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POSITIONING RESEARCH TO SUPPORT COMMUNITY EFFORT TO REVERSE HIV/AIDS AMONG YOUTH IN MARAGWA AND KIRINYAGA DISTRICTS – KENYA

Presented by

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ABBREVIATIONS

ACK	Anglican Church of Kenya
ACP	AIDS Control Programme
AIC	AIDS Information Centre
CAC	Constituency AIDS Committee
CBOs	Community Based Organisations
CCS	Christian Community Services
CDA	Community Development Assistant
D.O	District Officer
DDO	District development Officer
DAC	Divisional AIDS Committee
DEO	District Education Officer
DHS	Demographic and Health Survey
FPPS	Family Programmes Promotion Services
GOK	Government of Kenya
IEC	Information Education Communication
IGAs	Income Generating Activities
KAP	Knowledge Attitude Practice
KADET	Kenya Agency for Development of Enterprise and Technology
Loc	Location
MoH	Ministry of Health
M.P	Member of Parliament
NGO	Non-governmental Organisation
NASCOP	National AIDS Control Programme
PETG	Participatory Education Theatre Group
PHT	Public Health Technician
SAREC	Swedish Agency for Research Cooperation
SHR	Sexual and Reproductive Health
SIDA	Swedish International Development Agency
SOMA-Net	Social Science and Medicine Africa Network
STIs	Sexually Transmitted Infections
STD	Sexually transmitted Diseases
UDHS	Uganda Demographic and Health Survey
UNAIDS	United Nations AIDS programme
VANATA	Visual Aids Network for AIDS Transmission Awareness
VCT	Voluntary Counselling and Testing
WV	World Vision
WVK	World Vision Kenya

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Abstract

This paper covers the initial stages of the commencement of Phase One of a four-year participatory/action research project on " Reversing HIV/AIDS among Youth through participatory research" in Mwea Division of Kirinyaga District and Makuyu Division of Maragua District in the Central Province of Kenya. The divisions were selected because they have highest prevalence of HIV/AIDS in their districts. The research problem has been conceived to comprise to facets. The first facet refers to the unexplained lack of behaviour change in face of documented devastating effects of HIV/AIDS pandemic. The wide spread knowledge of the magnitude, causes and effects of HIV/AIDS demonstrated to exist in the community by KAP studies is expected to bring a realisation that there is a health crisis. The second facet identifies research methodologies as part of the problems that have disabled past interventions that have attempted to reverse the prevalence of the HIV/AIDS.

This project adopted a participatory/action approach that continuously involves the beneficiaries (target community) and the research team in active dialogue. Discussions and presentations from the community show that the level of awareness of the factors which predispose youth to HIV/AIDS very high. The list provided by the community includes substance abuse, poverty, multiple sex partners, Female Genital Mutilation, breakdown in family/social values, abdication of parental responsibilities, stigma, discrimination etc. Resulting form the discussions and sharing, the community realises that there is a lot that can be done locally even without external support. External support would reinforce the community effort. The community sees itself contributing in, organising micro financing, reinforcing social discipline and providing parental support for guiding the youth. The local structures e.g. youth groups should adapt some of the project functions.

The experience with the community during the early phase of the project underscores need for flexibility in setting timeframes for community activities. Communities must be consulted before scheduling activities that require their participation in order to take into account their social commitments. The participatory methodology will also help to deal with donor dependency tendencies that have resulted from past projects which were involved in making financial handouts in the community.

1 INTRODUCTION

This paper covers the initial stages of the commencement of Phase One of a four-year participatory/action research project on " Reversing HIV/AIDS among Youth through participatory research" in Mwea Division of Kirinyaga District and Makuyu Division of Maragua District in the Central Province of Kenya. The project is being implemented in two phases; Research phase will take 6 months and will involve mapping of HIV/AIDS reality in the two project sites. Phase two will introduce external support for interventions that are identified and adopted by the community from the analysis in phase one to develop and up-scale best practices for the control of HIV/AIDS among the youth.
Mwea division was selected for the study because it has the highest prevalence of HIV/AIDS in the district. It is estimated that 60% of the infected in Mwea are youth in and out of school, aged between 13 and 30 Makuyu division was selected on the same criteria as Mwea (GOK, 2002). HIV/AIDS situation analysis in the African region identifies school-going and out-of-school youth as one the groups facing the greatest danger from the pandemic (UNAIDS, 2002).

The project is sponsored by SIDA-SAREC and is being implemented under auspices of SOMA-Net. Funds have been released for phase one of the project. The funding for phase two of the project is dependent on the success of phase one. The overall project objectives are to:

- Reduce HIV infection and vulnerability to HIV/AIDS among the youth through participatory action research and scaling up innovative and best practices in Kenya
- Investigate personal, socio-cultural, economic and environmental behavioral determinants that can be targeted for behaviuor change
- Assess the responsiveness of HIV/AIDS policies to the needs and concerns of young people in order to strengthen policy implementation at the community level
- Assess the responsiveness of HIV/AIDS policies to the needs and concerns of young people in order to strengthen policy implementation at the community level
- Identify and document, best and innovative practices, which can be tested, replicated and scaled up in order to change behaviour
- Determine access and utilization of VCT, IEC and SRH services by the youth and to identify ways to improve the services in collaboration with practitioners
- Assess community and school responses to HIV/AIDS for the purposes of scaling up best and innovative practices
- Design interventions using the information generated, document, evaluate the various intervention options and plan further action based on the learning process.

The first requisite for action research is to develop a common understanding of the purpose and process of the research that is shared between the research agency and the community. As the two parties enter into dialogue a common language must begin to develop between them. The research agency, being external to the community, can only participate in changing the socio-cultural, economic and environmental factors that contribute to HIV/AIDS, if it understands and relates to the experiential reality of the community. The research process must facilitate the community to attain critical consciousness about the role of the socio-economic and environmental factors. The first activity towards developing the common understanding involves entrenchment of the research process in the community.

The paper is structured to show first, in Section two, the components of the research problem namely the socio-ecological complex within which HIV/AIDS is affecting the community and methodological lapses which have disabled past interventions directed to the same problem. Section Three presents the specific objectives of this phase of the project. A brief description of the project sites is provided in Section Four. Section Five presents the methodologies which have been adopted and adapted for this project. The recent experiences and responses of the community in respect of HIV/AIDS are discussed in Section Six. Section Seven presents the lessons gleaned from our interaction with the community this far. Section Eight draws some preliminary conclusions and indicates the proposed way forward into the base-line survey as part of mapping out the HIV/AIDS reality.

2 STATEMENT OF THE PROBLEM

The research problem has been conceived to comprise to facets. The first facet refers to the unexplained lack of behaviour change in face of documented devastating effects of HIV/AIDS pandemic. The second facet identifies research methodologies as part of the problems that have disabled past interventions that have attempted to reverse the prevalence of the HIV/AIDS.

2.1 Unexplained lack of behaviour change in the face of devastating effects of HIV/AIDS

The HIV/AIDS pandemic is devastating the young people. This is in addition to the high rates of other STIs, early pregnancies, induced abortion, school dropout and early marriages. Globally, more than half of the new HIV cases occur among young people 15-24 years. The incidence rates are estimated to be 4-6% among young women and 2-3% among young men. In Sub-Saharan Africa, the rates are comparatively higher, estimated at 6-11% among females and 3-6% among males (UNAIDS 2002).
In Kenya, the initial peak for HIV infection is among 15-19 years old in females and 20-24 years in males (NASCOP 1999). In Uganda HIV prevalence was until 2000 highest among young people 15-24, with females 3-6 times more infected than the males (STD/ACP 1997, 2000). Data from AIDS Information Center (AIC) in Uganda indicate that among youth 15-24 year, the prevalence rates have declined from 11% among males and 29% in females in 1992 to 2.5% and 12.1% respectively in 1999.This notwithstanding, the rates are still unacceptably high. In addition these data may not adequately reflect the overall national HIV Prevalence status. Besides, the high impact interventions and other factors linked to these the declining trends, in the surveillance sites are yet to be systematically evaluated and documented.

There is evidence that the youth engage in sex at very early ages with a large number having multiple or concurrent sex partners Some studies have reported first intercourse as early as 13 years (UDHS 2000/1, Mulindi et al, 1998). These reports indicate a significant period of sexual activity before marriage that exposes young people to the risk of HIV infection and other STDs.

With no vaccine or cure, education, has and continues to be the main intervention in prevention of HIV/AIDS. Education campaigns have provided information on HIV transmission and prevention, mainly emphasizing condom use, reduction in sexual partners, abstinence and delaying the age of sexual debut. They have been supported in terms of research, by KAP surveys, which have been used to evaluate the impact of the AIDS education and information on behaviour.

While a major finding from KAP surveys is that there is considerable knowledge about the risks of certain behaviours, evidence seem to suggest that there has been little behaviour change (Carael etal 1997, UNAIDS 2000). Apart from the problems entailed in the “risk group” strategy, KAP surveys have limitations in their assumptions, conceptualization and design. KAP surveys assume that individuals execute their preferences or choices regardless of societal pressures around them (Poppen and Reisen 1997). In the design and implementation, KAP surveys furthermore assume that respondents understand or have thought about the issues they are questioned about, while there is a tendency to link attitudes expressed in verbal responses to the behaviour of a respondent.
A fundamental problem could be that assumptions used for interventions and evaluation may be wrong. It is for example, assumed that knowledge is linearly associated with change of attitude and behaviour (Warwick 1993, Hauser 1993). The assumption that increased knowledge helps people take rational actions in health is as Kelly and colleagues (2001) argue, based on the analytical model of the concept of self-agency, a phenomenon closely tied to the development of biomedical knowledge. In the way it has been promoted in HIV/AIDS education and evaluations, there has been a tendency to ignore that the individual exists within complex social contexts. Yet, over the years there has been conflicting messages, controversies among different stakeholders even dissenting voices, making the context for intervention to promote sexual behaviour

change and prevent HIV/AIDS among young people even more complicated (Kelly et al 2001).

The wide spread knowledge of the magnitude, causes and effects of HIV/AIDS demonstrated to exist in the community by KAP studies is expected to bring a realisation that there is a health crisis. Behaviour change should be a quick and obvious result that would lead to a resolution of the health crisis. Just now, "to the outsider these communities are living through health crises. There is a high level of observable human suffering. But to the community the situation is very difficult but normal" (Wang'ombe 1995). Crises by their very nature are short term phenomena and are to be resolved quickly to allow normalcy to resume. The community needs resources and know-how to resolve the crises. The community has neither the resources nor the know-how. Hence, the community cannot deal with the situation as crisis. Innovations of interventions to resolve the crisis will require to adopt the community pace of resolving difficult situations and then provide support to quicken it.

2.2 The Social Ecological Conceptual framework for fieldwork methodologies on HIV/AIDS

The problem of research in this context refers both to its usage and methodology. Research has been divorced from policy and interventions and although research proposals state the relevance for policy, it is often left to the discretion of policy makers. Policy makers on the other hand may have no idea about the research while the language of research may be beyond the comprehension of the policy makers and programmers, not to mention the way the community and CBOs for whom research is intended to benefit are ignored.

What is required is research and methodologies or approaches that help not only understand the complex social contexts within which the young people live, but more significantly how such understanding can inform policy and programs at different societal levels. This is an understanding of the ways meanings are constructed in interaction with others, with cultural beliefs, norms and values and with different types of knowledge including scientific knowledge as well as how this influences action whether at the individual or group level. This type of understanding implies moving from only KAP surveys to combining them with other social science methods better suited for understanding meanings, experiences and contexts of those being studied and for enhancing participation. This implies collaboration between researchers and practitioners as well as communities. The research proposed here attempts to do this.

This study is informed by the social ecological thinking, which infers a belief that efforts to promote health should be based on the understanding of the interplay among diverse environmental and personal factors (Joffres et al 2002). AIDS, like many contemporary public health problems is complex. This is because it concerns not only sensitive issues of sexuality, reproduction and death but also because it does not present as a single disease, while its long incubation period poses problems in linking it to sexual activity.

As a disease, AIDS may be located in the body of an individual. However, it also involves all other patterns of life including the interlocking social roles, power and conflict, social status, networks of family and friends, bureaucracies and organizations, social control, social norms, ideas of moral worth, definition of reality and production of knowledge (Brown 1995). Moreover, as McEllroy and Jezewski (2000) argue, how people define and perceive symptoms, how they experience illness is inextricably intertwined with the self

and others across time. Thus illness is not only a self-experience. It is a social and community experience with contextual factors such as gender, environmental, economic and political constrains impinging on health, on illness and on availability and provision of health services (Frohlich 2001, Hahn 1995, Lane & Cibula 2000, Lorber 1998). Illness may be experienced and presented differently by women and men not to mention that they may be exposed to the risk of infection differently because of their gender roles, position and expectations (Cameron and Bernardes 1998, Lorber 1998). This is the human context of health and disease or the world of the “infected” (Agar 1996, Van der Geest 1995, Flick 1998).

Put in another way health related behaviours are, as described by Mc Leroy et al (1998), influenced by five determinants including:

- Interpersonal factors comprising of individual personal characteristics (skills, knowledge, self concept, attitudes).
- Interpersonal processes (e.g. formal and informal groups and networks within which individuals evolve).
- Institutional factors (e.g. social institutions with organizational characteristics, formal and informal rules of operation).
- Community factors (e.g. norms, beliefs and values that regulate the relationships and boundaries among organizations, institutions, formal and informal networks).
- Public policy.

According to the proponents of social ecological models (Kegler et al 1998, Wandersman et al 1996), health promotion interventions are most effective when they use this channel of influence through the multi-level strategies of change involving community partnerships or coalitions. Prevention of AIDS among young people with community involvement concern not only understanding AIDS –disease in its social, cultural, economic and political contexts, but also community organizations as well as factors that promote sustained community support. This is the area where social science can make a substantial contribution towards prevention of HIV/AIDS.

Given the discussion above, interventions, whether diagnosis, treatment or prevention at individual or societal levels cannot depend on knowledge of a single disease agent. Rather, it should depend on interpreting meanings and subjective worlds of the affected people and their realities and of local practices in which are embedded both risks and preventive measures (Agar 1996). This implies various forms of collaboration, linkages and partnerships including interdisciplinary, researcher/practitioners, researchers/community groups as well as a broad based involvement of varied stakeholders. These different forms of collaboration are expected to achieve synergy, create enabling environment for different stakeholders and communities to be part of the research and intervention process and ensure sustainability. The forms of collaboration mentioned here can be ensured through a participatory action research as elaborated further below.

3. OBJECTIVES

3.1 Objectives for mapping out the reality

The research team developed a logical framework for the first phase of the research project to achieve the objectives stated below. Phase one of the project on mapping of reality is expected to achieve the following objectives:

1. To entrench the research process in the community for enhancement of community participation/ownership and long-term sustainability of the project;

2. To establish the effectiveness and efficiency of the current IEC methodologies in the project sites;
3. To establish the socio-cultural, economic, behavioural and environmental factors, that contribute to the risk of HIV/AIDS infection among the youth;
4. To establish bottlenecks to economic empowerment among the youth;
5. To determine the effectiveness and efficiency of the current policies on HIV/AIDS in Kenya, with special reference to the youth;
6. To establish the accessibility and appropriateness of health services delivery to the youth; and
7. To apply the research findings in developing and up-scaling "Best Practices" for control of HIV/AIDS among the youth.

However, the paper covers the initial stages of the project and presents what it has entailed to achieve objective 1. Objectives 2-6 will be achieved during the project baseline survey. Objective 7 will be achieved during the second phase of the project. The achievement of objective 1 establishes the threshold from which work on the other objective(s) will spring.

3.2 Sub-o*bjectives of Research Entrenchment Process in the Community*

The activity of entrenching the research process in the community, is expected to achieve the following objectives:

1. To familiarize the research team with the realities of the project sites.
2. To establish contact points, persons and organizations in the study sites;
3. To establish community entry points and initiate community dialogue;
4. To hold community mobilisation and sensitisation workshops;
5. To identify advocacy and communications priorities for action research in HIV/AIDS at the community level;
6. To plan, organize and co-ordinate advocacy and communications activities to support the action-oriented research on HIV/AIDS;
7. To develop and implement partnership mechanisms for implementation of the activities for the project, by identifying organizations and institutions on the ground for networking; and
8. To collect any available relevant data through document review and community dialogue

4. BACKGROUND INFORMATION ON PROJECT SITE

4.1 **Population**

Kirinyaga District has a total area of 1478.1 km^2 and a total population of 457,105 (GOK, 1999 census) of whom 237,098 are male and 241,047 female. The female: male ratio - 100:98 and the estimated youthful population (15-25 years of age) is 124,114 and youth (6-13), 93,442. Population of Primary School going age (6-13) - 93,442, Population of Secondary school age (14-17) - 50,191. The district has the following health facilities: 4 hospitals; 5 health centres; 48 dispensaries; 5 nursing homes; 48 private clinics. The average distance to health centres is 6.32km. The Anglican Church is largest NGO among the once which are involved in HIV/AIDS work. The CCS is a programme of the Anglican Church and is the most prominent of 9 CBOs dealing with HIV/AIDS. There are 191 primary schools and 76 secondary schools (GoK, 2002)

Maragua District has a total area of 1065km^2 and a total population of 409,302 (GOK,1999 census) of whom 338,404 (83%) is rural. The estimated population of children <5 is 56,000 (14%); primary school aged (6-14 years) 97,304 (24%); 15-19, 50,422 (12%), 20-24, 34,180 (8%). According to the Maragua District poverty

assessment report 2001-2004, the average extent of poverty in the district is currently estimated at 60% of the total district's population. The district has two public district hospitals, two private health centres, four public health centres and 25 public dispensaries. The average distance to the nearest health facility is 10 kms. There are 187 primary schools with an enrolment of >100%. While the 85 secondary schools, have a total enrolment rate of 40% boys and 53% girls.

Table 1 below shows further information on population. The population structure in the two districts and the divisions within the district where the project is located are also shown relative to the Country and Province.

Table 1: National, Central Province and Project site districts population structure by selected age groups

	Total Population	Age groups		
		0 - 14	15 - 44	45+
National	28,686,607	12,536,673	12,536,673	3,515,910
Central Province	3,724,159	1,472,580	1,715,585	535,994
Kirinyaga District	457,105	165,472	225,082	66551
Mwea Division	63,926	23,141	31,477	9,308
Maragwa District	387,969	165,855	160,492	61,622
MakuyuDivision	125,962	53,848	52,108	20,006

Source: Government of Kenya, 1999 Population Census

4.2 HIV/AIDS Situation

Tables 2 and 3 below show the HIV/AIDS prevalence in Kenya and the project site. Table 3 breaks down the prevalence into sex and age groups in the country. The figures are fresh from a Demographic and Health Survey, 2003. They show a marked decline in prevalence from earlier figures which showed national prevalence to lie between 12 and 14 percentages (UNAIDS, 2002). There have queries about the accuracy of the figures but it is noted that there have been on going control efforts which can explain some of the decline in prevalence. However, the important message from the figures is that the prevalence rates are still extremely high both in rural and urban areas.

Table 2: Prevalence Rates of HIV/AIDS in Kenya and the Project Site in %

	Total	Urban	Rural
National	9.0	11.4	7.4
Central Province	7.3	8.6	4.0
Makuyu - Maragwa District	6.1	8	5
Mwea – Kirinyaga District	5.4	8	5

Source: GOK, Demographic and Health Survey 2003
MoH National Surveillance results 2003

Table 3: Prevalence Rates of HIV/AIDS by Age groups and sex in Kenya in %

Age	Female	Male	Total
15-19	3.5	0.5	2.0
20-24	8.7	2.4	5.8
25-29	12.0	6.5	9.9
30-34	11.6	6.1	9.1
40-44	10.3	8.6	9.4
45-59	4.7	6.0	5.3
Central Province	7.3	4.4	6.0

Source: Demographic and Health Survey 2003

5 FIELDWORK PREPARATIONS AND METHODOLOGIES

Following on the earlier contention that field methodologies for intervention have contributed to the failure of community based interventions This project has adopted a participatory/action approach that continuously involves the beneficiaries (target community) and the research team in active dialogue. The process entails community sensitisation and mobilization for entrenchment of the research process

5.1 *Team Building*

The project brings together personnel from institutions with expertise in different aspects of community development. The group from the University of Nairobi provides special skills on community/population-based research, World Vision in Makuyu and Christian Community Services in Mwea have experience in community-based development programmes. Family Programmes Promotion Services have skills and experience in community mobilization and non-formal community education.

The project proposal was written with the participation of personnel from all the above collaborating institutions. The mapping of reality phase of the project entails more research work than the intervention phase. Nonetheless, personnel from all the collaborating institution needed to participate in this phase. Interventions for which these institutions will be the main facilitators at the community level are to be determined from the analysis of the reality.

Participation of all the institutions in this phase of the project will serve two main purposes. First, it will build bridges across the participating institutions and also between the two phases of the project. The second purpose served by the participation of personnel from all the collaborating institutions is team building. The personnel from these institutions had never worked together before and needed to form as a project team

5.2 Entrenchment of Research process in the community

The entrenchment of the research process would manifest in community ownership of the project. This would in turn be observable from acceptance of responsibility for some of the project processes by the community leadership. Community structures to facilitate activities of the project would be created or such facilitation would be adapted into the functions of already existing community structures and programmes. From the various meetings and discussions, the research team and the community would attain the same level of critical consciousness on the character and magnitude of the problem. Interventions that are based on this level of awareness easily acquire community

ownership. Once the ownership has been attained project, leadership structures will emerge and involve people from other community programmes and functioning institutions. This is expected to create resource linkage across community-based activities e.g. a church leader who becomes a member of the project co-ordination committee will definitely bring in some aspect(s) of church resources to bear on the project.

The entrenchment objective would be achieved in four steps: reconnaissance visits, opinion leaders meetings, community meetings and follow-up leaders meetings**.** The meetings schedule that was followed is presented in Table 4 below. It shows the specific sites within the community where the meetings were held, conveners, leadership, attendance and the purpose for the each meeting.

Table 4: Meeting schedules

Date	**Venue**	**Title of meeting**	**Leadership in attendance**	**Convener**	**Number in Attendance**
28/11/03	D.O.s – Mwea	Reconnaissance meeting	D.O, M.P.,Councillor		13
	Chief's Office – Thiba		Chief,	Research Team	6
	Chief's Office – Tebere		Chief		7
27/11/03	D.O.s –Maragua		D.O, DDO/DAC, Secretary CAC,		12
	Chief's Office-Kamahuha		Chief,		11
	Chief's Office-Kambiti		Retired Chief		10
10/12/03	CCS Field Station – Wanguru/Kutus ACK	Opinion Leaders meeting	PHT, CDA, Chief Thiba, Chief Murinduko	CCS	38
11/12/03	World Vision Office – Makuyu	Opinion Leaders Meeting	Chief Kambiti, DEO, Assitant chief	WV	29
11/12/03	Chief's Office - Kamahuha	Opinion Leaders	Chief Kamahuha	WV	17
17/12/03	Chief's Office - Murinduko	Community Meeting	Chief, Murinduko Loc., Assistant chiefs, Research Team	Chief, Murinduko Loc/ CCS	125
17/12/03	Chief's Office - Nyangati	Community meeting	Chief- Nyangati Loc. Research Team	Chief- Nyangati Loc/CCS	50
18/12/03	Chief's Office, Thiba	Community meeting	Chief- Thiba Loc, CDA-Thiba Loc. Ass. Chief – Wamumu Sublocation, H/Techer- Rurii Pri.Sch., Corporal I/c Thiba Research Team	Chief- Thiba Loc.	200
18/12/03	Chief's office, Mutithi	Community meeting	Chief Mutithi, CDA, PHO, Assistant chiefs, opinion leaders, Research team.	Chief mutithi	150
31/12/03	Chief's Office - Kamahuha	Community Meeting	Chief- Kamahuha, Local Councillor, CDA-Kamahuha Loc.	Chief- Kamahuha Loc.	1000persons

			Research Team		
31/12/03	Chief's Office - Kambiti	Community Meeting	Chief – Kambiti Loc Research Team	Chief – Kambiti Loc.	57
31/12/03	Chief's Office - Gakungu	Community Meeting	WV field officer Project commitee	Chief Kambiti facilitated by committee chairman	57
6/1/04	Somanet Office	Management meeting	Research team	Team Leader	8
9/1/04	Somanet Office	Management meeting	Research team	Team Leader	8
12/1/04	World Vision Office - Makuyu	Project Leadership – Follow-up Meeting	Research Team Chief Gakungu Chief Kambiti	World Vision/Team leader	29
12/1/04	CCS- Wanguru Field station	Project Leadership – Follow-up Meeting	Research Team Chief Murinduko, chief Thiba	CCS/Team leader	28

Step 1
Reconnaissance Visits
The reconnaissance visits aimed at reaching especially political and administrative community leaders. This group of leaders is important because it holds some sway in opinions and has the 'key' to physical access to the community. Discussions were held between the research team and the leaders in the project sites. The meetings were held at the Divisional and Locational centres where the respective administrative heads participated in open discussions. The purpose of the deliberations was mainly to introduce the project and stimulate discussion on their perceptions, experiences and possible solutions to the HIV/AIDS pandemic. Due to the authority and influence that they wield in their communities, it is critical that acceptance of the project by them is secured.

Step 2
Opinion Leaders Meetings
The aim of the opinion leaders meetings was to obtain the views of the community on the HIV/AIDS pandemic, introduce the project, secure acceptance and subsequently engage the community in dialogue. The audience was drawn from personnel presumed to possess a lot of influence over the community in matters pertaining to social transformation. They included civil servants (public health personnel, locational departmental heads, community development assistants), community leaders (chairpersons of CBOs, FBOs) and local politicians. The engagement of the persons into dialogue was especially crucial in reaching a critical consciousness in social transformation and promote advocacy of the project and engage in community research through a participatory process.

The significance of the project and its potential benefits in the community were introduced through discussions and presentations on HIV/AIDS in the community on its effects and factors contributing to the spread of the disease among the youth. The discussions were base on the following questions so as to encourage critical thinking on the whole spectrum of the HIV/AIDS problem:

1. What contributes to the high prevalence and incidence of HIV/AIDS among the youth in the respective study sites?
2. What have been the community experiences with the scourge? What has the community done about it and what have been the constraints?
3. What are the communities doing about the problem?
4. What has the government done to address the problem?
5. What role do the opinion leaders feel they will play in the current project?

Step 3
Community Meetings
The third step comprised a series of larger locational community meetings, which were arranged and facilitated by the chiefs in collaboration with the opinion leaders. The research team was in attendance at the meetings. The community meetings were much larger with attendance in some places exceeding 1,000 (Kamahuha Location-Makuyu Division). The main purpose was to generate passion, elicit conscious critical thinking about the causes of transmission of HIV/AIDS among the youth and what home-grown remedies may be pursued to reverse the trend. The meetings were also meant to secure ownership of the project in the respective communities and assist in the evolution of community structures that would be used in the implementation and sustainability of the project. The existing structures were also mapped out.

The opinion leaders who included the local chief, civil servants, chairpersons of CBOs and FBOs, youth representatives and local politicians played an active role in the facilitation of the meetings. They had earlier on held a series of meetings with leaders of CBOS, FBOs, and youth representatives. It was from these meetings that the dates and venues for the larger community meetings were agreed upon. Like in the previous meetings, the process of these meetings engaged all community members into dialogue as a means of achieving the requisite critical consciousness level for social transformation. Furthermore, it was during these meetings that community ownership and leadership structures, both existing and emerging, were proposed and discussed.

Step 4:
Follow-up Leaders Meetings.
The fourth set of meetings was not in the original schedule. It was found to be necessary on consultation between some community leaders and the research team. A review of what had been achieved this far and a discussion on the agreements reached on various processes between the research team and the community was necessary. The meetings reviewed and agreed upon the obligations that fell on each stakeholder.

6 COMMUNITY EXPERIENCES AND RESPONSES

This section presents brief statements on matters raised in discussions at all the meetings. They were compiled through field notes. The research team selected those that occurred most frequently in the discussions. The issues regarding new and existing structures in relation to community response to HIV/AIDS were revisited in the final series of meetings with community leaders.

6.1 Community Entry and Critical Thinking Processes

Although there are considerable similarities in community experiences with the HIV/AIDS scourge, there were slight variations between the two project sites. Entry into the community was secured through preliminary field reconnaissance visits to the two study sites. The visits offered an opportunity to establish community entry points, contact with institutions and individuals, thus creating a basis for comprehensive community dialogue. The site visits also helped in mapping out the configuration of the CBOs, FBOs as well as the formal administrative structures at the grassroots level, that would inform and make input into the project's implementation.

The logistics involved briefing sessions in which the research team, assisted by World Vision-Kenya and Christian Community Services (CCS) of the Anglican Church, explained the nature and objectives/purpose of the SIDA/SOMA-Net HIV/AIDS Project. Then followed open discussions by individuals and in plenary after group brainstorming sessions. The responses were thoroughly rewarding as the participants poured out their experiences with the problem. Others recounted chilling tales of how they lost loved ones. More importantly, they came up with suggestions on possible solutions to the problem.

6.2 Factors Predisposing the Youth to HIV/AIDS

The factors predisposing the youth to AIDS are common in the two study sites while the details may vary. The factors mentioned in the discussions include:

6.2.1 Alcoholism, drug addiction and access to dangerous substances: These are common to the two sites and affect youth both in school and out of school. Brewing and consumption of local cheap liquors (e.g. *kumikumi, makabo, karikari, chang'aa)* is common in the communities. The widespread consumption of these substances was considered to be a major contributor to the spread of HIV/AIDS. When people are intoxicated with drugs/alcohol they sometimes engage in irresponsible sexual behaviour. Incidents of parents taking alcohol in the drinking places in company of their adolescent

children and subsequently engaging in incestuous relationships were reported in Mwea. Social controls for disciplining such parents do not seem to exist anymore.

6.2.3 Poverty: This is common in to both sites. The community assessment is that, young girls are lured into prostitution or end up doing jobs that predispose them to promiscuous sexual behaviour because of poverty. There were also reported incidents of young girls having sexual affairs with old men for money which their parent are unable to provide thus exposing or putting themselves at the risk of contracting the HIV virus. In some of the towns like Makutano, Ngurubani and Kambiti it was reported that teenage prostitution is rampant. Girls as young as 11 years are common clients to long distance truck drivers. Poverty also forces parents to share single rooms with their children, thus exposing them to sexual activities too early before they can appreciate what it is all about. Hence, young children are engaging in sex play without understanding the moral implications or consequences of their activities.

6.2.4 Unemployment and Idleness: This is a serious problem that affects a cross section of school leavers including university graduates. Lack of jobs and positive recreational activities lead to idleness among the youth, pushing them into sexual affairs. Unemployment among the youth, especially at Saba Saba urban centre is making them vulnerable to groups who hire them for illegal activities such as promotion of *"Mungiki" (a proscribed youth sect)* activities in the area.

6.2.5 Female Genital Mutilation: still practiced in some pockets where conservative traditions still persist. Use of same instruments on different girls without sterilizing them could contribute in transmission of the disease.

6.2.6 An Emerging sexual behaviour: '*Kuhuura Mbiro'*, which in the local dialect of Kikuyu language literally translations "to removing or cleaning off the ashes". When boys heal the circumcision wound, the age group expects that they will sleep with women soon after to proof to themselves that they are mature men. Unfortunately, they may end up sleeping with infected clients as happens at Kambiti and Makutano markets in Makuyu. This is a manifestation of break down of social mores that has promoted in-disciplined sex among the youth.

6.2.7 Age of sexual debut: seems to have dropped to as low as 9 years for the girls. This makes them especially vulnerable to the disease. Their knowledge of sex is very poor and they are in no position to make informed choices as far as sex matters are concerned. Older men easily take advantage of such girls. Early sex may also lead to early marriages and teenage pregnancies among girls.

6.2.8 Break-down of family/social values: There is evidence of a growing gap between the youth and their parents. Some parents blame it on drug abuse among the youth while others think it is due to the encroachment into the community of Western influence as evidenced by pornographic movies that are popular among the youth in market centres. It was reported that in polygamous families, it is more difficult to financially manage the large units. That makes the children vulnerable to risky sexual behaviour. It is also difficult to control the behaviour of a large number of children in such families. Breakdown of leadership structure in the family where men feel that women have take over their role as heads of the family was also reported. They feel that women are taking decision on family matters without involving them. The women are not performing their duty effectively like keeping the house clean and also maintaining good personal hygiene, this leads men to engage in extra-marital relationship with young well groomed girls.

6.2.9 'Abdication' of Parental Responsibility: it was reported that some parents have abdicated their responsibility of guiding and counselling their children. Indeed, some of the affluent parents go to the extent of giving money to their children to attend overnight

discos. At another level, it was reported that some illiterate parents are scared of disciplining or guiding their educated children. At the same time, the educated children tended to use languages not understandable by their parents (e.g. "Sheng", a dialect that mixes English and Swahili. It is commonly spoken by youth.), which alienate the latter. There appears to exist a conflict of values between many parents and their children.
***"Keshas"*:** These are overnight religious crusades, which often degenerate to rich grounds for socializing and sexual escapades instead of the worship forums they are supposed to be. School extra-curricular activities such as sports and athletics as well as night vigils held in honour of the dead *("Macakaya"),* were cited as avenues being exploited by the youth to engage sex orgies therefore promoting the spread of HIV/AIDS among the youth. Parents seem to have no control over these activities.
6.2.10 Settlement Patterns: The phenomenon of slum settlements which was previously only in big cities and towns is now common in this rural urban centres and markets. The character of social intercourse is similar to that found in big slum settlements in cities. As a result, there is considerable in-breeding and sexual interaction among youth is not subjected to adequate socially control. Close proximity of towns and urban centers to the rural populations was also reported to contribute to the spread of the disease. Makutano, Kagio, Ngurubani, and Kimbimbi, are the most affected market centres. In these towns, prostitution is rampant mainly because they are stopovers for long distance truck drivers who are the main clients for commercial sex workers. The centres attract youth form the neighbouring villages.
6.2.11 Single Motherhood: This phenomenon was reported to be on the increase and is affecting young mothers in their early 20s and 30s. The increasing pressure to provide daily bread for the family is pushing some to grant sexual favours in exchange for money from rich men. The issue of single mothers neglecting their children, who are then forced to look for alternative means of livelihood, was also cited as a contributory factor to the many girls and other youth that are found in the urban centres engaging in prostitution.
6.2 12 Peer pressure: Among the youth peer pressure was cited as a big factor in the spread of HIV/AIDS. The youth are under considerable pressure to behave like their peers, in order to have a sense of belonging. In the process, behaviours such as smoking, alcohol consumption and sexual promiscuity are perpetuated.
6.2.13 Stigma and Discrimination: For fear of social discrimination, many persons living with HIV /AIDS do not disclose their HIV status. Even when people die of the disease, the cause of death is never disclosed in the death certificate or during funeral services. This makes the widows and/or widowers continue having sexual relations freely without any extra precautions; hence, contributing to the spread of the disease.

Stigmatisation and discrimination attached to HIV/AIDS have resulted in anger and feelings of revenge against the society in some patients. Such people engage in indiscriminate sex and other behaviour that put their contacts at the risk of HIV infection. A case is reported of a female circumciser, who with full knowledge that she was HIV-sero-positive deliberately contaminated the instrument that she used to perform the operation with the discharge from her body sores. This way innocent girls who she performed the operation on were exposed to HIV infection.
6.2.14 Taboos: Some parents cannot discuss sex matters with their children since it is taboo to do so. In the olden days, this was the responsibility of aunts and grandmothers. Modern lifestyles no longer allow this to happen and this has created a communication barrier between the parents and the children and therefore children have no access to information that would otherwise have been passed on from the parents.
6.2.15 Availability of money: The majority out of school youth in Mwea work in the rice fields or other informal sector such that even the very young have their "own" money albeit very little. Due to this easy access to cash, there is a high school dropout rate and

the youth tend to use their earnings to pay for leisure activities that tend to encourage HIV transmission such as alcohol and bhang smoking.

6.2.16 Misconceptions about HIV: Many misconceptions about HIV/AIDS are propagated by religious groups which advocate practices of confession for healing and the healing power of prayer. They preach that confession of sin and prayer can health the sick. This gives false confidence about vulnerability and recovery from HIV/AIDS. The result may be that youth engage in unprotected sex. The misconception that children are ''clean'' (not infected and have cleansing power) leads older men and women to seek sex with them. Because such sex is not natural and is difficult to negotiate, children have been subjected to rape and incest in these communities.

6.2.17 Uvulectomy; This is the procedure of removing the uvula. It is very rare today. But it is practiced in some pockets where some old traditions still persist. The traditional surgeon may use of same instruments on different people without sterilizing them. Hence, contributing to the transmission of the disease.

6.3 Some Individual Experiences

In this sub-section, we provide insights into the personal experiences with behavioural tendencies, factors and practices that predispose the youth to HIV/AIDS. The accounts were provided by some of the community members. We capture two of such factors, namely, breakdown in family values and single motherhood.

6.3.1 Breakdown in family values: Wanyunjure is a mother of five. She is in her early 50s. Her ten-year old daughter became unmanageable. One day the latter leaves home and cautions her mother that she may not return home the same day. Wanyunjure protests bitterly and threatens a beating to the daughter. This never scares the little one. She goes out despite her mother's protests and threats. True to her word, the little one does not return home that day. She spends the night with a man somewhere. When she returns home the following day, she receives a beating from her mother. She is bitter for being beaten by her own mother. She even threatens to take her own life. She asks her mother whether she (mother) had ever been beaten by her parents. Wanyunjure is at a loss. The little girl continues having sexual relationships with men. She later gets married but soon is separated with her partner. Today, she is at home, with a baby, and with high chances of getting another one.

6.3.2 Single Motherhood: Mukami (not her real name) is now a grandmother. She has lived single all her life. Even at 60-plus, she has to work hard to feed, educate and clothe her nine grandchildren whose mother (Mukami's daughter) died of AIDS. She was also single. Some of the girls are teenagers and are already having affairs with men. Mukami is trying her best to bring them up, guide and counsel them but with little success. Poverty is having its toll and they have to get money by whatever means, including prostitution. Mukami's responsibility of parental guidance is made even harder by her marital status. When she admonishes the young girls about irresponsible sexual behaviour, they hit back at her, always reminding her that she herself never got married at any one time. To add salt to injury, Mukami recently discovered a packet of condoms under the mattress of her 17-year old grandson, who is in Form 1. Does this mean that the young man is taking precautions against infection? And when will Mukami's woes come to end?

6.4 Homegrown Remedies to HIV/AIDS

The discussions explored the possibilities for interventions. The community was challenged by the research team to also look inwardly for what it can do without first seeking help from government and other external agencies. Further discussions on the factors which encourage the spread of the disease identified those that the community should continue to work on even before the external aid is sought for. This section covers

the community responses to the pandemic and what they perceive to be their homegrown remedies to the problem, with respect to the youth.

6.4.1 Micro-finance: To address the issue of unemployment for the youth, the communities proposed that the youth be mobilized to form groups and the existing ones be strengthened. They should be supported to start income-generating activities (IGAs). Some of the income-generating activities proposed include:

- Honey and vegetable production for export (for Kambiti youth)
- Tree nurseries
- Entertainment Videos shows

As away of raising funds for the income generating activities, the community proposed the establishment of community banking systems through organized groups that can borrow money from micro-finance institutions and then give loans to their members at a slightly higher interest rate, This will make credit more accessible to more people beyond areas that are currently covered by the existing micro-finance institutions. Already, there is one group that borrows funds from the World Vision-Kenya (WVK) KADET organization at 11% and gives loans to members through *Jua Kali "B"* community bank at 14%. (This is a banking system run purely by the community and seems to be working in Makuyu).

6.4.2 Sports Clubs: In the case of idleness and lack of recreational activities, the youth requested that sports activities be supported. Competitive football youth clubs to play for trophies and prizes on a quarterly or half-year basis were proposed .

6.4.3 Extravaganzas: Communities proposed that awareness extravaganzas like those organized by WVK be promoted and used to pass on HIV/AIDS information to the youth.

6.4.4 Policy Lobby: The community wants to lobby for a policy that will legalize local brews in the hope that this might help regulate and introduce discipline in the consumption of the brews. It was also alternately suggested that the community should lobby the government for power to enforce the law on the sale of illicit brews through formation of community enforcement groups.

6.4.5 Social Discipline: It was proposed that in the case of errant children and community members, the community forms social discipline committees which will ensure that cases of indiscipline are dealt with and everybody takes responsibility for their actions as used to be the case in the past when social mores were respected. This would recreate discipline and reinforce the parental role that has been eroded.

6.4.6 Good role models: It was recognized that the youth are behaving recklessly because there are no good role models in the community. It was proposed that good role models be identified who can dialogue and work with the youth as a strategy to reduce the spread of the disease.

6.4.7 Alternative punishment for school errant youth: The Kenya school system does not allow corporal punishment and this is making some of the youth errant. The community was of the opinion that workable alternative punishment agreeable to parents should be put in place.

6.4.8 Openness about the disease: As a away of creating more awareness on HIV/AIDS and its impact on the community, it was recommended that policies be put in place to ensure that all people who die of AIDS have their death certificates showing AIDS as the cause of death and the same should be announced during funerals. In addition, people should be encouraged to go for VCT and those that are positive should be encouraged to declare their status.

6.4.9 Parents support: Parents play a key role in determining what the youth are involved in. It was proposed that parental capacity should be enhance to enable them to dialogue and counsel the youth in matters of HIV/AIDS. It was specifically proposed that the role of elders in the traditional African setting in disciplining the youth be revived.

6.5 Existing and Emerging Community Structures

It was observed in the discussions that in the community there are externally and locally based organizations and structures which can be tapped to back up the proposed solutions to the problem.

6.5.1 Existing Structures

Some of the existing structures within the community, which could be strengthened and used to support HIV/AIDS prevention activities include the following:

Micro-finance groups

- Pride Kenya
- Kenya Women finance Trust
- Faulu Kenya
- Bimas
- Jua Kali "B"
- KADET
- Merry go-rounds

School clubs

- Peer chastity clubs in schools
- Married couples clubs

Youth Groups

- Kambiti Christian Youth HIV/AIDS Awareness Group
- VANATA HIV/AIDS Youth group
- Kariguini HIV/AIDS Group
- IMANI
- TUMAINI
- PETG
- Youth crusades
- Gathungururu Football Team
- Kamahuha AIDS group
- Boda Boda Taxi Association of Mwea
- Kiamanyeki Football Club of Mwea
- Kibega self help group – youth that carry luggage
- Mkokoteni/donkey Transporters group

Community Groups

- Pastor coalition groups
- Gakungu Bursary Fund
- Kambiti men and women groups
- Gakungu Water CBO (started in 1991)
- Commercial Sex Workers Union in Kamahuha
- Matheng'eta Forum in Kambiti
- Women groups
- Single mothers' clubs of Mwea

6.5.2 Emerging structures

As part of the entrenchment of research process, the community organized themselves and voted in locational level committees to look after the project. The representative committees will also facilitate the community in the renewed fight against HIV/AIDS.

6.6 Project Ownership

The process of acquiring ownership of the project on part of the community falls into three steps. The first step involved introduction of the project to the respective communities in Makuyu and Mwea. This included presentation that the project will have two phases i.e.

Research and Intervention. During the former phase, research assistants recruited from the two communities will collect data and results of the follow up analysis will be shared openly at community meetings. Recommendations for implementation during the latter phase (intervention) of the project will also be agreed-upon with the community. Secondly, the communities participated in open and free discussions on HIV/AIDS; scrutinizing and analysing the behavioural tendencies and practices that lead to infection or predispose the youth to the risk of infection, and at the same time exploring possible community-based remedies. Thirdly, the existing and emerging (formal and informal) community structures were identified and their roles in the project defined and allocated. In some cases, the communities themselves selected their own committees to oversee and guide the implementation of the project. These committees are now in place in the two project sites. As the research team gears up to conduct a baseline survey (research assistants have been recruited from the two communities). The communities are beginning to see the potential benefits of the project and community support for the project is clearly evident.

7 LESSONS FROM THE PROJECT DESIGN AND THE ENTRENCHMENT PROCESS

Some research field methodologies were earlier identified as part of the problem that make such projects ineffective. It is expected that at this initial stage of the project certain lessons will be learned in respect of the methodologies.

7.1 Methodological Lessons

The field reconnaissance trips helped the research team to familiarize itself with the study sites and to meet key people. This also helped the team to understand the leaders' perception of the intended project and create rapport with them. The multidisciplinary nature of the research team has been useful in enriching the team's capacity to overcome research challenges.

Entrenchment of the research process in the community is not a one-time event. It must be continuous, with the research team remaining consistent and authentic in its pronouncements. The community determines its own speed of acceptance of the process. There must therefore be flexibility in setting timeframes for community activities. Communities must be consulted before scheduling activities that require their participation in order to take into account their social commitments. When setting the time for meetings, there is need to put into consideration factors such as modes of transport. When planning community meetings, the meeting venue must be appropriate and convenient to all the participants. In several instances the communities opted for alternative dates and venues for the meetings to those the research team had proposed.

The use of existing field networks and structures such as those already established by the World Vision and CCS helped the team in achieving greater efficiency in community mobilisation. The reputation of these agencies proved critical in determining community acceptance of the project (in this case the reputation was favourable). Partnership with the local agencies also reduces curiosity because of the community familiarity with them. Using opinion leaders as an entry point to the communities enabled the project to achieve fast acceptance.

The provincial administration was instrumental in mobilizing people for meetings and ensuring vital support for such a process. However, in Mwea, for instance, government officers seemed unwilling to work without financial benefits. In other areas, there was mistrust between the community and the provincial administration especially chiefs. The

existence of bad blood between the two sides should be taken into account when setting up a project of this nature. The ability and willingness by the community to openly challenge the existing structures such as those represented by the chiefs and come up with alternative structures was noted. The government officers were also noted to be dependent on government guidelines and circulars and were unfamiliar with the concept of community ownership.

7.2 Lessons from Community Response

There is a high level of awareness on HIV /AIDS in the community but behaviour change remains elusive. The community recognizes HIV/AIDS as a problem affecting them. At the same time, communities and their leaders readily recognize the factors contributing to the high prevalence of HIV/AIDS. Initially the communities had not realise that they could offer solutions and that they were already working on some of them. Faced with challenges at the discussion forums the communities eventually realized they had a lot to offer, before and after the introduction of the interventions.

The youth do not attend chief's "*barazas*" (general community meetings convened by the chief) in large numbers because they see them as a waste of time. A new strategy or methodology is therefore needed to persuade the youth to attend meetings. In some cases, absenteeism from meetings is caused by monotony of the subject of HIV/AIDS. Indeed, some people already feel they have adequate information on the subject. In addition, the world-view of the youth is fundamentally different from that of the older generation and so the youth must be involved in seeking solutions to their problems.

Previous experiences with externally funded intervention and research projects have made the community to develop donor dependency tendencies especially in Mwea. Several previous projects have been involved in making financial handouts in the community. Expectations for handouts from this project were detectable in the community as it was introduced. It was also reported that in the recent past there was a spate of formation of CBOs in anticipation of handouts. However, the CBOs have collapsed when the handouts were not forthcoming. This tendency is likely to have a negative effect on the implementation of this project. However, the participatory methodology has helped the communities to realise its potential and limitations in confronting the problem of HIV/AIDS. It also helped the community to acknowledge its potential as researcher and solution-seeker rather than being passive recipient of material hand-outs and development solutions from government, donors and traditional researchers.

The communities seemed to have been used to the traditional methods of research, whereby researchers interact with them only during data collection and do not share their research findings with them. The idea of community ownership of the project was therefore new to these communities.

8. CONCLUSIONS

The methodology employed by the research team and collaborating institutions helped the communities reach an appreciable level of critical thinking about HIV/AIDS. There is reason to believe that the project has generated enough interest and passion among the communities of Mwea and Makuyu. More importantly, it appears safe to conclude that the project has begun to achieve community ownership, after a successful initial entrenchment process. The next step of the process is **Research,** through which data collection will be carried out in a baseline survey. After data analysis, the findings will be used to inform the next phase of the project, which is **Intervention.** Dissemination sessions will be organised with community to share the report. The report will be finalised

after the community input. Research will also continue to form an essential and continuous activity during the four-year life of the project. And in line with the tenets of action research, the interventions are expected to be home-grown or locally generated by the communities themselves.

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