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COMMUNITY MOBILISATION SUPPLEMENTARY ISSUE

Obstacles to local-level AIDS competence in rural Zimbabwe: putting HIV prevention in context

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We explore the wider social context of an HIV-prevention programme in rural Zimbabwe. We make no comment on the programme itself, rather seeking to examine the wider community dynamics into which it was inserted, to highlight how pre-existing social dynamics may have influenced community “readiness” to derive optimal benefit from the intervention. Using the concept of “the AIDS competent community”, we analysed 44 interviews and 11 focus groups with local people. Despite high levels of HIV/AIDS-related knowledge, there were several ways gender, poverty and low literacy may have undermined its perceived relevance to peoples’ lives. Lack of opportunities for dialogue in the social milieu beyond the intervention may have limited opportunities for translating factual AIDS knowledge into action plans, or sharing hidden individual experiences of HIV/AIDS-affected family members or friends, given stigma and denial. The initiative of women and young people to respond effectively to AIDS was limited in a context dominated by adult males. People spoke of HIV/AIDS in a passive and fatalistic way, expecting outsiders to solve the problem. This tendency was exacerbated given the community’s previous experiences of HIV/AIDS-related NGOs, which had often regarded local people as unpaid volunteer labour rather than building their capacity to make significant decisions and play leadership roles in health programmes. Despite obstacles, however, there were many potential community strengths and resources. There were high levels of HIV/AIDS-related knowledge. Public denial of HIV/AIDS masked huge reservoirs of private support and kindness to AIDS-affected family and friends. There were many strong community organisations and clubs, potentially forming the springboard for more empowered community responses to HIV/AIDS. HIV/AIDS programmers should pay greater attention to community readiness for interventions, especially around: (1) identifying and anticipating pre-existing obstacles to programme success and (2) mobilising the social assets that exist, even in contexts of poverty and gender inequality.

Keywords: AIDS-competent communities; health-enabling contexts; empowerment; HIV-prevention; Zimbabwe

Introduction

We seek to contribute to on-going debates about how pre-existing local community contexts may enable or hinder the success of HIV/AIDS management programmes. Using the concept of the “AIDS competent community”, we present a study of local community responses to HIV/AIDS in Kumahuswa, a rural Zimbabwean community which was one of several sites of an HIV-prevention programme. This was run by a partnership between two local NGOs and the ministry of health, using state-of-the-art community and clinic-based activities. After three years of combined community-based peer education, free condom distribution and improved clinic-based STI treatment and counselling services, there were no reductions in HIV-incidence or health-related risk behaviours in the target populations of six intervention communities, of which Kumahuswa was one,

compared to six matched control communities (Gregson et al., 2007).

Most health and social development programme evaluations focus on technical reasons for programme success or failure, especially the design and implementation of programmes e.g., the cultural relevance of programme messages, the efficiency and effectiveness of programme management, the extent to which communities are adequately consulted in programme design and so on. However, Pawson and Tilley (1997) argue that programme success depends as much on the wider community contexts into which programmes are inserted, as on the technical details of the programmes themselves. This insight is summarised in their formula “programme + context = outcome”. Against this background, we make no comment on the HIV-prevention programme in Kumahuswa itself, rather seeking to raise questions about how the wider

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pre-existing social context might have framed the conditions in which the intervention was implemented.

Campbell, Nair, and Maimane (2007) and Campbell, Nair, Maimane, and Sibiyi (2008), characterise an HIV/AIDS-competent community as a context in which local people work together to contribute to the challenges of promoting behaviour change, stigma reduction, the support of AIDS patients and carers, and the appropriate accessing and optimal use of existing sources of health and welfare support.

They characterise such a community by six features. The first is access to HIV/AIDS-related information. Secondly, the existence of social spaces for critical dialogue where people feel confident, willing and able to freely engage in debate about obstacles to health-enhancing behaviour change, as the first step towards developing collective action plans to tackle these (Freire, 1970, 1973; Vaughan, in press). At this stage of the epidemic, even in remote rural areas, people often have the information they need about HIV/AIDS. However, it is frequently presented in ways they cannot translate into action plans in their own lives. What people are often lacking is not information but safe and trusting social spaces where they can collectively negotiate ways of making unfamiliar health-related information relevant to their own specific lives (Campbell, 2003; Epstein, 2007).

The third feature of AIDS competence is that community members have a sense of ownership of the HIV/AIDS problem and a sense of responsibility for contributing to its management. In conditions of denial and stigma, people may simply fail to acknowledge the existence of the problem. However, even when people do acknowledge it, they may respond passively, waiting for government or NGOs to solve it rather than acknowledging the role they too have to play (Barnett & Whiteside, 2006). Fourthly, community members should feel confident in their ability to contribute to tackling the problem. Fifthly, they should be able to identify ways they can make such a contribution, either individually or in groups. Even small-seeming contributions may have powerful effects on creating a supportive community context – prayers for the sick, greeting a person living with HIV/AIDS politely in the street, assisting an affected family with housework and so on.

The sixth property of an AIDS-competent community – particularly important – is the existence of bridges or partnerships between local communities and outside support agencies – be they in the public sector (e.g., health services), the private sector (e.g., employers) or civil society (e.g., national AIDS activist groups). Marginalised groupings seldom have the skills or resources to tackle devastating social problems without substantial support from

outside agencies with economic and/or political influence (Gillies, 1998).

We examine the extent to which these six features of AIDS competence were present in Kumahaswa in the interests of generating debate about pre-existing “community readiness” for interventions.

Research methods

Study site

Kumahaswa is a small rural town, with much movement in and out of the area. Unemployment is high, promoting high levels of sex work amongst women battling to survive economically. The difficult economic climate contributes to low morale amongst both adults and youth, and high levels of alcohol use/abuse. Kumahaswa has high levels of HIV/AIDS, and, as stated above, was the site of an HIV-prevention intervention which made no impact on the behaviour or sexual health of local residents compared to a matched control community.

Case study methodology

Our case study involved interviews with 44 individuals, 11 focus groups involving 55 people and fieldworker diaries. We interviewed a range of people living or working in Kumahaswa, focusing on those groupings whose views and actions might impact on the lives, health and sexuality of local people: teachers, AIDS volunteers, traditional leaders, local community organisations (e.g., women’s and youth groups), NGOs, school pupils, out-of-school youth, peer educators, traditional healers, clinic nurses, parents, people living with HIV/AIDS, church ministers and local government officials. Interviews were conducted by the first author, an experienced Shona-speaking social scientist familiar with local conditions and customs. She was introduced to informants through a “village guide”, a local resident who had a long association with the Kumahaswa HIV-prevention programme. Very few of those approached refused to participate. The programme had been highly regarded by local residents, who felt motivated to support associated research. An added incentive was the gift of a T-shirt or soap to research participants, much appreciated in conditions of poverty.

An open-ended topic guide elicited information about social dynamics which may have impacted on peoples’ receptiveness to the intervention’s goals: including informants’ experiences of local community life; their views of the causes of HIV/AIDS; its impact on the community; the role of different groups in HIV/AIDS management; and the potential of peer education,

grassroots participation and multi-stakeholder partnerships as HIV-prevention strategies.

Informants signed a consent form, and were promised confidentiality and anonymity. Interviews were audio-taped, translated into English and subjected to thematic content analysis (Flick, 1992) by the first two authors, working closely and engaging in extensive discussion of the material. The six dimensions of AIDS competence served as the core categories of our coding frame. These constitute the section headings in the presentation of our findings given below.

Findings and discussion: AIDS competence in Kumahuswa

Knowledge

Kumahuswa residents had sound basic knowledge about HIV/AIDS, including that HIV/AIDS is predominantly sexually transmitted, that it kills, that it can be avoided by ABC strategies (abstain, be faithful or condomise). However, various factors may have limited people in turning knowledge into action. The most obvious of these was poverty, which often appeared to undermine the psychological empowerment most likely to predispose people to exercise agency in changing well-established behavioural norms. People repeatedly referred to the negative impacts of poverty on mental health and confidence:

My neighbour beats her child whenever they run out of food. She displaces her emotions on to the child by beating her. (Woman living with HIV/AIDS, 22-years old)

People have no confidence anymore, when they are told there is work some won't even go, some don't believe it. Others have got used to a life without work. (Soccer club chair, man, 31)

Also potentially intervening between knowledge and action were the intertwined emotional, social and gender dynamics framing sexual experience and behaviour. Contrary to much HIV/AIDS prevention literature, which often presents women as willing to use condoms, but unable to insist in the face of male reluctance and power (Dunkle et al., 2004; Harrison, Xaba, & Kunene, 2001), our interviews highlighted a strong female resistance to condom use. Many women spoke of their unwillingness to use condoms due to their need for a sense of intimacy and trust with their partners, and because condoms reduced the pleasure of sex.

The third factor potentially intervening between technical AIDS-related knowledge and behaviour change was competing knowledge about HIV/AIDS, especially the view HIV/AIDS sufferers had been

“bewitched” by jealous others. This led many to conclude that HIV/AIDS was unavoidable by individual precautions. Technical knowledge often contradicted strongly held local myths, e.g., “If a man has a healthy five-year-old son, this means he is not HIV positive”.

Low levels of literacy may also have undermined the effectiveness of HIV/AIDS messages. The concept of “using information” to influence one’s behaviour seemed very foreign to many people. The concept of “having and applying knowledge” was not familiar to many with little or no formal education. The idea of separating the message from the medium was often also unfamiliar. People often said that peer education messages could not be believed, since most of the peer educators had died:

The ladies (sex workers) that were conducting peer education were the first to die. That is when we realised that peer education was not effective, because they were the first to die. (Women’s secretary for political party, 42)

In such a conservative community, the concept of behaviour change itself was often greeted with suspicion. People often expressed strong and negative views about change of any sort. Thus, for example, many informants spoke disapprovingly of young people who adopted western lifestyles and “forgot their own culture”. Such young people were variously referred to as “a shock”, “an irritation” or “a nuisance”. Others spoke disapprovingly of the way in which their behaviour served to dilute a valued African identity:

People from nowadays are wearing trousers, and these were never meant for women. As Africans let us dress as Africans, rather than copying western culture. (Methodist pastor, man, 32)

Many people appeared to have a strong gut-level resistance to change. Our case study gave the impression of a conservative semi-rural setting where innovation was often resisted:

Married people don't use condoms because they are not used to them. (Home-based club, elderly women, focus group)

I have never used condoms because I was not brought up knowing about them. (Garden cooperative, mixed focus group)

Social spaces for dialogue about HIV/AIDS

We have referred to the importance of social spaces where people can discuss HIV/AIDS information, debating doubts they might have about its relevance or accuracy, and collectively negotiating ways it

might be put into action in their own lives. Our study suggested that many (though certainly not all) community members had few opportunities to engage in frank discussion of HIV/AIDS with liked and trusted peers. Stigma and denial were high, as was the local tendency to refer to people with AIDS in veiled terms such as “a person who is dying” or “someone who suffers from the disease of nowadays”.

However, in our research setting, when given space to talk about HIV/AIDS to a sympathetic listener, interview participants took this opportunity and expressed great appreciation for it at the end of the interview. Despite the fact that the interviewer explicitly gave no information about HIV/AIDS at all during the interviews, many informants later thanked her for the opportunity to participate in the interview, saying they had learned a lot from participating. From the researchers’ perspective, rather than transmitting factual knowledge to interview participants, the interview setting had provided people with social spaces to talk about their doubts, uncertainties and experiences of HIV/AIDS in their own lives – a rare opportunity.

Thus, for example, a sex worker said she had “gained a lot of knowledge” from the interview, and that this had given her the confidence to think of going for voluntary counselling and testing (VCT) for HIV/AIDS. An Apostolic Minister began the interview by dissociating himself from HIV/AIDS, saying “it’s not necessary for somebody like me to talk about HIV/AIDS”. However, after the interview he said the experience had helped him realise it was important to discuss HIV/AIDS, and he asked the interviewer if she had any books on the topic to lend him. The soccer club coordinator (a young man) said:

In this interview I have learned a lot about AIDS that I was not aware of. I have also realised how many myths there are in the community, for example, how wrong we are to think we can’t catch HIV, just because we stay in a rural area.

Once again, this information had not been volunteered during the interview. Rather he had used the interview as a “social space” to start processing the various pieces of knowledge he had gained from various sources in his daily life, but never been able to apply to his own life through a lack of opportunity to process and discuss information in a safe and sympathetic context.

People repeatedly spoke of stigma as a key obstacle to effective HIV/AIDS management. Yet there was an interesting contradiction here. At the personal level most people appeared to have been kind and supportive to individuals with HIV/AIDS. Family members offered care, neighbours visited with

kindness and support. Church members prayed for the sick. Most people contributed to funeral expenses, a long-standing local custom. However, at the public level people went to great pains to publicise their disapproval of people living with AIDS:

I don’t want to lie to you, friends abandon their peers who get HIV. We had a friend who was dying, he used to be promiscuous, we used to laugh at him saying he was now “going to the man with the long beard”. (Apostolic church leader, male, 63)

Behind her back my mother’s friends laugh at her, saying they knew she’d come to this. (Carer of mother living with HIV/AIDS)

People with HIV are immoral and they are heathens, these people have been promiscuous, therefore it is only right and proper that the health clinics treat them badly. (Church elder, male, 55)

Acts of kindness were often committed in secret, behind the socially desirable mask of public anti-AIDS talk, or under the guise of helping “the sick” rather than naming AIDS as the issue. Interviews suggested there was no context in which individual acts of caring or assistance could add up to a more powerful collective response, given their highly secretive and individual nature.

Many people may have lacked opportunities for the type of “critical dialogue” that Freire (1970, 1973) says is so important for positive individual and social change.

People should be forced to listen to HIV/AIDS education. Because it is to their advantage. (Soccer club leader, male, 31)

Chiefs and nurses must give people instructions, education must come from people we look up to, who should stipulate strict regulations. (Female caregiver to PLWHA, 19)

Peoples’ references to AIDS education were often couched in the genre of instruction, with the targets of information being conceptualised as passive listeners rather than active interactants.

Appreciation of local strengths and resources

The likelihood of people contributing to HIV/AIDS management depends strongly on them believing they have strengths and resources to equip them to do so (Campbell, Foulis, Maimane, & Sibiya, 2005). Our case study suggested that the greatest AIDS resource in the community was women’s unpaid – and largely unrecognised – work in giving emotional and practical support to PLWHA. Yet women repeatedly said

that they were not respected, consulted or represented in local community affairs:

Men are regarded as the leaders. Us women's ideas are disregarded, even when they are brilliant. (Home-based care leader, woman, 52)

When women did exercise leadership it tended to be in gender-specific spheres of activity, such as women's church groups and in the women's section of the leading political party.

Men were generally not spoken of as a great community resource:

Men just loiter around the place, they don't do a thing that is beneficial. They just come home without even carrying a parcel. They are the stresses in our lives. (Leader of women's savings club)

Young people also tended to be discounted as a positive community resource, often described as "lazy" and "incompetent". In turn, young people said adult domination stifled any attempts they made to show initiative:

We can't do anything because we don't have the resources and we always have to appoint older people to lead us because we are regarded as minors. This has demoralised a lot of young people. (Political youth group, focus group)

We approached our councillor to help us raise some funds for a soccer ball. He said he would look into it, but nothing happened. We couldn't go back and ask again, because that would have seemed disrespectful. (Soccer club leader, man, 31)

Ownership of the problem of HIV/AIDS

To what extent do Kumahuswa residents think they have a role in addressing HIV/AIDS? To what extent do they have ideas for actions they might take as individuals, in groups, or through building links with outsiders? Many of our informants had little sense of ownership of the problem, with repeated reference to the need for outsiders to come and address it:

Come and educate children about their sexual rights, we have too many cases of child abuse. (Garden cooperative, mixed focus group)

People take it as stigma if you use gloves while you are nursing them, please come back and educate them. (Village health worker, woman, 39)

You people from AIDS organisations should come here and talk to our children. Perhaps if you talk to them they will be scared of AIDS. (Bee-keeping collective, mixed focus group)

I suggest you call a workshop for men to talk to them about what we are saying, perhaps if you talk to them, they will realise the importance of condom use. (Women's savings club, focus group)

We are stressed. These are the problems we encounter, can you please help us? We don't know what to do. (Women's church group, focus group)

There were many local organisations and clubs in Kumahuswa. These included a soccer club, a savings club, a traditional dance group, a garden cooperative, a political youth club, an Apostolic women's group, a bee-keeping society and a burial society. There was also a government sponsored Ward AIDS Action Committee (WAAC) dispensing government funding for local AIDS activities, and a home-based care club.

The WAAC focused on providing food parcels and school fees for AIDS orphans. People repeatedly stressed the importance of this assistance. However, given the scale of the problem, there would always be a need for further resources. In relation to our interest in AIDS competence, this qualified as welfare work rather than social development ("providing fish rather than fishing rods").

Generally people were positive about the benefits of groups. For example, interviewees repeatedly said "soccer keeps young people out of trouble", and that soccer club members were less likely to be HIV-positive than non-members. People talked about the help and comfort they derived from the church, the way it instilled empowering moral discipline in women, and the way in which church members visited the sick. People also spoke about the burial society as a beneficial support group, paying for members' funerals and also giving them loans whilst they were alive. The bee-keeping club was also seen as very effective – with members having been trained by an NGO, and now using these skills to generate income through selling honey. Moser (1998) reminds us that even resource-poor communities have "portfolio's of non-material assets". In Kumahuswa, a number of positive community networks served as key social resources providing various forms of emotional, practical and material support to members. However, factors such as stigma and lack of AIDS-related agency may often have stood in the way of these networks serving as AIDS-specific resources.

Bridging social capital

This final component of AIDS competence relates to empowering links with outside organisations capable of helping local people to respond more effectively to HIV/AIDS. The wider context of our research is an

interest in how best to facilitate local responses to AIDS, and in understanding how “interventions by outside professionals” may sometimes unintentionally undermine local coping mechanisms, and reduce the development of effective grassroots AIDS leadership.

As mentioned, our informants often emphasised information and instruction as the solution to HIV/AIDS. Many viewed AIDS as the responsibility of outside agencies, with little sense that local people might also have a contribution to make to HIV/AIDS management. This representation of AIDS management as centred around instructions and outsiders is directly contradictory to best practice. Our interviews suggested that earlier well-intentioned HIV-prevention and AIDS-care efforts (prior to our HIV-prevention programme of interest) may sometimes have had less than optimal success in promoting local ownership and leadership of prevention and care programmes. Informants referred to previous interventions that seemed to have focused more on enrolling community members to deliver unpaid services to programmes, than building their capacity to make a significant contribution to programme design, leadership or management.

We illustrate this point with a discussion of a long-standing local home-based care club (not linked to our intervention of interest), chaired by Mrs K, an energetic middle-aged woman with a deep calling to serve her community. She said she had been nominated by a local councillor to liaise with an internationally funded NGO around home-based care delivery. The NGO trained Mrs K and six other women (all volunteers) in home nursing skills and initially provided food parcels and blankets for distribution to AIDS-affected families. They met fortnightly to timetable their work and encourage each other to continue this gruelling work.

At the time of our interviews, Mrs K and her club peers were still working hard in delivering home nursing assistance – but she no longer had any contact with the NGO. In the course of a long interview it became clear that although group members worked with dedication and commitment, they knew nothing about the context of the work, the nature of the NGO or the origin of the blankets, and had certainly never been consulted about any aspect of it:

They no longer bring the blankets and the food parcels. I am not sure why...I am not sure who initiated this group...Our club members don't network with anyone else besides each other... We have run out of gloves and need a refresher course... I am not sure of the future plans of this group because I am not part of the management. (Home-based club chair, woman, 52)

There is a growing critique of programmes which interpret “community participation” as the use of local community members to deliver unpaid welfare services according to an externally imposed agenda, without involving participants in wider decisions about project design and management (or at the very least making sure that they are well-informed about such matters) (Campbell, 2003). In so doing, they may miss vital opportunities to build grassroots capacity in project design, management and decision-making, which could constitute vital capacity if/when the NGO withdrew from the community.

Conclusion

We have reported on the wider context into which an HIV-prevention programme was inserted in a rural Zimbabwean community. We have not sought to make any comment on the intervention itself. Rather we have sought to cast our net more widely to examine broader social dynamics, in the interests of advancing debate about ways in which pre-existing local dynamics may serve to facilitate or hinder programme efforts in particular settings. The key aim of HIV-prevention programmes is to bring about sexual behaviour change: increased condom use, delayed sexual debut, fewer sexual partners and so on. However, social psychologists have repeatedly pointed out that the likelihood of behaviour change is influenced not only by the information transmitted by health promotion programmes and the techniques that they use, but also by pre-existing levels of perceived self-efficacy – confidence in one's ability to change one's behaviour – amongst members of programme's target groupings (Bandura, 1995). This insight is echoed in the concept of “empowerment” which forms the cornerstone of community psychology (Nelson & Prilleltensky, 2005; Wallerstein, 1992) and social development (Parpart, Rai, & Staudt, 2002).

We have used the concept of AIDS competence as a framework for highlighting factors which might have undermined the sense of HIV/AIDS-related empowerment in Kumahuswa. People had relatively high levels of HIV/AIDS-related knowledge, but gender, poverty and low levels of literacy might have undermined the perceived relevance of this knowledge to their own lives. Lack of opportunities for dialogue in the social milieu beyond the intervention may have meant people had few opportunities for translating factual knowledge into action plans, or for sharing their hidden individual experiences of HIV/AIDS-related family members or friends in order to feed these individual experiences into a wider

social acknowledgement of the extent of the problem in Kumahuswa. The initiative and energy of women and young people, potentially a vital resource for an effective community response to AIDS were hindered by the dominance of adult males. Many people responded to HIV/AIDS in a passive and fatalistic way, waiting for outsiders to tackle the problem. This passivity may have been exacerbated by earlier experiences of HIV/AIDS-related NGOs, who may have used local people to deliver unpaid community services without building their capacity to lead more effective community responses to AIDS and indeed other future health threats.

However, in many respects our snapshot of Kumahuswa social relations was not an overwhelmingly bleak one. There were many potential strengths and resources in the community: people did have high levels of HIV/AIDS-related knowledge, despite the existence of potential obstacles to actioning this. Beneath high levels of public denial of HIV/AIDS, there were huge reservoirs of support and kindness towards AIDS-affected friends and family members, albeit often offered clandestinely in conditions of stigma. The community included many well-networked community groups, with many local clubs and organisations that might have formed the springboard for a more empowered and positive attitude to HIV/AIDS.

In preparing to implement programmes, there is an urgent need for HIV/AIDS programmers to develop understandings of the way in which the pre-existing social dynamics of their target communities might facilitate or hinder their efforts. Much remains to be learned about how potential obstacles can be identified and anticipated by interventions, and we believe the concept of “the AIDS competent community” provides a useful conceptual tool for guiding such investigations. Much also remains to be learned about identifying and mobilising the social assets that exist, even in conditions of great poverty and gender inequality. To date the efforts of many programmes have focused on technical details of programme design, implementation/management and evaluation. There is an urgent need to cast the spotlight more broadly to look at wider dimensions of pre-existing AIDS competence in target communities, in the interests of planning how best to optimise “community readiness” to derive optimal benefit from interventions in highly marginalised settings.

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