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Community Conversation Experiences Regarding HIV/AIDS Awareness and Beyond Awareness in Rural Community of Ethiopia: A Qualitative Study

Jeylan Kassim Esma'el[1], **Bethabile Lovely Dolamo**[2], **Tolesa Bekele**[1*] **and Muhammedawel Kaso**[1]

[1]*Department of Public Health, College of Medicine and Health Sciences, Madawalabu University, Bale Goba, Oromia, Ethiopia*

[2]*Department of Health Studies, College of Human Sciences, University of South Africa, Pretoria, South Africa*

[*]**Corresponding author:** Tolesa Bekele, Department of Public Health, College of Medicine and Health Sciences, Madawalabu University, Bale Goba, Oromia, Ethiopia, Tel: 2510910652069; E-mail: tolesa2003@yahoo.com

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Abstract

In the context of HIV/AIDS, community conversation is referred to as an interactive process which brings people together and engages them in discussions so that they explore the underlying factors fuelling the HIV epidemic. However, how and to what extent the community conversation programme has raised awareness about HIV/AIDS was not well addressed in Ethiopia.

Methods: A qualitative study was conducted in December 2013 in three selected zones of Oromia regional state of Ethiopia. A total of 22 in-depth interviews were conducted among purposely selected community conversation members in rural kebeles. The audio-taped data were transcribed verbatim into local language (Afan Oromo) and then translated directly into English. The study used Tesch's eight-step data analysis method. Translated narrations were reported as spoken by participants. Confidentiality of the participants was kept throughout the study.

Result: The study covered the participants' experience on community conversation regarding HIV/AIDS awareness and beyond awareness. The aspects were divided into sections: (1) schedule of the community conversation sessions, (2) community conversation programme as problem solving, (3) awareness level on HIV/AIDS, (4) level of misconceptions about HIV/AIDS since the programme started, (5) levels of stigmatisation and discrimination of HIV/AIDS victims after the programme came into action, (6) behavioural changes since the programme started, (7) the role of health extension workers in the programme implementations, and (8) the importance of the coffee ceremony during sessions.

Conclusions: The study shows community conversation creates social space for people to reflect on the possibility of more effective response to HIV/AIDS. The programme takes place within a wider social, political and economic context that plays a major role in response to HIV/AIDS. However, efforts are needed for continuous monitoring and evaluation or process evaluation of the CC activities to identify the major weaknesses and strength of the programme.

Keywords: Community conversation; HIV/AIDS; Awareness; Rural; Ethiopia

Introduction

In the last three decades human immunodeficiency virus (HIV) has spread rapidly and affected all sectors of society, young people and adults, men and women, and the rich and the poor with devastating socioeconomic impact to the globe [1]. The HIV or acquired immune deficiency syndrome (AIDS) epidemic affected communities at many levels simultaneously in terms of sickness and death, deepening poverty, and widespread orphaning [2]. Initially, HIV/AIDS was perceived as a health problem requiring strictly a public health approach. Accordingly, health services and communities were ill-prepared to deal with a health issue enmeshed in the complex issues of sex, terminal illness and death all raised to astonishing levels by HIV/AIDS. Innovative ways of working with communities were required to generate an effective structured response [2].

Globally, HIV prevalence was about 35.3 million in 2012 [3]. In 2010, the Kaiser Family Foundation reported that every day, over 6,800 persons became infected with HIV and over 5,700 persons died from AIDS. This is mostly because of inadequate access to HIV/AIDS prevention and treatment services. The HIV pandemic remains the most serious infectious disease challenges of public health.

Sub-Saharan Africa remains the most affected region, with AIDS and still it is the leading cause of death [4]. In 2012, an estimated 35.3 (32.2–38.8) million people were living with HIV globally of those about 68% were in Sub-Saharan African (SSA) countries, including Ethiopia [3]. According to the Federal HIV/AIDS Program Coordinating Office of Ethiopia estimated that 1,116,216 people were living with the virus, which accounted for 2.3% (1.8% male and 2.8% female) of the total population. About 339,917 of the infected population were found in the Oromia National Regional State. The prevalence varied between urban (7.7%) and rural (0.9%) areas and the incidence rate was estimated at 0.28% (131,145), of whom 91% were in the economically productive age group of 15 to 49 years old [1].

Ethiopia has adopted a coordinated multi-sectoral anti-HIV/AIDS response, which implements different policies, programmes, guidelines and strategies, including social mobilisation through

community conversation (CC). Community conversation is a process in which different members of the community come together, hold discussions on their concerns and by using their own values and capacity pass resolutions that can bring about changes and implement them accordingly [5].

The United Nations Development Program promotes community conversation due to its transformational success at community and institutional level in countries with different social, political and economic situations. Providing information for change in knowledge, awareness and attitude at individual level, however, does not guarantee change of behaviour at all levels. Individual practice is the result of community socialisation, especially in rural areas where the social dimension influences most of their actions [5].

Family Health International in Ethiopia promotes community conversation as a participatory process that focuses on building of the community's capacity to assess their socio-cultural, demographic and economic conditions that contribute to HIV and AIDS and related problems, such as discrimination, stigma, and care for orphans and vulnerable children. Community conversation mobilises communities through facilitated conversation to identify their concerns within the framework of their culture, values, norms and traditions, and then prioritise them according to their magnitude, severity, feasibility, and other criteria [6].

From the perspective of HIV/AIDS response, community conversation is a process in which the community uses their material wealth, social knowledge and positive norms to prevent and control the disease, and curb the social crises imposed as a result of the epidemic [7]. Community conversations take place across Ethiopia once a week or fortnightly in *kebeles* in which a group of 70 people sit together with trained local facilitators, mainly health extension workers (HEWs). A pilot project in Alaba and Yabello districts in Ethiopia led to significant changes in terms of improving existing misconceptions and reducing stigmatisation and discrimination regarding HIV/AIDS [8].

The community conversation programme was started in Oromia regional state during 2001. By the year 2001 the programme was implemented in limited areas of the region. In this region, the coverage was about 80.2% at the end of 2008. At present, the CC programme is under the 16 health extension packages of the Ethiopian health strategies. Furthermore, at first the CC programme was designed for HIV/AIDS, but now it also includes other developmental problems like child abuse, female genital mutilation, family planning, gender inequality and other harmful traditional practices. This was due to high attention given by the regional state [9]. However, a little is known how and to what extent the community experienced the CC as a strategy for HIV/AIDS awareness, control and prevention in the region.

Community conversation is envisaged as a significant way to address and strengthen community participation in raising awareness of the problem and fighting against HIV/AIDS in Ethiopia. Therefore, promoting and improving the implementation of community conversation is a practical means of involving the community about HIV/AIDS awareness, prevention and control methods. However, the knowledge gap is found at how and to what extent the CC programme has been raised HIV/AIDS awareness, prevention and control strategies in the study area. There are also still problems of discussing about HIV/AIDS issues openly in the families and community considering the issue as taboo that may indicates community level intervention gaps. Therefore, the study aimed to explore the experiences that community conversation programmes had contributed to community level HIV/AIDS awareness, prevention and control strategies.

Methods

Study area and population

The study used a qualitative study design in order to explore experiences on community conversation about HIV/AIDS awareness. The study was conducted in Oromia regional state of Ethiopia in December 2013. Oromia regional state is the largest regional state in Ethiopia; covering one third of the total country's land mass (359,619.8 Kms^2) and has an estimated total population of 32,065,118. Administratively, the region is divided into 17 zones comprising 304 woredas (districts), 375 towns, 7064 (564 urban and 6,500 rural kebeles) [10].

The study population comprised all community conversation members, who actively participated in community conversation programme on HIV/AIDS in the selected kebeles (smallest administrative unit in the governance) of Oromia regional state. To be included in the study, the participants had participated in the community conversation programme or be active participants of the CC programme during the study period.

Sampling

In this study, a total of twenty-two in-depth interview were conducted in three selected kebeles of Oromia regional state. Sampling was done in two phases:

First-phase sampling: From the total of 17 zones in Oromia region we took purposely three zones. The sampling was based on the zones CC programme performance report taken from the region. There was no overlapping (equal) performance report among the zones. These selected three zones comprised least performer, medium performer and best performer. Our intention is to explore more information about the cc programme considering the resource we have at hand. Furthermore, here we want to re-emphasise that we by no means seek to generalize for Oromia region or Ethiopia in general.

Second-phase sampling: In the three selected zones, one *kebele* was chosen from each selected zones purposely based on information-rich of the community conversation members.

Data collection

The interviews were pre-arranged and held in a location convenient and comfortable for the participants, like participants' homes, under a tree or in an office. On average the data collectors spent about 60 minutes per in-depth interview. The interviewers were two university lecturers those who had previous experience in qualitative data collection. The data collectors were trained for two days ahead of data collection. The interview guide was used to extract information on the following areas:

- How members arrange schedule for CC
- The roles of CC as a method of resolving issues regarding HIV/AIDS
- Level of community's awareness about the disease since the programme implementation

- Current misconceptions about HIV/AIDS
- The role of CC on stigma and discrimination of the victims
- Presence of behavioural changes on HIV/AIDS due to the CC programme
- Roles of health extension workers as facilitators of the programme
- The role of coffee ceremony at each session. The interviews were tape-recorded with the participants' permission in order not to miss any information during the interviews

Data management and analysis

The audio-taped information was transcribed verbatim into Afan Oromo local language. The research team used Tesch's eight-step data analysis method [11] as follows:

- All the tape recorded was transcribed verbatim from the audio tape and were read through in order to get a sense of the whole and ideas were written down in the margin.
- The underlying meaning was identified in the individual interviews. Themes, categories and sub-categories that emerged were written down.
- A list of all categories that were identified from the data was clustered to make sense.
- These categories were used as codes.
- Descriptive wording for topics was found and turned into categories.
- The codes were put in alphabetical order.
- Data were grouped under different categories as codes and analysis was enhanced. The participants' direct quotes were used as units of analysis.
- Preliminary analysis was performed.

The investigators spent more than three weeks listening to the tape-recorded interviews. Once we were familiar with the data, we commenced transcribing the data verbatim. The transcribed data were then transferred to personal computer, to enable printing and electronic data storage. Different coloured highlighters were used to indicate codes and highlights on concepts. Clustered and merged concepts were then reduced to sub-themes. Finally, direct quotes from participants and narrations were reported as spoken by participants without editing the grammar to avoid missing of the meaning. Quotes that best described the various categories and expressed what was said frequently were chosen.

Ethical considerations

Ethical clearance was obtained from University of South Africa (UNISA), Health Studies Higher Degrees Committee, and College of Human Sciences. Permission was also obtained from the Oromia Regional Health, *Zonal*, *Woreda* and *Kebele* officials. The research team explained the purpose and nature of the study for each participant. Confidentiality of the participants was kept throughout the study. The participants signed informed consent forms after the moderator read the agreement verbally.

Results

Socio-demographic characteristics of the participants

A total of 22 participants from the three selected zones of Oromia regional state participated in the study. Of the participants, twelve were males and ten were females (Table 1). About eight participants were in the age group of 38-47 years old. Sixteen of the participants were farmers by occupation and ten of them were illiterate by education. Of the participants, more than half were involved in the community conversation programme for less than six months.

Socio-demographic variables		Study sites			
		North Shewa zone	Bale zone	Arsi zone	Total
Sex	Male	3	5	4	12
	Female	3	4	3	10
	Total	6	9	7	22
Age					
18 - 27 years		2	2	3	7
28 - 37 years		1	3	2	6
38 - 47 years		3	3	2	8
48 years and above		0	1	0	1
Total		6	9	7	22
Occupational status					
Farmer		2	7	7	16
Student		0	1	0	1
Civil servant		2	1	0	3
Own Business/self employed		2	0	0	2
Total		6	9	7	22
Educational status					
Illiterate		1	7	2	10
Primary		1	1	5	7
Secondary		2	1	0	3
Diploma		2	0	0	2
Total		6	9	7	22
Duration in CC as member					
Less than 6 months		4	7	2	13
6-12 months		0	0	1	1
More than a year		2	2	4	8
Total		6	9	7	22

Table 1: Socio-demographic characteristics of participants, Oromia, December 2013 (n = 22).

The facilitation of community conversations by skilled and trained facilitators, hearing and respecting different views, and creating a positive and welcoming environment are critical determinants of the outcome of the community conversation programme. People have different visions of life, perceptions of the world, and concerns and

interests. An effective response to the AIDS epidemic must be community driven, with each individual identifying, exploring and making decisions about what social change is needed.

The study covered the participants' experiences community conversation programme regarding HIV/AIDS awareness and beyond awareness. The aspects were divided under eight section:

- Schedule of the sessions,
- Availability of the community conversation programme,
- Awareness level on HIV/AIDS,
- Misconceptions about HIV/AIDS,
- Stigmatisation and discrimination of HIV/AIDS victims,
- Behavioural changes since the programme started,
- The role of health extension workers (HEWs) as facilitators, and
- The presence of the coffee ceremony.

Schedule for community conversation was decided by CC members

This refers to the identification of preferable days and time by the CC members through discussion. Taking into account their context made CC members interested in the programme. The participants selected the preferable days and time through discussion. The CC members preferred dates of holidays when they did not work and stayed at home, like "Gabri'el Day" (19th day of each month).

"Well, the community conversation programme schedule was selected through discussion with all the members initially and agreed on it to be on Gabri'el day. This is because, on this day every body of us will be free, no job (not allowable) so we can make our dialogue, even if among participants one came late, one to two birr (currency in Ethiopia) punishment is there and agreed up on it."

"Personally, I see the community conversation programme dialogue days and time as golden time. Look, the members were not tired of discussion, we selected the time for discussion by agreement, so we identify the time when most of the community conversation members become free, that is on holydays. Due to this, there is no absenteeism, so in general I can say our schedule is so comfortable for all the members."

"It is okay, we in this group are more of Orthodox Christians, and thus we are doing the discussion usually on holydays, because we do not work those days. This decision is after we have openly discussed with all of our members to select preferable days and time of our programme. Therefore, we all are happy with schedule of the programme."

Most of participants stated that the schedule for community conversation did not affect their working time because it is for a short period and early in the morning. The members also have their own rules and regulations especially when he or she came late during the session.

"I see it is very good. We are here at 7:30 am and discuss for not more than 30 minutes then back to our job, thus it does not have any effect on our work. The time of CC is very good and I am happy with it. Since the time is not more than half an hour, any time convenient for others is convenient for me."

"It is Friday, every two weeks. During the beginning, our CC members themselves selected and decided to be on Friday every morning from 7:30 – 8:00 am. If one of our members is late or misses the session, he or she will be punished by providing joke for the members and contribute some money."

Availability of CC programme was a remedy for resolving the issue of HIV/AIDS

Participants considered that availability of the CC programme itself is a way of resolving the issue of HIV/AIDS. The programme is an interactive process, which brings the community members to explore and address the underlying problems regarding HIV/AIDS. According to the participants:

"I want to say the CC is very important by itself; you know it is about health if no health what is next? Look death, because it is up to us to discuss our problems including the 'blind disease' (HIV/AIDS) and resolve or notify to higher officials; but there is gap on those health centre providers."

"The programme is very nice, because it is about health issues so you can live if you keep your health good. If not, everything becomes meaningless. If something may be in our body, it will be checked and known, and thus you can search for the remedy early and correct the situation for your lives. In my opinion, the CC programme should stay in community till the community takes it as culture."

Some of the participants thanked the government for providing the programme in their community. They think CC programme as a tool to solve their problems.

"I really first thank our government for helping us through undertaking this very important programme in our kebele, because it is very important. You know it is about health, about hygiene, about AIDS, in general and about our community's problems, then we can discuss these issues, develop knowledge and ability of managing the problems."

"Community conversation is a very, very important programme. So this is a good opportunity to grasp something from the programme, because we have dozens of problems. Particularly the problem of AIDS is real and we should catch up something about this disease from the discussions, then it is the individual who needs to decide whether to get into the fire or not. This is, in fact, a great donation of our government. I do not want to bypass thanking the government on behalf of our kebele."

Awareness about HIV/AIDS was increased due to CC programme

Most of the participants indicated that awareness of community on HIV/AIDS had increased due to CC implementation. For instance, the modes of HIV/AIDS transmission were identified as sexual intercourse, mother-to-child, and sharing sharp materials. The abstinence, deciding to stay one to one and condoms use were the method of HIV preventions explained by participants. The participants also described some of sign and symptoms of AIDS that they had learned through CC programme. Participants also related the risk of HIV transmission to alcohol consumption.

"This disease for sure is easy to prevent. If you stop going out, I mean be faithful to your wife, it cannot reach you. Very simple to practise, but if you do not have a wife you should abstain and search as much as you can for a wife. You should not cross the border of others."

" Some of our group members also say using 'festaali san'(condom) which means 'that plastic' is an option, but I personally do not agree with them, because if you going out you violate the relationship of your wife and your wife can go out like you and bring the disease, very offensive."

"AIDS is a bad disease, but if you do not go to it, it does not come to you. You know AIDS get into us through 'illegal sex', sharing sharp materials and during pregnancy to the child. The virus can stay in the body for long period of time then through time it dissolves the individual, there will be scabies, diarrhoea, cough, no work, and if no drug, it kills. This is what I have heard during our dialogue and I have seen this is true in fact, but if there is drug and good diet, no problem."

"Before CC came, we used to go to town and have some drinks 'tella' and 'areke' (local drinking alcohols) and then made illegal sex. Now we stopped it, because we should be one-to-one and stop this bad disease. You do not know who is with the disease initially; then it makes the individual thin, weak, coughing, swelling of the body, and then kills. But before this, we have to be checked every three months and stop sharing sharp materials."

"Thanks to CC programme because you know, we now know through our dialogue what you asked me, it is killer disease, it make individuals very thin and weak, they cough, they are unable to work, they become old, their body becomes full of wounds ..., so during this time we can help them and take them to health centre."

Misconceptions about HIV/AIDS were showed remarkable change due to CC

Some of participants do not know that pregnancy and female genital mutilation had any contribution to the transmission of HIV. While others stated the pandemic is a punishment from Creator (God) for those breaking the law.

"I heard about HIV/AIDS, when people were saying as it is transmitted by sexual intercourse, using sharp material together but, it is not transmitted from mother to child during pregnancy and no means of transmission while female genital mutilation practised, because it is a disease of those doing sinful activities, I mean prostitution."

"HIV/AIDS means it is a disease which kills somebody when he or she was infected. Look, Allah brought this ugly disease to punish us due to those who are involved in non-sense activities breaking his law, but it also reaches others, no question."

"It can be transmitted by sexual intercourse, after eating the meat of the chickens or other animals that swallowed the used 'laastiki sana' (condom) and even may be by sharing common spoon with infected people."

"What I know about HIV is; it is not bad disease for me rather good. You know why? That one is you who violate the law of our Creator (WAQAA/God), so we have to be punished. It is transmitted through sexual intercourse. Using condom is his or her right, but violates the law God."

Changes on stigma and discrimination of HIV/AIDS victims due to CC programme

HIV/AIDS stigma is either of real or perceived negative views to a person by individual, communities or society. It is characterised by rejection, exclusions, denial and discrediting, disregarding and social distances in the case of HIV/AIDS. These views basically resulted because members of community may lack awareness about HIV/AIDS. The lack of awareness can then lead people to develop negative views against those people affected by HIV/AIDS. The participants revealed that the level of stigma and discrimination had been decreased since the CC programme has been started.

"Before CC implementation, I thought those individuals caught by this blind disease were different from us and really I fear even to see them. Many of us leave them alone eating and abstain talking with them. But nowadays I and my family eat with these people, play and live with them without any fear, because I know how it can be transmitted."

"Okay, it catches you through sexual act, which is out of one-to-one (if one to one no problem)... So we have to avoid this. But if once caught by this disease he has to go to health institution and start drugs. But before this CC programme came to us, we did not know this. But now we can even tell to our friends and help them and their family, particularly the orphans, just like our children."

Behavioural changes due to CC encouraged the members to work more and more

There are behavioural changes seen in the community due community conversations. The CC members explained that some of the behavioural changes observed after the initiation of the programme encouraged the CC members to work more. These behavioural changes included avoiding or minimising alcohol consumption, avoiding or stopping going out with women other than their partners, and minimizing abduction in their *kebeles*.

"...Yes, previously as we were farmers, we go to town at least once per week and have drinks like 'arake' and 'tella' (local alcoholic drinks). This will put us stay till night, so we may search for even bar ladies, due to this, we may be exposed to this ugly disease. But nowadays no such behaviour among us, even we cross-check each other not to do this risky activity, and go back home before the sun goes down."

"I have seen some behavioural changes after this programme started. Before CC started in our kebele, people infected by this disease seemed to be different and we were even afraid to talk with them, but after CC we understood that the disease cannot be transmitted through talking, playing or eating together and thus no problem. Any social linkage between us can be kept okay. The other thing is that individuals with this disease can live as anyone he or she starts the drugs, so why discrimination? All these changes encouraged and show us to work more on this programme."

"Because of the CC programme there were many changes achieved. For example, before this programme all of us feared to be tested. But after we got awareness about HIV/AIDS through the CC programme - without any fear we were tested. Really this is the great change for our kebele and community.

"Also our community nowadays is in a position to protect themselves and their families from this fire disease. Look the previous time, I mean before CC, but now, no going out to others' wife because it is about to live or die, so no one plays on himself."

Role health extension workers as facilitators of CC

Most of participants reflected the devoted role of health extension workers throughout the whole CC programme implementation, however the expected contribution of other concerned bodies was almost nil according to the participants. The role of health extension workers as facilitators during CC is a critical to a fruitful result of programme and the way to move a community forward.

"No, no help. We have not seen anyone from health centre. This girl is the only person who helps us always. Due to her support we got a lot. For instance, together with health extension workers, we are helping weak people or diseased individuals, old age people by constructing their houses and latrines."

"These girls are our life, they are doing everything to their best, they are the motor of this programme, and they facilitate the programme, lead the discussion and motivate the participants for the discussion. Additionally, really going to each home, they teach our community the way for the community to live a better life. I have not seen anybody from health centre or woreda health, who gives us any support during our CC sessions except these girls."

"The extensions, I mean these girls are helping every aspect to strengthen our programme and they are teaching us about the community conversation programme. But, health professionals from woreda were not supervising even the programme. Maybe during other meetings they come and tell us something about community conversation."

Importance of coffee ceremony during CC session

Almost all participants explained that presence of the coffee ceremony during the CC was very important and increases members' interest, concentration and pleasure. According to the participants' view, the internal social and cultural coherence of society, the norms and values that govern interaction among members holds them together. The coffee ceremony was previously funded by the woreda health office, but had been stopped. In some cases, the money comes from members' contributions and also from members' punishments if they late or absent from the sessions.

"I am very happy with the presence of coffee ceremony during CC at the end of each session. This is very good, because it refreshes and increases our interest and concentration, so that every member can participate in the discussion. Look, it adds colour and pleasure to our programme thus no one gets absent, even may wait for the coming session by interest. In addition, the coffee ceremony is our cultural trait that really fits well with this programme, so we have to keep it up."

"Anyone can compare the sessions held before without coffee ceremony and with coffee ceremony. It is very interesting and everybody is eager to talk and contribute, because the ceremony really refreshes us. During that time our women even do not lose the sessions, you know, it is our culture. Let me ask you one question, what do you ask just when you reach home? No question, you will say coffee, coffee!"

Discussion

In this study, the participants indicated that the schedule for community conversation programme session was decided through discussion and agreement by the CC members. The participants select the most comfortable day and time outside of usual working, marketing and praying time. In general, the schedule was comfortable for all participants and thus made them happy with the programme. The study done in Sweden revealed that CC schedules differ depending on the local community conversation interests and norms [12]. This shows that the sessions have been scheduled to make it easier for some other local businesses to attend.

When planning a conversation sessions, it is important to consider participants' interest. For example, a conversation session held in the morning when individuals are likely to go to work in their fields will not be well patronised. It is important to be flexible with the programme according to the community's interest [13].This study found that the participants make the schedule for community conversation sessions as comfortable for them since it has been selected by discussing with all CC members.

In present study, the participants reflected that the community conversation programme enabled the community to accept accountability and responsibility for their issues. Most participants viewed that the availability of the CC programme in their kebeles as a remedy for resolving the issue of HIV/AIDS. This is in agreement with the study that the CC programme is a participatory approach based on the idea that people have the capacity, knowledge and resources to transform individually and collectively once they articulate, confront and own a particular social issue affecting their lives, including HIV/AIDS [14]. Thus this finding relates action based on the concerns and the current status that the community will make plans for how to achieve what they want to be in future.

The participants indicated that behavioural changes seen in their community since the commencement of the CC programme encouraged them to work more. After the community conversations started in their *kebeles* a number of behavioural changes were seen in the community. The changes were such as decreased stigma and discrimination of HIV/AIDS victims or their families, minimised exposure to risk factors that could result in the spread of HIV/AIDS such as alcohol consumption.

Since the community conversations, the participants had awareness about HIV/AIDS, mode of transmission and method of prevention, and were even in a position to help the victims in different ways. According to participants, before the CC came into action, individual infected by HIV/AIDS had blamed each other, even took to the jungle to be killed, just to hide the information, because they perceived by community as prostitutes or breakers of the law of Creator (God). But nowadays the community is in a position to help the victims due to the fact that CC had changed the perceptions towards HIV/AIDS.

Our finding is in line with other study which revealed that CC programme not only benefited and strengthened the home and community-based care programme but also decreased stigmatisation and discrimination against people living with HIV/AIDS [6]. Positive change was observed as a result of CC in attitude related to HIV and AIDS, and there was a commitment to improve community-level responses to HIV and AIDS. The programme also strengthened the sense of teamwork among the participants [6].

This study indicated that awareness level on HIV/AIDS and involving the community was bringing about behavioural changes even if a number of factors need revision and consideration. The participants indicated that HIV/AIDS awareness level increased due to the CC programme, especially about common manifestation of HIV/AIDS, mode of transmission and methods prevention. A local

response supports an integrated and coordinated awareness level of the CC members that may result in positive behavioural changes [2]. Improving HIV/AIDS awareness level decreases high risk behaviours, which fuel the spread of HIV/AIDS in the community [6]. This indicated that views towards HIV/AIDS victims had changed since the CC programme started. The participants indicated that everybody whether they seemed healthy or diseased should be screened in order to know their status.

In this study, participants' knowledge to describe common manifestations of HIV/AIDS indicated practical changes in the awareness level. However, there was some confusion on the stage at which the infection does not show any sign and symptoms that requires attention. The possible justification might be most of these manifestations need further clinical knowledge.

The participants were also able to describe the HIV mode of transmission as through sexual intercourse, sharing sharp materials, and from mother-to-child during pregnancy. The previous study revealed that the most common modes of HIV/AIDS transmission are having unsafe sex with someone who is HIV infected, sharing the same sharp materials, like needles, and from an infected mother to her child during pregnancy, delivery and breast feeding [15].

The participants indicated that methods of HIV/AIDS prevention included abstaining from sex until marriage, being faithful to one partner, and using condoms. However, some community members regarded the use of condoms as allowing illegal sex and violating the law of God (Allah) and thus did not accept it personally. This result goes with the study that although a wide array of proven prevention tools exist, existing prevention efforts suffer from several weaknesses. Prevention efforts to date have overwhelmingly focused on reducing individual risk, with fewer efforts made to address structural factors as well as socio-cultural, economic, political, legal and other contextual factors that increase vulnerability to HIV [16]. This might be suggested that identifying HIV/AIDS-related awareness gap at the community level relates to the element of CC making visible of their unexpressed concerns. This helps community to identify the most important concerns and how to address the concerns according to their priority.

Misconceptions about perceived mode of HIV/AIDS transmission, such as eating a chicken that had already eaten a contaminated condom and sharing a knife of infected individuals for cutting vegetables are still exist in some community members. This suggests that more effort is needed to work on misperception and increasing the awareness of the community. Survey in Afghanistan reported that correct information is the first step towards raising awareness and giving people the tools to protect them from infection. Misconceptions about HIV are common and can confuse people and hinder prevention efforts [17].

Despite improvements in HIV related knowledge, Ethiopia continues to lag behind its neighbours in HIV knowledge. More than 70% of women in Kenya, Rwanda, Tanzania, and Uganda know the two major methods for preventing HIV compared to only 43% in Ethiopia [18]. According to the Ethiopian Demographic and Health Survey in 2011, the level of misconceptions has been decreased compared with 2005 survey, but still about one-thirds of women and one-fifths of men age 15-49 do not know that a healthy-looking person can be infected with HIV. About half women and two third of men in Ethiopia, incorrectly believe that HIV can be transmitted by mosquito bites [18]. This study found that identifying misconceptions about HIV/AIDS was among the concerns of the community that need to be cleared by means of the community conversation.

In our study, the level of stigma and discrimination about HIV/AIDS victims and their family had radically decreased since the beginning of CC programme in participants' respective kebeles. In Ethiopia HIV/AIDS related stigma and discrimination persists [18]. Eighty two percent of women and ninety two percent of men said that they would be willing to take care of a family member with AIDS in their own home. Only thirty two percent of women and forty seven percent of men reported that they would buy fresh vegetables from a shopkeeper who has the HIV/AIDS virus [18].

Stigma is a complex, diverse and deeply rooted phenomenon that is dynamic in different cultural settings. As a collective social process rather than a mere reflection of an individual's subjective behaviour, it operates by producing and reproducing social structures of power, hierarchy, class and exclusion, and by transforming difference into inequality [19]. Stigma remains the single most important barrier to public action. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions [20]. This finding indicates that awareness creation through CC specifically on mode of HIV transmission played significant role on stigma and discrimination reduction.

Health extension workers (facilitators) were dedicated and committed to the CC programme and found this highly encouraging them. Health extension workers are knowledgeable and skilled facilitators who understand the socio-cultural, individual and collective forces in the community during community conversation activities. Presence of coffee ceremony during CC sessions increases members' concentration and interest. The coffee ceremony was a cultural value and for this reason members came early and even waited for the next session with interest. The ceremony is an integral part of their social and cultural life. An invitation to attend a coffee ceremony is considered as a mark of friendship or respect. This indicates that the ceremony during CC programme is very important because it is considered as the community's cultural value and thus a good opportunity to enter in the community easily.

Limitations of the study

In interpreting these findings, there are limitations with the study design that might affect the conclusions drawn. First, the purposive sampling may be biased by including participants who are more comfortable talking about HIV/AIDS issues. Second, other acknowledgeable limitations associated with the use of qualitative method, the result may not be automatically transferred to other countries with different cultural contexts. Third, we want to emphasise that we by no means seek to make claims about linear or causal pathways from community conversations to behaviour change. Our aim has been a more limited to show that conversations can indeed provide social spaces that could be implemented by local people using existing community resources. Furthermore, we are not seeking to make any claims about whether such strategies may or may not be implemented following the conversation. The strength of this study lies in its richness of data, including community conversation members, which ensured adequate data triangulation.

Conclusions

Community conversations stems from their creation of social spaces for dialogue, which enables rural community to engage in critical thinking. Our study shows that community conversation creates social space for people to reflect on the possibility of more effective response to HIV. The programme takes place within a wider social, political and economic context that played a major role in response to HIV. In this process CC programme is a powerful mechanism to break the silence about the recent past ant to create new possibilities. Furthermore this study show that CC served as the main source of information and knowledge about HIV/AIDS and other issues of their areas. Due to their participation on the CC programme, some participants stopped marginalizing people living with HIV/AIDS; others change their misconceptions about ways of transmission and started to eat with HIV infected peoples. Some behavioural changes seen in the community like having multiple sexual partners and still others started to talk about HIV related topics without fear. The fact that participants started discussing collective problems, sharing information and solving problems on their own level leads to the decision that the CCs empowered some people. However, efforts are needed for continuous monitoring and evaluation or process evaluation of the CC activities will help to identify the major weaknesses and strength of the programme. Use of strengths and working on challenges will improve the effectiveness of CC programme in response to HIV/AIDS.

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Competing interests

The authors declare that they have no competing interests.

Authors' contribution

JKE carried out the conception and designing of the study and performed analysis. BLD participated in designing the study, analysis and in reviewing and editing the final draft of the paper. TB was involved in the conception, design, and analysis and drafted the manuscript. MK participated in designing the study, data collection and in reviewing and editing the final draft of the paper. All authors read and approved the manuscript.

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