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Moving beyond the 'KAP GAP': A community based reproductive health programme in Eastern Province, Zambia

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• The problem

Over and over again, we read that populations have a high level of knowledge of contraception and AIDS but this does not necessarily translate into safer sexual practice. We know that information alone is rarely enough to bring about a sustained change in behaviour and we must address the underlying determinants of behaviour by creating more supportive and enabling environments. Gender relations, socio-economic power, support and self-esteem are key components of these environments. Often the response to this so-called 'KAP¹-GAP' is a recommendation for more research to inform more targeted, persuasive messages, disseminated through social marketing or campaigns.

Until recently, family planning programmes have largely reached married women in their child-bearing years and sexual health programmes have reached men with sexually transmitted infections (STI). With the AIDS epidemic, condom use may now be reported as being for contraception *or* STI/HIV prevention. Adolescents have been at best provided with Family Life Education at school and/or local puberty instruction on how women and, occasionally men, are expected to behave. Older people rarely have access to sexual and reproductive health (SRH) services that meet their specific needs. Often there are separate service delivery points or days for each SRH service. Other SRH

needs such as sexual violence and abuse, abortion and emergency contraception, sexual information and problems are often only provided through private practitioners, if at all.

This fragmentation of services, education and user groups has made it more difficult to achieve behaviour change and therefore improvements in SRH. Many men are concerned about the effect of hormonal contraceptives on the body and suspicious of their partner's motives for using them. There is also a tendency for men not to tell their partners when they have an infection and it is widely felt that condoms are associated with disease and improper sex. Many family planning providers see condoms as a backup method for married women before the pill or contraceptive injection kicks in and tend not to promote them for prevention of infection.

This article describes a more holistic SRH health project in the Eastern Province of Zambia. It focuses on participatory approaches used, gender issues, male involvement and the integration of SRH issues at community and clinic levels. The article aims to demonstrate the opportunities and challenges faced by a government programme that uses participatory approaches in its everyday work to achieve the vision committed to at the International Conference on Population and Development held in Cairo in 1994.

The community based distribution (CBD) project

In CBD programmes, men and women are selected by the community to be trained as family planning workers. Until recently, these programmes have aimed to motivate people to plan their families and have distributed

¹ KAP stands for Knowledge, Attitude, Practice; and refers to the idea that if people have knowledge and positive attitudes, they will change their behaviour.

condoms, spermicides and pills to people in their neighbourhood. The Zambia CBD project began in Eastern Province in 1994 and is being implemented by the Planned Parenthood Association of Zambia (PPAZ) and the Ministry of Health of the Government of Zambia with technical assistance provided by Options Consultancy Services and funding from the UK Department for International Development (DfID). The project has trained 220 men and women to work as CBD agents in six districts.

As a process project, the team has had the resources and flexibility to test out innovative approaches. These focus on ways to actively involve all community members in project design, implementation, monitoring and evaluation, to integrate SRH issues, to address the underlying determinants of behaviour and to foster NGO, CSO and government collaboration. Participatory activities include participatory research; 'Stepping Stones'² activities; interactive use of visual and performing arts; non-directive counselling and regular sharing sessions on progress between all community, NGO and government stakeholders.

The CBD agents

CBD agents are men and women between 24 and 55 years old, mainly farmers with around seven years of schooling. They live in their own villages and serve a catchment area of around ten kilometres radius. They are provided with a small financial allowance, bicycles, contraceptives and locally produced brochures, flipcharts and booklets³. They receive a four-week training which includes interpersonal communication skills, counselling, group work and participatory skills, producing simple drawings and role-play or songs as discussion starters and some

Stepping Stones activities. Emphasis is placed on attitudes and behaviour, particularly in relation to gender, age and sexuality. Content includes contraceptives, condoms, STI, HIV/AIDS, abortion and emergency contraception, sexuality, managing logistics and planning their work. During the training, the CBD agents explore their own ideas and values in relation to SRH in the same way that they will later assist the communities. They work in separate sex and age groups and then share their ideas in plenary.

Participatory group work

Rural Health Centre staff supervise the CBD agents and support them in community work. They begin by explaining the project to the chief and headmen. A full community meeting is then organised where the work of the CBD agents is explained and people are invited to meet the CBD agent in six peer groups to discuss their needs and how they might like to work with the CBD agents. Peer groups comprise adolescent boys and girls, young men and women, and mature men and women. At the first meetings, the CBD agents facilitate participatory activities aimed at identifying the groups' idea of good SRH and priority problems; analysing the causes and consequences of these problems, looking at what they have tried, the achievements and challenges associated with the problems, and what actions they wish to take. The groups then hold in-depth discussions on priority problems using pictures, role-play, song and information sharing.

Work in separate peer groups is a key principle of the process. This gives people privacy and safety to explore their own values and feelings about their sexual lives without domination, sexual overtones or cultural expectations of age or gendered behaviour. The importance of this principle was reflected in Ghana when peer motivators began a group discussion with men and women on what helped sex to be pleasurable. The men launched into an excited sharing of the importance of physical beauty and female compliance with their desires and why women were so ready to have sex after minimal persuasion. The women were silent and angry. When it was suggested that the men and women go into separate groups and meet after some private discussion, the women

² Stepping Stones, written by Alice Welbourn, is a guide for a series of learning sessions on SRH, communications and relationship skills. It used participatory drama and drawing and is designed to be used with peer groups in communities.

³ CBD Booklets on related issues can be downloaded from Options' website: www.options.co.uk :

unanimously agreed that their partners' refusal to allow them to use contraception and fear of pregnancy was their major barrier to pleasure. When the groups met again, the women explained this to the men and a helpful discussion followed.

Counselling

Non-directive counselling is very important in sexual health programmes. It provides an opportunity for clients to explore their situation, to talk openly about their feelings and needs, to be listened to with empathy and confidentiality and to find ways of meeting their needs. The CBD agents provide counselling to men and women of all ages, separately or together on request. Many clients seek counselling following the peer group meetings. Male agents counsel women as well as men and visa-versa. Men rarely have an opportunity to discuss these issues. In Zambia, staff and communities reported that having time to express their anxieties about contraception and relationships was key to their acceptance of this service. Men with few resources have voiced fears that contraceptives will enable their partners to form relationships with richer or more virile men and leave them. As a result of the counselling and group work, there have been noticeable changes. Some men have stopped taking their wives' pills with them when they travel to prevent them from having affairs and instead are supporting them to take their pills correctly.

CBD agents were sometimes accused of having affairs because they counselled clients and provided contraceptives in a private place without their partners if they wished. This was most likely to happen with male agents and female clients. However, women have also accused the agents of providing condoms to partners and encouraging them to have affairs. As a way of tackling this problem, CBD agents have encouraged people in regular relationships to attend joint counselling together, whilst respecting the client's right to individual, confidential counselling.

Experiences of participatory group work

In the first participatory activity, people worked in separate peer groups and then came together to present their diagrams and findings at an open public meeting. This is normal practice in participatory research and the team did not perceive any risks with it. The young people used this opportunity to accuse the older people of failing to give them sex education and adequate support materially and pressuring young people to have sex with them. Women also expressed their dislike for some of the local customs relating to sexuality. These customs were supposed to be kept secret outside initiation teachings and not be discussed in public or between men and women. Initially the facilitators felt that the experience had been positive because usually submissive people were able to express their needs and feelings in front of those with decision-making power. However, CBD agents later discovered that there had been some negative repercussions in homes after the discussions, and also that some participants felt they had been misled in being asked to share their ideas with those from different generations and the opposite sex when confidentiality had been agreed.

Following this experience, the community leaders asked the CBD agents to meet with people in separate peer groups, without directly sharing their discussions in public meetings. They suggested that the CBD agents should act as mediators or negotiators between groups. They would share ideas from one peer group to another where relevant through role-play, stories or pictures, which would trigger discussion. The groups could then discuss any problems without feeling accused by a community or family member. This would prevent direct confrontations which older men and women found humiliating and responded to defensively.

For example, in Zambia, women complained that some men did not allow them to use contraceptives or refuse sex and this made it impossible to space births. The CBD agents created a set of picture cards, which they used to tell a story about a man who threw away his wife's pills and beat her. They asked the

men's group whether this situation occurred in their community, what were the good and bad points about it, why a man might behave this way and what the consequences might be. They were then invited to re-tell the story in a more positive way according to their perceptions of the situation. This was followed by a discussion on what would help men and women to talk about and agree on sexual decision-making.

This process has worked well but it does not actively encourage communication on sexual matters between the sexes or generations. However, in a participatory evaluation, people reported that men and women were talking more openly about sexuality because they had learnt to talk in peer groups and had greater understanding of the perceptions of others. Teachers, parents and grandparents reported that they now understood that adolescents are having sex in spite of traditional teachings and that they need condoms to protect themselves.

The CBD agents in some communities were trained to use an adapted 'Stepping Stones' process. This process provides several sessions with activities aimed at building trust, confidence and comfort with talking about sexual issues and preparation of drama in separate peer groups before presentation to the other groups. People develop role-plays for analysis in their own discussions and then adapt them for presentation to older or younger people and to the opposite sex. In this process men and women have been able to meet together and discuss in a frank way sensitive issues like condom use among married couples. For example, in one group, women said that they did not mind using condoms, but the men should wash first because they tend to be very dirty from working on the farm. They pointed out how dirty the condom had become when one of the men demonstrated its use.

• **The impact of the CBD project**

In a participatory evaluation of the Zambia CBD project, the top three positive changes reported by both men and women in equal numbers were good child spacing and its associated benefits, fewer STDs and happier sexual relationships. This indicates that there

has been some integration of the components of SRH in the perception of the community. Negative changes reported by fewer groups were the side effects of hormonal contraceptives, poor condom disposal and more sexual activity outside marriage because of reducing the fear of a negative outcome. A few groups mentioned more marital conflict because women were making autonomous decisions about contraception. Men comprised of between 40-60% of the clients and people appreciated that peer group discussions were held in separate peer groups.

The most difficult group to reach was adolescents, mainly because of disapproval from older people. They did not attend meetings and asked for contraceptives to be supplied on the roadside at night. Older men and women also thought that the programme was not relevant to them as people past childbearing.

This was partly because the CBD project had initially been introduced as a family planning project which distributed contraceptives. Those who were not expected to be sexually active did not see its relevance. This highlighted the importance of introducing the project as an integrated SRH intervention that helped people to identify their own needs and design activities to meet them, rather than to vigorously promote the use of contraception to all.

The CBD agents themselves felt that the project had brought many positive changes in their lives and also some negative ones. The men felt that they had become more 'caring and kind' rather than 'brutal and rough' as they were before'. Some said that their relationships with their wives had improved and they no longer had girlfriends as well. Some women said that they were better able to assert themselves and some had made good marriages as a result of the project. Both men and women reported that they were now able to talk about sexuality with groups and individuals and help people with a range of SRH problems. The difficulties of being a CBD agent included the hostility of some parents, partners and religious leaders towards their work and a lack of respect at times because they deal with sexuality.

- **Lessons learned from training staff to use participatory techniques and 'Stepping Stones'**

Working with groups

Facilitating participatory activities in sexuality and gender is a new skill for many health and development workers and they need an opportunity to explore their own values and feelings through participatory processes before they can facilitate others to do the same in a non-judgemental way.

In single sex and age group discussions, people have a degree of common understanding of their situation and shared values. However, this should not be overstated. There is a danger that group closeness encourages people to affirm norms and build consensus rather than express perhaps minority views and harsh realities. For example, a person who is attracted by people of the same sex may find it difficult to even introduce the notion of same sex activity and may receive a very negative response.

Gender and generational issues

Men tend to find it more difficult to talk about personal feelings and experience than women and this can have a major impact on the process. Many women will readily share their vision of a happy sexual life and their experiences of problems such as male abuse and unwanted or unsatisfying sex. Men tend to distance themselves from their personal experiences and feelings by talking about men from a different age group or context. In Stepping Stones training, women performed a role-play showing a day in their own lives as women based on collective experience, whilst men performed a role-play about a behaviour pattern in culturally distinct farmers in a remote rural area.

On the other hand, some men and women seem able to capture the situations, body language and behaviour of the opposite sex perfectly in role-play. Some male CBD agents in Zambia acted the part of women in oppressive or distressing situations so realistically that it brought tears to the eyes of

the audience. This appears to show an ability to understand the opposite sex, although this does not necessarily reflect a desire for change.

In one training, men felt that their drawings were too explicit or 'rude' to be shared with women. Members of the young male CBD agents group in the Zambia CBD project used their own slang and showed explicit scenes in a role-play and were reprimanded and asked to apologise by the older men.

Facilitation becomes more difficult when men and women come together to share their ideas. If women's presentations are based on their own lives and men's are not, women can feel aggrieved that they have 'bared their souls' and made themselves vulnerable whilst the men displaced their own concerns on to other groups. Men can tend to feel defensive when women present pictures of 'men behaving badly' and they react by generating an intellectual debate on the validity of the women's perceptions. Situations such as these are difficult for facilitators to handle and people who have personally experienced distressing situations may feel very upset.

A large group of men and women of different ages meeting together can exacerbate the problem because only the most vocal tend to speak and the whole ambience is one of challenge and 'a battle of the sexes' rather than listening and empathy. Arguing with women about sexual matters can be an arousing game for some men and they can use it to maintain control over women, especially young women. In Zambia discussions between generations were also confrontational in some cases, with older people eager to maintain the traditional culture and young people wanting to 'modernise'.

Some solutions to these difficulties

Conflict between groups is not in itself a bad thing; it is a normal part of life. Suppressing conflict limits growth and often has negative repercussions. We can use conflict constructively to build understanding and move things forward in a positive way. However, this requires training and practise in conflict management.

An important principle of all SRH work is that people are not pressured or manipulated to disclose personal experiences or feelings unless they are ready. If peer groups have different degrees of willingness to share personal feelings, it is not helpful to make those who are less willing feel inadequate. They need time, encouragement and supportive facilitation.

In a training with participants from South Asia, we found it helpful to divide the whole group into smaller groups of men and women, perhaps four or six. People in the small groups are asked to take it in turns to talk about their ideas for five minutes while the others actively listen and empathise. After each person has finished, the group members feedback the most important thing they have understood. When everyone has spoken, people identify the similarities and differences in their perceptions and how they can work together to improve things. This practice in expressing ideas with and listening to the opposite sex in an unthreatening way resulted in a significant increase in discussions between men and women.

When peer groups include two or three generations, this method could help adolescents and parents or older relatives to talk together more easily, with groups deciding who should sit together (in Zambia in-laws are forbidden to discuss sexual matters together.)

• Conclusions

The integration of the different components of SRH makes programmes relevant to all community groups. Men and women, boys and girls, need opportunities to work in separate peer groups in a private space to identify their own priorities and actions.

Sharing of needs, feelings and suggestions for improving their sexual lives between peer groups can accomplish a number of goals, depending on how it is organised. Programme workers can act as mediators between groups to share ideas in a non-threatening way. Small group sharing between men and women, young and old allows people to practise talking together about sensitive topics and develop mutual understanding. Public presentations from peer groups can act as a

powerful advocacy tool for change at community level and result in dramatic change. For example, in an evaluation of Stepping Stones in Uganda, the older men's group put on a drama about a local man who demanded sexual favours in return for employment and requested him to stop this behaviour. He was publicly shamed and it was reported that he had since ceased harassing women. Drama by adolescent girls about harassment by sugar daddies had the same effect. (ActionAid, Redd Barna, Kahcae, Aegy 1998) 'The teeth that are close together can bite the meat': a participatory review of Stepping Stones in two communities in Uganda. SSTAP, ActionAid. London, UK).

Men and women, young and old may respond differently to participatory work in SRH in context specific ways. It is essential to continually review and adapt the process as it goes along in order to find the most helpful approaches for all those involved.

Facilitation skills are play an essential role for safely and successfully using participatory processes in SRH. They take time and practice to acquire. Programmes should aim to design participatory processes that match the level of skill of the majority of facilitators in order not to undermine facilitators and put everyone at risk.

Opportunities for individual, couple or family counselling are crucial in SRH because many personal issues and feelings will not, rightly, be discussed in a group situation.

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