having more competence at that stage, also became more critical of the course, which should be regarded as a positive effect. Furthermore, the expectation to acquire more practical home-based skills is likely to have contributed to this effect. The more detailed responses suggested that learners wanted to learn more home-based care skills (including first aid skills), rather than other skills. This time more learners (10%) also felt that more time to cover the material would have been desirable.

In the Pilot group more than 80% indicated that they were satisfied and felt positive about the course and 96.2% of the learners in the Extension group.

Most of the learners in both groups stated that they were happy with the course because they gained more knowledge about HIV/AIDS in particular and it deepened their existing knowledge on HIV/AIDS.

In response to the questions on the learner’s expectations of the course a multiple of answers were cited. The three most common reason cited by the learner were, firstly that they attended the programme because they wanted to gain more knowledge about HIV/AIDS, secondly, they wanted to be in a position to help people who were infected by HIV/AIDS and thirdly, they wanted to counsel people both infected and affected by HIV/AIDS.

There were also two other frequently cited reasons for them attending the programme. The first was because they wanted to treat and prevent opportunistic infections and secondly, they thought they would only cover information about HIV/AIDS, but was glad that they learnt about other disease and the various aspects of health.

The learners indicated that they were very keen on acquiring practical knowledge and skills in the field of Home-Based Care, such as caring for bedridden people.

Even though it was made clear before and often during the training that learners would not received monetary compensation for their involvement in the programme and that the accreditation process was still in progress, learners indicated that they expected a certificate. As was mentioned to the learners, they would be receiving a certificate of attendance, but not a
certificate of competence. A few learners said that they would like to be placed in employment after the training.

The learners who made comment on the training in general stated that they felt very positive and satisfied about the programme, and found it educational. The major reason mentioned was that the participants received a lot of new relevant and real-life based knowledge, which allows them to face the issues in their communities confidently. All learners appreciated the participation in the groups and the support and experience from their peers as well as their trainers. Learners felt that everyone was accommodated in the training.

It can be concluded that the Learnership programme met the expectations of the majority of learners in both the Pilot and the Extension group.

In how far the employment expectations can be met will have to be reassessed, during follow-up research, after the qualification has been issued.

### Mother tongue

As mentioned above, the training in all the provinces took place in the mother tongue of the majority of the learners, except in the Western Cape. Two of the Western Cape groups, namely the Worcester learners that participated in the Pilot group and the Ottery learners that participated in the Extension group were taught in English. This was because the learners from these groups consisted of learners with mixed languages.

40% of the total learners who did not receive training in their own mother tongue stated that they were comfortable with the medium of instruction that was used and that they were able to follow the training easily.

More than 95% found the manuals easy to follow and the language easy to understand. While a few learners requested that the manuals be translated into their mother tongue (Zulu, Afrikaans), some indicated that more focus should be on English (Gauteng) who also asked their trainers to use English as the medium of instruction during the training.
The data received from the learners indicate that on the whole, language was not a problem and whether the training was in their mother tongue or in English the overall experience was a positive and enriching one. However, this result might be misleading, since the educational level of the majority of the present learners is higher than the minimal education level (level 9) targeted by this programme. Translations of the material into the dominant languages in South Africa will therefore be implemented upon finalisation of the manuals.

### Time allocated, group size and participation of peers

Learner’s responses were positive in relation to the availability of time to cover the material. The felt that sufficient time was allocated for each activity and for the various modules. The majority of the learners felt that the group size was acceptable. Some of the learners stated that an ideal group size was between 12 and 25. In some of the provinces, where the groups was small (6 learners) they indicated that certain activities and icebreakers did not work well because the group was too small. On the whole, they believed that the activities in the manual encouraged participation of all learners.

### Outcomes

In response of learners to questions about whether the outcomes of the materials were clear, the majority indicated that it was. For most of them it was to educate people and pass the acquired knowledge onto the community, to promote good health and to care for the sick. It was also motioned that developing yourself was a outcome of the programme. Many learners responded by saying that the outcomes were discussed and clarified per module but did not elaborate on what the outcome of the programme was according to them.

The almost 90% of learners that answered this question, said they were confident to implement this programme after SP1. They felt prepared to face the challenges thanks to the knowledge they received. They knew what
to expect, they knew how to deal with the situations they would encounter. They were very motivated to help and pass that knowledge on. They also indicated that they felt more confident to address people, to motivate and advise them as well as to answer their questions.

### Facilitator

100% of the learners indicated their satisfaction with the facilitators. They felt that the trainers guided them well through the training, explained the content in a clear manner, were knowledgeable about all relevant topics, granted them enough time for discussion and questions and were open for suggestions and problems. About 90% found that the trainers were capable of dealing successfully with the various activities in the manuals.

Almost 90% felt that the material linked well with their prior knowledge and almost 95% that all the relevant topics were included. Already after SP1, only less than 40% said that the training approach was new to them while 45% said it was not.

About 95% indicated that the activities and step-by-step suggestions in the material were very useful. Most frequently mentioned were the icebreakers.

### Results from the group discussions

Discussion groups were held in 6 of the 7 provinces that participated in both the Pilot and the Extension group. The provinces included the Eastern Cape, Free State, Gauteng, Limpopo Province, Western Cape and Kwa-Zulu Natal.

The questions were based on the initial questionnaire. The same questions were used to get more detail from the learners.

The discussions groups with the learners and the trainers separately revealed that the amount of prior experience indicated in the questionnaires (about 60% in both groups indicating they had experience) was not reflective of what the learners had in fact done in their communities. Most of them have
been involved in actual projects work in a voluntary capacity. Many cited their involvement in church youth groups. The majority of learners with experience have worked as caregivers in TB (DOTS) or HIV/AIDS treatment and care.

The feedback from the discussion groups generally confirmed the responses given in the questionnaires. The majority of learners mentioned that they wanted to attend the course in order to gain more knowledge. Many learners had very little prior knowledge before attending this programme. Some only learned here what HIV/AIDS actually stands for and what the difference is between the two. Many participants were aware of their own misconceptions (a few even thought HIV itself was just a myth) and the wrong information circulating in their communities, in combination with a general lack of knowledge, and wanted to clear up what is true and what is not.

Then there were the ones who had a background in this area already (working in an action group for example). They indicated that they could deepen their knowledge in this programme, understand links and the broader context better. For all the opportunity of sharing experience with each other, in a safe non-judgmental environment was very important and valued. The exchange with people of different ages and different backgrounds in similar situations but maybe with different approaches to solutions was a great benefit and the starting point for networking and a more coordinated approach to community development.

What made this programme special was its accessibility to learners with different backgrounds. Learners said that it was easy to understand and to follow even for the ones who knew literally nothing about HIV/AIDS and the related issues. It linked well with the prior knowledge of those who had some but did not exclude the ones without. The activities, the icebreakers in particular, and the participatory learning approach played a vital role in this experience. The learner’s, who had attended other HIV/AIDS courses, said that this one offered broader knowledge and more importantly guidance on how to implement and apply the knowledge in the field. Some learners said that other courses had little impact because they were provided with knowledge that remained unused because the learners did not know how to get it out to the people.
The motivation to gain knowledge stems mostly from the exposure to death and sickness in their own communities, families and circle of friends. The rising number of infections and weekly attendances at funerals fed the desire to do something about it and more importantly to learn how to do so.

Almost every learner said that this programme has given the confidence and the skills to go out to the communities and approach the people. This was true for the ones without prior involvement as well as for the ones who were already working in action groups for example. One learner said that he was a leader in his community already and could not answer all the questions. Now he can and feels very strong. Many learners mentioned that the people in the community would ask many questions and that before the course the learners were often not able to answer them. After the completion of the course they feel confident and motivated to stand in front of their communities and share their knowledge. As one learner put it: People listen if you are knowledgeable!

Several learners said that they were scared about the disease. Now equipped with coping skills about how to protect themselves, loved ones, care for others and how to improve peoples life, fear has been replaced by conviction that they can make a difference.

People have been given information on where and how to access resources for further information and support.

Many mentioned that they started implementing the newly acquired knowledge in their own families and that the programme has changed their own lifestyles. Many changed to a monogamous-relationship, and with the responsibility of being a community Health Worker (CHW) are proud to be a role model and to practice what they preached. One mentioned that she is generally more open to people in the community, greets them and interacts a lot more. Another learner reported that he managed to get more elderly people involved in his action group (20 new members).

Learners appreciated the great support from their trainers. The learners visited after SP1 all indicated that they would like to get more information on HBC, first aid and the caring aspect in general, which is covered in SP2 and will be further expanded in a third skills programme in 2004.
All in all the learners found that the programme to be a positive and totally new and enlightening experience.

### Results from the fieldwork

The fieldwork consisted of two parts each consisting of 15 days. Each skills programme was followed by 15 days of fieldwork. This was done for organisational reasons and mainly to use the limited time available most efficiently. The fieldwork gave trainers sufficient time to prepare for the second skills programme.

During the 30 days of fieldwork, learners were required to conduct a minimum of 60 visits (2 per day). The local coordinators in each province selected the clients for the fieldwork. In some cases learners were already involved in community work and had their own clients before the training. Depending on the planning of training in the different provinces, some groups did the whole 30 days of fieldwork in one stretch.

In some of the provinces where the first part of the fieldwork was done after SP 1, it was found that even though the general feedback from the learners after the training of SP 1 was that they felt confident to implement their knowledge in the field, when actually engaging the challenges in their communities, they found that the skill they had acquired were not sufficient for the learners that did not have prior experience in home based care.

A strong recommendation was therefore made by learners to first complete all the formal tuition before going commencing with the fieldwork.

Other groups contacted clinics that who placed the volunteers with clients in the communities closest to them.

In order to monitor the fieldwork, every learner had to complete a visit report for each visit, indicating date and time of the visit, condition of the client and tasks performed (also difficulties encountered) during the visit.

Pseudo names were used for the clients so that confidentiality would be guaranteed. At the same time it was also a way to track how a particular client is visited and cared for and the condition of the client between visits.
The discussion groups held during the site visits were useful in that it gave more contextual insight into the progress of the fieldwork.

Trainers and/or coordinators of each group were asked to preferable have weekly meetings with their learners to share experience in the field and discuss upcoming problems as well as solutions. The staff of IIZ/DVV recommended a minimum of 2 meetings per month. Minutes of these meetings were to be handed in as part of the report submitted by the trainers at the end of the programme.

The volunteers mentioned that they were faced with serious problems in the communities. These problems were said by them to be interlinked, but went far beyond just immediate health care. Some of the examples cited by the learners included the following: “Poverty does often not allow people to provide good nutrition even if they have been made aware of its importance, a referral to the clinic becomes useless if no transport is available, a grant cannot be applied for if one does not know how to obtain or does not have a valid identity document”, to mention just a few issues that that the volunteers have to deal with.

Nevertheless, the feedback about the experience was very valid and positive. The volunteers stated that the people in the community welcomed their work. Although many of the volunteers are still relatively young they say that they have no problems communicating with the older community members. Topics such as sexuality and HIV/AIDS are still not discussed as openly as it should be. In some areas they said it is also culturally not allowed for the younger generation to address the elderly about issues like sexuality and HIV/AIDS and that this sometimes caused problems for them.

Men seem to be a challenge for the female carers. They indicated that there are cultural barriers related to talking with males about sexual behaviour. Since most of the volunteers working in home based care, HIV/AIDS programmes, it to some extent limits there work. They stated that women in the communities are often afraid of their men and do not go to the clinics openly. The regular visits from the volunteers make the men (as well as the women) feel more comfortable with the issue.

Another difficult target group mentioned was the youth. They stated that in some areas the youth who are at such great risk, often still do not take
the issue of HIV/AIDS seriously. In other areas, where the young volunteers were already involved in youth projects, where they are recognised and accepted, taking and convincing youth was a lot easier because these youth belonged to organised structures.

Some volunteers cited that they organised awareness days at schools for example as part of their fieldwork and reported it on their visit report. They felt that they were making inroad because the teachers from these schools were inviting them to come back for more education and awareness programmes. The volunteers indicated that the students at these schools felt free to talk to them and especially, people of their own age rather than their teachers and also indicated that the information they received was a lot more conclusive and relevant than what was provided to them before by their schools.

One serious problem that was experienced by several volunteers were issues related to superstition. The volunteers mentioned that they often had to call in their trainer or coordinator to assist them in dealing with clients who responded to the volunteers with superstition. The volunteers also indicated that they often called in the help of the trainer when the felt inadequate to deal with a particular situation on his/her own.

Many of the volunteers stated that the use of a uniform would help them to be recognised as more ‘official’ service providers.

On the whole, the feedback from the volunteers who participated in the group discussion, feedback from meetings between volunteers and their facilitators and reports from their trainers suggest that there is a good spirit amongst volunteers and their clients and that volunteers found that the work they did in the communities greatly benefited and empowered their communities.

### Client Satisfaction

Client satisfaction was assessed through interviews with a selected sample of 3-4 community members or households in each province who received service from the learners. The trainer and/or coordinator in the area
were responsible for the selection. Although it would have been desirable for the evaluator to choose clients randomly in order to avoid the risk of only the most satisfied clients being selected and to increase validity, this was not viable from an organisational point of view.

Interviews were conducted in the following areas:
- Eastern Cape (Extension group);
- Free State (Extension group); and
- Limpopo Province (Pilot group);

The reason why interviews were not conducted in all provinces is that in several provinces the fieldwork had not yet commenced when the evaluators came for the site visit.

Some groups had difficulties organising and coordinating their fieldwork. In some of the provinces (Gauteng and Limpopo) the fieldwork had not started as negotiations were underway with local clinics regarding the placements of volunteers. Another difficulty that volunteers had was that they were restricted to provide services for clients only in the surrounding areas because of transport difficulties. The project did not make funding available for travelling of volunteers to distant areas. Often, these distant areas are the areas where the need for their services is the greatest.

In other cases transport to the areas where fieldwork was conducted was not available or the areas were inaccessible by car. Sometimes time constraint prevented the evaluators to conduct interviews.

Lastly, not all provinces could be visited due to lack of time and staff shortage.

On average, 30 minutes were spent in each household. Either one of the facilitators or the director of the organisation accompanied the evaluators for introduction and translations. Interviews were guided by the following questions:
- Introductory questions about well-being, diagnosis and living conditions?
- How is the volunteer helping you/What kind of tasks does the volunteer perform for you?
- How has your life improved since the volunteer visits you regularly?
What other service/help would you require from your volunteer?

How many of the clients are in fact HIV positive is difficult to estimate, as many do not know their status, others wish not to reveal it. Sometimes the family members have told the evaluators that the client was HIV positive while the client himself denied it. Only a few have openly shared that they have AIDS. The volunteers are confronted with opportunistic diseases, such as TB as a result of the infection with the HIV virus, but there were also cases of mental illness in some areas.

In some areas the clinics are inaccessible for the people either because their condition does not allow them to travel, sometimes because of a lack of money for transport. Therefore, caregivers have to deal with a set of symptoms that have never been professionally diagnosed.

In many households women take care of the families (children mostly), including at least one client, on their own. Financially they do so often from a small (old age or disability) grant. Other clients barely manage to take care of their own. Poverty is omnipresent. The role of the volunteer ranges from performing basic house keeping tasks such as grocery shopping (especially when the client is restricted in mobility), cleaning, washing, cooking, but also changing bandages, and helping the client to wash. It also involves a lot of counselling and advising from health education to support in how to apply for grants, and also simply listening and showing the people that they are not alone in their situations and take some of the pressure of the ones who care for the clients on a daily basis.

One client for example, said that his depression has gone since he talks to the volunteer regularly.

As mentioned above some volunteers in Limpopo province started the fieldwork after SP1. The interviews during a site visit after SP1 showed that the tasks performed by these volunteers were still quite limited as this group also lacked prior experience in community work.

This was not the case in other groups that started fieldwork before completion of the whole training, where all clients said that their situation has improved since the volunteers started assisting them.

When the particular area in Limpopo was visited for the second time after SP2, the situation had improved quite significantly since the volunteers were
able to engage more efficiently in their fieldwork and the effects could be observed among the clients.

Again this need was emphasised to first complete the theoretical aspect of the entire training course before starting with the fieldwork.

In one of the affected areas in the Eastern Cape areas, a client indicated that she benefit a lot from the coping strategies the volunteers offered, from basic health and hygiene rules, to help with grant applications etc. Since women have to often take care of sick family members as well as provide for the income, the additional support from the volunteer is more than welcome and has a great positive impact.

On one side they remove a lot of strain from the caring family member and on the other they help to improve the condition of the sick client.

The trainers who were very involved in the coordination of the fieldwork and often helped solving problem that arose from difficulties that the volunteers were not equipped to tackle on their own. Accessing grants for people who do not have the money to feed themselves and who have full blown AIDS is one of the difficulties volunteers encountered. For example, in one province, one of the women suffering from the effects of AIDS, who the evaluators had visited just recently, was apparently left to herself by her sister who had too little food to feed her own family and chose not to care for her anymore. In cases like this contacts to the relevant authorities were made.

Despite the tragedy of such events, volunteers start building networks with key players in their communities and increase the effectiveness of their work.

**Recommendation**

In the group discussions held with volunteers and separately with trainers, the following recommendations:

1. That the theoretical part of the programme should completed first before embarking on any fieldwork.

2. Placement of learners with clinics, NGOs, hospices and other institutions should be done prior to the commencement of the
programme. These arrangements should be negotiated with municipality and provincial government.

3. Volunteers should have first aid kits.
4. Volunteers should have a uniform that gives them ‘official’ status in their communities.
5. That the ideal classroom size should be 12 and the maximum should be 25.
6. Funding should be made available for transport so that volunteers can work in communities most affected and infected.

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**Conclusion**

Despite the challenges that we came across during this first implementation phase, the programme was a definite success. This has been confirmed again and again by the participants, learners as well as facilitators, but also representatives from the HWSETA and other stakeholders.

For the learners this course offers in the first place tools for hands-on contributions in their communities and before that in their own families and circle of friends. The knowledge and skills they received gave them a confident voice to address the issues related to the HIV/AIDS pandemic in a concrete manner. These volunteers are messengers of knowledge on how to deal with the daily challenges of living with HIV/AIDS that is so urgently needed in those areas but often does not reach the people.

By raising awareness, improving the lives of people living with HIV/AIDS, by caring for them but also by helping them access service structures for example, a noticeable contribution to the reduction of the spreading of HIV/AIDS is given. We are not talking about over night changes here of course, but ultimately the increased knowledge acquired in our programme had two major effects on the affected communities.

The first positive outcome of the programme was the **practical day-to-day assistance** our volunteers provided for people infected by HIV/AIDS. Some of the help they provided, included help with household chores, cooking
and general caring for people. The assistance provided to people affected involved helping people access grants, dealing with temporary custodies, etc.

The second positive outcome of the programme was the impact the increased knowledge had on the behavioural changes of the volunteers, their families and friends, and the client's who they interacted with. The two outcomes both have poverty implications.

On another level, the qualification in which this programme will result in the near future equips these volunteers with a currency that should improve their standard of living by increasing their employability, thereby also contributing to poverty alleviation at the same time.

Further research has to show to what extent the qualification will lead to the employment of these volunteers. Another future research question that needs to be answered in how far the valuable services provided to the affected communities are sustainable on a voluntary basis only.

The programme within its quantitative limitation was able to prove that training and adult education will contribute to the mitigation of the impact of HIV/AIDS especially in poverty stricken areas.
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<th>ACRONYMS</th>
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<td>ABET</td>
<td>Adult Basic Education and Training</td>
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<td>ChoiCe</td>
<td>Comprehensive Health Care (Pilot partner in Limpopo Province)</td>
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