POTENTIAL OF A LOCAL COMMUNITY INITIATIVE IN HIV PREVENTIVE STRATEGIES AND CARE: THE CASE OF *"NYOLUORO"* IN USIGU DIVISION, SIAYA DISTRICT

BY

GUNILLA ATIENO OUKO

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other university,

..... Date: 25/5/99

Gunilla Atieno Ouko

This thesis has been submitted with my approval as a University Supervisor.

..... Date: 15-6-99

Prof. Simiyu Wandibba

DEDICATION

In loving memory of my mother

Joyce Aoko Ouko

"Your candle burned out

long before your legend

ever will."

With love to my father

John Ouko Reru

To my children

Joy and Tony

"You have been bundles of joy"

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LIST OF ABBREVIATIONS

AIDS	:	Acquired Immuno Deficiency Syndrome
CAWs	:	Community AIDS Workers
GDP	:	Gross Domestic Product
HIV	:	Human Immune Virus
KNACP	:	Kenya National AIDS Control Programme
KCHP	:	Kariobangi Community Health Programme
KDAP	:	Kitui District AIDS Programme
MMM	:	Medical Missionaries of Mary
PWA	:	People with AIDS
RTIs	:	Reproductive Tract Infections
STDs	:	Sexually Transmitted Diseases
TASO	:	The AIDS Service Organisation
TCI	:	The Community Initiative
UNDP	:	United Nations Development Programme
VOWRI	:	Voluntary Women Rehabilitation Institute
WASN	:	Women and AIDS Support Network
WAMATA	:	Wako Katika Mapambano na AIDS

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ABSTRACT

This study examined the potential of a local community initiative, *nyoluoro*, in HIV/AIDS prevention and care in Usigu Division of Siaya District. It was designed to investigate whether the groups are in any way involved in disseminating health information to the community and to document the groups' perception of AIDS and anti-AIDS efforts. The study also sought to find out whether women, who constituted the majority in the groups, could provide home-care to AIDS patients, as well as to ascertain whether the groups could extend their financial resources from the rotations to provide support to AIDS widows and orphans.

The study, which was done between the periods of October 1997 and February 1998, enlisted a total of 100 respondents. In order to have a comprehensive study, the respondents were stratified into groups which included 91 respondents currently involved in the groups, 6 who had never joined the groups and 3 that had opted out of the groups. There were thirteen *nyoluoro* groups that facilitated the study; seven of them were registered while six were unregistered.

Data were collected by means of structured interviews, focus group discussions and key informants. Data analysis involved the use of descriptive methods and presentation was in the form of frequencies and percentages.

The study came to the conclusion that one, *nyoluoro* groups have positive perceptions of AIDS and anti-AIDS efforts and also have potential to disseminate health information. Two, women, being the majority in the groups, are capable of providing

home care to AIDS patients. Three, the groups have the capability to extend their financial resources to provide financial support to AIDS widows and orphans.

The study also revealed some limitations that might prohibit successful involvement of the groups in implementing AIDS preventive efforts. These include lack of adequate information on AIDS issues and fear of infection in the course of providing care.

The study, thus, recommends that there is need for training the group members on AIDS related issues, through seminars and workshops, to enable them provide accurate and adequate information on AIDS to the local community. It also recommends that simple medical kits consisting of gloves, disinfectants and other simple equipment, should be freely given to care-providers, to protect themselves against the possibility of infection in the process of providing care. Finally, many other local initiatives other than *myoluoro* groups existing at the local level, should be educated on the fact that they are potential resource persons in the fight against AIDS in their communities.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

AIDS (Acquired Immune Deficiency Syndrome) is spreading at an alarming rate in various parts of Africa. Sometimes one wonders whether any more efforts should be made to curb the pandemic or whether people should just resign themselves to fate. This is primarily because despite the numerous attempts made since the onset of the pandemic in the early 1980s, AIDS cases continue to escalate. In Africa the situation is worsened by chronic political unrest, famine, poverty, depreciating economies and balance of payments deficits. This shows that AIDS is not only a health issue but a complex one that encompasses all aspects of human life and, thus, a major peril to modern life (Forsythe and Rau, 1996). In Kenya, for instance, recent estimates by the National AIDS and STDs Control Programme show that about 900,000 to 1,000,000 adults and 60,000 to 80,000 children under the age of five are living but infected with the HIV virus which causes AIDS (Government of Kenya, 1997a). The numerical figures are not static but increase daily, thereby making AIDS the single most important health problem that can reverse gains already made in the life expectancy and infant mortality (Government of Kenya, 1997b). It is becoming evidently clear that the solution to the AIDS pandemic is not a simple one, especially as it has no known vaccine or cure. The only hope seems to lie in prevention and, as Frankenberg (1993:275) observes, "prevention is not only better than a cure but is a cure in itself". The ability of HIV/AIDS to disperse quickly across a population in a short while necessitates interventions that can curb the spread before it saturates populations (Coates 1994). One such intervention that may probably reduce the

potential of HIV/AIDS before it spreads across populations is a community initiative which can do the following:

1. Educate members of the community by providing consistent and correct messages;
2. Direct specific interventions to the most vulnerable groups in the community, such as women and young adolescents;
3. Provide an enabling social environment for people with HIV/AIDS so that they feel wanted and accepted in the community;
4. Provide a social environment which encourages healthy behaviour, such as, abstinence from both pre-marital and extra-marital sex; and
5. Provide a social environment which discourages ill-health sustaining behaviours through taboos, curses and ostracization (Coates, 1994).

It is on the basis of the strengths cited above that this study was designed to find out the potential of a local social initiative, *nyoluoro,* in HIV/AIDS preventive and care efforts. *Nyoluoro* may be defined as a rotating credit association (Lewis, 1976). Upon joining such an association each member assumes or creates an obligation to save a certain amount of money over a period of time. The money then becomes the property of each contributor in the group at every rotation. Generally, members use the money for various needs such as buying household goods, expansion of business, medical expenses, paying school fees for dependants and settling other pressing needs. Though such groups are economic-oriented, this study aimed at finding out in what ways such groups could extend its economic resources and group unity in mobilizing the whole community in HIV/AIDS preventive and care efforts.

1.2 Problem statement

The number of confirmed HIV infections and AIDS cases in Kenya rises daily. The disease adversely affects the economically productive age group (20-49years). Geographically, Nyanza Province has the highest recorded AIDS cases since 1990. The cumulative total AIDS cases amount to 22,214. The second highest is Eastern Province, with a cumulative total of 12,603 reported cases. The lowest reported AIDS cases are in North-Eastern Province, with a total of 279 cases (KNACP, 1997). In Nyanza Province, Kisumu District takes the lead, with about 5,611 full-blown AIDS cases reported. Siaya District follows, with a total of 5,201 AIDS cases. These recent statistics for Siaya show a notable increase of cases reported today as compared to the period between 1989-1993 when the cases ranged between 1,362- 2,118(Government of Kenya, 1994).

This increase is probably aggravated by factors such as resistance to condom use, male migration, widow inheritance, polygyny and increased pre-marital and extra-marital sexual relations which are cited to be extremely prevalent in the district (Government of Kenya, 1994). The government has limitations as to what it can do, especially with regard to individual behaviour change. Evidently, some of the cultural practices that predispose people to HIV infection are deeply entrenched and cannot be changed overnight. This scenario then means that the community has the burden of deciding what is best for its members. It is more at the level of the family and community that the pandemic's social, cultural and psychological dimensions can best be tackled if any substantive preventive efforts are to be made (UNDP, 1995). Similarly, despite the increased number of AIDS cases in recent years, donor funding has hit recession and decline worldwide. Furthermore, AIDS is also affecting western societies and this means

that national governments have the task of solving this problem on their own without expecting external support from donors. The many pressing needs that governments have to plan for, such as education, political stability, infrastructure and environmental degradation, other than AIDS, make planning for AIDS prevention by national governments difficult. The already existing national AIDS programmes established by national governments are either under-resourced or over-stretched and cannot serve the needs of the increasing AIDS patients. The terminal nature of AIDS implies that a lot of resources have to be spent on an individual patient, yet AIDS is incurable. These challenges facing national governments in their efforts to curb AIDS call for a concerted effort between the government and the community. Communities must then be empowered to cater for themselves where the government has limitations.

Communities have to face challenges of taking care of their ill patients, disseminating preventive messages, looking after an increased number of AIDS orphans and caring for AIDS widows and widowers. These challenges need immediate and urgent action before the situation becomes uncontrollable. The question is "Are communities sufficiently equipped to face the AIDS challenge?" To answer this question research should be undertaken to find out at what level and how communities can be integrated in anti-AIDS efforts. This study was, thus, designed to find out how a local community initiative, *nyoluoro*, can be integrated in AIDS prevention and care strategies. It was designed to answer the following questions.

1. Does the *Nyoluoro* group involve itself in the dissemination of health information to the community?
2. What would be the group's perception about being involved in anti-AIDS efforts?

3. Since women are caregivers and constitute the majority in the groups, can they provide home based care to AIDS patients?
4. Can the group extend the financial resources from the rotations to provide care to AIDS widows and orphans?

1.3 Objectives

1.3.1 General Objective

To investigate the potential of a local community initiative, *nyolouro*, in HIV/AIDS preventive strategies and care in Usigu Division of Siaya District.

1.3.2 Specific Objectives

1. To investigate whether the group is in any way involved in disseminating health-related information to the community.
2. To document the group's perception about being involved in anti-AIDS efforts.
3. To find out whether women, who constitute a majority in the groups, can provide home-based care to AIDS patients.
4. To ascertain whether the groups could extend the financial resources from the rotations to provide care to AIDS widows and orphans.

1.4 Justification of the study

HIV/AIDS is not a single problem for it comes with many other problems, which need urgent attention. Some of the problems include deaths of many adults, increased number of orphans, increased number of patients who need both nursing and clinical

care, "child- headed households" and many others. The government on its own cannot deal with these challenges. Thus, the community as a whole must respond to the epidemic in its own capacity and capability without waiting for external interventions. The ability of AIDS to spread widely across a population in a short time has sometimes necessitated quick interventions to be made in a desperate attempt to curb the pandemic. Sometimes, the interventions are implemented without actually finding out whether or not they are relevant to the given community and has often led to the miserable failure of some interventions. This research, therefore, aimed at finding out from the community itself what kind of interventions can be sustained at the local level and the areas in which the community has acute limitations. The results of the study should, thus, guide health interventionists, specifically AIDS interventionists, into formulating relevant, adequate and sustainable interventions at the community level.

The government's per capita expenditure on health has reduced by 2/3, that is, from US$9.5 during 1980/81 to US$3.5 in 1996/97 (Mati, 1997). Ironically, despite this reduction, the Ministry of Health's spending has had to provide seven times more on provision of health care to AIDS patients. If the pandemic is not checked, the government will spend 15% of its Gross Domestic Product (GDP) by the year 2000 on health care for AIDS patients alone (Mati, 1997). AIDS is an immense economic burden. In order to try and reduce this economic burden on the government, this research aimed at finding out whether an integrational association between the government and the community, through the community providing home based care to AIDS patients, could reduce the costs incurred when only the government provides health care. The results of this study should, therefore, provide guidelines on how best home care can be facilitated

at the local level, whether the community is capable of facilitating home care and, ultimately, reduce the costs the government incurs in providing health care on its own.

Healing is not only chemoprophilactic but is also social, psychological and emotional. AIDS is terminal and incurable and when it strikes an individual, that individual needs a strong social and emotional support network to survive. The support from families, relatives and friends can reduce stress and may prolong life and enable patients to die with dignity among their own people. Such a support network can best be obtained at the family and community levels. The research found out that there is support network at the family and community level that can facilitate AIDS prevention and care in the community.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter is divided into three sections. First, current literature on HIV/AIDS infection, socio-economic, political and cultural aspects of HIV/AIDS control, and local community initiatives, is reviewed to establish both the achievements made and any existing gaps in HIV control. Second, the theoretical orientation that guided the research and its relevance to the research is outlined. Finally, the hypotheses formulated are operationalized.

2.2 HIV/AIDS Infection

The World Health Organisation's Global Programme on AIDS (WHO/GPA) estimates that by mid-1995, over 20 million people were infected worldwide by the virus which causes AIDS, approximately one million of whom were in Kenya (Baltazar et al.1996). It is difficult to confirm with certainty the actual statistics because, sometimes, people with HIV infection may die of other opportunistic infections before ever being diagnosed as having AIDS. In addition, some health care facilities, especially in the rural areas, may not have the capacity to test for HIV and, lastly, some people never seek hospital care for AIDS (Baltarzar et al. 1996).

The HIV virus is transmitted from one person to another through unprotected vaginal or anal sexual intercourse with an infected partner. In Kenya, heterosexual intercourse is identified as the major avenue of transmission (Nyamwaya, 1991; Kamau, 1996). The other avenues of transmission include blood transfusions using infected blood and the use of contaminated sharp skin piercing instruments like blades, needles and syringes. The virus is also transmitted from mother to child during pregnancy, or through breasting (Nduati et al. 1995; Kamau, 1996). Sexually transmitted diseases (STDs) and reproductive tract infections (RTIs) also enhance an individual's susceptibility to HIV infection (Berer, 1993).

2.2.1 Social, Political, Cultural and Economic Aspects of HIV/AIDS Control

The AIDS pandemic is a multi-faceted phenomenon in the sense that it encompasses political, economic, social, cultural and psychological issues. The African continent is currently experiencing pervasive and substantial costs engendered by the HIV pandemic on human life, productivity, knowledge and experience (UNDP, 1995). The severe nature of the consequences of the pandemic can be reduced depending on efficient policy implementation. A global strategy to curb the pandemic was initiated upon the establishment of the WHO/GPA programme in 1987 and the United Nations Programme on AIDS (UNAIDS) in 1995. This strategy required that each country establish a national AIDS control programme. In the majority of the countries, these programmes assumed the role of a national superstructure for preventive efforts such as co-ordination of both national and external support of AIDS programmes, safe blood transfusions and organising health education and care to the general public (Krantz and

Staugard, 1996). These strategies, though vital in HIV prevention, had some flaws. In the first place, they were vertical in nature. This means that roles and rigid rules were dictated and adopted from the global level to the national level, and down to the local community. The community was not consulted as regards the preventive efforts but these efforts were dictated upon them, regardless of whether such efforts were relevant to the target community or not.

Another problem with the vertical approach was that the National AIDS programmes established were often either under-resourced or over-stretched to meet the needs of the majority. This, coupled with the fact that most national economies had insufficient resources that could be allocated to these programmes because of other pressing needs, resulted in insufficient preventive efforts. The Kenya government, for example, currently faces a great challenge of financing AIDS prevention. Whereas donor funds have declined, the epidemic continues to rise. Faced with this dilemma, the Kenya government was forced to ask for a credit from the World Bank to finance HIV prevention and care (Government of Kenya, 1997b). The government, on its own, has limitations as to what it can do, especially with regard to behaviour change. There is evidence that the pandemic's social, cultural, economic and psychological dimensions can best be tackled at the community level if any sustainable response to HIV is to be made (UNDP, 1995).

These shortcomings of the vertical approach paved way for the "second phase" in HIV prevention. This new phase was horizontal in nature and emphasized on active community participation in HIV prevention. It is little wonder, therefore, that the 1992 World AIDS Day theme was "A Community Commitment". Each community had to

respond to the HIV challenge within its capability without waiting for foreign initiatives. Community response was seen as a key factor in prevention because local people had accurate knowledge about their communities. Involving communities was also seen as a way of avoiding the costly vertical outreach models which relied on staff being transported into homes to provide care to AIDS patients.

In Africa, community response may have been or is an efficient response to the AIDS pandemic because of its rich extended family tradition, which was a vital component of societal cohesion. The African extended family is defined as consisting of a number of joint families covering several generations (Ntozi, 1997). Often, members of the clan are expected to provide a support network to other family members. They are required to assist other members during emergencies by giving an extra hand in caring for patients, bringing provisions such as food to the patient's home and helping in case of funerals. Often the patient care system exists as part of the larger extended family's mutual obligations (Ntozi, 1997). The extended family has been threatening to breakdown due to forces of modernization, family migration and urbanization, all of which have reduced the initial strength and influence the extended family had on people. Despite the severe repercussions AIDS has on committees, it may also provide a catalytic effect of the resurgence of the African family, especially when people have to face the pandemic as a family.

2.2.2 Projections on AIDS by the Year 2005

AIDS will increase death rates of all ages. The prevalence level of HIV in Kenya may continue increasing for the next 6 to7 years. Based on this assumption, adult

prevalence rates will increase from 6.7% of adult population in 1994 to 10% in the year 2000 (Baltazar et al., 1996). If these projections come true, it means that by the year 2000 there will be 1.8 million HIV infections and 2 million by the year 2005. In the absence of AIDS, adult deaths would increase from 90,000 to 100,000 by the year 2005. But in the presence of AIDS, adult deaths will increase to 220,000 a year by 2000 and to 300,000 by 2005 (Baltazar et al., 1996).

Increased death rates in adults due to AIDS will also increase death rates in children. About 30% to 40% of children born to HIV infected mothers die; 25% die before their first birthday while most develop AIDS and die within 2 years. If there were no AIDS, infant mortality would decline from 72 per 1000 live births in 1995 to 45-50 by the year 2005. In the presence of AIDS these gains would be reduced upto 56-60% per1000 births in the year 2000.

2.3 Women groups as an example of a local community initiative

Traditionally, women in Kenya came together into groups to promote their common economic, political and social interests (Wipper, 1984). In this country, the history of mobilization of women for whatever purpose can be traced as far back as the 19th century when the women councils among the Agikuyu came together and helped each other in birth, disease and death (Maas, 1991). In the late 1940's the groups became more formalized and expanded their activities into areas of nutrition, saving groups, work groups and handicrafts. Since then, women groups have been seen as a means by which women can participate in national development as well as improve their standards of living (Maas, 1991). Some of the groups that are discussed include women interest

groups, rural co-operatives and self-help projects, occupational associations, market associations and religious associations.

2.3.1 Women's interest groups

These groups often focused on protecting the rights of women against being abused. An example of an interest group that fought for women's rights is that of the Igbo women of Nigeria. In the traditional Igbo the women's power lay in their groups which performed various social, economic and political functions. The factor that brought these women to a common gathering was *mikiri,* which translates to wives of the same lineage (Wipper 1984). Women joined this group to promote their interests as farmers, traders, wives and mothers such that anyone who had a complaint brought it before the *mikiri*. Often, the offender would be given a first warning and then be asked to change. If the change was not forthcoming, the women would use other tactics like strikes, boycotts, force and making war to make the offender comply (Wipper, 1984). When making war, women bound their heads with ferns to symbolize war. They smeared their faces with ash, wore loin clothes and carried sticks wreathed with young palm fronds. The sticks were meant to invoke the power of female ancestors. They gathered at the offender's home, usually at night, where they would dance and sing derisive songs outlining their complaints. They also banged the offender's house with pestles and covered it with mud and, sometimes, completely destroyed the house. This behaviour would go on until the offender promised to change (Wippper, 1984). Thus, making war was a legitimate institution that the Igbo used to protect their rights from being abused.

2.3.2 Rural co-operatives and self-help groups

Presently, due to forces of urbanization and industrialization, there is constant rural-urban migration. Women are left in the rural areas while the men come to towns in search of jobs. Back in the rural areas, women pull their meager resources together to upgrade their living standards. A study done in Kenya by Audrey Wipper in 1976 shows that the members of the Riakaime group came together to do co-operative farming. The group had a membership of twenty-two. The women found it expensive to employ paid labour on their farms. They, therefore, joined together as a group and decided to cultivate for each other, build houses and work for wages. They jointly purchased manure and fertilizers and bought water tanks that they jointly used. They also bought farms and had bought shares in other companies (Wipper, 1984). Thus, they ultimately achieved the goal of uplifting their standards of living.

2.3.3 Occupational associations

These associations consist of persons with similar occupations. They could be teachers, farmers, commercial sex workers or traders. In West Africa commercial sex workers have joined into formal groups which protect the rights of these women (Wipper, 1984). The groups act as mutual aid organisations from which the workers can draw money. They also have formal structured leadership. These associations formed by commercial sex workers (CSWs) have helped them in various ways. These include paying for funeral expenses for deceased members, discouraging unprofitable business by setting up specific charges for sexual services rendered to clients, protecting the workers

from being harassed by police or street gangs, and encouraging those who are interested to continue with their studies.

2.3.4 Market associations

Most examples of market associations are found in West Africa where women dominate small-scale trade in the markets. The group is specifically for businesswomen within the market. These associations help the women in various ways. They assist members with capital to start business or lend them money to expand business, train them on business methods, introduce them to potential customers, regulate the prices of goods and put strict sanctions on a decrease or increase of prices of commodities.

Some market associations buy goods in bulk for their members, which would be more expensive if each trader bought on her own. In some cases, women join the associations because they deal with particular occasions that need money to facilitate, for example, some associations fund weddings. In which case a woman with a daughter of marriable age would join a group to enable her finance her daughter's wedding.

Rotating credit associations are also found in the market place. In these groups members contribute to a fund which they are entitled to upon each rotation. The money is used to fund pressing needs (Wipper, 1984).

2.3.5 Religious associations

These are often groups who come together as a result of similar religious beliefs. They may be Muslims, Protestants or Catholics. In Kenya a study by Wipper (1984) shows how Muslim women associations protect the rights of their members. These

groups have evolved from dancing groups to groups that concern themselves with contemporary issues affecting Muslim women. The groups focus on literacy issues and equip members with vocational skills such as sewing and handicraft. They teach the women the importance of voting and condemn the practice of forced marriages.

Women groups, thus, have helped women in various ways. Work groups have enabled women save money that they would have used on paid labour to buy farms or shares from companies. Market associations enable new women to participate in the trade by training them. Religious groups have protected the rights of Muslim women while commercial workers' associations protect the rights of such workers. All in all, the groups have enabled the women to face their economic, social and political challenges. The question is, can women groups take advantage of such strengths and mobilize their communities against the AIDS pandemic, thereby preserving not only their health status but also that of their communities?

2.4 Local Community Initiatives in HIV/AIDS prevention and care

One of the most successful local initiatives is TASO (The AIDS Service Organization) of Uganda. Uganda is one of the East African countries that has been hard hit by AIDS, a situation exacerbated by many years of political turmoil. Approximately 1.5 million people in Uganda, which is about 8% of the entire population, are infected with HIV. The prevalence rates are as high as 25-30% in Kampala and even higher (50%) in some trading centres along the main highway (Coghlan et al. 1994).

TASO was founded in 1987 by sixteen Ugandans who were infected or affected by AIDS themselves or their close family members. These people decided to set up a

voluntary organisation to provide psychological support to people infected or affected by AIDS (WHO, 1993). They had no office, no means of transport, no training, no experience in management as an AIDS support group and no precedent group to learn from. However, they were all united by one common thing, a deep commitment to practical action on behalf of people who were neglected by health services and ostracized by the society because they were infected with the HIV virus (Hampton 1990). To get started, TASO volunteers pleaded for funds from Action AID and World of Need organizations.

TASO is guided by "a positive living" philosophy. This philosophy encourages an individual to accept a positive diagnosis, seek counseling upon knowing a positive sero-status, maintain a balanced diet, practise safer sex, continue normal social life, and avoid harmful habits like smoking and drinking (WHO, 1993). The philosophy also encourages communities and families to uphold the rights and responsibilities of those infected and affected with AIDS. The rights and responsibilities means that people affected and infected with AIDS need to be supported emotionally, medically and socially (WHO, 1993). The objectives of TASO, include one, offering counseling services to people with HIV/AIDS and their families. Two, to train counselors. Three, to complement available health services. Four, to sensitize the public on having a positive attitude towards people with HIV/AIDS. Five, to minimize social ills caused by HIV/AIDS by providing material support to families affected by AIDS and, finally, to build and support community based efforts (WHO, 1993).

In order to empower community participation in HIV/AIDS prevention, TASO came up with a concept known as The Community Initiative (TCI). The TCI objectives

include, one, to provide education on HIV/AIDS with the aim of promoting behavouir change. Two, to involve the community in providing home-care to AIDS patients and to support community efforts by providing material support in order to try and alleviate the socio-economic consequences of HIV/AIDS (WHO, 1993). In order to facilitate this initiative community leaders are trained from each village. Each village then has a village AIDS committee who are responsible for identifying the community's needs (Hampton, 1990). The local leaders then select community AIDS workers (CAWs) who receive training from TASO on AIDS prevention, education and counseling. The CAWs conduct both formal and informal sessions with individuals and groups. In addition, they visit homes to provide counseling and home-care, distribute condoms and refer people for medical testing and treatment whenever necessary (Hampton, 1990).

TASO is also involved in the care of orphans, guided by the principle that orphans can be better taken care of at the community level than in orphanages. The organization pays school fees for the orphans and, in some cases, identifies foster parents for the children (Hampton 1990). Material assistance is also given to patients in the form of 30 eggs, 4 kilos of powdered milk, cocoa mix, baby porridge and second hand clothes, either on a monthly basis or whenever these are available. TASO also engages its clients in income generating activities like garment sewing, pig farming, shopkeeping and banana and vegetable cultivation (WHO, 1993).

One of the most unique attributes of TASO is the way it involves community members in its objective evaluation process. This is done by engaging adults in a given locality in what is called a feedback session. During this session people find out what objectives have been achieved and which ones have not been achieved. People in the

audience are asked to give their views and through this process TASO has been able to achieve many of its objectives, the most important being community ownership and participation in the programme. However, TASO admits that though it has achieved this objective, it has not been able to help the community translate the newly gained knowledge about AIDS into actual behaviour change. This necessitates the follow-up plan where each community is scheduled to meet with its trainers and village committee members and together decide how to return the results to the community at large (Coghlan et al., 1994). It is hoped that in this way various communities will be able to evaluate and critique their own progress, identify their problems and reformulate objectives into a new plan of action where necessary.

Another community initiative is WAMATA, which is based in Tanzania. WAMATA, which stands for *Walio Katika Mapambano na* AIDS, was created in June 1989 in Dar-es-Salaam when a social scientist and a few of her friends became concerned about the plight of people with the AIDS infection. Apart from Dar-es- Salaam it also operates in Mwanza, Kagera and Bukoba which are some of the regions hardest hit by the pandemic in Tanzania (Mwaikambo, 1995). WAMATA's objectives include: the prevention of HIV transmission; the amelioration of the socio-economic consequences of HIV/AIDS; and promoting the usage of condoms. Fourthly, the organization aims at encouraging the community to support persons with HIV infection by teaching them to provide home-care and finally, it gives support to orphans (Mwaikambo, 1995).

WAMATA gets its clients from hospitals where the staff go to provide bedside counseling. Upon release, the clients are followed up for further counseling by the staff. Others get to know about WAMATA by word of mouth. One of the most unique

attributes of WAMATA is its involvement in the advocacy of the rights of people with AIDS. In Tanzania it is against the law and is a punishable offense for a person to know his or her sero-positive status and insist on having unprotected sexual intercourse with another ignorant partner (Mwaikambo, 1994). The work of WAMATA's legal sub-committee is to promote and defend the rights of people with AIDS and their families. It is especially involved in the maintenance of job positions of people with AIDS such that they can work as long as they are healthy (Mwaikambo, 1994).

WAMATA also encourages its clients to get involved in group discussions at the central headquarters every Saturday. These group discussions enable the clients to freely discuss their experiences. The staff are often present to answer any questions the clients ask. During these sessions food, medicines and other supplies are often made available to the clients. These supplies are donated to WAMATA by the Red Cross and by AMREF.

The group also encourages clients to get involved in income generating activities. The clients are given seeds to plant and sell produce or given soft loans to start small-scale businesses. Upon establishing themselves, the clients are often asked to pay the money back if they can (Mwaikambo, 1994).

Despite the successful facilitation of the various activities described above, WAMATA also reports some difficulties that they face in their efforts to try and curb the AIDS pandemic. First, female clients often find difficulty in informing their partners about their positive sero-status. Another difficulty arises when explaining to a sero-positive woman about the risk of getting an infected child upon conception (Mwaikambo, 1994). The staff also report that male clients are less co-operative and are often reluctant to change their sexual behavouir even when they know they have a positive sero-status.

WAMATA staff also feel they have not achieved all their objectives. This is because they feel that the general community is still ignorant about AIDS. Similarly, they have not fully mobilized the community into providing home-care. Lastly, most of the information materials that WAMATA disseminate are in English and therefore not appropriate for a majority of the clients.

A third initiative that provides a unique role is Women and AIDS Support Network (WASN) of Zimbabwe. The initiative was established in 1989 by a group of volunteers guided by the assumption that women may overcome the consequences of HIV/AIDS if their self-esteem and confidence is enhanced. AIDS is a threat to women all over the world in three different ways, popularly known as the TRIPLE JEOPARDY (Rego, 1990). First, women face HIV/AIDS as individuals in that a sero-positive woman will develop AIDS and die. Secondly, as mothers, they transmit the infection to unborn children at birth or during breast feeding and, lastly, as health- care providers, women carry the burden of nursing a sick relative who develops AIDS. Many women often provide care because it is a traditionally designated role but more often than not they lack information about caring for the patient, where to go for medical attention and how to protect themselves from infection.

The vulnerability of women to HIV infection is partly determined by physiological factors, but the central issues are the cultural expectations of male dominance and female submission which, more often than not, condition their access to education, job opportunities and, most importantly, decision -making as regards their sexuality (Reid, 1996). Upon recognition of these problems that women face, WASN sought to establish a forum where women could come and share information about AIDS

and how it affects them. It also encourages group support to those already infected with the virus. It encourages young women and adolescent girls to understand the consequences of early sex and empowers them to assert themselves by refusing sexual advances made to them (UNDP, 1995). Most importantly, the organization also attempts to combat judgement images that blame women for spreading infection and those that enforce male sexual prejudice that AIDS/STDs are in general women's diseases.

The Voluntary Women Rehabilitation Institute (VOWRI) is an initiative in Kenya. VOWRI was set up to specifically meet the needs of women after a survey done in 1984 by University of Nairobi's departments of Microbiology and Community Health revealed that female sex workers had HIV prevalence rates as high as 30-80% (Muriithi, 1994). The project was a brainchild of Dr. Elizabeth Ngugi of Community Health and was set up in 1990 with funding from the Danish Government, Royal Netherlands Embassy and the Belgium Embassy. The project attempts to combat HIV transmission in three main ways, which include negotiating safer sexual practices, establishing STD clinics for the CSWs and helping the workers develop an alternative source of income other than commercial sex work. VOWRI's clients are drawn from about 3000 sex workers who are served by various STD clinics in urban Nairobi. It encourages its clients to form groups. These groups are based on common locality or interests. Each group consists of about 30 members, who maintain a bank account and engage in rotating credit activity. Members are accountable to each other for the regular contribution to the fund. The groups meet every week to share their experiences and challenges met as regards the profession during the week (Mwaikambo, 1994). During the meetings resource persons are invited to discuss various health issues on AIDS. They are also taught how to

negotiate for safe sex. They are taught how to try and convince their clients to use condoms by sharpening their communication skills. They do this by trying to persuade the clients that condom use is in their best interest. They also learn how to put on a condom, thus making the condom a must in every sexual act (Muriithi, 1994). In the discussions women who have used condoms are affirmed and those who have not are encouraged to do so. VOWRI also encourages the CSWs to use other forms of contraception besides the condom. The forms of contraception commonly used are pills, IUDs, injectables, female sterilization and Norplant. It is estimated that half of the women are on the pill or sterilized (Muriithi, 1994).

To enable the women develop interest in alternative sources of income, VOWRI does this in three main ways, including provision of soft loans to the groups to carry out small-scale projects like vegetable vending, charcoal selling and hair dressing. It also provides them with basic business skills. Despite these attempts, sometimes the women go back to prostitution because the small-scale businesses are less profitable yet time involving. In the rotating funds the workers meet weekly and each recipient often uses the money to re-invest into business or on any other pressing need (Muriithi, 1994). VOWRI also educates the general community as regards AIDS. This is done with the help of community health workers who share information with them. Finally, VOWRI contributes to public awareness by organising events, such as the AIDS exhibition staged in the museum in 1993 (Muriithi, 1994).

To date VOWRI has been able to achieve some of its objectives. The effective use of peer groups has enabled the workers to sharpen their negotiating skills on safer sex, thus reducing unprotected sexual encounters. Many workers have lessened their

dependence on sex work as the main source of income and being involved in the groups has enabled the workers develop a sense of self dependence, thereby becoming role models to other women and their children (Muriithi, 1994). Despite the above achievements, VOWRI was, at the time of this study, facing financial constraints to enable it support the orphans, the increasing number of CSWs coming to it and to continue its operations. It, therefore, needs to increase its ability to raise funding (Muriithi, 1994).

Another local initiative is the Kitale AIDS programme which was established 15 years ago by Medical Missionaries of Mary (MMM) with a vision of providing social and health support to residents of Kitale (Mulindi et al., 1998). Since the onset of HIV/AIDS the organization has been spearheading HIV/AIDS activities aimed at giving dignity to the person suffering from AIDS. This is done by encouraging HIV/AIDS education and behaviour change and training for home-based care givers who provide home care to HIV/AIDS patients. Presently, it supports 150 orphans whose parents died of AIDS, by providing counseling and basic needs in food, clothing and shelter (Mulindi et al., 1998).

Kitui District AIDS Programme (KDAP) is an intiative that supports those infected and affected by HIV/AIDS in Kitui District. In a concerted effort to fight against AIDS, the Catholic Church of Kitui, the Ministry of Health (MOH) and the Anglican Church of Kenya (ACK) have been providing support to people living with AIDS. Each organization gives a specific kind of support to Kitui district. The Catholic Church supports patients through counseling. Patients are mostly referred to the counseling centres from the hospitals. The counseling centres act as a place where they can assemble together to share their experiences. The Anglican Church on the other hand supports

community-based organizations through income generating projects. These projects in most cases enable persons involved to support those infected and affected by AIDS (Mulindi et al., 1998).

Lastly, Kariobangi Community Health Project (KCHP) is an initiative that provides support to the slum population infected and affected by the pandemic. Originally started as a primary health care hospice, the KCHP has grown into a project that supports people living with HIV/AIDS in Korogocho slum (Mulindi et al., 1998). The Hospice specializes in providing care to those patients who are too ill and are abandoned. It provides home visits through a network already established by CHWs. It also arranges for the hospitalization of people suffering from TB and follow up patients until they are discharged (Mulindi et al., 1998).

The above discussions from various parts of Africa indicate that one of the responses to the AIDS pandemic has been participation of the community through local initiatives. However, it is vital to point out that each initiative has been able to sustain a given intervention much better than another. For example, WAMATA has focused on legal issues, WASN has focused on women as a risk group and TASO has mobilized the whole community into anti-AIDS efforts. On the other hand VOWRI has focused on commercial sex workers and KCHP focuses on slum dwellers The seriouness of the AIDS pandemic has often necessitated quick interventions without prior research in an effort to try and contain the pandemic. Prior research is often seen as a slow response to the fast moving pandemic without realizing that this could enable the correct interventions to be put in place.

In their bid to fight against the scourge, social scientists have undertaken research on various aspects of AIDS. The most common research topics include causes of AIDS and the socio-economic impact of the pandemic. More research, however, needs to be conducted on prevention, especially community based prevention. One such research is that of Chiekh Ibrahima (1995), who undertook a study on the socio-cultural factors that favour HIV infection in women and how traditional women associations can be integrated into AIDS prevention in the Kolda region of Southern Senegal. The objectives of the study included: determining knowledge, beliefs, attitudes and behaviour associated with sexuality, STDs and HIV/AIDS among men and women; identification of sexual reproductive and therapeutic practices which increase the risk of HIV/AIDS infection in women; description of the structure and function of Dimba and Laobe groups; and identification of ways in which STD/HIV messages can be integrated into the daily interactions of the local community and the Dimba and Laobe groups (Cheikh,1995).

Dimba is a local social organisation whose membership is restricted to women who have experienced problems of fertility, repeated miscarriages, death of children at early ages, twin birth or orphan adoption. The duty of the Dimba is to ensure the fertility of women, protection of their health and to ensure the well being of an expectant mother and child. The members have a solidarity, which enables them to help each other socially, financially and in farmwork. They conduct community rituals and ceremonies as well as providing therapeutic advice to women and couples. The Dimba is divided into groups, each with its own responsibilities. An elderly woman who is also the spiritual leader heads the group. She has vast knowledge on maternal and infant health. She visits women with fertility problems and provides a follow-up for pre-natal and post-natal care.

There is also a father who has two assistants; he treats couples who suffer from sexual and reproductive diseases.

The Laobe, on the other hand, are an itinerant ethnic group who engage in making and selling erotic products such as perfumes, powders, objects to insert in the vagina, belts and necklaces. The women decorate pieces of cloth used as lingerie that serve different functions during fore play. The clothes have different names that evoke preparations for a sexual act. Laobe women are at a high risk of HIV infection because both husbands and wives lead migratory lives, have poor knowledge of condom use, are highly valued sexual partners and have poor knowledge of HIV/AIDS.

The study concluded that women in Kolda are at a high risk of HIV infection because of their limited knowledge on STDs and HIV/AIDS, low levels of condom use, non-monogamous sexual behaviour and the migratory nature of men and women. The Dimba and Laobe were seen as potential channels for community based HIV prevention programmes. This means that the results could enable any planner interested in community initiatives to implement relevant interventions because they identify the risk group, the reasons why the group is at risk, and also how community initiatives of Dimba and Laobe can be used as communication channels for HIV prevention.

It was on the basis of these strengths, that the researcher conducted a study on the potential of community initiatives in HIV prevention and care in Usigu Division.

2.5 Constraints faced by community initiatives

Despite the numerous breakthroughs made by these initiatives in various aspects of HIV prevention in many parts of Africa, as already pointed out, they have faced some

constraints in the process. First, more often than not these initiatives have not been effectively sustained because of their dependence on insufficient and sporadic funds. External assistance is sometimes unquestionably necessary but it must be noted that such assistance, however generous, is not a sufficient condition for primary health care and community development (Mburu, 1989). The motivating force has to be community participation and acceptance of the initiative so that even when funds dry up, the project does not wind up its business. Another constraint, faced especially by initiatives that focus on information dissemination, is that they may often not reach a wide audience because most information on AIDS has not been translated into many of the local languages that can easily be understood by the majority of the people targeted.

Apart from these two constraints, another serious problem is in the home-based care strategy. The initiatives that have this care strategy are often faced with constant shortage of medicinal supplies to give to patients. They may also not have adequate knowledge on how to prevent themselves from infection in the process of providing care.

Lastly, the initiatives are also faced with the burden of increased orphans, who need all basic necessities of life. This is one of the greatest challenges these organizations have to face. There is need for thorough research, especially to find out what communities are capable of doing without straining. This calls for a more intergrational support relationship between the government and communities in order to have a sustainable anti-AIDS effort.

2.6 Theoretical framework

This study adopted the systems and systems change model in achieving its objectives.

2.6.1 Systems and Systems Change Model

Systems and systems change model was designed as a contribution to applied anthropology and public health (Wellin, 1977). Its central concern is to examine where medicine and the community meet. A system is defined as an entity made up of identifiable parts that are mutually interdependent, each part affects the other and the several parts then form the whole system. The model also suggests that a system can be disturbed and Wellin (1977) poses the following questions: -

1. What happens when a system is disturbed with new health related elements?
2. What happens to new health related elements in the context of a given socio-cultural system?

Wellin (1977) suggests that a system is capable of reciprocal and feedback processes. This means that any new health related elements introduced into the system will affect the system and the system, in turn, will shape and affect the new health related elements in its socio-cultural context. A diagrammatic summary of the model is shown in Figure 3.1.

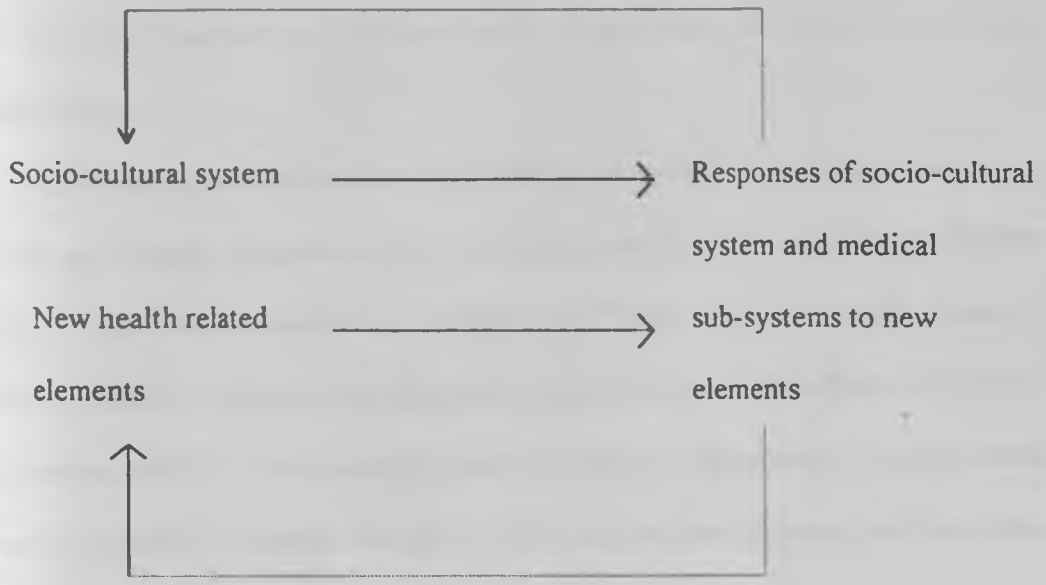


Figure 3.1: Systems and systems change model (after Wellin, 1977).

2.6.2 Relevance of the Systems and Systems Change Model to this Study

This model views a system as an integrated whole with interrelated parts. These parts complement and affect each other and in the event of change in one part, the whole system is disturbed. HIV/AIDS is a new health related element that has disturbed the normal functioning of socio-cultural and economic systems all over the world. The consequences of this new health related element (AIDS) are many, for example:

1. Death of many adults within the economically productive age groups;
2. An increased number of orphans due to parental death;
3. An increased number of sick individuals who need nursing care;
4. Its terminal nature and the fact that it is incurable;
5. Economic losses in many companies due to mortality of highly trained personnel; and

6. An increased number of children-headed households or houses headed by grandparents.

These consequences show how AIDS affects our system. Our system here can be defined as our country, villages and our general surroundings. For a system to function normally, it must counter the above consequences. This research, therefore, viewed a community initiative, *nyoluoro*, as one of the ways to counter the effects of the new health element, AIDS. The countering could be done by disseminating health related information on AIDS to people, caring for AIDS widows and orphans, peer education, condom use and home-based care.

2.7 Working Hypotheses

1. The *Nyoluoro* has an in-built capacity to disseminate health-related information to the community.
2. Decision to participate in anti-AIDS efforts is influenced by the group's perception of such efforts.
3. Women have a care-giving role and being the majority in the groups, they can provide home-based care to AIDS patients.
4. *Nyolouro* groups are capable of extending the financial resources from the rotations to provide support to AIDS widows and orphans.

2.8 Definition of variables

Independent variables

Nyoluoro refers to a local community initiative whose members contribute to a rotating fund and each member is entitled to a sum of money upon each rotation. Members often use the money for their personal needs such as paying school fees, buying household utensils, health expenses and investing in business.

Anti-AIDS efforts: these are various efforts and strategies that have been put in place to curb the pandemic. They include condom use, information dissemination, abstinence from sex and counseling.

Financial resources: these refer to money each member is entitled to upon each rotation.

Dependent variables

Health information: this refers to any general information, verbal or written, that guides the general community as regards maintaining good health.

Perception: refers to attributes, thoughts, feelings and views about AIDS and involvement in anti-AIDS effort.

Home-based care: this refers to the nursing and medical care given to patients with AIDS outside the hospital setting. It occurs at the family and community levels.

Care: includes attributes such as attention and nursing. In this case it involves nutrition financial care, medical care and nursing care.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

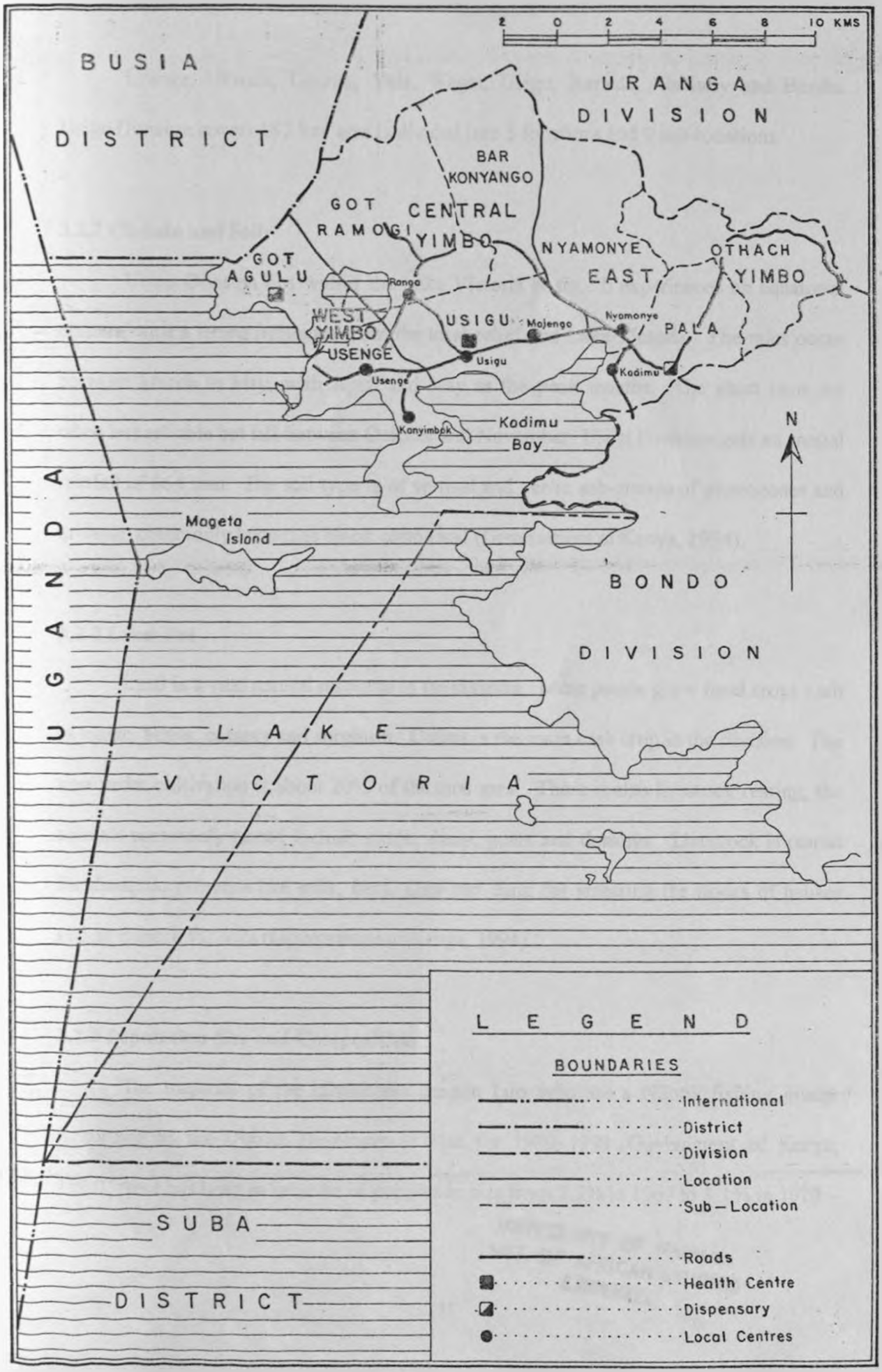
This chapter begins with a description of the basic physical and socio-cultural features of the research site. The topographical features of the area show a dry and quite unproductive agricultural area. Since the local land is less unproductive for both cash and food crops the majority of households derive income from fish. This means for men, long periods of stay on beaches and in most cases away from their families. In this, kind of situation, the men become very susceptible to HIV/AIDS.

The chapter also deals with issues concerning sampling, data collection and data analysis. Finally, information on the problems encountered in the field and ways in which they were dealt with is given.

3.2 Site description

The research was conducted in Usigu Division of Siaya District (Map 3.1). This district is situated in Nyanza Province of Western Kenya. It is bordered by Busia District to the north, Vihiga and Kakamega Districts to the northeast, Kisumu District to the southeast and Homa Bay district across the Winam Gulf to the south. To the west are Lake Victoria and Uganda. The district covers a total area of 3,523 km^2, out of which about 1,005km^2 is under the waters of Lakes Sare, Kanyabola and Victoria. It lies between latitudes 0 – 26° South and 0 - 18° North, and between longitudes 33 - 35° East (Government of Kenya, 1994). The district comprises 10 divisions, namely, Boro,

MAP 3.1 : THE STUDY AREA.



Uranga, Ukwala, Ugunja, Yala, Wagai, Usigu, Rarieda, Madiany and Bondo. Usigu Division covers 187 km^2 and is divided into 5 locations and 9 sub-locations.

3.2.1 Climate and Soils

Usigu Division lies within the Lake Victoria basin. It experiences an equatorial climate, with a strong influence from the local relief and Lake Victoria. The rains occur between March to May, with April and May as the peak months. The short rains are often less reliable but fall between October and November. Usigu Division gets an annual rainfall of 864 mm. The soil type is of vertisol and verlic sub-groups of phaeozones and luvisole, commonly known as black cotton soil (Government of Kenya, 1994).

3.2.2 Land Use

Land is a vital natural resource in the division. Most people grow food crops such as maize, beans, cassava and sorghum. Cotton is the main cash crop in the division. The area under cultivation is about 20% of the total area. There is also livestock rearing; the animals commonly reared include cattle, sheep, goats and donkeys. Livestock is reared for domestic products like milk, beef, ghee and dung for smearing the floors of houses and as manure for soils (Government of Kenya, 1994).

3.2.3 Population Size and Composition

The majority of the inhabitants are the Luo who are a Nilotic fishing group. According to the District Development Plan for 1989–1993 (Government of Kenya, 1994), there has been an increase in population size from 2.2% in 1967 to 3.1% in 1979 –

1989 in the district. The census also shows an increased population growth rate in Usigu Division, whose density rose from 71 persons per square kilometre in 1969 to 153 persons per square kilometre in 1989.

3.2.4 Women's Activities

Women participate in various activities in the district. The activities include crop and animal husbandry, rotating credit activities, small-scale business, tree planting, home crafts and arts. Siaya District has a total of 630 rotating credit groups. Ukwala Division records the highest number, with a total of 142 groups, while Usigu Division has only 18 registered groups (Government of Kenya, 1994). It is important to point out that the number of registered groups may be an underestimate because some groups engage in rotating credit associations but have not sought registration with the department of Social Services.

3.2.5 Health Situation

Siaya District has one of the highest infant mortality rates in Kenya. In addition, AIDS related health problems have increased in the district. However, the extent of increased AIDS incidences may not be known because Siaya District has only 2 testing sites, that is, Siaya District Hospital and Siaya Medical Centre. The other health centres do not have screening equipment so that the actual situation may be worse than depicted. Usigu, Madiany and Rarieda have the least reported AIDS cases. Since 1993, only a total of 19 cases have been reported in the three divisions. This may be attributed to the fact that the divisions are far from reporting centres, insufficient transport linkages and

because many people fear going for screening tests. Other health problems include malaria, diarrhoeal diseases, upper respiratory tract infections, aneamia, intestinal worms, measles, bilharzia, eye infections and pneumonia.

3.3 Sampling

3.3.1 Site Selection

Usigu Division was selected for this study because it is within the focus area for the Kenya Danish Research Project (KEDAHR) which funded my fieldwork. The KEDAHR project is based in Bondo and Usigu divisions and has two broad based objectives. These are to strengthen the research capacity of participating institutions within the fields of parasitology, nutrition, education psychology, anthropology and health services and to contribute to the improvement of health status and school performance of Kenyan primary school children by control of helminth infections and improved nutrition. Apart from AIDS and other health problems, the division experiences acute water problems due to lack of permanent water sources, lack of access roads, inadequate health facilities, poverty and famine. Due to the poor infrastructure, both in terms of roads and distribution of health facilities, people in the interior parts of the division may not have adequate information on AIDS, or may not even be aware of its existence. The researcher, therefore, felt that if the existing community initiatives were mobilized, empowered and equipped with adequate information on HIV/AIDS, they might be able to reach out, especially to the interior parts of the division, with the correct information on HIV/AIDS and so help to curb the AIDS pandemic.

3.3.2 Sample Size and Sampling Procedure

The first step in sampling is to specify the objects of study. The objects of study refers to the units of analysis (Bailey, 1978). The unit of analysis in this research was each and every individual registered member in the group. The population universe consisted of the sum total of units of analysis, that is, all registered members involved in groups under study.

To enable the researcher get the population sample, a sampling frame was drawn. A sampling frame is a list of all objects from which the sample is to be drawn (Bailey, 1978). A list of registered groups was obtained from the Divisional Social Services office and from this list the researcher was able to randomly select seven registered groups. In the sampling frame, therefore, the researcher had two types of groups, which included seven registered groups and six non-registered groups. Thus, a total of thirteen groups were used to facilitate the research. To obtain the study sample, a list of all registered members was obtained from their respective group leaders. A random sampling procedure was then used to select from the list members who were to participate in the research.

In order to have a comprehensive study, the researcher used stratified random sampling to group respondents into three categories:

1. 91 respondents that were currently involved in the groups.
2. 6 respondents that had never joined the groups despite their knowledge of the existence of such groups.
3. 3 respondents that had opted out of the groups.

It is important to point out that at the time of research the harambee for the Women's Development Fund was scheduled to take place. One of the requirements of the harambee was that all women groups be registered and contribute some amount of money to the fund. Groups that contributed to the fund would get some money in relation to the ratio the group contributed towards the fund. This means that, for example, if a group contributed 1,500 shillings towards the fund then upon completion of the fundraising they expected to gain another 1,500 shillings to make 3,000 shillings. These perceived benefits influenced registration of groups. Many groups hurriedly registered during this period but, in fact, had not been there prior to the fund. The nature of the research, however, required groups that had been active for a considerable period of time. The researcher, therefore, included into the sampling frame groups that were not registered but were active prior to the setting up of the fund.

The sample population, thus, consisted of 100 respondents. The research covered two locations of Usigu Division, namely, Central Yimbo and North Yimbo. A total of eight groups were selected from Central Yimbo while five groups were obtained from North Yimbo.

3.4 Data collection

Data for the research were derived using both quantitative and qualitative techniques. The qualitative techniques included focus group discussions and key informants. On the other hand, quantitative techniques included structured interviews.

3.4.1 Structured interviews

This was an important technique used to facilitate this research. Each questionnaire had 64 items, consisting of both open-ended and closed-ended questions. Open-ended questions were used for questions that could not be answered in a few simple categories. They allowed the respondents to give more detailed, exhaustive views about a given item. Closed-ended questions, on the other hand, were generally simple and specific category questions that were quickly answered.

3.4.2 Focused group discussions

This method of data collection has become popular in anthropology. It has a major advantage over the questionnaire because it allows for clarity of information that may have not been clearly or adequately answered in the questionnaire. A total of four groups were randomly selected to participate in the discussions. It is important to point out that respondents who were involved in the focus groups had been previously subjected to the questionnaire interviews. This enabled them to exhaustively discuss the questions.

A total of ten questions that needed in-depth information were selected from the questionnaire to facilitate the group discussions. The discussions were conducted on specified dates when each of the groups had its meeting in a given member's house. The focused groups often consisted of about 8 to10 respondents. This method enabled the researcher to obtain more in-depth information that could not be obtained from the questionnaire.

3.4.3 Key informants

Key informants are often people occupying influential positions in the local community. For the purposes of this research, seven informants were identified and interviewed on their perceptions about rotating credit associations in the area and whether the groups were capable of mobilizing the entire local community in anti-AIDS efforts. The key informants were not subjected to questionnaire interviews. They were instead subjected to a structured informal interview on some key areas of the research.

3.4.4 Data analysis

Data for the study were analyzed using both quantitative and qualitative techniques. Quantitative data consisted of all quantifiable items such as age, number of groups, number of members, number of persons who preferred home care and number of persons who could participate in any anti-AIDS effort. These items were coded and analyzed on computer using the Statistical Package for Social Sciences (SPSS) and then presented in the form of frequency tables and percentages.

Qualitative analysis was used to describe those aspects of data that are not quantifiable, like why a respondent could not participate in a rotating credit association or why a given respondent preferred home care for widows and orphans. In-depth explanations and descriptions were also used to give meaning to the statistical representations from the quantitative data analysis. The advantage with a descriptive study is that it allows people who are not competent in statistics to understand the results of the study.

3.5 Problems encountered in the field

While in the field the researcher experienced some problems that threatened data collection. For instance, some respondents thought that they would be paid after participating in the interview. The researcher was able to take care of this problem by emphasizing that the results of the research would not provide any monetary gain to the researcher, but were simply needed for degree work. The emphasis on the researcher being a student made respondents answer questions without expecting any monetary gain.

Some respondents, on the other hand, thought that only literate respondents were needed and, thus, shied away from answering the questions. The researcher was able to restore their confidence by emphasizing that the interviews would be conducted in *Dholuo*, the local language, and needed no writing skills.

Lastly, some respondents simply refused to be interviewed. In such cases, the researcher would go over introducing the research topic again and try to make the respondent understand the research objectives. If the respondent still refused to be interviewed, the researcher had no alternative but to exclude that respondent from the study and replace her with a receptive one.

CHAPTER FOUR

THE FINDINGS

4.1 Introduction

This chapter presents the research findings. It is divided into two sections. The first section presents the socio- economic characteristics of the *nyoluoro* groups. This is achieved through focusing on various research variables, including age, marital status, occupation, organization and leadership, activities of the groups, reasons for joining the groups, reasons for opting out of the groups and reasons for non-involvement in the groups. The second section presents findings of the main research objective, which was to find out the potential of local community initiative involvement in HIV/AIDS prevention and care. In order to verify this objective, a number of questions which dealt with the following were asked: the role of the groups in disseminating health information, the groups' perceptions regarding involvement in anti-AIDS efforts, the groups' ability in providing home -based care to patients and whether the groups would extend its economic resources from the rotations to provide care to widows and orphans.

In all, thirteen *nyoluoro* groups were used in this study. The groups included Nyi-Alego, Nyi-Ugenya, Nyi-Kisumu, Sare Group, Wambasa Tumaini, Jusa Teachers, Konyri-Kendi, Coptic Church, Saint Catherine Church Group, Sixteen Friends, Nyamonye Market, Chwak wiyi and Nyamonye Business Women's Group. Each of the groups had varied membership and engaged in a variety of activities.

4.2 Findings

4.2.2 Socio-economic characteristics of *Nyoluoro* group members

4.2.3 Age and Marital Status

A majority of the group members tended to be of middle age, especially between ages of 31-35 years which constituted 31% of the sample. The age groups of 21-25, 26 - 30 and 36-40 were represented by 15% each. The lowest represented age groups were 41-45 and 46-50, which constituted 3% each of the total sample (see Table 4.1). Most members involved in the groups were married, with the status only changing upon the death of a spouse. Married women had a representation of 83% of the sample, 12% were widowed while 5% were remarried widows. Single women were virtually unrepresented.

Table 4.1: Age representation of group members

Age group	n	%
15 - 20	11	11.0
21 – 25	15	15.0
26 – 30	15	15.0
31 – 35	31	31.0
36 – 40	15	15.0
41 – 45	3	3.0
46 – 50	3	3.0
51 – 60	7	7.0
Total	**100**	**100.0**

4.1.4 Education

Fifty-one percent of the respondents had not had formal schooling while forty-nine percent had schooling. The number of women with secondary level education was

smaller than that of those who had attained primary education. Probably, therefore, since a majority lack of the women lack formal training skills, they may join the groups to enable them learn informal skills such as basketry, pottery and knitting. Upon mastering such skills, the women can earn a living by putting to use the skills they have learnt in the groups. For example, Sare Women Group members actively involve themselves in pottery. They make pots, cooking devices of various sorts and sell the products in various parts of the country. The income earned from the sales, no doubt, benefits the group's members.

4.2.5 Occupation

Slightly more than half of the group members (56%) are peasant farmers. The farming is often small scale in nature and does not require technical skills or equipment. The crops commonly planted include maize, millet, sorghum and sugarcane. Others (26%) are engaged in small-scale businesses such as vegetable vending, food kiosks, fish mongering and saloons. Other occupations include teaching (9%), tailoring (6%) and shopkeeping (3%). These occupations of whatever type often enable the group members to contribute to the rotating fund as well as meet their financial needs (see Table 4.2).

Table 4.2: Occupation of informants

Occupation	n	%
Small-scale business	26	26.0
Farming	56	56.0
Tailoring	6	6.0
Shopkeeping	3	3.0
Teaching	9	9.0
Total	**100.0**	**100.0**

4.2.6 Organization and Leadership

The *Nyoluoro* groups are run by a formal structured leadership. Members must choose representatives to various leadership positions. The most common positions among all the thirteen groups include chairpersons, secretary and treasurer plus their assistants. The positions are officially recognized and are registered at the local divisional social services office. In order to secure membership in any of the groups, an individual must pay a membership fee. The fee varies from group to group though it generally ranges from 20 to 50 shillings. New members are often familiarized with the rules and regulations that govern the groups such that if in future a member breaches any of the rules, an appropriate action is taken against such a member. One of the most common regulations among all the thirteen groups is that which deals with lateness. Any member who comes late for a meeting has to pay a fine. The amount of fine varies from group to group but generally ranges from five to twenty shillings. Another regulation common to the groups is that concerning absenteeism. If any member intends to be absent from an already scheduled meeting, the member has to notify the group officials prior to the meeting.

Members are also expected to contribute promptly to the fund at each rotation so as to avoid inconveniencing others. In case a given member has no money to pay at a given rotation, the member can be excused but reminded to pay at the next rotation. Any member who fails to pay money at each rotation without any serious reason is often ultimately expelled from the group.

These few examples of some of the regulations show that the groups are regulated by strict formal regulations.

Repeated of p. 45

4.2.5 Occupation

Slightly more than half of the group members (56%) are peasant farmers. The farming is often small scale in nature and does not require technical skills or equipment. The crops commonly planted include maize, millet, sorghum and sugarcane. Others (26%) are engaged in small-scale businesses such as vegetable vending, food kiosks, fish mongering and saloons. Other occupations include teaching (9%), tailoring (6%) and shopkeeping (3%). These occupations of whatever type often enable the group members to contribute to the rotating fund as well as meet their financial needs (see Table 4.2).

4.3 Group activities

The common activity that all the thirteen groups engage in is that of the revolving fund. The organization of the fund differs from group to group. Generally, the amount paid and duration of payment vary. An example using three groups could illustrate how the revolving funds are differently organized. The three groups include Konyri-Kendi, Nyi-Ugenya and Sare Women groups. The Konyri-Kendi group consists mostly of

businesswomen who deal in fish mongering. On the other hand, the majority of the members in the Nyi-Ugenya group are peasant farmers while Sare group specializes in pottery.

Konyri-Kendi has a membership of five. The group members contribute to three types of funds at three different durations. They make monthly contributions of 250 shillings, weekly contributions of 50 shillings and daily contributions of 20 shillings. Since this group's membership stands at five, it means that each of them gets 1,250 shillings a month, 250 shillings weekly and 100 shillings daily. The frequent contribution is necessary to keep each individual's business running. On the other hand, the Nyi-Ugenya group has a membership of eleven, and meets once every week. However, unlike Konyri-Kendi, this group pays 35 shillings at each rotation, 10 shillings for funeral expenses and 5 shillings would be given to the hostess of the day. The total contribution by each individual at a given rotation totals to 50 shillings. If all the eleven members make their contributions during the meeting, it would mean that a given hostess has 385 shillings for her savings and 55 shillings for hosting the group members. The funeral savings are kept by the treasurer until need arises.

Sare Women group has a membership of five, and engages in pottery as an income generating activity. The group organizes its funds in such a way that income generated from the sale of various pottery items is put into a central saving and is left to accumulate for one calendar year. At the end of the year, the money is equally divided among the five members who meet once a month to discuss the sales made and to make funeral contributions of 50 shillings. Members also meet twice a week on Wednesday and

Friday afternoons to do the pottery work. Each member is often given a target and at the end of the week each of them would often have met the target.

Nyoluoro groups engage in many other activities other than revolving funds. In some cases some groups engage in more than one activity simultaneously. Thirty-percent of the groups engaged in revolving funds and paying medical expenses for their members. Another 24% engaged in joint farm-work and revolving funds. In joint farm-work members either work on each other's piece of land as a group or they jointly own a piece of land and farm it and then share the benefits. Some of the crops commonly planted include maize, millet, sugarcane, vegetables and beans. Nineteen percent of the groups were involved in revolving funds and group counseling. In group counseling, members in the various groups discuss the social problems they experience in their homes with each other. One of the most commonly mentioned problems among many of the women was that of marital infidelity, especially in this era of AIDS. Some of the solutions given to this problem included spouses talking about their marital problems, use of condoms, especially female condoms, because men rarely accept to use male condoms. In some cases where a woman thought her life was in danger, for example, a case where her husband inherited a widow whose husband is suspected to have died of AIDS, the members were of the view that the woman should run away and come back to take care of the sick man. Twenty-seven percent of the groups engaged in revolving funds only. Table 4.3 shows the various activities the groups are involved in.

Table 4.3: Group Activities

Group activities	n	%
Revolving funds only	27	27.0
Revolving funds and medical expenses	30	30.0
Revolving funds and joint framework	24	24.0
Revolving funds and group counseling	19	19.0
Total	**100**	**100.0**

4.4 Reasons for joining the groups

The *Nyo'ouro* groups have women as the majority in membership (94%) with only 6% being men. Both men and women are often united by a common cause such as birthplace, business or occupation. Nyi-Ugenya, Nyi-Kisumu and Nyi-Alego are examples of groups whose members have a common birth place. On the other hand, Jusa Teachers, for instance, are bound by their common teaching occupation while Nyamonye Business Group consisted mostly of shopkeepers Apart from being united by a common cause, members join the various groups for many other reasons. Some of the reasons cited included saving money (59%) and spiritual uplifting (14%). The groups whose main activity was spiritual uplifting were church oriented groups whose members worshipped in the same church. Other reasons for joining groups included joint farm-work and funeral expenses (11%), medical expenses (5%), soft loans (6%) and paying school fees and buying household goods (5%) (see Table 4.4).

Table 4.4: Reasons for joining groups

Reasons	n	%
Financial savings	59	59.0
Joint framework and funerals expenses	11	11.0
Spiritual uplifting	14	14.0
Medical expenses paid for	5	5.0
Acquisition of soft loans	6	6.0
Paying school fees and buying household goods	5	5.0
Total	**100**	**100.0**

Members often get to know about the groups from their friends who are already involved in the groups. Friends tell others about the benefits they get from joining the groups. In some cases the benefits are evident, for example, catering for funeral expenses by a group for its members. Ninety-five percent of the respondents interviewed knew about the group from a friend who informed them about the groups. Others knew about the groups from mothers-in-law (2%), husband (2%) and a neighbour (1%).

4.5 Reasons for opting out of the groups

Some respondents had previously joined the groups, but opted out later. This is represented by (3%) of the total sample. The reasons given for opting out include financial problems, husband's refusal and funds being mismanaged. Of these 1% attributed their pulling out to financial problems and, thus, their inability to remit money to the fund regularly because of other pressing financial needs at home. Another 1% opted out because officials mismanaged their group's funds and so there were no funds to keep the group running. Sometimes meetings took unnecessarily too long, meaning that

the women stayed away from home for long hours. This led to conflicts between the women and their spouses, with the women choosing to opt out of the groups.

4.6 Reasons for non-involvement in the groups

Despite many activities the groups engage in, some respondents have never joined these groups. This was represented by 17%. The reasons given for non-involvement include husband's refusal (6%). The women thought it unwise to defy their husbands since husbands are the heads of households. Another 5% attributed their non-involvement to lack of finances. The need to pay to the fund regularly is not possible for these respondents because of other financial needs. Another 3% observed that the groups consist mostly of women and thus, being men, they shy away from the groups despite perceived benefits. Another 3% of the respondents indicated that meetings take too long and are sometimes far away from their homes, meaning that they have to come back late at home. Table 4.5 shows reasons for non- involvement.

Table 4.5: Reasons for non-involvement

Reason	n	%
Husband's refusal	6	6.0
Lack of finance	5	5.0
Most of the members are women	3	3.0
Meetings take too long	1	1.0
Distance	2	2.0
Already involved in the groups	83	83.0
Total	**100**	**100.0**

4.7 Potential of *nyoluoro* groups in hiv/aids prevention and care

4.7.1 Dissemination of health information by *nyolouro* groups

As already stated, it was found that the main activity of the *Nyoluoro* groups is that of merry-go-rounds. In fact, more often than not these groups are started with an economic orientation in mind but later venture into other activities. It is, therefore, not surprising to find that 53% of the sample do not disseminate health information to the community. The main reason given by these respondents is that whenever a group starts, the members focused more on the monetary gains they would attain by being involved in the group. Even though a majority of the respondents mentioned that they do not disseminate health information to the community, almost a half (47%) have at one time or another disseminated health information to the community. Of these, thirty - eight percent have educated the community on general aspects of health such as boiling drinking water, building racks for drying utensils and constructing pit latrines (see Table 4.6). Nine percent have talked to the community about AIDS. The respondents who have disseminated health information to the community more often than not pass on this information in their occupational roles, either as community health workers or traditional birth attendants and not as members of a given group.

Table 4.6: Types of health information given by *Nyolouro* groups

Type of information	n	%
General aspects of health	38	38.0
Information on AIDS	9	9.0
Groups that do not disseminate health information	53	53.0
Total	100	100.0

Despite the fact that a majority of the groups do not disseminate health information, this does not necessarily rule out their potentiality as disseminators of health information to the community. This is evidenced by the fact that 45% of the respondents felt that the groups should make health information, especially on AIDS, a priority as this would create awareness and ultimately preserve both lives of individuals and the health status of the community. Further emphasis on dissemination of health information was made during focused group discussions where the members observed that for the groups not to be disseminating health information in the first instance was a serious oversight. However, thirty-one percent of the sample did not think diverting into health information was of any importance. These respondents felt that doing other activities targeted at the community without any payment was not a priority. Besides, doing other activities other than of revolving funds meant taking on additional responsibilities on top of their household duties for which it would be difficult to find ample time. Another 20% of the respondents felt that talking to the community about AIDS issues was a waste for people already knew about AIDS and mentioning AIDS was mere repetition (see Table 4.7).

Table 4.7: Importance of health information

Importance	n	%
The information will preserve health status of both individuals and their community	45	45.0
It is a form of employment for those involved	4	4.0
A waste of time	20	20.0
Health information not a priority	31	31.0
Total	**100**	**100.0**

4.7.2 Perceptions about AIDS and anti-AIDS efforts

More than half the respondents (68%) perceived AIDS as a serious health problem in the division. They observed that its seriousness lies in the fact that it is incurable and ultimately leads to death. Similar observations are made by Frankenberg (1993), who asserts that AIDS is a serious health problem because it has no known cure or vaccine. Another 25% thought that AIDS was a serious health problem because of its terminal nature while 6% attributed the seriousness of AIDS to its increased incidence. The increased incidence can be observed in the growing numbers of orphans, number of adult deaths and number of widows and widowers in the division. In fact, 98% of the respondents were aware that AIDS exists and that it is a serious health problem and only one person thought this disease is not serious. This indicates a very high level of AIDS awareness among the study population. Table 4.8 gives reasons that make AIDS a serious health problem.

Table 4.8: Why AIDS is a serious health problem

Reason	n	%
It is incurable and leads to death	68	68.0
Its terminal nature	25	25.0
Its increased incidence	6	6.0
Not serious	1	1.0
Total	**100**	**100.0**

AIDS is caused by a number of factors. About a half (46%) of the respondents were aware that AIDS is caused through unprotected heterosexual intercourse between two or multiple partners. Previous studies also indicate that AIDS in many African countries is caused by unprotected heterosexual intercourse (Nyamwaya, 1991; Kamau, 1996). Other sources of transmission enumerated by the respondents include cutting and piercing using sharp unsterilized skin piercing instruments such as blades, needles or knives (15%), indiscriminate widow inheritance (38%) and blood transfusion using contaminated blood (1%).

The incurable nature of AIDS was known to almost all the respondents (95%) while 4% stated that AIDS could be cured through faith healing and herbal medicine. One percent of the respondents did not know whether AIDS was curable or not. In faith healing, an individual with AIDS could pray and fast and God would, in return, cure the individual. On the other hand, herbal treatment involved the use of herbal medicine, either in powder or liquid form. A herbalist who was one of the key informants claimed that AIDS could be cured using herbs. He alleged that he had treated five people using a

herbal mixture of 45 medicinal herbs. Each dose consists of three tablespoons taken four times daily. He declared that a patient could get healed within five days.

A vast majority of respondents also know the symptoms of AIDS. Some of the symptoms given include emaciation (2%), diarrhoea (2%), hair loss (1%), wounds (2%) and rashes (2%). Eighty - eighty percent were able to identify all the above symptoms as being AIDS related while 3% did not know the symptoms of the disease as they had never seen a person suffering from it. Table 4.9 summarizes the information on symptoms of AIDS as given by the informants.

Table 4.9: Symptoms of AIDS

Symptom	n	%
Emaciation	2	2.0
Diarrhoea	2	2.0
Hair loss	1	1.0
Wounds	2	2.0
Rashes	2	2.0
All the above	88	88.0
Not known	3	3.0
Total	**100**	**100.0**

During the focus group discussions, the respondents were able to differentiate between the symptoms of AIDS and *chira*. *Chira* is an ill - health condition among the Luo which inflicts an individual who breaks stipulated societal norms. It has similar symptoms as AIDS. However, some respondents observed that the main difference

between the two ill-health conditions lies in the type of diarrhoea. Diarrhoea is a common condition in both ill - health conditions but a person with *chira* has what could be literally termed as "normal diarrhoea" such as the kind one gets in an upset stomach. This diarrhoea is less watery and less heavy in nature. On the other hand, an AIDS patient suffers severe diarrhoea, which makes the patient weak within a short time. The diarrhoea is extremely heavy and mucus like in nature. The mucus nature is because of what could be literally translated as erosion of the contents on the walls of the intestines. The ability of local people to differentiate between the two ill health conditions is a further indication of an increased knowledge about AIDS.

Another indication of increased AIDS knowledge consists of the various local names people have given to designate the disease. Some of the local names for AIDS include *ayaki matieka* (AIDS the finisher) and *ayaki fut auchiel* (AIDS six feet) meaning that one ultimately dies of AIDS. Almost all respondents (96%) observed that AIDS can be prevented while 4% did not think AIDS was preventable and attribute AIDS infections to fate upon which no human being had control. This is a fatalistic attitude towards the infection and is likely to prohibit the success of preventive efforts. The various methods of prevention given by the respondents included avoidance of multiple sex partners (55%), protected sex using condoms (17%), sexual abstinence (8%), use of sterilised skin piercing objects (6%) and avoidance of indiscriminate wife inheritance (9%). During the focus group discussions, some respondents observed that wife inheritance could in a way decrease the spread of AIDS. They argued, for example, that in a case where a widow was inherited the infection could be contained within a limited number of people. On the other hand, if she was free and not inherited by anyone, the infection could

indiscriminately spread among many people whom she came into sexual contact with. The respondents, thus, suggested that couples should go for the blood test to ensure the safety of either partner. In a case where couples were skeptical about going for AIDS tests, they should practise safe sex by using condoms. Table 4.10 illustrates the various preventive measures as mentioned by the respondents.

Table 4.10: Preventive measures of AIDS

Measure	n	%
Avoidance of multiple sexual partners	55	55.0
Use of condoms	17	17.0
Sexual abstinence	8	8.0
Sterilised piercing objects	6	6.0
Avoidance of indiscriminate widow inheritance	9	9.0
All the above	4	4.0
Total	**100**	**100.0**

Members freely discuss AIDS in their various groups. They discuss various aspects of AIDS such as its increased incidence, preventive measures that need to be put into place, death of many parents, increased number of orphans and the terminal nature of the pandemic. More than a half of the respondents (67%) had discussed AIDS during group meetings while 33% had never had such discussions. One reason given for not discussing AIDS among such groups was that often they were pre-occupied with savings. Other groups like the Coptic Church Group and St. Catherine were often pre-occupied with spiritual issues. Some respondents feared talking about AIDS because of the stigma

attached to the infection.

Respondents were also asked whether they would participate in anti -AIDS efforts. Most of them (93%) indicated that they would participate in such efforts. However, seven percent indicated that they could not participate in such efforts. The reasons given for non- participation included husband's refusal, fear of being identified with AIDS issues, while others felt they did not have adequate knowledge about AIDS to be able to face the community with the issue. The most popular preventive activity, which the respondents would want to get involved in, was information dissemination, which was represented by 41%. This activity was considered popular because of its time-saving and less involving nature, meaning that respondents could easily balance between this activity and their household chores. It was also considered popular because it would address many people at once, especially if done at a chief's baraza or during a market day. Other preventive and care activities the respondents would want to get involved in include sale of condoms (14%), care for widows and orphans (19%), counselling (5%), care for orphans (12%) and all the above mentioned efforts (9%) (see Table 4.11).

Table 4.11: Preventive and care efforts respondents would want to participate in

Type	n	%
Information dissemination	41	41.0
Sale of condoms	14	14.0
Care for widows and orphans	19	19.0
Counselling	5	5.0
Care for orphans	12	12.0
All the above	9	9.0
Total	**100**	**100.0**

Generally, 83% of the sample thought that anti- AIDS efforts were commendable because they create awareness and this would save the lives of those who took heed. Conversely, other respondents thought that the efforts created employment opportunities for those involved in them. However, 10% of the respondents felt such efforts were difficult as they were time consuming. According to these respondents, anti-AIDS efforts needed a lot of dedication for one to be able to adequately reach out to the whole community. This means that if they got involved in such efforts they would have to balance between the efforts and household duties, yet the efforts were voluntary. Some respondents also stated that facilitating such efforts would be difficult because people often had their own preconceived ideas about AIDS. For instance, some people had a belief that AIDS does not exist; instead there was *chira*. These pre - conceived ideas make the efforts more difficult because such people would definitely reject AIDS messages and this would be discouraging to those facilitating the efforts. Seven percent of the respondents also stated that anti-AIDS efforts were time wasting because despite

the efforts that have been in place, a large number of people were still dying from the disease.

4.7.3 Provision of home-based care

One of the requirements of the home - care concept is that care must be provided by either family members or the surrounding community. Sometimes, home-care is provided by the community even though there is no blood relation between the patient and the care provider. The process of home-care involves providing adequate nutrition, cleanliness, changing clothes and napkins and giving medication, among others. The caregivers must also have adequate knowledge as regards avoiding infection, knowledge on how the virus can be transmitted from one person to another and the value of providing care to patients in the home. Respondents were, therefore, questioned on their view about providing home-care to patients. Ninety-three percent of them observed that they would provide nursing care to patients at home. The care would be provided in the form of bathing, feeding with nutritious foods, giving medication to the patients, comforting the patients by spending time with them and, in case of diarrhoea, a patient would be given oral - rehydration. However, seven percent of the respondents said they would not nurse an AIDS patient even if the patient happened to be a close relative. Some of the reasons given for not nursing AIDS patients include fear of infection (2%), emotional and non-appreciative patients (11%), multiple needs of the patients (63%) and the costly nature of providing care in terms of buying foods and detergents to wash clothes and bedding 6% (see Table 4.12).

Table 4.12: Difficulty in provision of home-care

Problem	n	%
Patients have multiple needs	63	63.0
Takes time	11	11.0
Emotional patients	7	7.0
Costly	6	6.0
Non-appreciative patients	4	4.0
Fear of infection	2	2.0
Not difficult	7	7.0
Total	**100**	**100.0**

Respondents were also asked whether they would provide nursing care to patients in the locality regardless of blood ties. Sixty-three percent stated they would provide the care voluntarily even to patients not related to them. This would be made possible by members of the various groups taking turns to visit and care for the patients. For example, if a location has five women groups and a total of fifteen patients, the respondents would take turns in such a way that all members had a chance to visit and care for the patients. Each of the groups would have one day of the week to send two or three of its members to provide care until such a time that the patients died. Other respondents suggested that visiting and caring for patients would be easier if a central place was established so that on their visits did not have to interfere with people in their homes. However, thirty- seven percent felt it would be difficult to provide care to other patients who did not belong to the group or had no blood relation with the care provider. Some of the reasons given that make caring for patients within the locality difficult

include: acceptance by the patients and the patient relatives (8%), often only a few people want to acknowledge that a given patient has AIDS; sometimes even the patients do not accept their condition and this would then make it difficult for persons providing care. Six percent of the respondents mentioned that they would be willing to volunteer the care but feared that their husbands may not allow them. In such a case, they would rather obey whatever the husband says. Other respondents (19%) observed that caring for a patient would be time-consuming, especially if there was no blood relation between the patient and the care - provider. Four percent would not get involved in the efforts because they feared being associated with the disease. The costly nature of AIDS care (8%) also makes provision of care difficult. On the other hand, forty - four percent of the respondents do not have a problem with providing care to any AIDS patients because they view it as a vocational duty and as a spiritual duty. Table 4.13 displays reasons that would make care for patients in the locality difficult.

Table 4.13: Factors prohibiting provision of care

Factor	n	%
Time consuming nature of the care	19	19.0
Acceptance by the patient and the patient's relatives	8	8.0
Fear of infection	11	11.0
Husband's refusal	6	6.0
The costly nature of the care	8	8.0
Fear of being associated with AIDS efforts	4	4.0
No difficulty	44	44.0
Total	**100**	**100.0**

The process of providing care requires that the care - provider has adequate knowledge as regards infection so that such a person can prevent himself or herself from infection in the process of providing care. Respondents were questioned as regards transmission of AIDS in the home. Nineteen percent of the respondents observed that one could contract AIDS by sharing spoons and other utensils, especially in a case where a patient had mouth sores and a healthy person also had sores or an open cut in the mouth. The exchange of saliva between the two persons using the utensils leads to the possibility of an infection. Greetings could also cause AIDS, for example, in case a healthy person greeted a patient the virus would get transmitted through the sweat pores on the palms. Obviously, then, for this 19%, provision of home-care would be difficult unless they are provided with accurate knowledge regarding the transmission of AIDS. However, 61% of the respondents had adequate knowledge about contracting AIDS in the home. For them, one cannot contract AIDS by sharing spoons, utensils, clothes or even greetings, especially in cases where high hygienic standards were maintained.

Despite respondents having a positive attitude towards provision of home-care, a majority (78%) maintained that hospitalisation was the most appropriate option for AIDS patients. The reasons given for preference of hospital care included fear of infection in the home, especially where there were young children who may use the utensils already used by the patient and thus risk infection. The patients also needed to go to hospital to confirm a positive sero-status, and AIDS had multiple opportunistic infections that would require handling by qualified medical personnel. Some respondents felt that hospitalisation would be a way of consoling a patient because it would show the patient that the family was trying to do something about the patient's condition.

Others felt that hospital care would keep the patient away from relatives who came to pity the patient, thereby being a source discouragement to the patient. On the other hand, 21% preferred home - care to hospitalisation. This is because AIDS is incurable and hospitalisation meant incurring a lot of expenses that would rather be saved later to take care of orphans. Other respondents stated that AIDS is still a stigmatising disease and, thus, hospitalisation of a patient would subject such a patient to harassment from hospital staff. For this group, home was the best for such a patient because the patient would have the comfort of family members. Another reason given for preference of home care is the fact that an AIDS patient often had multiple needs in terms of food, constant changing of clothing and bedding as well as constant attention. People at home can easily attend to these multiple needs because they are with the patients all the time, unlike in the hospital where the family can only see patients at scheduled times.

4.7.4 Women as peer educators

Peer education is a concept of AIDS prevention where people of the same sex, age or occupation talk to each other about AIDS. This study had the intention of establishing whether women can be peer educators to other women. Several questions pertaining to women's risk to HIV infection, whether women can reduce their risk to HIV infections and whether AIDS is discussed in group meetings or among other women, were asked. The answers seem to indicate that women are at a high risk of HIV infection. This is evidenced by the fact that 35% of the respondents stated that women were at a higher risk of HIV infection than any other categories of people mentioned. Only ten percent of the respondents indicated that men were at a higher risk of getting infection.

On the other hand, 12% stated that adolescent girls were at risk, 6% gave adolescent boys as a risk group, 22% gave young adults, and 15% felt that all the above categories of people were at the risk of contracting infection, meaning that anybody risked HIV infection as long they were involved in unprotected sexual intercourse (see Table 4.14).

Women were perceived to be at a higher risk because of marital infidelity on the part of the husbands. Eighty - seven percent of the respondents indicated that the society allows men to have multiple sexual relations such as polygyny, yet such relations put an individual at a higher risk of infection.

Table 4.14: Persons at risk of HIV infection

Persons	n	%
Women	35	35.0
Men	10	10.0
Adolescent girls	12	12.0
Adolescent boys	6	6.0
Young adults	22	22.0
All the above	15	15.0
Total	**100**	**100.0**

The respondents further stated that since most men are breadwinners of their families, they have control over everything, including the women's sexuality. This means that even though women may perceive themselves to be at the risk of infection, there is often very little they can do about it because they lack negotiating power. Thirteen-percent of the respondents observed that widow inheritance puts women at a high risk of

infection. This is because in the Luo community a widow is expected to be remarried. In the past, the tradition was such that a brother to the late husband or a very close male relative would inherit the widow. This has changed since the onset of the AIDS scourge. The women are, thus, forced to look for men to inherit them. Being conditioned by societal expectations, the women are forced to go for what would be termed as professional inheritors. Such men are often foreigners who move from place to place to perform the rite. This obviously increases the chance of HIV infection on any widow being inherited by such a man because nobody knows either his sero status or those of the women he has previously inherited.

Some respondents (13%) also mentioned that it is difficult for women to reduce their risk to HIV infection because of the fear of violence at home. In this case, women fear denying their husbands sexual favours because of the fear of being beaten. Others (13%) perceived men as ultimate decision-makers whose decisions were unquestionable. Other factors that put women at a higher risk of HIV/AIDS infection include marital infidelity 27%, widow inheritance 13% and disregard of using male condoms (24%). Women face similar challenges as regards the HIV/AIDS infection. There is, therefore, a need for a concerted effort among the women to enable them successfully face the pandemic. One of the ways in which women could successfully face the pandemic is by educating one another on how this disease affects them. Respondents were then asked whether they had ever shared knowledge on AIDS with other women. Three quarters (75%) had shared some knowledge with other women. The common topics of discussion often included origin of AIDS, marital fidelity increased incidence of AIDS, and preventive activities and the need to end widow inheritance. On the other hand, 22% had

never shared any knowledge they have on AIDS with other women, and the main reason given was lack of adequate knowledge on subject.

Ninety - four percent of the respondents declared that if they were equipped with adequate knowledge on AIDS, they would disseminate the knowledge to other women, both within the group and outside the groups. This would be done by making individual visits to homes and freely discussing AIDS issues with them. However, most respondents (63%) preferred individual visits because the visits provided ample time for individuals to adequately share discussions on AIDS. Others (37%) preferred to share the knowledge with other women in a group during a chief 's baraza, during an ante-natal clinic visit or at a market centre. Group discussions were preferred because a variety of opinions could be given during the discussions and also the fact information would reach a wider audience within a short time as compared to door to door visits.

The respondents were asked whether educating other women would be difficult. Seventy-one percent of them found no difficulty in educating other women as regards AIDS, while 10% were of the opinion that since, sometimes, people had their own perceptions about AIDS, and changing this perception would be difficult. Twelve-percent indicated that household chores would be a hindrance while seven percent mentioned husband's refusal as hindrance to being educators of other women

4.7.3 Care for widows and orphans

The death of many adults means an increased number of orphans who not only need basic necessities but also solid financial support. The research aimed at finding out how the group members can extend their economic resources to provide financial support

for widows and orphans by asking question pertaining to uses women put their economic resources to, and whether they could divert their financial resources to provide care for widows and orphans. The respondents use their economic resources to satisfy a variety of needs. Many respondents use the money to purchase household goods (34%), purchasing livestock (24%), investing in business (20%), paying medical expenses (12%) and for satisfying personal needs such as clothing and shoes (10%).

More than half of the respondents agreed to the possibility of providing financial support to AIDS widows and orphans from their economic resources. Seventy - eight percent would give financial support in the form of donations while eighteen percent preferred a centralised saving where all members would give a fraction from their savings which would then be put together and be used to pay school fees or purchase school uniforms for an orphan or, alternatively, build a house for a widow. Four percent thought that the money from the rotations was too minimal to be diverted to providing financial assistance to either widows or orphans. Those respondents who were interested in providing assistance would do so at different intervals. Most respondents (60%) would give money on a monthly basis because orphans and widows have many needs that require frequent attention. Eleven percent of the respondents thought that a monthly duration would not satisfy daily needs of the widows and orphans and, thus, preferred a weekly donation to enable these people meet their daily needs. On the other hand, 15% felt that yearly contributions would be better if they were to give substantial financial support. This was better because in a whole calendar year they could have saved a substantial amount of money to be able to donate without any prohibitions (see Table 4.15).

Table 4.15: Duration of financial support

Duration	n	%
Monthly	60	60.0
Yearly	15	15.0
After six months	11	11.0
Weekly	10	10.0
At each rotation	4	4.0
Total	**100**	**100.0**

Respondents were also asked whether they could give any other forms of assistance to widows and orphans other than financial support. All respondents acknowledged the fact that they would give other forms of assistance which included constructing houses for widows (6%), providing school fees and uniforms to orphans (15%), providing food, clothing and utensils to widows and orphans (57%), adoption of orphans (5%), weeding shambas for widows (8%) and orphans (9%) (see Table 4.16).

Table 4.16: Other forms of assistance

Forms of assistance	n	%
House construction for widows	6	6.0
School fees and uniforms for orphans	15	15.0
Provision of food, clothing and utensils	57	57.0
Adoption of orphans	5	5.0
Weeding shambas for widows	8	8.0
Praying for widows and orphans	9	9.0
Total	**100**	**100.0**

In conclusion, the results of this study show that, one, *nyolouro* groups are capable of disseminating health information to the community. The main limitation here is lack of knowledge about AIDS to be able to exhaustively discuss AIDS issues with the community. Secondly, the group members have positive perceptions about AIDS and anti-AIDS efforts. This is evidenced by the fact that members freely discuss AIDS issues and want to engage themselves in anti-AIDS efforts. Thirdly, women in the groups are capable of providing home-care to AIDS patients who are related to them and also to those not related to them but are within the community. Lastly, group members were willing to extend not only their financial resources but also non-financial resources to give support to AIDS widows and orphans.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 Introduction

This chapter discusses and draws conclusions from the study findings. It is divided into five sections. In the first four sections each research question is discussed in relation to the findings, whilst in the last section recommendations and areas of further research are suggested.

The purpose of this study, which was carried out in Usigu Division of Siaya District, was to determine the potential of a local community initiative, *Nyoluoro*, in HIV/AIDS prevention and care. As pointed out in chapter one, HIV/AIDS prevention requires concerted efforts between the community and the government if any sustainable achievement is to be made. It is on this basis that the following questions were asked. One, does the *Nyoluoro* group involve itself in the dissemination of health information to the community? Two, what would be the group's perception about AIDS and anti-AIDS efforts? Three, can women, being the majority in the groups, provide home-based-care to AIDS patients? And, lastly, are the groups prepared to extend their financial resources from the rotations to provide care to AIDS widows and orphans?

5.2 Discussion

5.2.1 Does the *nyoluoro* group involve itself in the dissemination of health information to the community?

The findings of this study suggest that the motivating force behind the formation of *nyolouro* groups is the revolving fund. In fact, all the thirteen groups that facilitated

the research started off as rotating credit associations, and it was only later that the members decided to venture into other activities. Some of the other activities the groups involve themselves in include joint farmwork, group counselling, potting, spiritual uplifting, paying medical expenses for members and catering for the members' funeral expenses. Respondents further stated that the main reason why they joined the groups in the first place was the financial savings each individual is entitled to upon joining such a group. There is no indication that any of the thirteen groups started off purely as a health disseminating information group. Similarly, no respondent in the first instance joined the group because it was a health information-disseminating group. However, though the groups do not disseminate health information to the community, the possibilities of these groups' involvement in disseminating health information to the community cannot be automatically ruled out. This observation is based on the fact that nearly half of the respondents admitted the importance of disseminating health information, especially on AIDS, to the community. The respondents further asserted that not making health information a priority was an oversight. To further justify this observation, most respondents perceived dissemination of health information as a priority preventive activity compared to other preventive and care activities (see Table 4.12). This activity is viewed as time saving and also it is the preventive activity that can reach a wide audience within a short time.

Therefore, *nyolouro* groups are potential health information disseminators to their local communities.

5.2.2 What would be the group's perception of AIDS and anti-AIDS efforts?

Respondents perceived AIDS as a serious health problem in the division, especially because of its increased incidence, its terminal nature and the fact that it is incurable. The seriousness of AIDS makes it a vital issue of discussion in the group meetings. One of the most pressing issues that prominently features in these group discussions is the women's" vulnerability to HIV/AIDS infection. Women perceive themselves as being at risk of HIV/AIDS infection because of marital infidelity. Double standards have since time immemorial been set with regard to male and female sexuality. Often, men are allowed by tradition and custom to engage themselves in multiple sexual relationships while women, on the other hand, are expected to maintain fidelity. In the process, multiple sexual relations, such as polygyny, may expose the man to HIV infection. Once the man is infected, all his wives will definitely be infected. Some of the suggestions made in regard to vulnerability included use of female or male condoms, marital fidelity or running away and returning later on when the man is about to die to nurse him. Reducing their vulnerability to infection, especially in a marital situation, is difficult because men are viewed as the ultimate decision-makers even with regard to matters of female sexuality. It is thus difficult to negotiate safe sex in a marital situation.

The respondents also viewed anti-AIDS efforts as being commendable since these are likely to save the lives of both individuals and the community at large. The fact that the efforts are commendable also makes the respondents want to participate in implementing such efforts. It can, thus, be concluded that *nyolouro* groups have a positive perception about AIDS and anti-AIDS efforts.

5.2.3 Can women who are designated as care givers and constitute a majority in the groups provide care to AIDS patients?

The incurable nature of AIDS means that a patient not only needs emotional, economic and medical support but also immense social support. Social support can protect a person in crisis to the extent that it may ultimately reduce the amount of medication required by an individual to speed up recovery (Ntozi, 1997). In the case of AIDS, social support may prolong the life of a patient, especially if the patient is in a non-discriminatory environment. Social support often involves spending time with the patient and feeding, washing and changing bedding for the patient. More often than not, women have played an important role in providing support to patients. They have since time immemorial been informal health care providers as daughters, sisters and grandmothers to their families and their communities at large (Pirzuka et al., 1987). Similarly, the results of this study reveal that women in the groups can provide informal health care to AIDS patients, both those related to them by blood as well as those with no blood relations.

However, it should be noted that despite a majority of the respondents mentioning the possibility of providing home-care, most of them seemed to prefer hospitalisation for AIDS patients. They assumed, like most people, that hospital care is the most appropriate for the patients (Tuju, 1996). Hospitalisation was preferred because of the nature of AIDS infection, in the sense that its multiple symptoms often need professional medical attention. Besides, hospitalisation was seen as a way of keeping the patient away from gossip and also as a way of consoling such a patient. Hospital care is often mentioned without persons thinking of the socio-economic implications it has on patients, the

patient's family and the community at large. One such implication is in the form of enormous medical bills, which may lead to the selling of family assets in order to offset them. In the event of death, such a family is left in an irreversible financial crisis Such implications make home-care a more acceptable option.

All in all, the results of the study seem to suggest that women, being the majority in the groups, have the willingness to provide care to AIDS patients, both those related to them as well as those not related to them but are within their communities.

5.2.4 Can the groups extend their economic resources from the rotations to provide financial support to AIDS widows and orphans?

The number of AIDS orphans is increasing daily in sub-Saharan Africa. In the past, the problem of orphanhood was attributed to civil strife but in the past decade HIV infection has caused many widows and orphaned children as a result of the death of spouses and parents (Ntozi, 1997). Concern for orphans is often raised because of the need for the children to grow as normally as possible. On the other hand, concern for widows is also raised because, sometimes, upon the death of a husband, widows may be left helpless, especially in cases where selfish relatives take away all the property. Such a woman will need to support herself and her children. This research, thus, aimed at finding out how *nyoluoro* groups could support AIDS widows and orphans. The results of the study indicate that these groups would be willing to provide financial support to AIDS widows and orphans at varied intervals. Some groups preferred to give financial support on a monthly basis while others preferred yearly contributions so as to have enough money to adequately share it out with the widows and orphans. The study further

revealed that apart from finance, the groups could also provide non-financial assistance in the form of adoption of orphans, house construction for the widows, offering prayers, and food and clothing donations.

The focus group discussions also considered care for widows and orphans as being an important activity because these are the most needy people in the society. In providing such support, the members argued that they would be performing a spiritual duty.

The results of this study suggest that *nyoluoro* groups are capable of extending not only their financial resources but also non-financial resources to AIDS widows and orphans.

5.3 Conclusion

The study set out to investigate the following, the capacity of *nyoluoro* groups as health information disseminators, the groups' perceptions of AIDS and anti-AIDS efforts, the groups capability in providing home-care to AIDS patients and whether the groups can extend their economic resources to provide financial support to AIDS widows and orphans. The study found that *nyoluoro* groups are potential health information disseminators, the groups have a positive perception of AIDS and anti-AIDS efforts, the groups can provide home-care to AIDS patients and, lastly, the groups can extend their economic resources from the rotations to provide financial support to AIDS widows and orphans.

5.4 Recommendations

This study has revealed that *nyolouro* groups are potential health information disseminators to the community. However, one of the limitations cited by respondents in facilitating this preventive activity is the lack of adequate knowledge on AIDS to be able to hold exhaustive discussions with community members on the subject. In order to enable the groups reach out to the community with accurate and adequate information, the group members need to be trained through seminars and workshops. This can be done by health educators in the Ministry of Health as part of the government's support of community initiatives in HIV/AIDS prevention as mentioned in Sessional Paper No. 4 on HIV/AIDS prevention (Government of Kenya, 1997). This should be further implemented by inviting resource persons on the subject of AIDS to these seminars and workshops. They would, in turn, clarify various issues on AIDS, thus making it more comprehensive to group members who would then confidently disseminate the information to the community members.

Hospitalisation of AIDS patients has immense social and economic implications on the patient, the family and the community at large. Some of these include enormous hospital bills and the use of family assets to settle the bills. The results of the study indicate that a majority of the respondents prefer hospital care for AIDS patients. Since AIDS is an incurable condition, the community at large needs to be educated on the values of home-care, including reduction of health care costs, the patient dying amongst caring family members and the need for patients to spent time with the family. The community needs to be sensitized on the fact that a patient should only go to hospital to ascertain a positive sero-status or for treatment of complicated symptoms of AIDS, such

as growth on the lymphatic tissues, and not long periods of hospitalisation. This should also be part of the government's support of community initiatives. Educating the community can be done by health educators who can educate the group members directly and the latter would then pass on the information to the community. Alternatively, the health educators could target the community directly through a chief's baraza, at a market centre on a market day or at a hospital where they would educate community members on the benefits of home-care.

Lastly, the study has revealed that the groups would be willing to provide home-care both to their own patients and patients not related to them. One of the reasons that make home-care difficult is fear of infection. The government, as part of supporting community initiatives, should provide caregivers with simple medical equipment that would enable them to protect themselves from infection in the process of providing care.

5.5 Areas for further research

This study is not exhaustive since it has only covered a small section of a division in the whole country. To provide more comprehensive information on groups' potential for AIDS prevention and care, similar studies should be undertaken in various parts of the country where such groups exist.

In-depth studies also need to be carried out on the concept of home-care at the local level. The studies should focus on:

1. The socio-economic impact of home-care on the family and the community at large.
2. The possibility of an integrational relationship between the community and government as regards home-care. In which case, research needs to be carried out to

find out how both institutions could support each other in providing home-care to AIDS patients.

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APPENDICES

APPENDIX A

QUESTIONNAIRE

Biographic Information

1. Questionnaire Number: .....

2. Sex [F] [M]

3. Age [ ]

4. What level of formal schooling did you attain?

   a) None
   b) Primary
   c) Secondary
   d) College
   e) University
   f) Others

5. What is your occupation? .....

6. What is your marital status?

   a) Single
   b) Married
   c) Widowed
   d) Divorce

Structure and function

7. Have you ever heard about *Nyoluoro?*

☐ YES ☐ NO

8. If yes, how did you know about its existence?

a) Friends
b) Mother in law
c) Husband
d) Neighbour

9. Are you currently involved in the activities of such a group?

☐ YES ☐ NO

10. If yes, what reasons made you get involved?

.....

.....

.....

11. If no, why have you never joined such a group?

.....

.....

.....

12. If opted out, what reasons made you opt out of the group?

.....

.....

.....

13. What kind of activities does a *Nyoluoro* undertake?

a) Merry- go- round activities

b) Joint farm work

c) Group counselling

d) Funeral activities

e) Medical activities

14. Does the group disseminate health information to the community?

☐ YES ☐ NO

15. If yes, is this information based on general health or specific health issues?

.....

.....

.....

16. Does the group provide information on AIDS related issues?

☐ YES ☐ NO

17. Does the health information given help the community in any way?

☐ YES ☐ NO

18. If yes, in what ways does the information help the community?

.....

.....

.....

Anti-AIDS efforts

19. Do you think AIDS is a serious health problem in this division?

☐ YES ☐ NO

20. If yes, why do you think it is a serious health problem?

.....

.....

.....

21. Is AIDS a curable disease?

☐ YES ☐ NO

22. If yes, how?

.....

.....

.....

23. Do you think AIDS can be prevented?

☐ YES ☐ NO

24. In what ways do you think AIDS can be prevented?

.....

.....

.....

25. Can you as an individual help in the prevention of AIDS?

☐ YES ☐ NO

26. Which of these preventive or care activities would you get involved in? .....

a) Information dissemination

b) Sale of condoms

c) Care for patients

d) Care for widows and orphans

e) Counselling

27. During your group meetings, has the group ever discussed AIDS issues?

☐ YES ☐ NO

28. If yes, what did members discuss about AIDS?

.....

.....

29. If no, why have you never discussed AIDS?

.....

.....

.....

30. In your view, do you think the group should get involved in any AIDS preventive activities?

☐ YES ☐ NO

31. Which of these activities would the group get involved in?

a) Information dissemination
b) Sale of condoms
c) Counselling
d) Home based care
e) Care for widows and orphans

32. Do you know of an organization or group involved in anti-AIDS activities in Siaya District?

☐ YES ☐ NO

33. What is the name of the organization or group?

.....

34. What kind of preventive efforts are they involved in?

.....

.....

35. What do you think about such efforts?

a) Difficult
b) Commendable
c) Time-wasting

36. If difficult, what in your view makes such efforts difficult?

.....

.....

.....

37. If commendable, what in your view makes the efforts commendable?

.....

.....

Home-based care

38. What symptoms does an AIDS patient show?

.....

.....

.....

39. Does one contract AIDS by

a) Sharing spoons
b) Sharing utensils
c) Sharing clothes
d) Greetings

40. If, for example, you knew or had an AIDS patient in your household, would you prefer that the patient be taken care of at home or in hospital?

.....

41. If hospital, why?

.....

.....

42. If home, what reasons would you give?

.....

.....

.....

43. If you had an AIDS patient at home, would you nurse him/her?

☐ YES ☐ NO

44. If yes, how would you go about it?

.....

.....

.....

45.Do you think it could be difficult to nurse such a patient?

.....

.....

46. Do you think your group could get involved in nursing patients within your location?

☐ YES ☐ NO

47. If yes, in what ways would this be done?

.....

.....

.....

48. Is there anything that could prohibit group members from nursing patients?

.....

.....

.....

Peer education

49. In your opinion, which group of people are at a high risk of getting HIV infection?

a) Women
b) Men
c) Adolescent girls
d) Adolescent boys
e) Young adults

50. Do you think women are at a higher risk of infection?

☐ YES ☐ NO

51. If yes, what in particular do you think puts them at a higher risk?

.....

.....

.....

52. Do you think that they are capable of reducing this risk?

☐ YES ☐ NO

53. If yes, in what ways could they reduce this risk?

.....

.....

.....

54. Do you think it is difficult for women to reduce this risk to HIV infection?

.....

.....

.....

55. Have you ever shared any knowledge you have of AIDS with a woman friend?

☐ YES ☐ NO

56. If yes, what did you discuss?

.....

.....

.....

57. Do you think you as a person, if equipped with adequate knowledge, would share it with other women?

☐ YES ☐ NO

58. If yes, how would you go about it?

.....

.....

.....

59. Is there anything that could make it difficult for you to share such knowledge with other women?

.....

.....

.....

Care for orphans and widows

60. Do you think the group is capable of giving any assistance to widows and orphans?

☐ YES ☐ NO

61. How would the group go about this?

.....

.....

62. What do you use your economic resources for?

.....

.....

62. Can the group extend their economic resources in providing care for widows and orphans?

.....

.....

.....

63. Can you give suggestions as to how the group would go about doing this?

.....

.....

.....

64. Apart from financial assistance, is there any other assistance the group could give to widows and orphans?

.....

.....

.....

APPENDIX B

KEY INFORMANT GUIDE

1. What do you think about *Nyoluoro* activities in this location?
2. Do you think the group influences the community in any way?
3. If yes, in what ways?
4. Do you think the group would be able to mobilize the community in AIDS preventive efforts?
5. If yes, in what ways?
6. If no, what would prohibit them?
7. With regard to specific efforts, do you think the group can provide home-based care to patients?
8. If yes, how would they go about it?
9. If no, what in your opinion would prohibit them?
10. Do you think the group can educate the community if provided with correct information on AIDS?
11. If yes, how do you think they would go about it?
12. If no, what would prohibit them?
13. Do you think the group can facilitate educative efforts specifically to women?
14. In your opinion, which of the preventive efforts discussed would the group best facilitate?
15. Why do you think the group would best facilitate that effort?
16. Which one would they least facilitate?
17. Why do you think so?

18. Are there any preventive efforts not discussed the group would facilitate?

19. What would these efforts be?

20. Generally, in your opinion, do you think it would be difficult for the group to engage the whole community in anti-AIDS efforts?

21. Why would this be the case?

APPENDIX C

INTERVIEW GUIDE FOR FOCUSED GROUP DISCUSSIONS.

1. Tell me what you know about the causes of AIDS? Is AIDS preventable and, if so, in what ways can it be prevented?
2. As a group, do you think you can mobilize the community to participate in anti-AIDS efforts? If yes, how would you go about this and if no, what would make it difficult?
3. What do you see as the advantages and disadvantages of home-based care for AIDS patients?
4. Would you as a group facilitate home-based care? What difficulties are you likely to encounter in this?
5. If you had correct information about AIDS, would you disseminate such information to the community?
6. Among the preventive efforts discussed which were;
    a) Home-based care;
    b) Information dissemination;
    c) Peer education,

    Which one of these would you prefer to facilitate?
7. Give reasons why?
8. Are there any preventive efforts not mentioned you as a group would easily facilitate