

Community Conversation as a catalyst for stigma reduction and behaviour change

Lessons learned from a CARE project in Ethiopia

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CC group from East Haraghie, Ethiopia

Photo: Nancy Russell, CARE 2008

Community Conversation (CC) is an interactive process which brings people together and engages communities to discuss and explore the underlying causes fuelling the HIV and AIDS epidemics in their environment. Hence, people will discover e.g. unequal power relations, harmful traditional practices or girls' vulnerability as drivers and maintainers of the epidemic. CC is explicitly based on the recognition that people have capacities, knowledge and resources to transform individually and collectively once they perceive ownership of a problem. The CC approach lays a unique ground which is participatory. It creates space for listening, speaking, being, inclusion and agreement. The aim is to deepen a community's understanding of the pandemic, facilitate decision making and taking action in the local context.

Community Conversation was initiated in Ethiopia in 2002 by the National HIV/AIDS Prevention and Control Office (NHAPCO) and in a first phase rolled out by NGOs with UNDP financial assistance targeting HIV prevention. The original set-up encompasses eighteen discussion sessions of 50-70 people living in one Peasant Association (PA)¹ who commit to follow the cycle, which is completed over one year. CARE International in Ethiopia's HIWOT (Health Improvement and Women Owned Transformation) programme adopted the approach. It initiated 105 CC groups in fourteen districts in four zones (5-7 districts), one per selected PA, on issues related to HIV and sexual and reproductive health (SRH) between 2006 and 2007. NHAPCO provided training materials, led the facilitator's training and participated in supervision.

Facilitators with leadership competencies were identified after volunteering for this activity. They were trained for two weeks prior to setting up their group. Three facilitators were trained per CC group and equipped with background information and skills to foster

group dynamic processes. Literacy status was considered as a major selection criterion for CC facilitators, however, flexibility was allowed in pastoralist areas where literacy levels are generally low. At the beginning of each session one person was chosen to document the process while others facilitate the discussion and ensure adherence to ground rules. Supervision was provided as peer support by sharing challenges and lessons learnt at quarterly review meetings of CC facilitators at district health head offices.

Ideally participants of a CC discussion group are representative of different segments of the community. They include diverse community members: farmers, civil servants, shopkeepers, craftsmen, religious and informal leaders, PA administrators, men, women, adolescents, etc. Participation in these groups is voluntary. The participants are self-selected and motivated by an interest in HIV/AIDS issues. Most of the 105 groups fulfilled the criteria of representing all segments of the community, however, a slight gender imbalance was present in all four zones.

Changes in risk behaviours and stigmatization

There are a number of documented success stories of CC in many parts of Ethiopia since 2002. Our experience is the first of its kind in adopting CC on integrated HIV/SRH issues including harmful traditional practices and family planning. After 12 months of implementation, we witnessed changes in risky behaviours and stigmatization in remote rural areas where HIWOT is working:

- Some CC groups have condemned early marriages in their communities and are committed to protecting school girls from discontinuing their education due to forced marriage. Forced and early marriages are associated with severe health problems such as HIV transmission, complications during pregnancy and childbirth, and maternal mortality.
- Other CC participants decided to stop Female Genital Cutting (FGC) in their PA or penalize traditional circumcisers (frequently

Lessons learned

- Community Conversation is a powerful tool to reduce risk behaviour towards HIV embedded in a community's local context and promote HIV prevention and stigma reduction. It is highly flexible but dependent on the facilitators' skills to foster instead of dominate a group.
- Identifying, training and follow-up of skilled facilitators is critical for successful implementation of CC. The facilitators must be guided by a value system that includes sensitivity to local community experiences, gender sensitivity, respect, commitment to reduction of vulnerabilities, improvement of sexual and reproductive health and upholding human rights.
- When communities are fostered to express and understand their own problems and concerns, and can explore their values and issues in their own language, they may come up with decisions driven by values that they appreciate, but may contradict globally accepted values and ethics promoted by human rights activists and donors.

traditional birth attendants) who do not use new razor blades for each girl they circumcise. In some places, participants discussed harmful traditional practices apart from HIV/AIDS (e.g., milk teeth extraction), and passed by-laws to stop FGC in their locality. They charged village leaders with the responsibility to follow-up adherence to the new rules and report to the CC members and a legal body if anyone in the community is found practicing FGC.

- CC participants in some PAs reached a consensus to avoid practicing risky behaviours that predispose to HIV infection, such as going to night clubs and drinking alcohol, which is very common in the target community, as well as practices like widow inheritance.
- The sessions have helped reduce stigma and discrimination towards people living with HIV (PLWH). In first sessions after CC group inception participants shared negative attitudes regarding PLWH, but through discussion they changed their mind and concluded that 'all of us are at risk of acquiring HIV for one reason or another'.

Some CC groups started providing care and support to PLWH and their families by contributing money monthly. Thus, affected families were encouraged to disclose their health and social problems as a positive HIV status was the entry point to receive support and linkages with available associations. Other groups transformed into Anti-AIDS clubs, doing advocacy and fighting misconceptions. Some are giving social support to PLWH. All CC groups in different sites agreed on the importance of utilizing Voluntary Counselling and Testing (VCT) services and knowing one's HIV status and most members underwent VCT. For example in West Harerge district 2916 CC members and their spouses underwent VCT during the project period. Those who tested positive (13 female and 5 male participants) were referred to health facilities.

Dealing with unexpected results

CC is well accepted and regular dialogue has been held in all target districts. Although in many sites the sessions based on the modules have been completed, some CC groups continue to meet regularly and identify topics important to their community. For instance, one-third of the 24 groups in East Harerge district have organized themselves into social support groups. They save money to invest in income-generating activities and support orphans and vulnerable children in their locality. Actions taken were beyond expectations in many sites and HIWOT had to adapt activities to meet the demand. Demand for VCT services increased due to the discussions and the flexible HIWOT programme embarked on facilitating VCT outreach services provided by health-centre staffs.

An intrinsic outcome of CC is empowerment of communities and individuals to identify and address issues that are important to them. The majority of CC groups identified HIV transmission occurring more frequently in newly married couples and decided to make VCT mandatory for both partners before marriage. Decisions to undergo VCT as a CC group or mandatory VCT before marriage were unexpected results of the CCs, for which the supervisors and the HIWOT team were not sufficiently prepared. This aspect was not originally reflected by the staff and midterm evaluation feedback from the consultant (and simultaneously from this magazine's editor) led to a vivid discussion among HIWOT staff on human rights approaches in regard to social pressure for VCT. HIWOT presented these findings to the team leader of the CC programme at NHAPCO and hence initiated a fruitful but uncompleted discussion on the challenges of the aspect of 'voluntary counselling' in the VCT from an African Human Rights context.

There is a dilemma here. When communities are fostered to express and understand their own problems and concerns, and can explore their values and issues in their own language, in their own words (not driven by donor/project-imposed target accomplishments), they may come up with decisions driven by values that they appreciate, but may contradict globally accepted values and ethics promoted by human rights activists and donors.



CC group members discussing HIV in their community

Photo: Nancy Russell, CARE 2008

Challenges for the future

The midterm review revealed weaknesses and strengths of the CC concept as developed and franchised by NHAPCO and implemented by HIWOT. The consultant stressed the need for better assessment of impact and follow-up of community actions agreed upon by the CC groups. However, CC implementation has no budget to support these actions. Currently, HIWOT's financial contribution to CC sessions is limited to refreshments. The trainers' curriculum doesn't address community actions and possible discrimination and human rights violations if communities exert social pressure to change risk behaviours or to undergo HIV testing. Since November 2007, HIWOT staff includes one of the National Trainers (trained to teach the CC curriculum to facilitators). This allows a faster exchange of challenges with the NHAPCO CC programme coordinator. Also, HIWOT is using advocacy to address community actions and prepare the facilitators on how to handle these topics if they come up for the next round of CC groups planned by NHAPCO.

Other challenges identified were:

- *Representation* – This arises from ensuring that all community groups including the marginalized, disabled etc. are represented and there is no gender bias as participation is voluntarily. Leaders had only influence on the group composition at the inception stage according to their list of criteria when community members subscribed to participate according to their interest. However, there was no evaluation on the bias of leaders and concept to assess the composition according to the criteria, as the activity is based on voluntarism and self-selection is leading to overrepresentation of active community members.
- *Facilitation* – Identifying, training and follow-up of skilled facilitators is critical for successful implementation of CC. The facilitators must be guided by a value system that includes sensitivity to local community experiences, gender sensitivity, respect, commitment to reduction of vulnerabilities, improvement of sexual and reproductive health and upholding human rights. However, the context of Ethiopia with high illiteracy in rural communities poses a special challenge in ensuring high performance of these facilitators as they are supposed to work on a minimal incentive base while they are supposed to have several skills (literacy, report writing, being non-judgmental towards HIV and AIDS etc). Successful CC requires close follow-up of facilitators through supervision or review meetings. Joint supervision was to be provided by NHAPCO, district health officers and HIWOT staff but only in one out of four districts this really took place according to the guidelines as NHAPCO staff were involved in other activities.
- *Monitoring & Evaluation* – Although the activity was popular, neither the curriculum nor HIWOT had an indicator framework to measure impact, inclusion, trust, etc. The midterm evaluation stated: *“It is true that there were extensive positive statements about these groups, but there is no consistent method of assessing statements that are made in terms of whether practices have changed generally, or whether they changed only for particular individuals – something which in any event could*

be predicted in the absence of any intervention.” Before embarking on a new phase such a framework needs to be developed.

Conclusion

Community Conversation is a powerful tool to reduce risk behaviour towards HIV embedded in a community's local context and promote HIV prevention and stigma reduction. It is highly flexible but dependent on the facilitators' skills to foster instead of dominate a group.

The group dynamic processes empower communities and their members to revise values and cultural practices and give them ownership of their problems. Knowledge gain is accompanied by overcoming misconceptions. Jointly, the community can decide to be more inclusive, i.e. provide a supportive environment for PLWH and other marginalized groups. The approach is equally important to identify and solve other problems in the community. Although the presented experience has been focused on the HIV/AIDS context; the new government modules under development follow the HIWOT implementation and also address SRH and human rights issues. NHAPCO has secured funding to implement a second round of CC groups countrywide with an extended curriculum for 24 sessions planned to start in spring 2008. The criteria where to introduce these groups includes a risk approach, hence the priority will be given to higher transmission areas – the urban centres. In the capital city of Addis Ababa alone, 198 groups will be established. ■

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1. A Peasant Association is the smallest administrative unit in Ethiopia with an average population of 5,000.