

Chapter 5

The community-health services interface: the critical issue for AIDS prevention*

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Abstract

Drawing on results from a number of studies exploring the community and health-services response to the AIDS epidemic in Eastern Africa, this chapter discusses the role of different providers of health care: traditional healers and private and public professionals. More than half of all visits to health care providers (pharmacies excluded) for STD seem to occur outside the public services. The studies cited indicate that different approaches may be appropriate to enable different groups of providers of care to promote sexual health through behavioural change.

What actually makes community members, individually or as groups, take actions and adopt safer sexual practices to prevent sexually transmitted diseases including AIDS? This chapter discusses the role of different health service providers. Examples are drawn from a research project, supported by the Swedish Government through SIDA/SAREC and conducted as a collaborative effort between Zambian, Kenyan and Swedish institutions, as indicated in the papers cited below. Our work deals with research for community capacity building and the focus has been on the interaction between the community and health service providers. It focuses on behavioural change and prevention of HIV transmission by improved control of conventional STDs. It is well recognized that safe sexual behaviour is probably the best available method for individuals to protect themselves against contracting STDs, AIDS included. The effect of activities to promote 'safer sex' is hard to assess, but certainly such activities have so far saved more lives than medically-oriented preventive or curative interventions. An increased knowledge about people's perceptions of sex, and dialogue within the society on matters of sexuality, facilitate openness and understanding of how people could protect themselves.

The studies cited here have mainly been addressed from the perspective of prevention of 'conventional' STDs, known to facilitate the transmission of HIV (Cohen 1998), including strategies to improve the quality of STD care. As stated by D'Cruz-Grote (1996), STD programs will have little chance of success in prevention of HIV/AIDS unless '...service provision is reoriented to meet the long-term sexual needs of men and women'. This is particularly true in the case of young people (Hitchcock and Fransen 1999).

This chapter presents selected observations on perceptions by the community, particularly clients and providers of care, regarding prevention of STDs, including HIV. It

* This chapter is based on collaborative research involving researchers (see reference list) from Institute of Economic and Social Research (former IAS), University of Zambia; Department of Community Health, University of Nairobi; Kenya Medical Research Institute, Nairobi; Department of Anthropology and Sociology, University of Hull; and IHCAR, Karolinska Institutet, Stockholm.

highlights methods to enhance community response for the prevention of HIV transmission, particularly through behaviour change and improved quality of care of conventional STDs. The studies were conducted in a rural district about 100 kilometres north of Nairobi, Kenya; in a rural area in the south of Zambia; and in a suburban setting of Lusaka city, Zambia.

Our explorative studies indicate that private practitioners and different kinds of traditional healers constitute a major part of the providers of STD care in Kenya (Ahlberg *et al.* 1997) and Zambia (Ndubani 1997; Faxelid *et al.* 1998), which also has been reported by others (Msiska *et al.* 1997; Webb 1997). Ndulo *et al.* (n.d.) found evidence from focus-group discussions, including in all 101 persons, that the most popular practice was to combine traditional and modern treatment, in the belief that the combination is essential for 'cleansing' the body (Ndulo *et al.* n.d.). However, about half of the interviewed traditional healers participating in a complementary study claimed that treatments should not be combined (Ndulo *et al.* n.d.). The researchers in these studies have thus become increasingly oriented to exploring, understanding and possibly influencing the activities of providers in both the formal and the informal sectors.

From awareness to behavioural change: witchcraft

In the early stages of the AIDS epidemics in Africa great efforts were made to make people aware of AIDS and its transmission. Reports have been published indicating that a high level of awareness had been achieved. However, there is little evidence that awareness in the sense of 'knowing what AIDS is' has much effect on behaviour. A deeper understanding of the disease and possibly also occurrence of the disease in the family or neighbourhood may be necessary prerequisites for behaviour change.

During the baseline survey in 1991 in Chiawa, the rural area in southern Zambia, it became clear that people in general were 'aware' of the AIDS disease. It was reported that 225 deaths had occurred in the 613 households enrolled during the preceding two years. Malaria and diarrhoeal disease were recorded as the two most common causes of death, constituting about 20 per cent each. Bewitchment took a third place (13 %). In spite of awareness AIDS was mentioned as the cause of death in only three per cent of cases. People seemed to believe that AIDS cases were caused by witchcraft (Bond and Wallman 1993).

It also became clear that there was a potential for response to the new disease (AIDS) from the community, but there was little understanding of possible protective measures. One way of responding was to turn to traditional beliefs and witchcraft. The community mobilization for getting rid of the evil that had struck the area also involved engaging a witchfinder. One of the research group members followed the activities of the witchfinder, who was, without much success, opposed by the local authorities. His methods seemingly led to the death of 15 people who were apparently poisoned during the witchfinder's efforts to find the source for the bad things occurring in the community (Yamba 1997).

Behaviour of the young people and the community

Entering the community in Muranga District, Kenya, the research group aimed to understand the meaning of sexuality and create a dialogue as a prerequisite to changing sexual behaviour. Through an analytical, interactive process it became clear that although young people were familiar with symptoms of STDs they had little knowledge of contraception, the function of their bodies and the nature of STDs or HIV. From a medical perspective, they generally exposed a great deal of wrong information and myths in relation to STDs and HIV. Questions raised by the youth revealed their curiosity about sexual relationships and also indicated a high level of sexual activity. They also illustrated the meaning the adolescents attach to sexual

activity. On the other hand, interviews with community members revealed a silence about adolescent sexuality. Different techniques were used to facilitate discussions among young people on matters of sex.

The feedback to different groups and networks, including school teachers, health staff and adult community members, was found to be an important component of the intervention. During analysis of the research observations it was found that local cultures might offer impetus for change, although different officials often see culture as an obstacle to change. It was concluded that culture could be problematic only when solutions to problems are formulated and introduced from outside and from assumptions and knowledge generated from experiences outside the local context (Ahlberg *et al.* 1997). Obviously, the health staff often shares some of these community attitudes, which should be recognized in planning for improving health promotion work directed to youth.

Traditional healers

Studies involving traditional healers, herbalists as well as diviners, in the rural site in Zambia made clear the central role of these providers of care for treatment of conventional STDs. Some reasons for consulting traditional healers were, according to community members, the lack of privacy, poor quality of care and poor attitudes of the health staff in public settings. Apparently, privacy, good care and good attitudes could be offered by the traditional healers and it was, as mentioned above, also felt that there were advantages in combining different kinds of treatment (Ndulo *et al.* n.d.). Focus-group discussions with traditional healers indicated a fairly high interest in preventive measures. All of 23 interviewed traditional healers, working in a defined geographical area, claimed that they gave health education during the client encounters. Twenty of the 23 said that they advised the clients to stick to one partner and five gave advice on condom use. Most of them mentioned the radio as their main source of information and many requested more information on prevention such as use of condoms from the health authorities (Ndubani and Höjer 1999). In a study addressing care for urethral and vaginal discharge it was found that about half of the traditional healers gave the women advice on how to avoid re-infection. Three kinds of advice were given in these cases: to use herbal medicine, to stick to one partner and to use condoms (Ndulo, Faxelid and Krantz n.d.).

Private practitioners

Our fieldwork has also highlighted the role of private practitioners. From a client perspective these seem to offer advantages in quality of care. In comparison to public services there is a higher degree of privacy, and drugs or other remedies recommended are usually provided or can be obtained from the local market. Besides, private practitioners in Kenya were found to be involved in very important traditional rituals like male circumcision. Among 1531 clients observed at the private practitioners' clinics more than half were under 25 years of age and a majority were women (Krantz *et al.* n.d.). Groups of private practitioners expressed an interest in closer co-operation with people with a higher degree of technical competence in order to get an opportunity to improve their own services.

Public health care

Drawing on findings from studies in rural and suburban areas in Zambia we found that community members perceived quality of public care to be particularly characterized by availability of proper drugs, treatment with respect, treatment in privacy and by a person of

the same sex and, finally, treatment without much delay. Very few of these qualities were, according to the clients, to be found at the clinics. In focus-group discussions comments were made on the absence of health education. Several participants emphasized that they were usually not given information on their disease.

Interactive video sessions were used where community members were asked to illustrate a 'real' and an 'ideal' encounter at the local health clinic. The video was afterwards discussed in the groups and some parts were, with the permission of the participants, displayed and discussed with the local health staff. One of the messages that came out clearly was the feeling of lack of communication on the causes of the health problems and lack of information on prevention (Freudenthal and Faxelid n.d.). In a survey in 1993 in health centres in central Zambia most clients were not given appropriate information and health education. In 59 cases where STD treatment was observed by a research assistant, 33 per cent of the providers gave information on transmission routes, 16 per cent gave information on protection against infection and 10 per cent about risk of contracting AIDS. The proportions were slightly higher for staff who had got special training in STD management (Hansson *et al.* 1997).

Conclusions

In different groups of the communities within this project there is an awareness of the risk of STDs and there is a preparedness for activities. However, the knowledge on how to initiate this process is limited. Our studies indicate that interventions for behavioural change have to be developed through an interactive process, based on an understanding of the local context. This should create the basis for evidence-based interventions offered to the society and involving different kinds of public and private services, including health staff. Ways should be sought to open up a dialogue between the older and young members of the community in sensitive matters like sex. Traditions may, in such a dialogue, turn out to be more important than usually thought.

Important components in such a process are the understanding and use of local vocabulary related to sexual and reproductive health (Bond and Ndubani 1997). Different kinds of interactive methods could be used, one example being video tape recording and display. Another important component is the feedback of local research findings, for example on the development of HIV epidemics, in the intervention area.

Since the advent of the AIDS threat a gradual process has developed, consecutively leading to embedding new or modified concepts of sexual behaviour in the local culture. Health professionals do participate in this development and this chapter aspires to give some background to a discussion on how they could be involved in promotion of behavioural change. The public health care providers seem to offer a quality of STD care, which is, from a client perspective, below what is acceptable. This affects the trust the clients have in the care providers and the health promotion messages they may convey. The private practitioners seem to be well regarded by the clients, and they express willingness to be involved in training activities, workshops etc. in the community. However, their management of diseases is very much oriented to prescription of drugs, which may make them less aware of the need for behaviour change. Traditional healers, finally, do give advice to their clients and generally express an interest in getting more information on how to promote healthy sexual behaviour. The three groups of providers included in the studies hence highlight different kinds of obstacles to behaviour change. There is a need to elaborate strategies, relevant in the local and cultural context, to enable different kinds of health service providers to contribute to health promotion through behaviour change.

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