Outcomes of a community-based HIV/AIDS education programme for rural older women in Botswana

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Abstract

This article describes the experience and outcomes of a community-based educational programme to prevent HIV infection in older rural women in Botswana and to utilize the women as resources to educate members of their communities in the prevention of the disease. The programme used the primary health-care approach to develop and test gender-specific and culturally-relevant materials for the older women. Programme evaluation employed a quasi-experimental design with older women in a second village serving as a control group. Six months after programme implementation, the older women in the target village were more knowledgeable about HIV/AIDS than those in the control village. The sexually-active women were practising safer sex, and all were collaborating with health personnel in community activities for HIV/AIDS prevention and care. These activities are continuing and are being sustained by the village health committee.

Introduction

The Republic of Botswana, located in Southern Africa, is estimated to have a cumulative total of 207 000 persons with HIV infection and over 27 000 persons with AIDS (AIDS/STD Unit, 1998). In a country of only 1.5 million persons, this poses an enormous economic and social burden and has created a situation whereby hospitals cannot cope with the care of people with HIV/AIDS. The care of these clients has been increasingly shifted to their homes, especially in rural communities, and research has shown that older rural women have become the major carers of people with AIDS (Tlou, 1996). What this means is that the major burden of care has been placed on them even though they have little knowledge on the provision of care to people with AIDS in the home. Older women are also themselves at risk of contracting the disease and need to be educated in the prevention of the disease.

These practical considerations indicated a need for the consideration, implementation and evaluation of a special programme on peer education for older women in a rural village. Such a programme arose out of the success of the Women and AIDS Prevention Programme (Norr, Tlou & Elmurry, 1993) and a later pilot project with a sample of 67 older women which was found to be successful (Tlou, 1996).

This article reports on the subsequent intervention study whose aim was to evaluate the programme and to use it as a demonstration of best practices in research initiatives to collaborate with rural lay people in HIV/AIDS education and control. Through such programmes, health personnel can work with communities to develop gender-sensitive programmes that empower rather than disadvantage older women in rural villages and communities.

Methodology

The methodology and the rationale of the programme have been described in the report of a previous pilot intervention (Tlou, 1996). In the pilot survey, it was found that older people have beliefs about HIV/AIDS which are based on cultural perceptions regarding disease causation and have limited knowledge about HIV/AIDS due to inappropriate and irrelevant educational messages, but can be educated to be community resources in HIV/AIDS prevention for the nation of Botswana. Similar projects done in other countries have shown the success of using lay people as resources in HIV/AIDS prevention and care (Barbosa, Cavalcanti, Rodrigues *et al.*, 1998; Djafalo-Potcho, 1998; Martin, 1995). None of the reported projects targeted older rural women, yet it is known that in most of sub-Saharan Africa young urban people who have AIDS often go home to the rural areas to be cared for by older female relatives. These older rural women need to be empowered in HIV/AIDS prevention and the care of people with AIDS.

In the current project, the peer group leaders from the pilot project were assisted to train 100 women aged 50 to 68 years in one village; another 100 women of the same ethnic and age groups in a nearby village would serve as a control group. Each peer group leader had six to ten group members to lead in discussions on HIV/AIDS. The same objectives for the pilot intervention were used, i.e. an increase in knowledge about HIV/AIDS and safer sex practices, and discussion of gender issues and sociocultural factors in Botswana women's lives that increase their vulnerability to HIV/AIDS (Tlou, 1996).

The group leaders were supported by community nurse-students as part of their clinical nursing practicum. Two nurse students were assigned to each group. Their main role was to help the group leaders in further clarifying some of the concepts, to give the groups stationery and materials as needed,

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to assist by showing and explaining videos, to co-ordinate group reports and process recordings, and to collect and process data. In short, the nurses were the actual support system for the group leaders, with the instructor (researcher) being the overall project co-ordinator and evaluator. All members of the Village Health Committee, including those under 50 years of age, also participated in the peer group training sessions so that they could later sustain the activities.

Evaluation design

The education and support intervention was evaluated using a modified time series design (Campbell & Stanley, 1963). A total of 100 group members were interviewed before they commenced the educational activities. A convenient sample of 100 older women which served as a control group were interviewed in a different village. The survey instrument was developed from the results of the original qualitative survey and assessed HIV-related knowledge and beliefs, attitudes and self-reported risk behaviours, as well as HIV/AIDS sufferer care activities in the home and in the community (Tlou, 1996).

About six months after the completion of the peer group training sessions, the survey instrument was again administered to the groups in the two villages to see if there had been changes in the intervention group as a result of the intervention. The group numbers were fewer (86 and 79, respectively) due to deaths and members moving to town or another village.

Results

Table 1 shows the demographic characteristics of the older women in the two villages. The two communities are of the same ethnic group and are similar in most characteristics such as marital status, education and literacy in Setswana. All members of the communities are homemakers and farmers. The majority of the respondents have obtained a primary school education which is consistent with the high adult literacy rate (78%) in Botswana. Most of the respondents were married or widowed, and the latter had all undergone cleansing rituals after their spouses' deaths to avoid *boswagadi* (the widow's disease).[1]

In the baseline surveys, the respondents in both village communities had demonstrated low levels of knowledge about HIV transmission. They were all aware that the major routes of transmission in Botswana are sexual, perinatal, and through blood and blood products, but in the end all of this was tied to their belief of AIDS as *boswagadi*. They therefore believed that traditional healers could cure AIDS. All also believed that mosquitoes can transmit HIV since they are blood sucking and that one can tell if a person has HIV. However, less than 20% of the women in the intervention group and the control group had seen someone with AIDS, let alone cared for a such a person.

Table 1
Demographic characteristics of older women: percentages

	Intervention group (Village 1) %	Control group (Village 2) %
Total	100	100
N	100	100
Age group (years)		
50 - 54	20	23
55 - 59	45	37
60 - 64	23	25
65 - 69	12	15
Education		
None	8	5
< 8 years	76	78
8 - 12 years	10	7
> 12 years	6	10
Marital status		
Never married	4	5
Married	65	60
Widowed	29	31
Divorced	2	4
Number of children		
None	3	3
1 - 3	21	18
4 - 6	76	79

Impact evaluation

Knowledge and concern about HIV/AIDS

Table 2 shows some of the HIV/AIDS knowledge and related prevention behaviours of the intervention group and the control group after the intervention. The results suggest that there has been a general increase in knowledge as a result of the intervention. Specific items where the scores after the intervention were high include: AIDS is caused by a germ; AIDS is not *boswagadi*, AIDS cannot be cured; AIDS cannot be transmitted through use of public toilets, handshaking, sharing utensils or through mosquito bites. Knowledge of STD symptoms also increased for the post-intervention group. When asked what behaviour changes would help to avoid AIDS, the post-intervention group mentioned more correct safer-sex practices than the control group. Even attitudes towards condoms became more positive with women in the intervention village becoming eager to learn for themselves and to teach younger male and female family members. All could correctly demonstrate the correct use and disposal of condoms, and were bold in being able to go to the village clinic and request free condoms for distribution to other community members.

Table 2
Post-intervention HIV/AIDS knowledge and prevention activities: percentages of "yes" responses

Knowledge/activity	Intervention group (Village 1) %	Control group (Village 2) %
N	86	79
Knowledge (agreement)		
AIDS is *boswagadi*	2	72
AIDS can be cured by traditional doctors	2	78
AIDS is transmitted through mosquito bites	0	65
Behaviour (sexually active, n=56, 63)		
Has only one sexual partner	98	95
Used condom at last sex	56	20
Talked to partner about HIV/AIDS	100	36
Knows how to use a condom	100	27
Celibate/abstains	35	20
Community activities		
Seen a person with AIDS	58	18
Cared for a person with AIDS	19	9
Buried a person with AIDS	32	3
Talked to four relatives about AIDS	100	14

It is worth noting that for both groups of women, none reported exchanging sex for money, being involved in a scarification ritual, or being a traditional midwife. The latter finding is not surprising since more than 90% of Botswana women deliver their babies in a health facility attended by trained health personnel and not at home.

Safer-sex practices

Previously very few women in both groups had ever used condoms, let alone talked to their partners about them. The peer-group intervention enabled more women (100%) in the intervention group than in the control group to discuss AIDS and its implications with their husbands and partners. There was also an increase (56%) in the number of women who used condoms correctly, but the women only used condoms with partners whom they had reason to believe were "having affairs with other women." Where there were no such suspicions, the women talked to their partners about HIV/AIDS and mutually "contracted" to use condoms outside the relationship if such a situation ever arose. Issues of trust still prevent many women from negotiating the use of condoms with their husbands.

Women who had received the intervention were more likely than those in the control group to have talked about HIV/AIDS to their partners, female relatives, daughters or sons, and co-workers and neighbours. For example, the proportion in the intervention group who had talked to at least four male or female relatives increased from 12 to 100%.

Community activities

Before the intervention, some of the older women had heard about AIDS in the media but claimed that they had not seen a person with AIDS. After learning about the signs and symptoms of AIDS, they were able to even recall that some of the relatives they had cared for or buried had probably died of AIDS. With their new knowledge and awareness of the disease the majority now each knew of someone in the village, or of a relative who has AIDS, and most have participated in the actual care of a person with AIDS and have taught others how to care for such a person both physically and emotionally. More than half (72%) have also addressed community meetings on HIV/AIDS. In the control group on the other hand, the majority of older women appear to still be caring for and burying relatives, but not understanding the real cause of AIDS and how people can be protected from the disease. The majority of this group appeared to continue to believe that AIDS is witchcraft or *boswagadi,* and that it can be cured by traditional doctors. However, the number of believers has decreased generally, and this may be related to the activities and success of the national HIV/AIDS educational programme which is transmitting more messages and talk shows in Setswana.

Discussion

The main limitation of this project is that only one community was targeted for the intervention, while another village served as a control group. The results may not be generalizable to older women in other villages. However, this particular project was initiated to test the effectiveness of a theoretically derived peer education intervention model which was previously evaluated and found to be successful among childbearing women and adolescent women in Botswana (Norr, Tlou & McElmurry, 1993). The results suggest that programmes for older women using the same theoretical model could be successful.

A year after the intervention, the older women were still enthusiastic and continuing with their AIDS prevention activities. Even those who had stopped for grain harvesting resumed their activities and completed them before the next ploughing season.

The self-reported changes that the older women experienced may be categorized into four main themes:

(1) **Increased knowledge about sexual health, HIV/AIDS and other sexually transmitted infections.** The most important outcome was the ability of the women to differentiate between AIDS and *boswagadi* The intervention helped the older women in the intervention village to clarify the myths and superstitions regarding witchcraft, mosquitoes and sexual taboos relating to *boswagadi.* It is now commonly known among these women that AIDS and *boswagadi* are dissimilar but that their prevention is similar (abstain and be faithful), and that while *boswagadi* may be cured by a traditional doctor, AIDS has no cure. A recent study by Chimidza, Shatera, Baleki and Nxumalo (1998) in the same community using a larger sample of men and women revealed that the majority (76%) of the older people stated and explained that AIDS is not *boswagadi.* Beliefs are indeed changing, but it will take a long time.

(2) **Sharing and discussing problems with partners, peers, daughters and sons, daughters-in-law, grandchildren and other youth in the village.** These empowered older women were able to empower others through imparting greater knowledge about HIV/AIDS. The women reported that these discussions have brought them closer to their relatives, especially their own sexual partners with whom they had rarely talked about matters of sexuality.

(3) **Accepting responsibility for the way in which their own very influential behaviour affects others and working hard to change that behaviour.** A great deal of discussion during some of the sessions centred on how older women themselves perpetuate harmful traditions such as advising a bride not to question the movements of her husband *(monna ga a botswe, ga a latelwe),* to maintain peace in her home. This message, they stated, forced women to tolerate infidelity and predisposed them to sexually-transmitted infections, not to mention the mental anguish of wondering where one's husband is at midnight and not being able to ask him about it when he eventually returns home in the early hours of the morning. They campaigned to revise the messages given to newly-weds and even had talk shows on the national radio about them. Indeed, the advice given to brides and grooms these days emphasizes fidelity, mutual sexual satisfaction and good communication. The menfolk do not seem to be threatened by these messages and feel that "the women were always the ones who wrongly encouraged us."

(4) **Caring for those infected and affected by HIV/AIDS.** It is still uncommon for relatives at a funeral to mention that the deceased family member died of AIDS but such announcements are being made increasingly, with speakers at funerals exhorting youth to follow traditional values and to act in a sexually responsible manner. This is due partly to the fact that the women collaborate with community-health nurses and family-welfare educators to identify and work with families in the community who are caring for chronically ill persons regardless of the diagnosis. They provide gloves and, in some instances,

food packages, teach the main carers to observe the universal precautions of caring, and provide respite care where it is needed so that the carer can rest or do other outstanding chores. AIDS is being accepted as a disease, just like any other disease that requires physical and emotional care. Indeed, a 22-year-old youth of this village has recently gone public about her HIV diagnosis and is being helped by two of the older peer leaders to form an HIV/AIDS support group. She is accepted throughout the community although some people still believe that it is "just a publicity stunt, she is too beautiful and healthy to be infected with HIV," a manifestation of the denial that still exists in the whole of Botswana.

Conclusion

Baseline data suggest that although basic knowledge about HIV/AIDS is generally high in Botswana, there are still older people who hold myths and superstitions that could reinforce fatalistic behaviour even among younger people. Community-based interventions are still needed to augment knowledge of HIV among older people and to empower them to care for those infected and affected. The major outcomes of this intervention were that older women became more knowledgeable about HIV/AIDS and its prevention, learned how to discuss and negotiate sex with their partners, shared and supported their relatives in HIV prevention and care, and generally became more effective leaders and decision makers in their communities. Thus community-based HIV/AIDS education programmes, led by older rural women, may help to reduce the impact of the epidemic on the nation of Botswana which is currently one of the most affected countries in the world.

Note

1. *Boswagadi* is a state of widowhood whereby after the death of a spouse, the remaining spouse has to undergo ritual cleansing and observe several taboos, the major one being sexual abstinence for a period of a year. The purpose of these rituals is to dissolve the physical and spiritual unity between the living and the dead spouse that was established at marriage and at subsequent births of children. At the end of a year, only a traditional doctor can perform the purification rituals and declare that the widow(er) can now live as a single person, i.e. have sexual relations, marry, etc. It is believed that failure to observe the rituals and abstinence can result in disease and ultimate death of the widow(er), or any person who has sex with him/her. The term *boswagadi* is also used to name the disease resulting from failure to observe the prescribed rituals.

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