

Community counselling

In December 1987 the chief of Sinadambe, on the northern shore of Lake Kariba, called a meeting of all the village heads in his area to discuss the problem of AIDS. He did this at the suggestion of a health worker from the local health centre, which is part of Chikankata Hospital's primary health care network. For several months, the home care team from Chikankata had been visiting three AIDS patients in the area. One, the son of a village headman, had died only a few weeks earlier. Surprisingly few people, however, were aware of the seriousness of the AIDS threat to themselves and their families. Some had not even heard about AIDS, despite frequent radio broadcasts.

Held in the local primary school, the meeting was attended by about 20 village headmen, as well as three members of the Chikankata AIDS team. The discussion demonstrated how little the great majority of community leaders understood about AIDS. Most believed it was spread by shaking hands, sharing utensils, or standing in the shadow of someone with the disease. Few could accept that there was really no cure: if the hospital had no remedy, there must surely be a traditional healer who did. And was it really such a new disease? Perhaps it was just another form of *kayanga*, a disease with which local people had long been familiar. Finally, the father of the young man who had recently died of AIDS stood up and made an impassioned plea:

"Look, you all saw how my son suffered before he died. You all saw how he was.

Have you ever seen anything like that before? There is no cure for this disease. It's something completely new. We have to do something now to stop it spreading any further."

This meeting marked the start of a gradual process of raising community awareness of the gravity of the AIDS problem, and of the need for changes in sexual behaviour which reduce the risk of HIV transmission. The Chikankata AIDS team describes this process as 'community counselling'. As in the counselling of individuals or families, the team members spend a great deal of time listening and learning before giving information or trying to guide the discussion in a particular direction. The emphasis is on helping people develop a

sense of collective responsibility for dealing with the threat of AIDS.

"We believe," says Thebisa Chaava, social worker and AIDS counsellor, "that the only long-term hope for prevention is for communities themselves to feel a sense of responsibility for dealing with the problem of AIDS. They are the only ones who can change their behaviour and stop the spread of the virus."

The Chikankata team are convinced that the most sustainable form of safe sexual behaviour is faithfulness to one partner for life. Given the current high levels of sexual activity outside marriage, that ideal may seem unattainable for many. But only two decades ago extra-marital sex was far less widely practised in Zambia than it is today. The Chikankata

strategy is to encourage communities to reactivate traditional values and norms of sexual behaviour, which have been lost in the recent wave of 'modernization'. These include not only chastity before marriage and monogamy within marriage, but stable polygamy as well.

The Chikankata AIDS team is now involved in community counselling in ten different communities, which can be categorized as traditional villages (4), commercial farms (4), one peri-urban farming settlement and one urban area.

The process of community counselling passes through six stages:

- community selection
- building a relationship
- exploring the problem
- making decisions
- implementation
- evaluation.

The team usually enters the community

through patients coming to hospital for treatment. As with one-to-one counselling, the next stage of the process consists of building a relationship of mutual trust between the counselling team and the community group. The third stage is that of problem exploration, in which the team employs skills such as reflective listening, paraphrasing and summarizing, to help the community understand and define the problem – in this case, HIV infection. In the fourth stage, decisions are made: the community sets specific goals for behaviour change, and tries to arrive at a consensus on a strategy for action to achieve these goals. In stage five of the process, the community tries to implement this strategy, with the support of the counselling team. In stage six the counselling team and the community evaluate the extent to which the agreed goals have been achieved.

In Nega Nega, for example, a farming settlement near the railway line between Lusaka and Livingstone, the Chikankata team held a series of meetings with the community as a whole, and also with church leaders, other community leaders,

and the chief himself. The community reached a consensus that certain 'problem behaviours' were likely to place the health and wellbeing of community members at risk, in particular: premarital sex, unfaithfulness in marriage, drunkenness

leading to indiscriminate sex, and ritual cleansing by sexual intercourse. The community also agreed that they should try to achieve the following behaviour goals: abstinence from sex until marriage, faithfulness in marriage, and abolition of ritual cleansing by sexual intercourse.

After much discussion, the community also agreed on four courses of action to try to achieve these goals. First, they would reinstate traditional marriage ceremonies and pre-marital instruction and advice by elderly women. Second, they would organize talks about AIDS and health for village meetings, women's groups, church groups and school-age children, to be given by community leaders trained at Chikankata Hospital. Third, they would ask Chikankata Hospital to organize a training programme for local community leaders in ways of coping with and preventing AIDS. And fourth, they would replace ritual cleansing through sexual intercourse with alternative methods that carried no risk of transmitting HIV or other infections.

But not all communities are yet able to reach a consensus on the action strategies required to achieve agreed behaviour goals. In the urban setting of Kafue Gorge, for example, the community group defined its problem behaviours and behaviour change goals in much the same terms as the people in the Nega Nega farming settlement. They have not yet agreed, however, on action strategies to achieve these goals because some members of the community appear to be either unwilling or unable to stay faithful to one sexual partner for life.

The longer term importance of community counselling is its potential multiplier effect. It will never be possible for the Chikankata AIDS team to meet with more than a small handful of individuals, families, and community groups. What is needed is for communities to identify individuals who can become 'AIDS communicators' – influential local

leaders who can speak about AIDS with groups such as church congregations, trade union branches, women's groups, youth clubs, sporting and cultural associations, political parties and schools.

Ritual cleansing

Some traditional practices require particular counselling approaches. One of these is the 'ritual cleansing' of widows and widowers. In the Chikankata area, as in many other parts of Zambia, the family of the deceased has an obligation to prepare the bereaved spouse for another marriage. This is usually done by a member of the dead person's family having sexual intercourse with the widow or widower. It is believed that failure to carry out 'cleansing' correctly will result in the bereaved person going mad. In an area with a high prevalence of HIV infection in the sexually active population, however, this practice obviously carries the risk of further spreading the virus.

The Chikankata AIDS team tries to encourage safe alternatives to sexual intercourse as the preferred means of 'cleansing' after death. These alternatives have always been practised whenever sexual intercourse was not acceptable, for example if the widow was known to be pregnant. Three main alternatives are encouraged:

- The widow or widower sits undressed indoors, and a hoe is placed under his or her bent knees. The hoe is then presented to the bereaved person's family.

- The widow or widower is made to jump over a cow lying on its side. The cow is then killed and the meat distributed to the mourners.

- A member of the deceased's family sits on the widow or widower's lap. This is done indoors, no other persons being present.

In promoting safe alternatives to sexual intercourse as a means of 'cleansing' after death, the Chikankata team has been

struck by the influence of the family unit on individual behaviour. In several well-documented cases, the bereaved person has wanted to be 'cleansed' through intercourse, but has been persuaded not to do so by other family members. This underlies the importance of counselling the whole family about AIDS rather than individuals⁶.

Training

Training health professionals and others involved in AIDS care and prevention is an extremely important aspect of the work of Chikankata Hospital's AIDS Department. Every month, the Department organizes a one-week AIDS Management Seminar for groups from other parts of Zambia and abroad. Between July 1989 and February 1991, a total of 19 seminars were organized for 159 participants, 117 of whom were from Zambia and 41 from seven other African countries. Half the participants were nurses, most of the others consisting of clinical officers, teachers, health educators, medical assistants, social workers, doctors and pastoral care givers. The participants came from 70 different institutions, 40 of which were church-related, 23 were governmental, and seven were NGOs with no religious affiliation.

The approach to training is 'hands on': participants meet AIDS patients in the hospital and accompany the home care team on visits. At the end of the seminar participants present an action plan for implementing what they have learned. As of 1991, the AIDS Department also began visiting participants to provide follow-up support and guidance. (For details about how to register for an AIDS Management Seminar at Chikankata Hospital, please see p. 31.)

The AIDS Department has also organized one-week training courses for 39 people selected for training by the ten communities involved in the community counselling programme. Most of those

selected are farmers, some of whom are also volunteer Community Health Workers. The training covers AIDS prevention, and care and support for people with HIV/AIDS and their families.

The future

An important new development in the field of patient care is about to take place. Construction of a 25-bed hospital ward, to be called a 'special care' ward, is nearing completion. The new ward will be used to care for terminally ill patients, including many with AIDS-related illnesses. An additional ward is necessary because of existing pressure on hospital bedspace and the expected influx of even greater numbers of AIDS patients in the near future.

The new ward, however, also has an additional purpose: to prepare people to care for family members who are terminally ill. Family care-givers will take part in the care-giving activities in the ward, and will acquire practical knowledge and skills which they can use within the home when their family member is discharged. Since the new ward is close to the counselling centre, it will also be possible to provide the patient and his or her family with psycho-social support.

The new ward will be staffed by nurses and 'ward auxiliaries'. The latter is a new type of health worker, selected from people living within walking distance of the hospital, who do not qualify for nursing school but who have the qualities needed to care effectively for patients in this ward. They will complete a year of intensive training, with special emphasis on meeting the emotional, psychological and spiritual needs of terminally ill patients. They will also help to fill the gap caused by a shortage of nurses, which is a common and never-ending problem in many African countries.

The 'special care' ward will not function as a hospice for terminally ill patients or

as an isolation ward, but will be a normal part of the hospital. Patients from the ward will be free to walk around the hospital and socialize with other patients. Patients with HIV infection will still be present in other hospital wards.

Other important new developments will include new programmes to train school teachers, church leaders, members of women's associations and other community groups in AIDS care and prevention.

External assistance

The Chikankata AIDS control programme has been fortunate to receive financial assistance from donor organizations such as World in Need (U.K.), NORAD, the Australian Development Assistance Bureau, SIDA, the World Health Organization (through the Zambian Ministry of Health), CIDA, the Christoffel Blindenmission, and the Rotary Clubs of Sweden. This assistance has been used to fund a vehicle, a training centre, drugs,

medical supplies, HIV testing kits, laboratory equipment and reagents, a new hospital ward, an office building and staff accommodation, home-based care and community counselling, and AIDS management training seminars.

No health institution in Zambia can afford to maintain a comprehensive AIDS control programme without some external assistance, particularly to cover transport costs. But this should not deter anyone from doing what is possible, now, with existing staff and resources – for example, by training nurses and doctors in AIDS counselling techniques, or starting a 'pilot' home care scheme in communities that can be reached by bicycle or motorbike. A growing number of health institutions in Zambia are now adopting this approach.

Chikankata has been extremely fortunate in having donor agencies who are prepared to 'listen and learn' before deciding on what type of assistance to give. Other organizations working in AIDS control in Africa, however, may come under pressure to implement programmes which reflect the views of donor agencies rather than their own priorities. Consciously or unconsciously, donors may seek to impose models of AIDS control which have limited relevance to the African situation. It is vital for donor organizations to realize that the social, economic and epidemiological features of AIDS in Africa are often different from those in industrialized countries. AIDS control strategies and programmes in Africa will therefore differ in important ways from those of the industrialized world.

A national strategy

The Chikankata AIDS control team advocates a three-stage 'strategy for national behaviour change', as follows:

1. Care and counselling of individual patients and family members, starting in hospital and continuing at home.

2. Community counselling through regular meetings between community leaders and the AIDS team.

3. Communities counselling communities, as part of a national effort involving every available means of social organization, communication, and community leadership, with the goal of promoting the changes in sexual behaviour needed to curb the spread of HIV/AIDS. Those who could help to make this vision a reality include:

- political leaders at all levels
- community leaders (chiefs, village heads, councillors)
- church leaders and organizations
- voluntary agencies
- teachers and schools
- farmers' organizations
- trade unions and employers
- service organizations (Rotary, Lions, Jaycees etc)
- artists and entertainers
- women's organizations
- youth movements
- sporting clubs and cultural associations
- community health workers and village health committees.

"What we have to aim at," says Ian Campbell, the Salvation Army's Medical Adviser and formerly Chief Medical Officer at Chikankata Hospital, "is to move beyond counselling individuals, their families, and community groups. We have to get to the point where communities are counselling communities. That is the key ingredient in changing behaviour on a national scale."

One particularly pressing need is for AIDS counsellors – people who can give psychological, social and spiritual support to AIDS patients and their families. Every hospital in Zambia should have a core of trained AIDS counsellors. But counsellors need not be hospital-based health professionals. They can also come from other walks of life and can work within

community-based organizations, such as The AIDS Support Organization (TASO) in Uganda⁷.

A climate of hope

Pioneering initiatives such as the Chikankata approach to AIDS care and prevention are invaluable because they blaze a trail for others to follow. But the fight against AIDS needs to become a broad-based social movement involving people from all walks of life. At national level, such a movement is starting to take shape in Zambia. The government's National AIDS Prevention and Control

Programme promotes the message 'One man, one woman for life'. Cabinet Ministers, members of parliament and other political leaders have taken part in workshops and seminars on AIDS. Drama groups have reached large audiences through plays about AIDS. Groups of traditional healers, media workers, teachers and hotel staff have taken part in AIDS workshops, talks and discussions. Over 700 Anti-AIDS clubs, with over 27,000 members, have been started in primary and secondary schools, in companies and church congregations, in health centres and hospitals, in tertiary

institutions and Army training schools, and also by nursery school teachers, nutritionists and Red Cross volunteers.

The mass media have also helped to raise public awareness of the threat of AIDS. It is important that the mass media help to create a climate of hope rather than fear, to dispel public misconceptions about how AIDS is spread, and to combat discrimination against people with HIV/AIDS.

The magnitude of the challenge ahead, however, should not be under-estimated. HIV infection is already so widespread that, in the absence of a cure, tens of thousands of Zambians will die prematurely of AIDS during the 1990s.

Many thousands of children will be orphaned, families decimated, and old people left without social or economic support. Within five to ten years, virtually everyone in Zambia will have known someone who has died from AIDS. The economic consequences will also be grave, as many thousands of skilled people in their most productive years will fall ill and die.

Tragically, most people are unlikely to alter their sexual behaviour until evidence of the need for change becomes overwhelming.

But the message emerging from Chikankata is that there is hope.

There is hope for people with HIV and AIDS: that they will not be rejected by their families, abandoned by the health services, and ostracized by society, but can still lead socially useful lives.

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There is hope for the families of people with HIV and AIDS: that, in caring for their loved ones, they will receive the support of the nursing and medical professions, of religious and community organizations, and of their neighbours and friends.

There is hope for members of the community: that, through changes in their own sexual behaviour, they can protect themselves and their families from HIV infection.

There is hope for doctors, nurses, paramedics and social workers: that they can come to grips with AIDS by forging new working relationships with family members and community groups, rather than trying to deal with the problem on their own.

There is hope for community organizations, schools, employers, religious leaders, voluntary agencies, political parties, and all levels and branches of government: that they can help to combat AIDS by promoting responsible sexual behaviour and positive living.

And there is hope for society as a whole: that in a spirit of honesty and openness, people can be mobilized to confront and eventually overcome one of the greatest health threats of the twentieth century.

The Chikankata experience of AIDS care and prevention is an embodiment of these hopes, based on faith in God and in the capacity of human beings to act in the interests of their own survival.

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FROM FEAR TO HOPE

AIDS Care and Prevention at
Chikankata Hospital, Zambia



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