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# Introducing participatory methods to HIV prevention workers in the Southwest United States

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### ● Introduction

In recent years, the demographics of the HIV epidemic in the United States have changed. What was once a disease that largely affected white gay men now disproportionately affects the poor, people of colour, the young, and women. Sexually transmitted diseases have historically had most impact on these same populations. Because of this, and the fact that prevention efforts have often centred around knowledge-sharing alone, participatory learning and action (PLA) methodologies offer an opportunity to make HIV prevention a more innovative, effective, and collaborative effort.

The philosophy behind participatory research was presented in workshops for HIV prevention workers in Dallas, Texas and for health educators taking on HIV as a new issue in New Mexico and Arizona. The latter training occurred in the Pojoaque Pueblo in New Mexico. Many of the prevention workers who participated in the trainings were indigenous to the populations they work with. In both workshops, careful attention was paid to the collaborative nature of participatory research, and both began with Edstrom and Nowrojee's 'Steps of Unlearning'<sup>1</sup>. The workshops incorporated several activities, including mapping exercises, Chapati diagrams, causal flow diagrams and problem solving techniques.

### Mapping the body

Participants engaged in body mapping in both sites, illuminating several issues around the

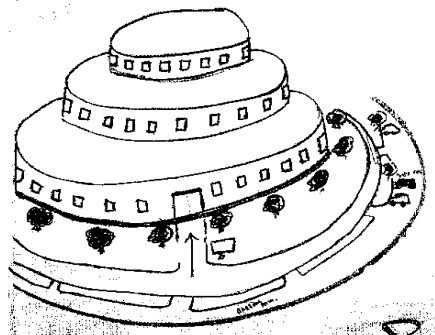
use of this method. In one site, when participants were asked to divide into gender-specific groups, one transgendered person, born biologically male but living as a female, did not know in which group she should participate. She was given the option to choose and chose to participate with the females, mapping the male body. This situation illustrates how important it is to consider transgendered/transsexual individuals when doing gender-specific exercises and groupings.

Participants in Dallas mapped erogenous zones; those in New Mexico mapped organs associated with the birth process and those affected by sexually transmitted diseases. For participants in both workshops, desire and sensuality came into play during the mapping exercise, expressed by both the female and male participants. The women mapped males with broad shoulders and chests and flat stomachs. Men mapped the 'ideal' woman with large breasts and lips, and (in one case) blonde hair. The exercise in one site was made interesting by the fact that the group of males mapping women was largely made up of gay men. The map of the female produced by this group replicated some of the same idealised female attributes as might usually be seen in an all-straight male group.

Following the body mapping activity, the women processed what they saw that the men had drawn and the men discussed what women had mapped, eliciting strong emotions on both sides that called for good mediation skills. The exercise illustrated the persistence of stereotypical body images, such as large breasts and penises, for example. The groups then discussed body image as a barrier, especially for females, in the prevention of transmission of Sexually Transmitted Diseases (STDs)/HIV and how this exercise could be

<sup>1</sup> Eldstrom, J. and Nowrojee, S.,(1997) *Visit to Sri Lanka: Report on a PRA workshop for sexual health needs assessment*, International HIV/AIDS Alliance, London, UK.

used to address this barrier directly. In New Mexico, participants saw how various health issues might be analysed through the use of body mapping, including cancer and 'appropriate and inappropriate touch' for children.



**Figure 1. Facilities mapping exercise: Pojoaque Pueblo, New Mexico, United States**

### Facilities mapping

Participants from both sites participated in 'facilities mapping,' a technique used in the workplace that is also known as 'hazards' and 'social' mapping. For this activity, in small groups, one individual acts as the 'describer' of a facility, such as a health clinic. Others in the group act as different types of 'mappers.' First, the general mapper sketches a general design of the facility as the describer dictates. After rooms, corridors and waiting areas are all drawn, the general mapper uses arrows to describe the usual 'flow' through the facility. The social mapper uses red and green stickers to identify where 'leaders' are (red dots) and where people gather (green dots). The final mapper uses a green marker to indicate 'safe' areas and a red marker to indicate 'hazardous' areas, however those terms are defined by the describer.

### Process dynamics

The describer being different from the mappers allowed the participants to understand what it's like to cede control and taught them to be specific in their instruction. For mappers, it encouraged listening skills. A note-taker in each group also described what s/he observed during the activity. Feedback from the two sites revolved around how the activity can illustrate barriers within

organisations and can identify the perceptions of both staff and clients of the agency in terms of what's the same, what's different etc.

At the Pojoaque training, a group of five individuals from various American Indian tribes pondered the exercise for a time before asking if they could map something they would like to see, rather than what already exists. They mapped a building where all services could be centralised, a building of three levels constructed as a round structure (see Figure 1). The round structure was important, according to the group's reporter, so that 'you won't get boxed into a corner.' The significance and preference of the shape of the circle versus the square came up at various times during this training. The group also saw the centre of the second level as a place to carry out rituals, and then discussed the possibility of creating a jogging track on the bottom around the outside of the structure to encourage physical activity. Although I had thought of the activity as a way to describe what already exists, the creativity expressed by this group also raised the issue of using mapping potentially to describe 'desire': what can be as well as what is.

### • Lessons learnt

These two trainings illustrated that participatory research holds promise as an innovative way to elicit information and develop and evaluate programmes, especially in the health field. In the Dallas workshop, a caution emerged in that fascination with PRA tools may result in superficial use of them without true collaboration with affected communities. Some participants wanted to use the visual techniques as interventions alone. Given those cautions, my initial experience with training on participatory methods for HIV prevention and other health workers gives some hope that this community collaboration can occur. Strategies to continue to inform and motivate front-line health workers are necessary if the approach is to take root.

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