The challenge?
Improve / build skill-sets of young people to better manage their sexual health.

Results - expected
The challenge with the young people is that they feel overwhelmed by the demands of school, care work, and other social responsibilities, and don't have the time or energy to engage in healthy sexual practices.

Unexpected Results
- Relationships with people changed: they were very honest about things that were bothering them.
- But, the dynamics of the system changed.

What did we find out?
Participants believe that the lack of knowledge about the subject leads to fear and anxiety, which further exacerbates the situation.
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We started with the Cynefin Framework, a ‘leader’s guide to decision making’ (Snowden and Boone, 2007)

In the context of:

At this time (around 2011) we heard a lot about...
In the context of:

Rural South Africa (Ga-Dikgale, Limpopo Province);
- ~ 35,000 marginalised people, high levels of unemployment, regular migration in/out of the community;
- HIV prevalence antenatal women age, 2011, –
  15-19 = 7.4%
  20-24 = 17.5%
  25-29 = 27.4%
  30-39 = 33.6%.
At this time (around 2011) we had heard about 'complexity' but we were not at all confident about applying it in a rural space.
We started with the Cynefin Framework, a 'leader's guide to decision making' (Snowden and Boone, 2007)
Un-ordered domain, non-linear relationships. The space of real-world interactions & relationships associated with complex, social messes.

Complex
- Probe
- Sense
- Respond
- Emergent

Complicated
- Sense
- Analyze
- Respond
- Good Practice

Chaotic
- Act
- Sense
- Respond
- Novel

Simple
- Sense
- Categorize
- Respond
- Best Practice

Ordered domain, linear, cause-effect relationships. The preferred space of modern science, reductionism & discernible correlation.
Un-ordered domain: Most prevention strategies ignore this (the space of real-world [naturalistic] interactions & relationships associated with complex, social messes.

Ordered domain: Most prevention strategies are conceptualised in ways that assume the decision making is made here.
And our assumption was that if we were to deal with / confront the un-ordered aspect of 'prevention' we needed to find out what it represented so we could better understand the properties, patterns & dynamics of the complex adaptive system.
What did we do about it?

Archetype Extraction, a technique we had learnt about via the Cognitive Edge website and a private sector consultant from Johannesburg (properties) & social network analyses (patterns).
Methodology: Two Phase Emergence (1)

- Anecdote circle: facilitators note 'characters' in stories; put them on post-it notes on wall & ask participants to cluster;
- Each cluster is named by the participants and the original characters are removed
- These are the ordered properties of the system.
Methodology (2)

• Ask the participants to ascribe 4 good & 4 bad human attributes to each cluster name;
• Then remove the cluster name, scatter randomly on wall and give a name that includes an adjective and a noun;
• These are the archetypes (second phase of emergence).
Then request an artist to sketch the archetypes.
Which means that the participants have:
- Given you stories;
- Clustered the characters in the stories and coded them in a way that makes sense to them;
- Then given you the human attributes that they associate with the structured properties;
- And then told an artist how to draw them.
Social Network Mapping (influence mapping, MSC stories) looking for patterns
Results - expected

- The archetype extraction process gave us insights into the un-ordered & ordered properties and the
- Social network gave us some patterns of interactions in the complex adaptive system
One of the more powerful images was this one
He used one razor on all of us!!!
The topics that emerged included: Mental health, hopelessness, stigma, [non]-adherence, testing, traditional / modern health practices, witchcraft, fake medicine sellers, community strengths / support, male circumcision (initiation ceremonies); teenage pregnancy, alcohol & substance abuse, school trauncy, selling / use of body parts for medication, lack of government support;

- Almost 50% of the un-ordered issues were things we can work with.
SNA gave patterns of treatment seeking behaviour
Un-expected Results

- Relationships with people changed (they were very honest about things that were harder to reach before);
- But the dynamics of the system eluded us.
They told us what they should do -

1/. Clinic
2/. Hospital
3/. Medical Doctor
4/. Self medication
5/. Prophet
6/. Traditional Healer
And they told us the places they trusted

<table>
<thead>
<tr>
<th>Treatment Option</th>
<th>Confidence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>5</td>
</tr>
<tr>
<td>Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Home Based Care</td>
<td>5</td>
</tr>
<tr>
<td>Old Age Home</td>
<td>5</td>
</tr>
<tr>
<td>Family</td>
<td>5</td>
</tr>
<tr>
<td>Prophets</td>
<td>3</td>
</tr>
<tr>
<td>Traditional Healer</td>
<td>1</td>
</tr>
<tr>
<td>Community</td>
<td>1</td>
</tr>
</tbody>
</table>
But the dynamics of the system were still elusive
What did we do about the dynamics?

- We realised that we were part of the complex adaptive system;
- And that all of us (researchers and participants) were framing the health challenge in silos and not through an interdependent process of developing skill-sets for managing health.
- What sort of competencies / mind-sets were required?
- Distributed cognition / ideas come together that enable both deductive and inductive processes to coalesce.
Dynamics?

- We realised we were locked into a 'path dependent' trajectory (based on the now discredited ABC approach to HIV prevention & reductionist / linear thinking);
- Which was contrary to our original plan.
We re-visited the ordered domain of the Cynefin Framework and realised that we had ignored the multiple ways of managing HIV/AIDS and moved from the 'prevention' metaphor to 'viral load management'.
• Continued the community dialogue and began to re-conceptualise our own biases;
• Stopped analysing the complex adaptive system (because it is like 'chasing a rainbow');
• And moved from aiming for 'self'-efficacy to 'distributed'-efficacy.
IN CONCLUSION

- We have moved from 'prevention' to "viral load management";
- Self-efficacy to "distributed-efficacy";
- That includes both ordered and un-ordered aspects of a complex adaptive system (which we are a part of) - PROPERTIES, PATTERNS & DYNAMICS;
- And will implement (2014) using community based safe-fail interventions that incorporate the ordered biological knowledge of viral load management & the un-ordered information that local communities are better able to work with than we are.
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