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Community mobilisation against HIV infection in Kenya

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· Introduction

There are few successful models of rural HIV counselling and testing in Africa. Work in Uganda has shown the difficulties of setting up rural access to counselling and testing without the villagers themselves participating in decision making and planning (Seeley et al., 1991). When, in 1993 villagers in 15 villages in Siaya District, Kenya asked CDC/KEMRI to provide access to HIV-antibody testing, a participatory methodology was sought that would involve the villagers and which would be culturally sensitive. Furthermore, subsequent meetings established that the needs of these villages in relation to HIV and AIDS went beyond a simple request for access to HIV testing.

An initial survey of knowledge, attitudes, practices and beliefs (KAPB) about AIDS revealed that villagers felt the responsibility for HIV prevention lay with the government or with health officials, and that communities and individuals felt powerless in the face of the threat of HIV infection. We wanted the participatory activities to empower these communities to do something for themselves. We realised that there is only so much a community can do in a situation where they may, for instance, not have access to condoms or safe blood. However, we hoped that participatory mobilisation would reveal gaps in knowledge, attitudes, risky practices and beliefs, which the villagers have the potential to change without a huge resource input.

Developing the methodology

We knew of only a few examples of the use of participatory approaches for mobilising communities against HIV infection (Barnett, 1994; Duangsa, this issue). We thus decided to use a modified form of Participatory Rural Appraisal (PRA) to which we added selected SARAR[1] techniques and our own activities. To emphasise that it is the villagers themselves who collect and analyse data and make decisions based on what they find, we called the new methodology Participatory Rural Research on AIDS (PRRA - yet another acronym).

Appendix 1 summarises the range of PRRA activities involved, also described in a handbook (Sellers, 1994). The approach is used to assist villagers in finding out what it is that stops them from protecting themselves and others from becoming infected with the AIDS virus. Once they know this, it helps them to look at solutions and actually make a plan against the spread of AIDS within the community.

PRRA is not designed to change behaviour. It hopes instead to allow communities to make informed decisions about future interventions against HIV infection, although we do expect to see some change in behaviour as a result of PRRA.

[1] From PROWESS, developed by UNDP for water and sanitation.

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

· Implementing the methodology

From the beginning it was made clear by village leaders that to discuss sensitive topics such as sex and cultural practices involving sex, all the participants should be from the same ethnic background. Thus we decided that all project team members should come from the target villages themselves. In other words, we would train 'insiders' and eliminate the need for foreign 'experts'. However, since we realised that poverty, development issues and lack of resources would all be identified as contributing to the spread of HIV infection, representatives from other organisations were invited to participate (with agreement from the village concerned) as long as they came from the same ethnic background.

Six local men and women were selected for the project team by the villagers. The method of selection was left to them (usually it was done through the clans and sub-clans), but the criteria included a minimum educational level, being respected by the villagers, a certain maturity regardless of age and an interest in helping to prevent the spread of HIV infection. HIV counsellor training was given to project team members over a period of six months, part of which involved the trainees taking placements with local HIV/AIDS support organisations and in the District and Provincial hospitals.

The PRRA process took place over five days in each village. Appendix 1 summarises the main activities carried out during the process. Examples of the findings of some of the activities are discussed below.

KAPB pocket charts

Kaminogedo is one of the villages which participated in the PRRA. On the second day project workers dispersed in pairs throughout the village to facilitate activities with different informal and formal groups. One pair met with a group of men and women of mixed ages to facilitate an activity called KAPB Pocket Charts. As with all the KAPB activities (activities which explore the Knowledge, Attitudes, Practices and Beliefs about AIDS), the discussion is the most important part. While the outcomes of these activities provide villagers with baseline information, the discussions pave the way for them to identify the barriers to prevention and finally to look for solutions to these barriers.

The project workers displayed two pocket charts written in the local language. One has pictures of people across the top, the other lists places and events (see Table 1). The project workers explained the activity carefully and six people were chosen to vote. The pocket charts were hung in such a way that voting was confidential. Each person voted once for each question in the two charts by placing a small disc in the pocket corresponding to their belief. When they had finished, the votes were quickly counted by the participants and a chart of the results was made (Table 1).

The important part of the activity began as the facilitators asked whether the group agreed that the results accurately reflected the situation in Kaminogedo. First discussion was carried out in age/sex groups, then the whole group came together and agreed on the following points:

- Old people don't have the strength to play sex so they can't contract AIDS or other STDs;
- Old people should be responsible for AIDS prevention, especially the adults;
- Mothers can help prevent the virus from spreading by educating husbands and children;
- Alcohol and drugs speed up the sexual urge in men;
- Men shy away from family health matters and show their denial of AIDS by remarrying;
- Drinking and dancing places promote sexual immorality which leads to getting STD/AIDS;
- In a polygamous family it is only the first wife who is responsible for sex related cultural practices like having sex at the time of sowing, planting etc.;
- Condoms cannot be used during wife inheritance practices for fear of breaking a taboo and contracting *chiraa*[2] (but the

[2] *Chiraa* is a traditional wasting disease caused by breaking taboos. AIDS and *Chiraa* are often thought of as one and the same in this culture (see also page 71 of this issue).

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

women felt it would be better if condoms could be used);

- Traditional stools and tobacco could be used instead of sexual wife inheritance (see page 73 of this issue);
- AIDS education can only be got from health centres outside Kaminogedo;
- Men are most responsible for transmitting STD since they have more partners than their wives;
- Women take a long time to discover they have an STD and therefore risk re-infecting their partners; and,
- Everybody would like counselling/education on AIDS.

Table 1. KAPB pocket charts

WHO (pictures)	Man	Old man	Young girl	Young boy	Woman	Old woman	All of them	None of them
Is least likely to get STD?	0	4	0	0	0	2	0	0
Is responsible for AIDS prevention?	0	0	1	1	0	1	3	0
Is responsible for family planning?	2	0	3	0	0	1	0	0
Is responsible for health in the family?	2	1	0	0	3	0	0	0
Would like AIDS counselling & education?	0	1	2	2	0	0	1	0

WHERE (pictures)	Church	Farm	Clinic	Beer party	Disco	Homestead	Lake shore	Barber	All	None
Is one most likely to get AIDS?	0	0	1	1	3	0	1	0	0	0
Can one get an HIV test?	0	0	6	0	0	0	0	0	0	0
Is one least likely to get AIDS?	5	1	0	0	0	0	0	0	0	0
Can one get AIDS counselling & information?	1	0	4	0	0	1	0	0	0	0
Can one get general STD information?	1	0	4	0	0	1	0	0	0	0

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Barriers to prevention

On day three of the PRRA, after sharing information about modes of transmission and prevention of HIV infection, a specific activity is facilitated in sex/age groups which aims to elicit barriers to prevention from villagers themselves. This activity follows on from the previous exercises with the question *"given that villagers clearly know how to protect themselves from infection, what actually stops them from doing so?"*.

In Kaminogedo, Damarice and Eudiah (project workers and both married women themselves from nearby villages) sat with a group of ten other married women to discuss what they felt to be major barriers to prevention/protection for them. Sitting in a circle, a picture of a cart (a traditional hand cart known as a *cocoteni*) was placed in the middle of the group. A pile of blank coloured paper circles of different sizes was used to represent barriers/rocks. Eudiah told the group to think of all possible things (attitudes, resources etc.) that would stop them from using those methods of prevention that were mentioned in the previous activity. Each statement was recorded on a 'rock' of a size selected by the group and then placed into the back of the cart. The resulting barriers were finally discussed and verified (they could also be ranked). The barriers this group came up with are shown in Table 3.

The women strongly believed that their main barrier to protecting themselves and their families from HIV infection was poverty or lack of money to buy syringes, needles, condoms, safe blood, medicines and so on.

Table 3. Barriers to prevention

Problems sticking to one sex partner	Problems with condom use	Problems getting safe blood	Problems not sharing toothbrushes and razors	Problems keeping wounds covered
• Lack of money • Desire	• Leave you with a lot of sexual desire • Can enter womb • Not available in village • Difficult to discuss with partners • Can burst • Brings scratches to private parts • Are slippery • No money to buy them • Prevents pregnancy • Men don't like them • Men think you are prostitute	• No money • Lack of places which screen • Timing, if patient is critical	• No money to buy for each member of family • Lack of knowledge, people don't know they shouldn't share or should sterilise	• Bandages not available • No money to travel and buy them • General lack of medicines

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Finding solutions

The day after barriers to prevention have been identified, all the barriers recorded throughout the week are presented at a full village meeting by the village volunteers to be verified by the villagers. Once they have a list of barriers which they feel apply to their situation, activities to find and categorise solutions are facilitated. Finally, these categories are ranked according to their impact on the spread of HIV infection and according to how easily the villagers themselves can do something about it.

Obadiah and Richard looked for solutions to barriers with a group of nine married men in Kaminogedo. The barriers had been posted across the top of a sheet of newsprint and the group were asked to split into two and to brainstorm solutions to each barrier. Whereas married women in Kaminogedo had stressed poverty as a barrier to prevention, married men had also included *"too much money"* as a barrier (Table 4).

Table 4. Solutions to barriers

Barriers	Solutions
Lack of money	Hard work, giving condoms at a fair price, free syringes and needles, bringing health facility within reach of community
Lack of knowledge	Workshops, *barazas*, radio, training through women's groups etc
Lack of HIV testing places	Bringing HIV testing and counselling to the village, training counsellors from Kaminogedo, avoiding blood transfusion by eating well and treating malaria promptly
Commercial sex work	Go for zero grazing, always live with your wife, don't work away from home
Too much alcohol	Getting saved, not drinking too much
Too much money	Becoming calm over your wealth, be loyal to God
Living far from wife	Stop working away, creating real love and trust atmosphere in the family
Lack of children	Adding another wife, taking HIV test
Traditional practices	Use condoms, both parties to have HIV test before wife inheritance
Problems with condom use	Mass education, demonstrating them, make them free, make them more accessible, make people understand the need for them

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Selection of village AIDS forum members (VAF)

Originally, the PRRA week ended with the village selecting a Village AIDS Forum. Village AIDS Forum members are charged by the village to plan and implement the solutions to barriers identified during PRRA, and to report back to the village. They are not organised, supported or funded by CDC/KEMRI, but are welcome to negotiate access to training. The first VAF requested training to give them more facts about HIV/AIDS and to help them to use their PRRA outcomes to plan solutions to barriers identified by the village.

However, after the first three PRRAs, it was clear that the villagers regarded the VAF as an extension of the project. This had not been the intention. Consequently, this part of the project has been handed over to members of one very active VAF and is no longer part of PRRA. Now, existing VAF members visit villages where PRRA has been carried out and talk about their own AIDS Forum, how it was set up, the training it has received and the work it is doing.

· Conclusion

There seems to be enormous enthusiasm for this approach to HIV prevention from the villages concerned. Although it is still too early to tell, our personal feeling, based on feedback from the PRRAs to date is that 'learned helplessness' (ie. villagers feeling powerless in the face of this potentially enormous threat to themselves and their families) is giving way to a feeling that they can take on the responsibility and actually do something to change the situation. Only monitoring behaviour change will prove whether this is really the case. What has become clear, however, is that access to HIV counselling and testing is a priority for the majority of villages and that they see it as a way of promoting behaviour change.

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REFERENCES

Barnett, T. 1994. The Effects of HIV/AIDS on Farming Systems and Rural Livelihoods in Uganda, Tanzania and Zambia. Report for FAO. ODG, University of East Anglia.

Duangsa, D. 1995. A participatory approach to promoting AIDS awareness in Thailand. PLA Notes 23. IIED, London.

Seeley, J., Wagner, U. and Mulemwa, J. 1991. The development of a community-based HIV/AIDS counselling service in a rural area in Uganda. AIDS CARE, 3 (3).

Sellers, T. 1994. PRRA RAPAR. CDC/KEMRI, Kenya.

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Appendix 1. PRRA objectives and activities

Objective	Activities
1. Giving villagers enough information to decide whether to be involved in the project	Distribution of field work schedules to groups and village leaders and visiting a variety of groups and individuals culminating in a meeting where questions are answered and at which a decision is made Inclusion of villagers in PRRA training course
2. Establishing that AIDS is a problem and that the community want to do something about it	Disease ranking by sex/age groups Presentation and verification of findings Finding and ranking solutions to barriers to prevention
3. Sharing expectations of the PRRA period and of the project as a whole	Eliciting expectations from sex/age groups and addressing these expectations on the spot
4. Establishing links and ensuring representation of the different formal and informal groups that make up the community	Pre-mobilisation activity Inclusion of villagers in PRRA training course Community walk/ self-selection of volunteers Identifying formal and informal groups through mapping Migration calendar (identifies when migrant workers and students return home so that interventions can be planned to include them) Homestead semi-structured interviews (usually 10)
5. Personalising the risk of HIV infection; sharing information on modes of transmission and on the ways in which different individuals can protect themselves, their partners and families from HIV infection	Expectation sharing TAPWAK personal experience (a member of The Association of People with AIDS in Kenya gives a personal experience of HIV infection) Family Story transmission exercise (looks at how each member of a typical family could become infected by HIV, and how they could infect each other Pasting for prevention (uses the individuals from the same family to determine the best ways of protecting each one from HIV infection) Discussions
6. Sharing information about counselling and testing (C and T) and about attitudes to confidentiality	C and T open-ended story Confidentiality focus group discussions Homestead semi-structured interviews KAPB pocket charts (see Table 2)
7. Understanding cultural beliefs and practices, gender issues relating to negotiating safer sex and gaps in community resources (ie. STD services, condom availability) which may create barriers to prevention or protection	KAPB pocket charts Odindo's Activity (examines cultural/ social factors which promote sex) Three-pile attitude sort (looks at practices and beliefs) Mapping Services activity (looks at where villagers go for STD diagnosis and treatment, access to safe blood transfusion, condoms and clean needles and costs involved) Homestead semi-structured interviews Community walk (verifies map) Rocks and Cart - Barriers to Prevention (see Table 3)
8. Verifying barriers to the prevention of HIV - do they really apply to these villagers?	Presentation and verification of findings
9. Identifying and prioritising solutions for the removal of these barriers	Finding solutions (sex/age group brainstorming of barriers) Categorising solutions (eg. general HIV education). Categories are ranked according to the number of times a solution is allocated to each one Ranking categories according to their impact on the spread of HIV infection and according to how easily the village can do something about it Mapping (maps can show where condoms, needles and syringes are available in the village; meeting places of sex/age groups; location of artists and musicians; homesteads with deaths between 15 and 40 years in the past year; child or grandparent headed households etc.)
10. Choosing one or more solutions and making a detailed plan for its implementation, monitoring and evaluation	Choosing a starting point by discussing the highest ranking category to see if it falls into the high impact/easily achievable part of the matrix Village selection of Village AIDS Forum (VAF) members Training the VAF to use PRRA outcomes for planning Training the VAF in participatory monitoring and evaluation
11. Implementing the plan	Supporting VAF where requested with training Providing access to HIV counselling and testing where requested, along with relevant support for those affected by AIDS

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London