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Habari: Spreading the news about HIV to African communities in London

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This paper reports on an innovative HIV awareness project for African communities in London. Some of the challenges faced and lessons learned are described and reflections on the specific role and contributions of psychologists to this work are offered.

Introduction

African communities in the UK are disproportionately affected by HIV. However, African people have not benefited from improved medical interventions for HIV to the same extent as other groups, as they are often diagnosed at a later stage of disease progression (Department of Health, 2005). Furthermore, African people living with HIV in the UK have been identified as having greater overall need in terms of poverty, housing, and immigration problems compared to other groups (e.g. Anderson & Doyal, 2004; Wetherburn *et al.*, 2004)

Qualitative research indicates that, amongst migrant African communities, fears of HIV-diagnosis and related stigma and discrimination are key factors among those reluctant to uptake voluntary confidential HIV testing (Elam *et al.*, 2006). Earlier studies of the sexual attitudes and lifestyles of African communities in the UK also

indicated that a majority of people did not perceive themselves as being at risk of HIV infection (e.g. Chinouya *et al.* 2000).

It is widely acknowledged that behaviour change in the context of HIV risk reduction involves change not just in individual attitudes, beliefs and behaviour but also at the level of communities and cultures. Information alone cannot change behaviour and reduce risk. It is necessary to address issues of power and control and to build a 'safer sex culture'. Successful models of HIV prevention include community-based outreach activities, often involving peer workers or volunteers who are seen as credible with the target populations (Pulle *et al.*, 2005). The information provided and the format in which it is presented must be culturally appropriate and not simply adapted from that used with other groups. Sexual health issues that have been identified as requiring culturally competent attention among African communities include: perceptions of condoms and particular sexual practices, polygamy, reproduction, breastfeeding and secrecy and taboos regarding sex and relationships (Department of Health, 2005).

The authors worked in clinical psychology (AB and CB) and health promotion (FM) in an inner London borough with a high population of first generation Sub-Saharan African residents. We combined our resources as trainers and group facilitators with our experience of working in sexual health settings to further develop a program to target the local population and spread the news about HIV with a culturally informed approach. This paper reports on some of the challenges and successes of the project.

Habari

Habari is a Swahili word meaning “Hello” and “News” normally used in greetings in East Africa. The Habari project was founded by a group of African people who were diagnosed with HIV/AIDS in the early 1990’s. Having felt that they had contracted HIV due to lack of awareness, they decided to start up a project that would carry the HIV message (the ‘Habari’ or ‘news’) to alert fellow Africans with the objective that they would then go on to inform others about how to prevent the spread of HIV infection. Sadly, as time went on these founders of Habari died and it was decided that, to honour their wishes, Habari would continue under the African Communities Team of the Health Promotion Service of Camden and Islington Primary Care Trusts.

The aim of Habari is to reduce HIV transmission among African communities by raising awareness of HIV and dispelling myths; increasing safer sex practices; increasing uptake of HIV testing and improving access to HIV and sexual health services. Habari consists of a rolling programme of workshops on HIV awareness and safer sex. In order to gain a certificate participants are required to attend three workshops: Basic and Advanced HIV/AIDS awareness and a workshop on Cultural/Social Issues. The latter addresses key cultural beliefs and practices that may put African people at increased risk of HIV and is always led by African facilitators from the African Communities Team. All workshops are provided in English and French and take place on Saturdays. The provision and sharing of lunch and the availability of a crèche increase accessibility and promote openness, warmth and trust between participants. Participants and Habari staff go on to promote sexual health services and information to other African people through ‘word of mouth’. Habari also involves outreach activities, including distribution of condoms and reading materials at community venues and events.

Recruitment

Habari is promoted via informal networks and in venues such as African restaurants, barbershops, minicab drivers, African night clubs, Sexual Health Clinics, relevant statutory and voluntary sector organisations and local libraries. Outreach is also extended to community events including African wedding functions and parties, funerals, Christenings, African Summer sporting events, house parties, African National celebration days and political gatherings.

Data collected from workshop participants indicated that most people learnt about Habari through their community groups (23.5%) or word of mouth (22.6%). A significant proportion also first heard about Habari through coming into contact with a Habari volunteer (19%) or seeing a flyer (17.4%). This community-based recruitment was only possible because of the excellent contacts the African Health Promotion Team had built with local communities in the borough, strengthened by employing staff from these communities.

Participants

Habari has been operating since 1999. During that time, it is estimated that more than 450 people have attended the seminars. Demographic data from the first six years of operation indicated that 57.8% of attendees were women. The majority of attendees were in their 30's (40%), with 26% in their 20's, 22% in their 40s and 6.7% in their teens. 80% of attendees were from African communities, with 38.3% from Uganda. The next largest groups attending were Congolese (9.8%), Rwandese (5.8%) and Kenyan (4%).

Challenges and successes

Habari has established itself within community networks to allow information about workshops to cascade through locally based African communities. However, Habari has been most successful targeting women, and those from countries where the risks of HIV are well publicised with well-established health promotion campaigns (e.g. Uganda). It would seem that Habari still has some way to go to try to increase participants who are more at risk, namely young people (particularly young men) and those from communities where HIV carries the most stigma, thereby making it more difficult to talk about. Doing this successfully may require a different approach, for example, Habari worked in partnership with ‘Horn Reflections’ – a community-based organisation working with young people from Horn of Africa communities. Following an individually tailored set of Habari workshops, the young people produced a play addressing issues of HIV, teenage pregnancy and mental health and this was performed for members of the community.

If lessons are learnt from existing successes, another way to improve access for different communities would be to train volunteers from these groups to be peer educators and recruiters. This would involve linking with established community groups such as youth groups, religious organisations or through school networks. In addition, the use of interpreters could widen the communities targeted beyond English and French speakers. For all these endeavours, the need for confidentiality for personal reflections, culturally sensitive information and respect is paramount.

Difficulties and dilemmas: A clash of cultures

One of the difficulties in establishing and supporting Habari was the clash of cultures between the NHS and ‘grassroots’ African community organisations. An example of this was the NHS requirement of formalised records of meetings and expenses in order to provide funding, which caused offence to some who attended. Indeed, there was a reduction in attendances when the organisers stopped giving cash and people had to produce receipts and fill forms to claim back expenses. As Habari was run on a Saturday, people already felt they were generously giving up their time without being scrutinised to prove attendance.

The roles and involvement of clinical psychologists

As noted earlier, information alone is insufficient to bring about behaviour change in relation to HIV risk. As clinical psychologists, we feel that we have been able to bring our knowledge and experience of helping people make changes in their sexual behaviour, adjust to HIV infection and negotiate in relationships. We feel that taking part in projects such as Habari fits with a community psychology approach, which aims to build capacity within communities and prevent both mental and physical health problems. However, our participation was not without challenges.

As white Western women (AB & CB), we were faced with a number of challenges and dilemmas in doing this work. For example, we were positioned as ‘experts’, yet from a different culture to the participants. We were aware of the potential for taking a ‘colonial’ position, righting misunderstandings and myths and imparting ‘true’, ‘scientific’ knowledge. This sits somewhat uncomfortably with the ‘non-expert’ approach we use in our clinical work (Anderson & Goolishian, 1992) and challenges the sense of relativism inherent in many post-modern approaches to therapy. It helped

us to be reflexive about our own beliefs and acknowledge that we believe that some ideas about HIV are ‘better’ than others, e.g. that it is not a punishment from god, that lemon juice or prayer won’t protect, that Western medicine is not incompatible with putting one’s faith in God.

Negotiating the challenges

Inviting multiple perspectives, both from within the room and outside, (e.g. *is there anyone else in your church who holds a different view?*). An example of this occurred during one session, where a man said that he had heard that if a woman put lemon juice in her vagina prior to sexual intercourse, it would protect against HIV infection. We responded by asking the women in the room what they thought of this. They were unanimous in declaring this a potentially painful and counterproductive strategy as it would lead to soreness and abrasions (this is exactly what the ‘scientific’ approach asserts).

Highlighting African expertise

While the Western media almost invariably presents African people as passive ‘victims’ of HIV requiring Western aid, Africa is in fact the site of many innovative and successful approaches to HIV prevention, care and research. For example, Uganda and Senegal’s successful HIV prevention programmes and Botswana’s success in improving rates of HIV testing. Furthermore, much research from Africa has placed HIV in a wider social, economic and political context rather than focusing on knowledge, attitudes and beliefs. Successful projects have involved addressing issues of gender inequality, providing employment and thus economic empowerment to women and young people (Pronyk et al., 2005). We refer to these as examples of

good practice in the training and find that participants are usually interested to discuss the developments in HIV programmes in Africa as well as the UK.

An important figure in African HIV prevention has been the Ugandan singer turned AIDS activist, Philly Bongole Lutaaya. His music and his death from AIDS in 1989 had a huge impact and most participants in Habari were familiar with him and shared stories about his influence. There has never been such a prominent figure in Western popular culture who has spoken so openly of his/her HIV status.

Acknowledging limitations and challenges in Western approaches

We found that participants often assume that HIV prevention efforts are relatively unproblematic in other communities, e.g. they may say ‘it’s ok for people in the UK because you can talk openly about sex, but we can’t in our communities’. We have found that people are generally very interested and sometimes surprised to learn that, at the beginning of the HIV epidemic, it was anything but easy to discuss sex openly, for example, we share stories about the furore when a TV presenter demonstrated putting a condom on a cucumber on TV, or when a Health minister in the then conservative government did not know how to pronounce ‘vagina’. We emphasise that it was largely HIV that made us have to begin talking more openly about sex and that many challenges remain. We also share some of the difficulties and taboos we encounter trying to do sex education in schools.

Being transparent about what we don’t know

While presenting the current ‘scientific’ evidence on HIV/AIDS, we are also open about the fact that much remains to be known and there are questions that science has

not been able to answer. For example, people are often interested in the debates about the origin of HIV and we acknowledge that there are numerous ideas about this, none of which have been definitively supported. We try to facilitate discussion of the impact of various ideas or beliefs, seeing them as not right or wrong but more or less helpful.

Knowing when to step back

The Habari seminars specifically focusing on cultural issues have always been facilitated only by African facilitators. We have always respected this desire for an African-only forum for discussion and have had to manage our curiosity about the discussions that happen there.

Information sharing is therefore two-way, as in the position of trainers we feel we are guests and not experts on culture, but there to share our knowledge and process together how this fits into participants' lives. It has been a rich and generous learning experience for all involved.

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