Family Communication and AIDS: A Strategy

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Abstract

Introduction: One year after a weekend workshop was held (at the request of a local community), some of the participants were still implementing what had been learnt at the workshop setting. The workshop had two main components: 'communication in the family' and 'AIDS'.

Method: A qualitative research project using an 'exploratory case study method' approach was undertaken to evaluate the 'successful components' of the workshops. Free-attitude interviews in the participants own language were undertaken and analysed for common themes. The themes were ordered and combined into a set of common themes, which were then amalgamated to create a schema.

Results: The central and most striking components of the model are 'Improved Communication', a 'Change in Self', and ability to 'Talk about Sensitive Issues'. 'Improved communication with neighbours' was an unexpected finding. The benefits and changes were recognised by the participants themselves as well as by members of the community.

Conclusion: In those participants who were successful in implementing the changes suggested during the workshop, the changes were sustained for at least a year afterwards. This form of research has particular relevance in highlighting subtle aspects, which may be overlooked in both quantitative and traditional qualitative methodologies. The research is also suggestive that coaching people in the art of respectful communication may well be one of the most appropriate strategies in tackling the stranglehold of the HIV/AIDS pandemic in our country.

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Introduction

Health education and health promotion are important components of primary health care[1,2,3]. Unfortunately most family physicians have neither the time nor training to adequately address these issues. Health education is but one of several components in the bigger picture of health promotion. The Ottawa Charter of Health Promotion is one of the most profound and comprehensive consensus statements about Health Promotion yet to be formulated[4]. In Family Medicine, 'opportunistic health promotion' (including health education) as part of the consultation has been recommended for many years[1]. However, most health education programmes take place outside of the consulting room and are carefully constructed complex media-based campaigns[5].

Active participation in health education initiatives enhances a person's self esteem which in turn leads to the ability/confidence to make decisions to change behaviour[6]. Working in small groups, paying attention to listening, and showing mutual respect also improves the outcome of health education[7].

This research project took the form of an exploratory qualitative case study[8]. A particular health education strategy and some of its outcomes are described.

One of the researchers (GM) started work as the Community Medical Officer in the Letaba Hospital health ward (now Halegratz district around Tzaneen) of rural Northern Province in 1992. An existing organisation of women, known as the 'Care Group' voluntarily involved themselves in health issues. GM asked Care Group members what they themselves regarded as their main problems. Their responses are summarised in Table I.

The Intervention

In order to address these problems, the researcher organised, in collaboration with Care Group members a weekend workshop on 'communication in the family' and on 'AIDS'. They wanted to ensure that men were not excluded from attending the workshop. Each Care Group elected two men and two women to represent their various villages. These people were expected to report back to their respective communities after the workshop.

The workshop was held over a weekend in April 1993 and was attended by 105 delegates. The first session (Friday evening) was spent getting to know each other. The next day two speakers presented the requested topics, namely:

1. Communication in the family.
This presentation was given in Tsonga by a pastor who is a trained Famsa counsellor. He described how people in marriage could improve their communication through politeness and respectful but honest discussion. (Sensitive matters should still be discussed privately).
In improving communication between parents and children, the focus was on listening to the other, as well as communicating with respect.

2. The threat of Aids to the family.
A medical doctor, who was not one of the researchers, gave this presentation in Tsonga. He discussed how HIV is spread, how to prevent being infected with the virus, the danger of acquiring HIV through extra-marital relationships and the need for faithfulness in marriage.

After each presentation, the delegates were divided into 8 small discussion groups. Two hours were allocated for each session. Each group was given a different topic chosen by the presenters.

The presenters, researcher and assistant researcher participated as equal members in these groups.

The topics were:
1. Teenage pregnancies.
2. Alcohol abuse.
3. Marital problems, such as infidelity and disagreement about contraception.
4. School drop-out.
5. Substance abuse.
6. Communication problems between spouses.
7. Communication problems between parents and children.
8. Problems with the extended family.

Table I: *Care Group members' main problems*

1. Problems between spouses	2. Problems between parents and children
• Family Planning	• Dropping out of school
• Prevention of AIDS	• Teenage pregnancies
• Alcoholism	• Use of addictive substances

During the first group discussion, the perceived **causes** of a specific problem were discussed. During the second group discussion, possible **solutions** to the same problem were explored.

A report back session was held after each discussion.

A brainstorming exercise was held during the closing session on the Sunday morning to formulate a plan of action based on the previous day's work. The following ideas were put forward:

1. To tell the various organisations in the villages about what had been learned over the weekend
2. To arrange mass meetings in the respective villages to pass on the information
3. To form youth groups where the issues can be discussed
4. To plan one day workshops on 'family communication' and on 'AIDS' in the villages

Methodology

In evaluating the impact of the workshop a year later, the researcher chose to focus on positive effects the workshop had had on participants' lives. This is in accord with accepted qualitative exploratory case study research where selecting cases must be done so as to maximize what can be learned in the period of time available for the study[8].

The specific objectives of the evaluation were:
i) to find out what the positive effects on the lives of participants had been; and
ii) to understand the process through which those changes had taken place

Sample

Eight participants were selected by the Care Group organisers. They chose people who had participated actively in the group discussions, were well able to articulate their experiences, and whose lives had been positively affected through participating in the workshop. Two participants were excluded, as they were not available for interviews. Three women and three men were interviewed. None of these women or men was married to each other.

Data Collection

The interviews took place in March and April 1994 – one year after the workshop. The interviews were conducted by the researcher in Tsonga and recorded on audiotape. Each interview started with the question, "What has changed in your life since the workshop last year at Giyani concerning communication in the family and

concerning Aids?" The researcher then facilitated further discussion using reflection and clarification. Consent for the interviews and permission to record them was obtained from the participants. Confidentiality was maintained by coding the interviews and names did not appear in the transcriptions. The researcher and a Tsonga-speaking research assistant listened to the original interviews several times. They then transcribed them verbatim, and translated them into English.

Data Analysis

The interviews were analysed using a modified form of 'hermeneutics'[9,10] and 'deconstruction'[11]. The research assistant identified themes in the Tsonga transcripts and marked these using coloured pens (the 'colour line method')[12]. The researcher independently identified themes in the English translations and collated these using a 'cut and paste method' with a word-processor[13].

The themes identified in the Tsonga transcripts were compared with those identified in the English translations. A list of themes for each interview was drawn up. A combined list of themes was then created from all the lists. (Table II) An integrated model illustrating the relationships between the themes was made with the help of one of the co-authors. (Figure 1, overleaf)

Validity

The findings were validated through a process of 'triangulation'[13]. The components of this were:

i) peer-review (by one of the co-authors, not involved in the initial workshop process)

Table II: ***Combined List of Themes***

Theme	Example of Data
New knowledge was gained at the workshop	• When there is a problem in your heart, sit down with your husband and talk about the matter.
Information was respectfully communicated at home	• Condoms are an acceptable alternative (to infidelity) when a woman is breastfeeding
Solution to an existing problem that led to frequent quarrels with spouse was found	• I showed him what I have written in the book and he understood
The new information was reinforced by notes from the workshop and congruent with radio programmes, health messages from the clinic and community health workers visits	• It was also on the radio and it was taught at the clinic
Improved communication and relationship with spouse	• I sat down with my husband and told him everything I have learnt at the workshop
Change in workshop participant	• I have changed and know how to behave myself. When I see he is angry, I answer him softly and he cools down
Change in spouse	• My husband understood and now he tells me where he goes
Improved communication and relationship with children	• Spend time with your children to sit down and communicate and they will not be afraid of you
Prevention of AIDS through discussion, the use of condoms, and limitation of extramarital affairs	• I have learnt to use condoms • I believe it is best to refrain from extra-marital relationships • A poor relationship between husband and wife can lead to AIDS
The influence on neighbours	• I can discuss these matters with my neighbours
Knowledge gained was communicated to others	• We invited the whole village and they were taught all that we learnt at Giyani
Need for more teaching	

ii) a discussion with the six interviewees of the list of themes and the model, two years after the initial interviews (i.e. three years after the workshop)

iii) a discussion of the list of themes and the model with five Care Group members who had attended the workshop but had not been interviewed, three years after the workshop.

Results

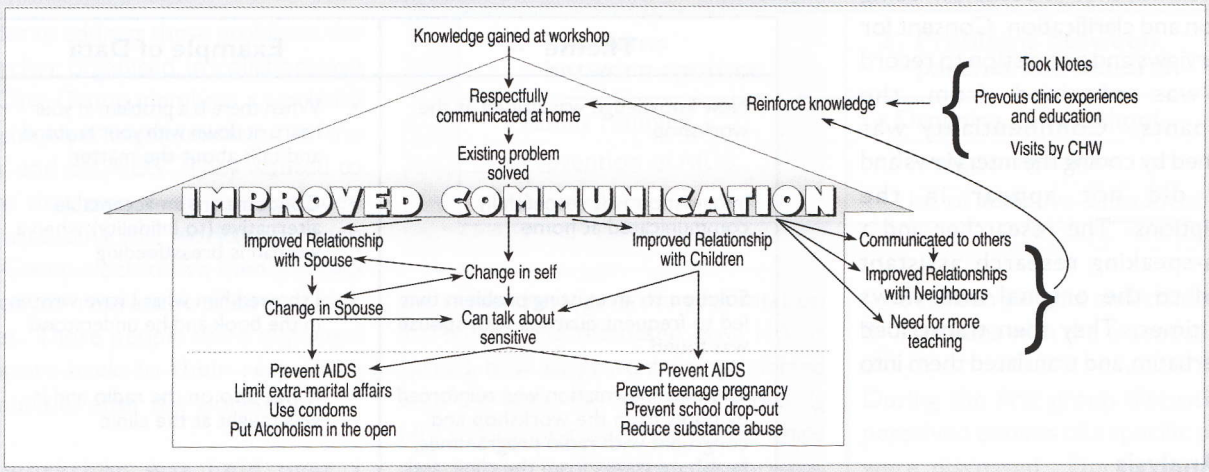
The combined list of themes and examples is detailed in Table II. The model derived from the themes demonstrates, in a stylised format, the inter-relationships of the themes within the setting of a 'house' (Figure 1).

The central and most striking components of the model are 'Improved Communication', a 'Change in Self', and an ability to 'Talk about Sensitive Issues'. Three main aspects of improved communication were reported on. These were:

i) With spouses
ii) With children
iii) With neighbours and the community

Although numbers i) and ii) were part of the original problem definition by

Figure I: ***Model of Combined Themes***



the Care Group members (Table I), iii) was an unexpected finding.

The initial 'respectful communication of the information' was a direct result of the workshop itself. The credibility of this information was enhanced through its congruence with messages previously received from the clinic(s), via the media, and through visits of Community Health Workers.

Sharing the information and putting it into practice led to the solving of existing problems, 'proving' that the process 'worked', thus reinforcing the improvement of communication. Changed behaviours and attitudes in the interviewees as well as in their spouses led to a further improvement of relationships.

In a similar way, improved relationships with the interviewees' children developed, and the whole family became involved.

Discussion

This 'exploratory case study' highlights not only the impact of the intervention, but also the value of this methodology. Although the case study method of research has been predominantly confined to sociology and psychology in recent years, it is once more being applied in medicine. Much of our own medical discipline was built up around the 'case study'[8]. The concept of 'case study' has been widened to incorporate an 'event' or 'situation' rather than just a 'patient'.

The effects of community-based prevention programmes have been widely investigated using case study methodology[8]. Most of these findings have been published in sociology journals and have not been widely accessed by health workers.

In this study, the researcher became aware, after the event, that something profound had happened to some of the participants in the workshop, and that these effects had been long-lasting. He then retrospectively decided to find out what had happened to these particular people.

In looking at the success of the intervention, several aspects can be highlighted that may well have contributed to its success.

1. Men were actively included in both the workshop and the research.
2. The whole exercise was conducted in the local language.
3. The presenters and the researcher consciously modelled the behaviours that they were talking about.
4. The messages were congruent with those from other sources.

1. Including men

Many community projects in recent years have focused only on women. This has been in line with the widely promoted strategy of improving health through 'female education'[14]. The rationale for this has been based on research that showed that health outcomes are improved the more 'well-schooled' women are. However the kind of education offered in this weekend workshop had more to do with universal communication skills than with literacy, numeracy or problem-solving capacities.

It could be argued that 'respectful communication' is part of this culture anyway. The difference in this workshop was that the respectful communication was between 'equals', and did not follow the traditional patriarchal format. Women were able to speak to men as equals, and in turn the men recognised the need to share with women at home, the information they had gained.

2. Using the 'mother tongue'

Many 'workshops' for rural communities in South Africa are held in English with translators conveying the messages to the participants. This

is in fact a subtle way of retaining power over the messages and the proceedings, no matter how well-intentioned the organisers of these events are.

In this case, respect for the community's own language was given priority, and apart from their expertise, the presenters were chosen on the basis of their being able to communicate in Tsonga. Although the researcher was from a different ethnic group, his fluency in Tsonga added to the impact of the workshop and contributed to the theme of 'respectful communication'.

It will not always be possible to achieve this in our multi-lingual country, but this case study seems to indicate that when it is achieved, effectiveness is improved.

3. Modelling behaviour

The presenters, researcher, and assistant researcher all consciously modelled the behaviour (of 'respectful communication') that they were talking about. Modelling has been well-described in the education literature, and forms a significant part of Albert Bandura's Social Learning Theory[15].

4. Congruence of messages

The compound effect of health messages with other sources of similar messages must always be considered[5]. In this case study, the recognition of the workshop messages as being congruent with messages in the media, from other health workers and the clinic, meant that they must be 'true' and could therefore be believed and trusted by those who had not been present at the workshop.

In planning or holding health education experiences for groups, it is vital to ensure that we do not contradict other messages – unless of course those messages are incorrect. It would then be important to overtly state that a particular message emanating from a particular source is in fact not correct.

Conclusion

This exploratory case study focused specifically on those who had had a 'positive' experience and explored how their behaviour had changed. The change was found to be mainly in terms of communication and in the observed behaviour of oneself and others. This would be considered 'empowerment' in many circles.

One particularly positive 'empowering' finding in this case study was that some of the participants shared information about 'sensitive issues' with their neighbours and communities.

Some unanswered questions remain:

- To what extent were the participants 'pleasing' the researcher, who clearly had invested a lot of time and energy in the project?
- Have the positive changes continued after the initial three years?
- Were there participants who experienced the workshop 'negatively' – why and how?
- To what extent were the 'action plans' created at the workshop carried out?
- Did the behaviour changes in terms of communication mean that other areas of behaviour change were sustained – and can these be measured? *For example:*
  - *Have any of the participants (and/or family members) contracted HIV/AIDS in the meantime?*
  - *Have any of the teenagers dropped out of school and/or become pregnant?*

These questions can only be answered with time and through further research. However we consider the outcome of this project highly promising. Coaching people in the art of respectful communication may well be one of the most appropriate strategies in tackling the stranglehold of the HIV/AIDS pandemic in our country.

References

1. Stott NCH. Primary Health Care: Bridging the Gap Between Theory and Practice. Berlin. Springer-Verlag. 1983. p.13.
2. Glanz K, Lewis FM, Rimer BK. The Scope of Health Education: Parameters of a Maturing Field. In: Glanz K, Lewis FM, Rimer BK. Eds. Health Behavior and Health Education: Theory Research and Practice. San Francisco. Jossey-Bass Publishers. 1991. p.7-9.
3. McWhinney IR. A Textbook of Family Medicine. New York. Oxford University Press. p.160-61.
4. Ottawa Charter for Health Promotion. Health Promotion 1986, 1(4): iii-v
5. Flay BR, Burton D. Effective Mass Communication Strategies for Health Campaigns. In: Atkin C, Wallack L. Mass Communication and Public Health: Complexities and Conflicts. Newbury Park. Sage Publications. 1990. p.129-146.
6. (active participation)
7. (Group learning)
8. Tellis W. Introduction to Case Study. *The Qualitative Report*, 1997:3(2) http://www.nova.edu/ssss/QR/QR3-2/tellis1.html
9. Rowan J, Reason P. On Making Sense. In: Reason P, Rowan J. Eds. Human Inquiry: A Sourcebook of New Paradigm Research. Chichester. John Wiley & Sons. 1981. p.132-35
10. McWhinney IR. A Textbook of Family Medicine. New York. Oxford University Press. p.65.
11. Olivier B. Deconstruction. In: Snyman J. Ed. Conceptions of Social Inquiry. Pretoria. Human Sciences Research Council. 1993. p.241-261.
12. Webb G, Dez-Penley H: Research as Meaning: Qualitative Methods. New Zealand Family Physician. Winter 1992. p.141-142.
13. Britten N., Jones R., Murphy E., Stacy R.: Qualitative research methods in general practice and primary care. Family Practice. 1995. Vol.12. No.1. p.104-112.
14. Goosen M, Zimbizi D. Work. In: Goosen M, Klugman B. The South African Women's Health Book. Cape Town. Oxford University Press. 1996. p.101.
15. Hergenhahn BR. An Introduction to Theories of Learning. 2nd Ed. Englewood Cliffs. New Jersey. Prentice-Hall Inc. 1982. p.325-353.